Board of Directors

27 February 2019, 12:00 to 16:00
Boardroom, Trust HQ, Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN

Agenda

1. Chair and quorum

Information

Robert Armstrong

2. Apologies for absence

Information

Robert Armstrong

3. Declarations of interest

Information

Robert Armstrong

4. Minutes of previous meeting

2 minutes

Approval

Robert Armstrong

Minutes - P1 board - Jan 2019.pdf (8 pages)

5. Patient experience video

8 minutes

Discussion

Pauline Law

6. Chair and Chief Executive's report

5 minutes

(To follow)

Information

R Armstrong/A Foster

7. Assurance and governance

65 minutes

7.1. Committee chairs' reports

Information

Comittee Chairs

- IM&T Strategy Committee, 5 Feb 2019, Chair: L Lobley
- Audit Committee, 6 Feb 2019, Chair: I Haythornthwaite
- Workforce Committee away day, 12 Feb 2019, Chair: L Lobley
- Quality and Safety Committee, 13 Feb 2019, Chair: T Warne
- Finance & Perf. Committee, 27 Feb 2019, Chair: M Guymer

7.2. Performance report

Discussion

P Law/M Fleming/S Arya

Trust Board Performance Report January 2019.pdf (18 pages)

7.3. Financial position as at 31 January 2019

Discussion

Ged Murphy

Finance report.pdf (6 pages)

7.4. Safe staffing report

Discussion

Pauline Law

Safe staffing report.pdf (12 pages)

7.5. Board assurance framework

Approval

Robert Armstrong

BAF Patients - Feb 2019.pdf (2 pages)

BAF People - Feb 2019.pdf (3 pages)

BAF - Performance - Feb 2019.pdf (2 pages)

8. Items for approval

8.1. Seven day service assurance

Approval

Sanjay Arya

Seven day service assurance.pdf (8 pages)

8.2. Committee terms of reference

Approval

Paul Howard

Committee terms of reference.pdf (2 pages)

Audit TofR 2019.pdf (6 pages)

F&P ToR 2019.pdf (3 pages)

IM&TSC ToR 2019.pdf (3 pages)

Q&S ToR 2019.pdf (5 pages)

8.3. Board cycle of business 2019-20

Approval

Paul Howard

Cycle of business 2019-20.pdf (4 pages)

8.4. Appointment of Senior Independent Director

Approval

Robert Armstrong

Appointment of SID.pdf (1 pages)

8.5. Changes to Standing Financial Instructions

Approval

Ged Murphy

Standing Financial Instructions.pdf (5 pages)

SFI 2018-19 Jan change.pdf (51 pages)

9. Identification of key risks and successes

Discussion

Robert Armstrong

10. Questions from the public

Discussion

Robert Armstrong

11. Resolution to exclude the press and public

Approval

Robert Armstrong

12. Date, time and venue of next meeting

27 March 2019, 9.30am, THQ Boardroom

Information

Robert Armstrong

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

HELD ON 30 JANUARY 2019, 12.00 NOON

AT MACDONALD KILHEY COURT HOTEL, CHORLEY ROAD, STANDISH, WIGAN, WN1 2XN

Members' attendance record:		**25/04/2018**	**30/05/2018**	**27/06/2018**	**25/07/2018**	**26/09/2018**	**31/10/2018**	**28/11/2018**	**19/12/2018**	**30/01/2019**	**27/02/2019**	**27/03/2019**
Mr R Armstrong	Chair (in the Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Dr S Arya	Medical Director	✓	✓	✓	✓	✓	A	✓	✓	✓		
Mrs A Balson	Director of Workforce	✓	A	✓	✓	✓	✓	✓	✓	✓		
Mr N Campbell	Non-Executive Director	✓	✓	✓	A	---	---	---	---	---		
Dr S Elliot	Non-Executive Director	✓	✓	✓	✓	✓	A	✓	✓	A		
Mrs M Fleming	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Mr R Forster	Director of Finance and Informatics	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Mr A Foster	Chief Executive	✓	✓	✓	✓	✓	✓	✓	A	✓		
Mr M Guymer	Non-Executive Director	✓	✓	A	✓	✓	✓	✓	✓	✓		
Mr I Haythornthwaite	Non-Executive Director	✓	✓	✓	✓	✓	A	✓	✓	✓		
Mrs C Hudson	Non-Executive Director	✓	✓	✓	✓	✓	✓	---	---	---		
Mrs L Lobley	Non-Executive Director	✓	✓	✓	A	✓	✓	✓	✓	✓		
Mrs P Law	Director of Nursing	A	✓	✓	✓	✓	✓	✓	✓	✓		
Mr R Mundon	Director of Strategy and Planning	✓	✓	✓	✓	✓	✓	A	✓	✓		
Prof T Warne	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓		

In attendance:

Dr A Abbasi	Divisional Medical Director (Medicine)
Miss C Alexander	Director of Governance
Mrs N Guymer	Deputy Company Secretary
Mr P Howard	Company Secretary and Data Protection Officer

2 members of the public and 1 governor were also in attendance.

1/19 Chair and quorum

Mr R Armstrong took the chair and noted that due notice had been given to all directors and that a quorum was present. He therefore declared the meeting duly convened and constituted.

2/19 Apologies for absence

Apologies for absence were received as shown in the members' attendance record, above.

3/19 Declarations of interest

No directors declared an interest in any of the items of business to be transacted.

4/19 Minutes of the previous meeting

The minutes of the previous meeting held on 19 December 2018 were **APPROVED** as a true and accurate record. Note was made of the fact that all actions shown on the action log had been completed.

5/19 Patient experience video

The Director of Nursing introduced the monthly patient experience video, which this month introduced the board to the experiences of an elderly gentleman and the associated discharge process, as read by his brother.

In discussing the patient's experience, the board noted that the matters described within the story were not an isolated occurrence and the Chief Operating Officer agreed to use the video at the next multi-agency discharge event to promote discussion and to highlight the issues with the senior leadership team across the borough.

ACTION: Chief Operating Officer

Particular note was made of the need to challenge nursing and residential homes that refuse to allow patients to return, and the board noted the need for community services to be available to patients in residential accommodation.

The Director of Nursing commented that significant work is being undertaken by the local council with homes in the area to educate the staff and to ensure that residential clients are able to remain in their own homes as much as possible.

The Chair also noted the lessons that could be learned within the foundation trust and the Chief Operating Officer commented that she had found the video to be powerful and noted that the patient's story had encouraged her to give appropriate challenge to partner organisations in future scenarios. It was agreed that it would be beneficial for the video to be shown at the beginning of the next Secondary Care Transformation Board, as representatives from all partner organisations would be in attendance.

ACTION: Company Secretary (to schedule)

The board received the patient story and noted the content.

6/19 Chair and Chief Executive's report

The Chief Executive presented a report which had been circulated in advance of the meeting to update the board on the foundation trust's in-month performance against the key operational and quality metrics. He noted that performance against the majority of

operational metrics remained strong but highlighted the impact that sustained levels of high activity have on staff. As a result, monthly staff meetings had been reinstated in order to ensure that the organisation is responsive to any concerns and confirmation was provided that best practice from across Greater Manchester is being reviewed to identify further ways of supporting staff.

Dr Abbasi noted that the most effective way of reducing the burden on staff would be to avoid the need for escalation through improvements in patient flow, however the board acknowledged that such improvements are not entirely within the foundation trust's gift and that significant work with partner organisations is ongoing to try and reduce demand on the organisation. The Chief Executive advised that he had attended an accountability teleconference in the previous week and confirmed that the levels of demand had been identified as an area of challenge. He also reminded the board that the foundation trust's request for additional capital funding to extend the Accident and Emergency Department and to increase the hospital's bed base, whilst supported by Greater Manchester, had ultimately been unsuccessful. The Chair noted that this investment would have been the single most beneficial way of improving patient flow and the board confirmed that it remained committed to pursuing such investment in the future.

The Chief Executive also informed the board that, in response to the request that had been submitted, the Care Quality Commission had agreed to defer the forthcoming inspection of the foundation trust. The rationale for seeking this deferral surrounded the fact that the organisation is currently focused on progressing the transfer of Wigan-based community services from Bridgewater Community Healthcare NHS Foundation Trust and also due to the impending retirement of the Director of Nursing. With regard to this latter point, the Chief Executive confirmed that recruitment for a successor, under the revised job title of Chief Nurse, had commenced and that Mrs Law had agreed to being employed on a part-time basis to provide continuity until the new Chief Nurse has taken up post.

The Chair took the opportunity to update the board on the two non-executive director vacancies that had arisen as a result of the unexpected deaths of the previous post holders. He noted that the Council of Governors had supported the appointment of a non-executive director with community services experience if the proposed transfer of community services takes place. As no decision on this will be taken until around March 2019, the Chair was minded to suggest that the Council of Governors considers appointing an interim non-executive director for a short period of time. The board endorsed this approach and therefore the Chair agreed to formally suggest it to the Council of Governors through its Nomination and Remuneration Committee.

ACTION: Chair

The board received the report and noted the content.

7/19 Performance report

The Director of Nursing opened by summarising the highlights and lowlights of the clinical metrics; echoing the Chief Executive's earlier comments around the infection control metrics and drawing the board's attention to the low level of avoidable harms. With regard to the lowlights within the report, she drew the board's particular attention to the

ward closures that had been necessary as a result of norovirus and flu. She assured the board that a review of infection control practices had been undertaken to ensure that ward closures are avoided wherever possible.

The Chief Operating Officer highlighted the foundation trust's performance against the 18-week referral-to-treatment standard, however noted that it is becoming increasingly difficult to balance scheduled and unscheduled care demand. In terms of lowlights, the Chief Operating Officer drew the board's attention to the higher number of cancellations which had mainly been on the acute site and had partly been driven by ward closures and through patient choice.

With regard to unscheduled care performance, the board noted that there had been no significant changes since the previous board meeting and noted that all other quality standards, such as delayed transfers of care and the number of stranded and super stranded patients, perform well which indicates that the issues being experienced are primarily demand-driven.

The Medical Director delivered a short presentation to outline the foundation trust's performance in relation to mortality and the board acknowledged the importance of dying patients being given the opportunity to die with dignity in the home environment if they wish to do so. Prof Warne commented that the Quality and Safety Committee had recently considered the issue of end of life care and had been impressed by the way that the matter is being addressed. He particularly commended the notion of ensuring prescribing is relevant and appropriate, rather than a response to a situation.

The board received the performance report and noted the content.

8/19 Reports of Committee Chairs

The board received verbal reports from the following committees which had met since the previous meeting of the board:

(a) Quality and Safety Committee, held on 16 January 2019; and

(b) Finance and Performance Committee, held immediately before the meeting.

Prof Warne provided an overview of the Quality and Safety Committee and noted the development of a quality dashboard in the Division of Medicine, which provided assurance around performance against a number of quality metrics and allowed a number of quality initiatives to be shared more widely. The Committee had, however, noted the reporting of three incidents to the Strategic Executive Information System since its last meeting; one of which had been categorised as a never event. He confirmed that a comprehensive review of all never events had been undertaken and the committee had noted the intention to seek an external review to ensure that the organisation can identify lessons learned and share these across the organisation. An amber delivery confidence against the board assurance framework for patients was reported.

With regard to the Finance and Performance Committee meeting, Mr Guymer noted that the committee had reviewed a number of items but reminded the board that a number of significant topics had also been discussed by the board at its away day earlier in the week. The committee meeting had therefore built on the discussions held at the away

day and noted the requirement for draft financial plans to be submitted to the regulator in the near future. An amber-green delivery confidence for the board assurance framework relating to performance was reported, and Mr Guymer clarified that this was due to the fact that the vast majority of operational and financial metrics within the weighted dashboard were performing well, with only the Accident and Emergency 4-hour standard significantly away from the target. He also noted that there was a pathway to the achievement of the control total by year-end.

The committee had also noted the requirement for the foundation trust to determine whether or not to accept the proposed control total. In considering its recommendation to the board on this issue, the committee had noted that there was not yet sufficient information available to allow it to formulate a firm recommendation either way. The committee had therefore agreed that its recommendation to the board would be that authority to accept the control total or otherwise should be delegated to the Director of Finance, who would be able to take a holistic view once all information is available. The board considered this recommendation and **APPROVED** the delegation of authority to accept the proposed control total or otherwise to the Director of Finance.

The board received and noted the verbal updates.

9/19 Financial position as at 31 December 2018

The Director of Finance presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at 31 December 2018. He confirmed that the foundation trust had delivered its intended Q3 performance and therefore had received the Provider Sustainability Funding of £1.7m for the financial position and an additional 30% for its Accident and Emergency performance. The board extended its thanks to all who have contributed to the achievement of these results.

The Director of Finance cautioned that the final quarter of the year would be challenging to deliver but advised that work is ongoing with partner organisations to address this at an early stage. The potential for a commercial opportunity on the Leigh Infirmary site was also noted.

The board received the report and noted the content.

10/19 Board assurance framework

The board had previously received updates from the Committee Chairs on the board assurance frameworks for patients and performance.

With regard to the board assurance framework relating to partnerships, the Chair noted the delay in progressing the theatre pilot with Bolton NHS Foundation Trust and recent feedback on wider initiatives across Greater Manchester. An amber-red delivery confidence was therefore reported.

Mrs Lobley noted that there had been little change to the board assurance framework relating to people since the previous meeting of the board, and noted that the delivery confidence remained at amber-red. This was due to continued recruitment issues around the nursing workforce and the ongoing issues with staff morale as a result of the industrial relations issues during the previous year. The Chair noted that the Workforce Committee

would be reviewing matters in more detail at its next meeting and noted the importance of the committee seeking assurances on behalf of the board.

The board **APPROVED** the board assurance frameworks as presented.

11/19 Safe staffing report

The Director of Nursing presented the regular safe staffing report which provides a summary of staffing levels on all in-patient wards across the foundation trust. The report also included exception reports surrounding staffing levels, related incidents and red flags which are triangulated with a range of quality indicators.

The Director of Nursing noted that a good fill level was reported but caveated this by noting the fact that there had been a number of areas escalated over the previous month which served to reduce staffing, as staff are necessarily redeployed to cover the escalated areas. She noted that four areas of the organisation are currently piloting a safe care module on the electronic roster system which reviews patient acuity and turnover to determine how many registered nurses are required in order to provide safe care to the patients.

The Director of Workforce noted the impact the operating with continued escalation has on staff and the reluctance of staff to accept additional shifts because they do not want to work across different areas. The Chair noted the issues and requested that the assurances surrounding staff resilience be sought through the Workforce Committee.

ACTION: Workforce Committee

The board received the report and noted the content.

12/19 European Union exit preparations

The Chief Operating Officer presented a report which had been circulated with the agenda for information. The board acknowledged the publication of recent operational readiness guidance from the Department of Health and Social Care and noted that the Chief Operating Officer had been appointed as the foundation trust's Senior Responsible Officer for preparing for the impact of a "no deal" exit of the United Kingdom from the European Union. The board also noted the work that is ongoing within the organisation and across the borough, as outlined within the report.

The Chair requested that the report be shared with the Council of Governors for information.

ACTION: Company Secretary

The board received the report and noted the content.

13/19 Identification of key risks and successes/opportunities

The board identified the key risks as follows:

- Lack of capital funding to provide additional beds and to expand the Accident and Emergency Department, noting that it is intended to continue to lobby on this issue and to avoid any requirement to undertake a further bed review;
- The challenging Q4 financial position, noting that work is ongoing to address this; and
- Never events, noting that the board is aware of the incidents and the matter is being monitored through the Quality and Safety Committee.

The board identified the key successes/opportunities as follows:

- The ability to influence end of life care and the ability to ensure that patients are able to die with dignity in the home environment where appropriate;
- The continued reduction in the foundation trust's Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio; and
- The prospect of receiving Provider Sustainability Funding and the ability to determine whether to accept the proposed control total.

14/19 Questions from the public

There were no questions from the public.

15/19 Resolution to exclude the press and public

The board resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted.

16/19 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on 27 February 2019, 12 noon, at Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
30 Jan 2019	5/19	Patient experience video	Raise the issues in the video at the next multi-agency discharge event.	Chief Operating Officer	ASAP	Shared with the borough's senior leadership team. **Action complete.**
30 Jan 2019	5/19	Patient experience video	Include video on the agenda of the next Secondary Care Transformation Board.	Company Secretary	March 2019	Added to the agenda. **Action complete.**
30 Jan 2019	6/19	Chair and Chief Executive's report	Liaise with the Council of Governors around the potential use of an interim non-executive director	Chair	ASAP	Nominations and Remuneration Committee meeting held on 11 Feb 2019. **Action complete.**
30 Jan 2019	11/19	Safe staffing report	Seek assurances around the issue of staff resilience in times of prolonged escalation	Workforce Committee Chair (Mrs Lobley)	March	To be added to the next committee agenda in March 2019.
30 Jan 2019	12/19	European Union exit preparations	Share the report with the Council of Governors for information	Company Secretary	ASAP	Paper shared. **Action complete.**

Chief Executive's Report 26 February 2019

PART ONE

PERFORMANCE

February A&E performance is better than January but with just 69% achieving the 4-hour standard for Type 1, it is only a little better than January's 64%. The figure for all types is 79% compared to 75% in January. The underlying factors remain much higher volumes of attendances (up about 15% for the calendar year to date), higher acuity at this time of year and the lowest bed base in GM. Staff have also suffered sickness absence and have been under considerable pressure. On the positive side we continue to have one of the lowest delayed discharge rates in the country and we have relatively low numbers of long stay patients compared to other Trusts. Our on-site primary care centre performs very well and the GP Out of Hours service has now relocated into the Christopher Home.

GM as a whole is performing less well than the country and this has now resulted in regulatory intervention. There was a teleconference between senior NHSI figures and GM Chief Executives on 4th February followed by a UEC Summit in Manchester on 14th February. These events both expressed dismay at GM performance and showcased best practice, notably in Tameside with requests that other GM localities make renewed efforts to improve. We are indeed, implementing some of the Tameside Care Home technology solutions and would like to also emulate their high involvement of primary care in tackling the issues.

As far as I know, we continue to meet other major targets.

QUALITY

There have been no cases of C Diff so far in February leaving our year to date total at 7. At the end of February last year we had already reached 24 cases.

The most up to date HSMR figure is 78.1 for October taking our year to date figure to 96.8. We have no new SHMI data.

Deaths in hospital to the end of January were 978; this is 142 less than the first ten months of 2017/18.

Andrew Foster 26 February 2018

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Board Performance Report

January 2019

Your hospitals, your health, our priority

Performance:
We aim to be in the top 10%

NHS Wrightington, Wigan and Leigh NHS Foundation Trust

Group	ID	Measure	Period Covered	Date Last Updated	National Top 10%	Performance	Percentile	Rank / Trusts
Safe	1	Hospital Standardised Mortality Ratios (HSMR)	AUG-18 - OCT-18	14/02/19	Yes	90.18	9.30%	13/130
Safe	2	Summary Hospital-level Mortality Indicator (SHMI)	JUL-17 - JUN-18	14/01/19	No	111.87	86.82%	113/130
Safe	3	Safety Thermometer / Harm Free Performance	JAN-19	14/02/19	No	92.49%	74.55%	83/111
Safe	4	Cancer 2 Week Wait Performance	DEC-18	14/02/19	No	95.50%	44.70%	60/133
Safe	5	18 Week Incomplete Referral To Treatment (RTT) Performance	DEC-18	14/02/19	No	92.55%	13.18%	18/130
Safe	6	Patient-led assessments of the care environment (PLACE)	JAN-18 - DEC-18	26/09/18	Yes	0.98%	0.74%	2/136
Effective	7	Accident & Emergency 4 Hour Wait Performance	JAN-19	14/02/19	No	60.18%	93.94%	125/133
Effective	8	Diagnostic 6 Week Wait Performance	DEC-18	14/02/19	No	0.74%	30.30%	41/133
Caring	10	Friends & Family Assessment Result	DEC-18	14/02/19	No	95.40%	42.75%	57/132
Caring	11	National Patient Survey Result	JAN-17 - DEC-17	19/07/18	No	0.84	14.93%	21/135

Top 10 %	Top 25 %	Top 50 %
2	2	3

Bottom 50 %	Bottom 25 %	Bottom 10%
1	1	1

*Please note that the Safety Thermometer data includes non-hospital acquired harms.

Top 5 Performing Metrics

1: Patient-led assessments of the care environment (PLACE) - (Rank : 2)

2: Hospital Standardised Mortality Ratios (HSMR) - (Rank : 13)

3: 18 Week Incomplete Referral To Treatment (RTT) Performance - (Rank : 18)

4: National Patient Survey Result - (Rank : 21)

5: Diagnostic 6 Week Wait Performance - (Rank : 41)

Bottom 5 Performing Metrics

1: Accident & Emergency 4 Hour Wait Performance - (Rank : 125)

2: Summary Hospital-level Mortality Indicator (SHMI) - (Rank : 113)

3: Safety Thermometer / Harm Free Performance - (Rank : 83)

4: Cancer 2 Week Wait Performance - (Rank : 60)

5: Friends & Family Assessment Result - (Rank : 57)

Local Trust Positions

Provider	GM Rank	North Rank	National Rank
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1/7	12/44	26/136
BOLTON NHS FOUNDATION TRUST	2/7	14/44	28/136
SALFORD ROYAL NHS FOUNDATION TRUST	3/7	16/44	41/136
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	4/7	19/44	49/136
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	5/7	21/44	56/136
STOCKPORT NHS FOUNDATION TRUST	6/7	31/44	94/136
PENNINE ACUTE HOSPITALS NHS TRUST	7/7	44/44	132/136

About the Trust

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) is a major acute Trust serving the people of the Borough of Wigan a population of over 300,000.

The Trust employs approximately 5,000 members of staff, all of whom play their part in delivering high quality, safe and effective patient care from the following facilities:

Royal Albert Edward Infirmary – our main district general hospital site, located in central Wigan, that hosts our Accident and Emergency Department

Wrightington Hospital – a specialist centre of orthopaedic excellence

Leigh Infirmary – an outpatient, diagnostic and treatment centre

Thomas Linacre Centre – a dedicated outpatient centre in central Wigan

About the Report

This report is designed to provide a clear insight into the Quality & Performance of the Trusts services.

We hope you find the report intuitive however please fell free to send any queries to BI.Performance@wwl.nhs.uk who will be more that happy to help.

Key Contacts

Chief Executive	Andrew Foster
Deputy Chief Executive & Director of Finance	Rob Forster
Director of Operations & Performance	Mary Fleming
Director of Nursing	Pauline Law
Director of Strategy & Planning	Richard Mundon
Director of Workforce	Alison Balson
Medical Director	Sanjay Arya

Report Considerations

Provisional Positions (based on information still being validated)

VTE, Total Pay vs Budget, Clinical & Non Clinical Vacancy Rate and Cancer

Other

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Executive Summary (January 2019)

Objective	Pages	No Metrics	Green Metrics	Amber Metrics	Red Metrics	Total Metrics
1.1 : Harm Free	4	3	4	0	3	10
1.2 : Harm Free - Infections	5	2	6	0	2	10
2 : Mortality	6	4	3	1	1	9
3.1 : Access	7	1	4	0	1	6
3.2 : Access - Cancer	8	1	7	0	0	8
3.3 : Access - Tumour Pathways	9	0	7	0	2	9
3.4 : Access - A&E	10	10	0	0	1	11
4.1 : Productivity - Part 1	11	5	1	0	3	9
4.2 : Productivity - Part 2	12	0	0	0	4	4
5.1 : Midwifery - Part 1	13	1	5	0	5	11
5.2 : Midwifery - Part 2	14	1	5	0	4	10
6.1 : Patient Experience - Part 1	15	1	7	0	2	10
6.2 : Patient Experience - Part 2	16	0	4	1	0	5
7 : Workforce	17	0	1	5	3	9
NHSI	18	1	8	0	1	10
Total		**30**	**62**	**7**	**32**	**131**

* Summary based on latest available data ~ RAG based on whether actual is achieving target

Highlights

HSMR and SHMI continue to show a downward trend. Infection rates remain low. Achievement of the 18 Weeks, Diagnostic and Cancer targets. Reduction in the Outpatient Follow-up Waiting List.

Lowlights

1 Orthopaedic Never Event. 9 incidents submitted to StEIS, 3 of which were related to ward closures due to infections. 1 MRSA bacteraemia. Drop in Theatre Effectiveness. Failed the Stroke 90% Stay target. Continued pressures within A&E.

Month

18 Weeks: Incomplete

Target: 92.0%

Cancer 62 Day: GP Referral

Target: 85.0%

Diagnostics: 6 Weeks

Target: 99.0%

A&E: 4 Hour Target

Target: 95.0%

Year to Date

C. Difficile Infections

YTD Target: 15

Serious Falls

FY Target: 0

Never Events

FY Target: 0

MRSA

FY Target: 0

1.1 : Harm Free

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Harms: Total	**	84	Jan-19		↑	68	Dec-18	723			57	90	Jan-18 to Jan-19
Serious Harms: Total	**	5	Jan-19		↑	4	Dec-18	51			3	8	Jan-18 to Jan-19
Serious Harms: Number of Never Events	<= 0	1	Jan-19	🔴	↑	0	Dec-18	5	🔴		0	2	Jan-18 to Jan-19
Serious Harms: Number of Serious Falls	<= 0	0	Jan-19	🟢	→	0	Dec-18	6	🔴		0	2	Jan-18 to Jan-19
Serious Harms: Grade 3-4 Pressure Ulcers	**	0	Jan-19	🟢	→	0	Dec-18	2			0	1	Jan-18 to Jan-19
Number of Serious Incidents	<= 0	9	Jan-19	🔴	↑	0	Dec-18	32	🔴		0	9	Jan-18 to Jan-19
Mod/Low Harms: Hospital Acquired Pressure Ulcer Grade 2	**	1	Jan-19		↑	0	Dec-18	16			0	4	Jan-18 to Jan-19
Mod/Low Harms: Number of Moderate Falls	<= 0	3	Jan-19	🔴	→	3	Dec-18	18	🔴		0	3	Jan-18 to Jan-19
Mod/Low Harms: Safety Thermometer	>= 95.0%	98.55%	Jan-19	🟢	↓	99.50%	Dec-18	98.68%	🟢		96.68%	99.75%	Feb-18 to Jan-19
Mod/Low Harms: Settled Clinical Litigation Cases	**	3	Jan-19		→	3	Dec-18	31			2	5	Jan-18 to Jan-19
Mod/Low Harms: VTE Assessments (% of Admissions)	>= 95.0%	96.08%	Jan-19	🟢	↓	96.21%	Dec-18	96.99%	🟢		85.41%	97.90%	Jan-18 to Jan-19

Commentary (Page Owner : Director of Nursing)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

In January 2019, the Trust has uploaded nine incidents to StEIS, one of which was a Never Event. Three of the incidents related to ward closures due to infections, with the closures being undertaken to safeguard patients. These incidents become StEIS reportable when beds are empty for over 24 hours, thereby having an adverse effect on flow. Nine incidents is a large number of incidents for one month, although by way of comparison, seven incidents were uploaded in January 2018. In relation to Never Events, NHSI has agreed to review our Never Events and the Director of Governance is liaising with them to arrange this. The Safety Thermometer percentage of patients receiving harm free care in hospital for January 2019 was 98.55%.

1.2 : Harm Free - Infections

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Infections/Bacteraemias: Total	**	5	Jan-19		↓	6	Dec-18	54			2	10	Jan-18 to Jan-19
Serious Harms: Infections: Clostridium Difficile	<= 1	0	Jan-19	●	→	0	Dec-18	7	●		0	4	Jan-18 to Jan-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	<= 0	0	Jan-19	●	→	0	Dec-18	1	●		0	1	Jan-18 to Jan-19
Serious Harms: Infections: Ventilator Acquired Pneumonia	<= 0	0	Dec-18	●	→	0	Nov-18	0	●		0	0	Jan-18 to Dec-18
Infections: Catheter Associated Urinary Tract	<= 0	1	Jan-19	●	↑	0	Dec-18	6	●		0	2	Feb-18 to Jan-19
Serious Harms: Bacteraemias: MRSA	<= 0	1	Jan-19	●	↑	0	Dec-18	2	●		0	1	Jan-18 to Jan-19
Serious Harms: Bacteraemias: MRSA - Avoidable Cases	**	0	Jan-19	●	→	0	Dec-18	0	●		0	0	Jan-18 to Jan-19
Serious Harms: Bacteraemias: MSSA	**	1	Jan-19		→	1	Dec-18	13			0	3	Jan-18 to Jan-19
Serious Harms: Bacteraemias: E-coli	**	2	Jan-19		↓	3	Dec-18	16			0	3	Jan-18 to Jan-19
Bacteraemias: Klebsiella	**	0	Jan-19	●	↓	1	Dec-18	7			0	2	Jan-18 to Jan-19
Bacteraemias: Pseudomonas	**	0	Jan-19	●	↓	1	Dec-18	3			0	3	Jan-18 to Jan-19

Commentary (Page Owner : Director of Nursing)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

One MRSA Bacteraemia is currently under investigation but is likely to be ascribed to WWL. No inpatient Clostridium Difficile cases, with year to date total remaining at 7 cases. Other organisms remaining at low numbers.

2 : Mortality

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Number of Hospital Deaths	**	127	Jan-19		↑	118	Dec-18	980			81	136	Jan-18 to Jan-19
Hospital Crude Death Rate	**	1.77%	Jan-19		↓	1.79%	Dec-18	1.37%			1.10%	1.84%	Jan-18 to Jan-19
PFD Coroner Notifications	**	0	Jan-19	●	→	0	Dec-18	0	●		0	0	Jan-18 to Jan-19
Deaths after Readmission	**	27	Jan-19		↓	38	Dec-18	307			25	43	Jan-18 to Jan-19
HSMR (Latest Month)	<= 90	78.1	Oct-18	●	↓	83.3	Sep-18	N/A			78.1	123.6	Apr-17 to Oct-18
HSMR (Latest YTD)	*	96.8	Oct-18		↓	99.3	Sep-18	N/A			96.8	103.1	Dec-17 to Oct-18
HSMR Weekday	<= 90	70.8	Oct-18	●	↓	82.3	Sep-18	N/A			70.8	121.2	Apr-17 to Oct-18
HSMR Weekend	<= 90	96.7	Oct-18	●	↑	86.0	Sep-18	N/A			74.3	162.1	Apr-17 to Oct-18
SHMI (Rolling 12 Months)	<= 90.0	110.3	Sep-18	●	↓	111.9	Jun-18	N/A			110.3	122.2	Dec-16 to Sep-18

Commentary (Page Owner : Medical Director)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Both indicators of mortality (HSMR and SHMI) have reduced again during the latest reporting periods and have continued the downward trend. HSMR year to date is below 100 at 96.8 and SHMI is 110.3 which is 'as expected'.

3.1 : Access

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Access: 18 Weeks Referral To Treatment Incomplete Pathway	>= 92.0%	92.56%	Jan-19		↑	92.54%	Dec-18	93.45%			92.54%	94.69%	Jan-18 to Jan-19
Access: Referral to Treatment over 52 weeks wait	<= 0	0	Jan-19		→	0	Dec-18	0			0	1	Jan-18 to Jan-19
Outpatients: Backlog of Follow Ups	**	12,482	Jan-19		↓	13,618	Dec-18	N/A			11,523	13,618	Jan-18 to Jan-19
Stroke - High Risk TIA Patients Treated within 24 Hrs	>= 60.0%	65.00%	Jan-19		↓	86.67%	Dec-18	73.86%			52.63%	91.67%	Jan-18 to Jan-19
Stroke - Stroke Patients spending 90% of their Hospital Stay on a Stroke unit	>= 80.0%	70.37%	Dec-18		↓	88.24%	Nov-18	76.92%			60.00%	91.30%	Jan-18 to Dec-18
Diagnostics: Patients waiting over 6 weeks	>= 99.0%	99.37%	Jan-19		↑	99.26%	Dec-18	99.18%			98.79%	99.40%	Jan-18 to Jan-19

Commentary (Page Owner : Director of Operations & Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

We continue to meet both the 18 Weeks and Diagnostic Waiting Time standards and have seen a marked reduction in number of patients awaiting a Follow-up appointment. Unfortunately we did not achieve the 90% Stroke Target, which is mainly attributed to bed pressures and unscheduled care demands.

3.2 : Access - Cancer

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	>= 93.0%	95.54%	Dec-18			97.95%	Nov-18	95.87%			94.67%	97.95%	Jan-18 to Dec-18
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected)	>= 93.0%	95.19%	Dec-18			92.86%	Nov-18	94.22%			90.15%	100.00%	Jan-18 to Dec-18
All Cancers: 31 day wait for diagnosis to first treatment	>= 96.0%	99.03%	Dec-18			100.00%	Nov-18	98.85%			97.27%	100.00%	Jan-18 to Dec-18
All Cancers: 31 day wait for second or subsequent treatment: anti cancer drug treatments	>= 98.0%	100.00%	Dec-18			100.00%	Nov-18	100.00%			100.00%	100.00%	Jan-18 to Dec-18
All Cancers: 31 day wait for second or subsequent treatment: surgery	>= 94.0%	100.00%	Dec-18			100.00%	Nov-18	99.16%			93.33%	100.00%	Jan-18 to Dec-18
All Cancers: 62 Day Cancer Standard Treated - Pre Allocation	**	91.15%	Dec-18			88.46%	Nov-18	87.72%			85.15%	92.09%	Jan-18 to Dec-18
All Cancers: 62 day wait for first treatment from urgent GP referral to treatment	>= 85.0%	92.79%	Dec-18			89.15%	Nov-18	89.51%			86.84%	92.79%	Jan-18 to Dec-18
All Cancers: 62 day wait for first treatment from consultant screening service referral	>= 90.0%	92.31%	Dec-18			95.92%	Nov-18	97.28%			92.31%	100.00%	Jan-18 to Dec-18

Commentary (Page Owner : Director of Operations & Performance)

All Cancer Waiting Times Targets have been achieved for December 2018.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

3.3 : Access - Tumour Pathways

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Cancer - Breast 62 Day Wait	>= 85.0%	100.00%	Dec-18		→	100.00%	Nov-18	95.12%			87.50%	100.00%	Jan-18 to Dec-18
Cancer - Colorectal 62 Day Wait	>= 85.0%	70.00%	Dec-18		↓	72.22%	Nov-18	82.31%			70.00%	100.00%	Jan-18 to Dec-18
Cancer - Gynaecology 62 Day Wait	>= 85.0%	100.00%	Dec-18		→	100.00%	Nov-18	77.78%			33.33%	100.00%	Jan-18 to Dec-18
Cancer - Haematology 62 Day Wait	>= 85.0%	100.00%	Dec-18		→	100.00%	Nov-18	85.96%			50.00%	100.00%	Jan-18 to Dec-18
Cancer - Head & Neck 62 Day Wait	>= 85.0%	100.00%	Dec-18		↑	71.43%	Nov-18	69.81%			42.86%	100.00%	Jan-18 to Dec-18
Cancer - Lung 62 Day Wait	>= 85.0%	100.00%	Dec-18		↑	76.47%	Nov-18	75.00%			42.86%	100.00%	Jan-18 to Dec-18
Cancer - Skin 62 Day Wait	>= 85.0%	100.00%	Dec-18		→	100.00%	Nov-18	95.43%			84.00%	100.00%	Jan-18 to Dec-18
Cancer - Upper GI 62 Day Wait	>= 85.0%	66.67%	Dec-18		↑	60.00%	Nov-18	75.90%			50.00%	100.00%	Jan-18 to Dec-18
Cancer - Urology 62 Day Wait	>= 85.0%	100.00%	Dec-18		↑	92.86%	Nov-18	92.36%			85.71%	100.00%	Jan-18 to Dec-18

Commentary (Page Owner : Director of Operations & Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

In December there were 5 accountable breaches of the 62 day pathway: Upper GI: 1 patient initially investigated by colorectal team prior to referral to Upper GI where an UGI cancer was confirmed following diagnostics; 1 patient breached due to diagnostic delays for MR, endoscopy & EUS. Colorectal: 1 patient's treatment cancelled due to bed closures due to D&V, next available date was beyond 62 days; 1 patient initially investigated by Upper GI Team & subsequently transferred to colorectal team who subsequently confirmed a colorectal cancer; 1 patient required repeat investigations which caused delays.

3.4 : Access - A&E

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
4 Hour A&E Breach Performance % (inc GP Streaming Activity)	>= 95.0%	63.65%	Jan-19		↓	77.33%	Dec-18	83.76%			63.65%	94.84%	Jan-18 to Jan-19
Number of A&E Attendances (exc GP Streaming Activity)	**	7,379	Jan-19		↑	6,879	Dec-18	69,616			6,072	7,383	Jan-18 to Jan-19
Average Daily A&E Attendances	**	238.0	Jan-19		↑	221.9	Dec-18	227.5			204.3	246.1	Jan-18 to Jan-19
NWAS: Handovers between 0-15 mins	*	943	Jan-19		↓	1,067	Dec-18	10,790			688	1,302	Jan-18 to Jan-19
NWAS: Handovers between 15-30 mins	*	612	Jan-19		↑	601	Dec-18	6,022			460	748	Jan-18 to Jan-19
NWAS: Handovers between 30-60 mins	*	269	Jan-19		↑	231	Dec-18	2,044			119	381	Jan-18 to Jan-19
NWAS: Handovers over 60 mins	*	209	Jan-19		↑	121	Dec-18	953			30	296	Jan-18 to Jan-19
A&E Attendances that result in an admission	*	2,449	Jan-19		↓	2,460	Dec-18	24,643			2,253	2,698	Jan-18 to Jan-19
A&E Attendances: Out of Area	**	1,060	Jan-19		↑	1,058	Dec-18	10,813			790	1,200	Jan-18 to Jan-19
A&E Attendances: % Result in Admissions - Aged 75+	*	28.46%	Jan-19		↓	29.80%	Dec-18	27.93%			26.50%	31.85%	Jan-18 to Jan-19
NWAS: Conveyances from Care Homes	**	315	Dec-18		↑	271	Nov-18	2,401			244	365	Jan-18 to Dec-18

Commentary (Page Owner : Director of Operations & Performance)

Please see Unscheduled Care Report.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

4.1 : Productivity - Part 1

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
% Hospital Cancelled OP Appointments	<= 5.0%	7.39%	Jan-19			7.14%	Dec-18	7.00%			6.58%	8.51%	Jan-18 to Jan-19
% Hospital Cancelled OP Appointments < 6 weeks	<= 0.0%	79.84%	Jan-19			77.44%	Dec-18	76.92%			70.50%	82.11%	Jan-18 to Jan-19
% Hospital Cancelled OP Appointments < 6 weeks (Pts Best Interest)	*	11.97%	Jan-19			12.89%	Dec-18	12.75%			10.83%	15.31%	Apr-18 to Jan-19
Cancelled Operations %	<= 0.8%	1.89%	Jan-19			2.08%	Dec-18	1.73%			1.42%	2.08%	Jan-18 to Jan-19
Cancelled Operations: 2nd Urgent Hospital	<= 0	0	Jan-19			0	Dec-18	0			0	1	Jan-18 to Jan-19
Average Spell Length of Stay (Elective Inpatient)	*	2.7 Days	Jan-19			3.0 Days	Dec-18	3.0 Days			2.7 Days	3.7 Days	Jan-18 to Jan-19
Average Spell Length of Stay (Non Elective)	*	3.9 Days	Jan-19			3.6 Days	Dec-18	3.5 Days			3.1 Days	4.2 Days	Jan-18 to Jan-19
Delayed Transfers of Care	**	81	Jan-19			37	Dec-18	468			21	81	Jan-18 to Jan-19
Delayed Transfer of Care Days	**	284	Jan-19			153	Dec-18	1,660			78	284	Jan-18 to Jan-19

Commentary (Page Owner : Director of Operations & Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Despite seeing a reduction in the average Length of Stay for elective inpatients, we have seen a drop in Length of Stay for non electives and an increase in Delayed Transfers of Care. This is partly attributed to the high acuity of admissions, delays in discharge due to ward closures and community infections. We continue to work with system partners to minimise delays to patient discharges. We saw a slight increase in the number of Cancelled Outpatients in the month which was partly due to cancelations as a result of adverse weather.

4.2 : Productivity - Part 2

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Theatre Effectiveness % - Total	>= 70.0%	59.88%	Jan-19			63.79%	Dec-18	N/A			59.59%	64.54%	Jan-18 to Jan-19
Theatre Effectiveness % - RAEI	>= 70.0%	54.77%	Jan-19			59.81%	Dec-18	N/A			51.53%	63.75%	Jan-18 to Jan-19
Theatre Effectiveness % - Wrightington	>= 70.0%	63.51%	Jan-19			66.36%	Dec-18	N/A			60.20%	68.87%	Jan-18 to Jan-19
Theatre Effectiveness % - Leigh	>= 70.0%	54.15%	Jan-19			61.83%	Dec-18	N/A			49.63%	61.83%	Jan-18 to Jan-19

Commentary (Page Owner : Director of Operations & Performance)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

We saw a drop in overall Theatre Effectiveness in January which was mainly attributed to an increase in on day cancellations on all sites as a result of adverse weather conditions. Each Division continues to work on recovery plans to improve Theatre Effectiveness and reduce cancellations through the use of an improved patient reminder service led by Pre-Op teams.

5.1 : Midwifery - Part 1

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Maternity: Midwife / Birth Ratio	<= 1.30	1.25	Jan-19			1.26	Dec-18	N/A			1.25	1.29	Jan-18 to Jan-19
Maternity: Skills drills/2 day Mandatory Training Attendance	>=	8.09%	Jan-19			95.37%	Dec-18	N/A			7.20%	95.37%	Jan-18 to Jan-19
Maternity: Total monthly bookings	>= 240	203	Jan-19			234	Nov-18	2,043			197	295	Jan-18 to Jan-19
Maternity: Booked by 12+6 Weeks	>= 90.0%	91.28%	Dec-18			89.32%	Nov-18	N/A			84.07%	94.96%	Jan-18 to Dec-18
Maternity: Induction of Labour	<= 30.0%	32.03%	Jan-19			37.50%	Dec-18	N/A			26.13%	39.81%	Jan-18 to Jan-19
Maternity: Normal Deliveries	>= 60.0%	58.55%	Jan-19			57.62%	Dec-18	N/A			54.71%	67.89%	Jan-18 to Jan-19
Maternity: Water Births	>= 8	11	Jan-19			13	Dec-18	122			6	18	Jan-18 to Jan-19
Maternity: Instrumental Deliveries	<= 10.0%	12.82%	Jan-19			10.48%	Dec-18	N/A			9.35%	13.88%	Jan-18 to Jan-19
Maternity: Elective Caesarean Sections	<= 15.0%	14.96%	Jan-19			11.43%	Dec-18	N/A			7.80%	16.59%	Jan-18 to Jan-19
Maternity: Emergency / Non Elective Caesarean Sections	<= 17.0%	13.68%	Jan-19			20.48%	Dec-18	N/A			11.96%	21.08%	Jan-18 to Jan-19
Maternity: Total Caesarean Sections	<= 27.0%	28.63%	Jan-19			31.90%	Dec-18	N/A			22.48%	34.53%	Jan-18 to Jan-19

Commentary (Page Owner : Director of Nursing)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Midwife to Birth ratio remains above the recommended 1:28 ratio at 1:25 which is reflective of the improvement in staffing levels with the additional supernumerary shift coordinator. Bookings slightly below target levels, however compliance for booked by 12.6 above the target at 91.28%. Mandatory training achieved 95% rolling compliance for 2018. Attendance for January remains on track to achieve monthly target attendance. Induction of labour rate has reduced by 5% in January but remains consistently high due to the agreed thresholds and care bundles for reduced fetal movements and fetal growth pathways implemented nationally to reduce the incidence of stillbirths. NHS Maternity Statistics, England 2017-18 reports the proportion of deliveries where labour was induced has increased from 20.4 per cent in 2007-08 to 32.6 per cent in 2017-18.

5.2 : Midwifery - Part 2

		Latest				Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Maternity: Total Births	>= 240	234	Jan-19			210	Dec-18	2,179			183	246	Jan-18 to Jan-19
Maternity: Episiotomy with normal birth	<= 6.0%	5.84%	Jan-19			4.96%	Dec-18	N/A			1.80%	9.92%	Jan-18 to Jan-19
Maternity: 3rd/4th degree tears	<= 3.0%	1.73%	Jan-19			0.96%	Dec-18	N/A			0.00%	3.20%	Jan-18 to Jan-19
Maternity: Initiation of breastfeeding	>= 55.0%	51.71%	Jan-19			44.29%	Dec-18	N/A			42.85%	57.35%	Jan-18 to Jan-19
Maternity: Average post-natal length of stay	<= 1.8	2.0	Jan-19			1.6	Dec-18	N/A			1.6	2.0	Jan-18 to Jan-19
Maternity: Still Births (>24 weeks)	<= 1	2	Jan-19			0	Dec-18	7			0	3	Jan-18 to Jan-19
Maternal Readmissions within 30 Days	<= 5	5	Jan-19			2	Dec-18	26			0	6	Jan-18 to Jan-19
Maternal admissions to ICU	<= 2	0	Jan-19			0	Dec-18	1			0	1	Jan-18 to Jan-19
Maternity Complaints	<= 2	1	Jan-19			0	Dec-18	7			0	2	Jan-18 to Jan-19
Maternity: New Claims	*	0	Jan-19			0	Dec-18	4			0	3	Jan-18 to Jan-19

Commentary (Page Owner : Director of Nursing)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Operative vaginal delivery is above target at 12.82%, however latest statistics identify a rise in the national rate to 12-13%. Total births back within target however Nationally there is a downward trend. Total Caesarean section rate has reduced by 3% and is in line with the National average. There were 2 stillbirths reported in January. Both cases will receive a full MDT review and will be reported within the quarterly report.

6.1 : Patient Experience - Part 1

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Number of Complaints Upheld by Ombudsman	**	0	Jan-19		→	0	Dec-18	1			0	1	Jan-18 to Jan-19
Percentage of Complaints Responded to on Time	**	52.00%	Jan-19		↓	65.91%	Dec-18	72.34%			52.00%	89.13%	Jan-18 to Jan-19
Patient Survey Q1: Staff Introduction	>= 90.0%	91.08%	Jan-19		↑	90.28%	Dec-18	92.65%			89.40%	95.77%	Jan-18 to Jan-19
Patient Survey Q2: Worries and Fears	>= 90.0%	91.08%	Jan-19		↑	89.58%	Dec-18	89.97%			84.77%	95.40%	Jan-18 to Jan-19
Patient Survey Q3: Pain Control	>= 90.0%	95.54%	Jan-19		↓	96.53%	Dec-18	94.85%			90.16%	97.66%	Jan-18 to Jan-19
Patient Survey Q4: Family and Doctor	>= 90.0%	92.36%	Jan-19		↓	92.36%	Dec-18	92.85%			88.08%	97.70%	Jan-18 to Jan-19
Patient Survey Q5: Decisions about Care and Treatment	>= 90.0%	80.25%	Jan-19		↓	82.64%	Dec-18	82.02%			68.87%	93.22%	Jan-18 to Jan-19
Patient Survey Q6: Food Choice	>= 90.0%	98.73%	Jan-19		↑	98.61%	Dec-18	96.79%			93.75%	98.73%	Jan-18 to Jan-19
Patient Survey Q7: Healthy Food	>= 90.0%	92.99%	Jan-19		↓	93.06%	Dec-18	91.71%			88.60%	96.21%	Jan-18 to Jan-19
Patient Survey Q9: Know Consultant	>= 90.0%	81.53%	Jan-19		↑	77.78%	Dec-18	80.21%			72.85%	91.53%	Jan-18 to Jan-19

Commentary (Page Owner : Director of Nursing)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

During January, 13 out of 25 complaint responses were sent within the timescales agreed with the complainant at the start of the complaints process (52%). Comprehensive, open and transparent responses to complainants are incredibly important and improve patient experience and satisfaction. For Real Time Patient Survey commentary, please see overleaf.

6.2 : Patient Experience - Part 2

Metric Title	Target	Latest Actual	Latest Period	Latest RAG	Trend	Previous Actual	Previous Period	YTD Actual	YTD RAG	Sparkline - Latest 13 Months Chart	Min. Value	Max. Value	Period
Patient Survey Q10: Enough Privacy	>= 90.0%	98.73%	Jan-19		↓	100.00%	Dec-18	99.33%			97.70%	100.00%	Jan-18 to Jan-19
Patient Survey Q11: Call Bell	>= 90.0%	92.99%	Jan-19		↓	96.53%	Dec-18	95.32%			92.73%	98.31%	Jan-18 to Jan-19
Patient Survey Q12: Compassion	>= 90.0%	98.09%	Jan-19		↓	98.61%	Dec-18	97.99%			95.98%	99.30%	Jan-18 to Jan-19
Patient Survey Q13: Given Required Care	>= 90.0%	94.90%	Jan-19		↓	99.31%	Dec-18	96.66%			94.25%	99.31%	Jan-18 to Jan-19
Friends & Family: Decisions about Discharge Home?	>= 90.0%	89.35%	Jan-19		↑	84.96%	Dec-18	N/A			51.52%	91.94%	Jan-18 to Jan-19

Commentary (Page Owner : Director of Nursing)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

In relation to the RTPS, a number of questions have decreased, including “Have you been involved as much as you wanted to be in decisions about your care and treatment?” and “Have you always had access to a call bell when you needed it?”. Worryingly, “Have you be given the care you felt you required when you needed it most? dropped by 4.41%. Conversely, we have seen a slight improvement in the question “Do you know which consultant is currently treating you?” of 3.75%.

7 : Workforce

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
Total Pay vs Budget	<=£ 0 k	£ 1,151 k	Jan-19			£ 1,276 k	Dec-18	£ 8,009 k			£ 195 k	£ 1,736 k	Jan-18 to Jan-19
Friends & Family Test - Recommendation as place to work	>= 75.0%	71.59%	Jan-19			63.25%	Oct-18	N/A			63.25%	71.92%	Jan-18 to Jan-19
Clinical & Non Clinical Overall Vacancy Rate	<= 3.5%	7.90%	Jan-19			7.41%	Dec-18	8.02%			7.35%	8.89%	Jan-18 to Jan-19
Sickness absence - Total	<= 4.5%	4.88%	Dec-18			4.29%	Nov-18	4.27%			4.04%	5.92%	Jan-18 to Dec-18
Quarterly Engagement Score	>= 4.00	4.01	Jan-19			3.91	Sep-18	N/A			3.91	4.04	Jan-18 to Jan-19
Appraisals over rolling 12 months	>= 90.0%	89.45%	Jan-19			86.87%	Nov-18	N/A			86.87%	92.50%	Jan-18 to Jan-19
Friends & Family Test - Recommendation as place for treatment	>= 80.0%	79.42%	Jan-19			78.21%	Oct-18	N/A			75.09%	83.33%	Jan-18 to Jan-19
Mandatory Training over rolling 12 months	>= 95.0%	94.82%	Jan-19			95.12%	Nov-18	N/A			94.82%	97.25%	Jan-18 to Jan-19
Agency vs NHSI Ceiling	<=£ 429 k	£ 695 k	Jan-19			£ 556 k	Dec-18	£ 5,622 k			£ 429 k	£ 695 k	Jan-18 to Jan-19

Commentary (Page Owner : Director of Workforce)

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

Rolling 12-month sickness from Jan 18 - Dec 18 decreased marginally to 4.54% (compared to 4.58% last reported). However, the in-month sickness rate for Dec 18 increased to 4.88% (compared to 4.29% in Nov 18). Temp spend in Jan 19 increased by £85k to £1,620k (compared to £1,535k in Dec 18). There were decreases in the following categories: Additional Sessions, Locum, and Zero Hours Contract (decreased by £50k, £20k and £13k respectively). In addition there was a small decrease in Cost per Case. However, there were increases in Agency, Bank NHSP, Overtime and Bank (increased by £139k, £19k, £9k and £2k respectively). Overall, the results of the January 2019 Staff Engagement Quarterly Pulse Check highlight a moderate level of engagement within the Trust. The overall engagement score for January 2019 is 4.01, compared to 3.91 in October 2018. In October 2018, a large shift in the results was observed, however, it appears that in this quarter, engagement scores have recovered. Whilst Consultant job plan compliance is at 100%, the plans are at various stages within the system. Trustwide there are 214 job plans at the following stages: 40 (Discussion), 49 (1st sign off), 18 (2nd sign off), 34 (3rd sign off), 70 (fully signed off) and the final 3 are locked down. Please note that Speciality Doctors are now recorded on Allocate and are included in these figures.

NHSI Metrics

	Latest					Previous		YTD		Sparkline - Latest 13 Months			
Metric Title	Target	Actual	Period	RAG	Trend	Actual	Period	Actual	RAG	Chart	Min. Value	Max. Value	Period
4 Hour A&E Breach Performance % (inc GP Streaming Activity)	95.0%	63.65%	Jan-19			77.33%	Dec-18	83.76%			63.65%	94.84%	Jan-18 to Jan-19
Access: 18 Weeks Referral To Treatment Incomplete Pathway	92.0%	92.56%	Jan-19			92.54%	Dec-18	93.45%			92.54%	94.69%	Jan-18 to Jan-19
Diagnostics: Patients waiting over 6 weeks	99.0%	99.37%	Jan-19			99.26%	Dec-18	99.18%			98.79%	99.40%	Jan-18 to Jan-19
Two week wait from referral to date first seen: all urgent cancer referrals (cancer suspected)	93.0%	95.54%	Dec-18			97.95%	Nov-18	95.87%			94.67%	97.95%	Jan-18 to Dec-18
Two week wait from referral to date first seen: symptomatic breast patients (cancer not initally suspected)	93.0%	95.19%	Dec-18			92.86%	Nov-18	94.22%			90.15%	100.00%	Jan-18 to Dec-18
All Cancers: 62 Day Cancer Standard Treated - Pre Allocation	-	91.15%	Dec-18			88.46%	Nov-18	87.72%			85.15%	92.09%	Jan-18 to Dec-18
All Cancers: 62 day wait for first treatment from urgent GP referral to treatment	85.0%	92.79%	Dec-18			89.15%	Nov-18	89.51%			86.84%	92.79%	Jan-18 to Dec-18
All Cancers: 62 day wait for first treatment from consultant screening service referral	90.0%	92.31%	Dec-18			95.92%	Nov-18	97.28%			92.31%	100.00%	Jan-18 to Dec-18
Serious Harms: Infections: Clostridium Difficile	1	0	Jan-19			0	Dec-18	7			0	4	Jan-18 to Jan-19
Serious Harms: Infections: Clostridium Difficile Lapses in Care	0	0	Jan-19			0	Dec-18	1			0	1	Jan-18 to Jan-19

The updated Single Oversight Framework has been published, this will be reviewed and metrics developed accordingly.

*Threshold not confirmed
**Threshold not confirmed ~ based on assumption

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Finance Report

Financial Position for the period ending 31st January 2019

The WWL Way

Contents

1. Executive Summary

1.1. The Trust is reporting a year to date trading deficit of £1.3m which is £1.0m behind plan.

	In Month - £000			Year to Date - £000		
Key Metrics	**Actual**	**Plan**	**Var**	**Actual**	**Plan**	**Var**
UOR	3	1	**(2)**	3	3	**0**
Operating Surplus / (Deficit)	(127)	1,021	**(1,148)**	(1,285)	(314)	**(971)**
Capital Expenditure	1,348	897	**(451)**	3,758	7,149	**3,391**
Cash	14,815	14,532	**283**	14,815	14,532	**283**

1.2. Cumulative income of £262.7m is £6.8m better than plan.

1.3. Cumulative expenditure of £260.6m is £7.8m worse than plan.

1.4. The year to date UOR rating for the Trust is a 3 which is on plan.

1.5. The Income & Expenditure summary can be seen at Appendix 1.

2. Capital Expenditure & Statement of Financial Position

2.1. The Trust has spent £3.8m on capital expenditure versus planned expenditure of £7.1m.

2.2. The statement of financial position can be found in Appendix 2.

3. Cash, Liquidity and UOR

3.1. The cash balance is £14.8m, which is £0.3m higher than the planned balance.

3.2. The year to date UOR rating is a 3 against a plan of 3.

3.3. The cash flow statement can be found in Appendix 3.

Appendix 1 – Income & Expenditure Summary

	In Month - £000			Year to Date - £000		
	Actual	Plan	Var	Actual	Plan	Var
Income						
A & E Attendances	1,016	975	**42**	10,013	9,621	**392**
Daycase	2,931	3,147	**(216)**	28,042	30,293	**(2,252)**
Elective	2,781	2,793	**(12)**	26,576	27,046	**(469)**
Non Electives	6,139	5,888	**251**	61,133	58,087	**3,046**
Outpatients	3,627	3,785	**(158)**	34,812	36,466	**(1,654)**
Other**	10,753	9,632	**1,121**	102,112	94,381	**7,731**
Total Income	**27,247**	**26,219**	**1,028**	**262,689**	**255,894**	**6,794**
Operating Expenses						
Pay	(17,814)	(17,083)	**(731)**	(174,974)	(170,701)	**(4,273)**
Non Pay	(9,155)	(8,079)	**(1,076)**	(85,277)	(83,486)	**(1,790)**
Reserves	0	302	**(302)**	(340)	1,355	**(1,695)**
Total Operating Expenses	**(26,969)**	**(24,860)**	**(2,109)**	**(260,590)**	**(252,832)**	**(7,758)**
EBITDA	277	1,359	**(1,081)**	2,099	3,062	**(963)**
EBITDA %	*1.0%*	*5.2%*	**(4.2)%**	*0.8%*	*1.2%*	**(0.4)%**
Non Operating Expenses	(404)	(337)	**(67)**	(3,383)	(3,375)	**(9)**
Surplus / (Deficit)	**(127)**	**1,021**	**(1,148)**	**(1,285)**	**(314)**	**(971)**
Surplus / (Deficit)%	***(0.5)%***	***3.9%***	**(4.4)%**	***(0.5)%***	***(0.1)%***	**(0.4)%**
Impairment	0	0	**0**	0	0	**0**
Tech Surplus/ Def	**(127)**	**1,021**	**(1,148)**	**(1,285)**	**(314)**	**(971)**

Appendix 2 – Statement of Financial Position

31.03.18 - £'000		In Month - £'000			Movement to previous month - £'000		31.03.19 - £'000
Actual		Actual	Plan	Variance	Last month	Movement	Plan
	Non-current assets						
140,409	Property, plant and equipment	139,617	142,382	(2,765)	138,830	787	144,198
2,429	Intangibles	1,972	1,756	216	2,014	(42)	1,621
223	Trade and other non-current receivables	242	223	19	301	(59)	223
143,061		**141,831**	**144,361**	**(2,530)**	**141,145**	**686**	**146,042**
	Current assets						
4,199	Inventories	4,367	4,199	168	4,422	(55)	4,199
28,388	Trade and other receivables	24,921	19,911	5,010	24,226	695	16,285
12,598	Cash and cash equivalents	14,815	14,532	283	14,462	353	15,697
45,186		**44,103**	**38,642**	**5,461**	**43,110**	**993**	**36,181**
188,247	**Total assets**	**185,934**	**183,003**	**2,931**	**184,255**	**1,679**	**182,223**
	Current liabilities						
(32,202)	Trade and other payables	(35,000)	(31,824)	(3,176)	(32,925)	(2,075)	(29,169)
(4,484)	Borrowings	(4,486)	(4,418)	(68)	(4,486)	0	(4,352)
(295)	Provisions	(248)	(145)	(103)	(300)	52	(111)
(501)	Other liabilities	(1,126)	(501)	(625)	(1,268)	142	(501)
(37,478)		**(40,860)**	**(36,888)**	**(3,972)**	**(38,979)**	**(1,881)**	**(34,133)**
7,708	**Net current assets/(liabilities)**	**3,243**	**1,754**	**1,489**	**4,131**	**(888)**	**2,048**
150,769	**Total assets less current liabilities**	**145,074**	**146,115**	**(1,041)**	**145,276**	**(202)**	**148,090**
	Non-current liabilities						
(21,932)	Borrowings	(17,564)	(17,609)	45	(17,639)	75	(17,609)
(2,196)	Provisions	(2,161)	(2,196)	35	(2,161)	0	(2,196)
(584)	Other liabilities	(372)	(584)	212	(372)	0	(584)
(24,712)		**(20,097)**	**(20,389)**	**292**	**(20,172)**	**75**	**(20,389)**
126,057	**Total assets employed**	**124,977**	**125,726**	**(749)**	**125,104**	**(127)**	**127,701**
	Financed by						
	Taxpayers' equity						
97,119	Public dividend capital	97,324	97,119	205	97,324	0	97,119
17,107	Revaluation reserve	17,106	17,107	(1)	17,107	(1)	17,107
11,826	Retained earnings	10,547	11,500	(953)	10,673	(126)	13,475
126,057	**Total taxpayers' equity**	**124,977**	**125,726**	**(749)**	**125,104**	**(127)**	**127,701**

Appendix 3 – Cash Flow Statement

	In Month - £'000			Year to Date - £'000			Full Year - £'000
	Actual	Plan	Variance	Actual	Plan	Variance	Plan
Opening cash	14,462	15,402	(940)	12,598	12,598	0	12,598
Operating activities							
Technical surplus / (deficit)	*(127)*	*1,020*	*(1,147)*	*(1,285)*	*(326)*	*(959)*	*1,650*
Net interest accrued	*19*	*29*	*(10)*	*209*	*293*	*(84)*	*353*
PDC dividend expense	*304*	*304*	*0*	*3,043*	*3,043*	*0*	*3,652*
Unwinding of discount	*4*	*4*	*(0)*	*36*	*36*	*(0)*	*44*
Operating surplus / (deficit) per annual accounts	200	1,357	(1,157)	2,003	3,046	(1,043)	5,899
Depreciation and amortisation	520	596	(76)	5,125	5,951	(826)	7,139
(Gain) / loss on disposal	77	0	77	93	0	93	0
Non cash donations/grants credited to income	0	(10)	10	(218)	(100)	(118)	(120)
Changes in working capital							
(Inc)/Dec in Inventories	55	0	55	(168)	0	(168)	0
(Inc)/Dec in trade & other receivables	(635)	(1,324)	689	3,302	8,324	(5,022)	11,951
Inc/(Dec) in trade & other payables	1,744	(500)	2,244	1,667	(1,501)	3,168	(3,006)
Inc/(Dec) in other liabilities	(142)	0	(142)	413	0	413	0
Inc/(Dec) in provisions	(56)	(19)	(37)	(120)	(190)	70	(228)
Investing activities							
Interest received	13	2	11	109	25	84	30
Purchase of non-current assets	(1,348)	(897)	(451)	(3,757)	(7,149)	3,392	(10,000)
Financing activities							
Public dividend capital received	0	0	0	205	0	205	0
Other loans received	0	0	0	55	32	23	32
Loan principal repaid	(75)	(75)	0	(4,425)	(4,421)	(4)	(4,487)
Interest paid	0	0	0	(394)	(411)	17	(411)
PDC dividend paid	0	0	0	(1,674)	(1,672)	(2)	(3,500)
Total net cash inflow / (outflow)	**353**	**(870)**	**1,223**	**2,217**	**1,934**	**283**	**3,099**
Closing cash	**14,815**	**14,532**	**283**	**14,815**	**14,532**	**283**	**15,697**

REPORT

AGENDA ITEM: 7.4

Wrightington, Wigan and Leigh NHS Foundation Trust

To:	Board of Directors	**Date:**	27 February 2019
Subject:	Safe Staffing Report		
Presented by:	Director of Nursing	**Purpose:**	Information

Executive summary

This report is provided to the Board to provide assurance of the ongoing monitoring of nurse staffing levels across inpatient areas.

The Board are asked to note;

- The detail relating to staff fill rates and quality in Appendix 1 of the report
- The risk relating to vacancies across some medical wards and actions to be taken
- The overall registered nurse fill rate of 90% for the month and positive impact of the nursing incentive scheme
- The positive position of the Trust in comparison to nation and peer benchmarking data for CHPPD, cost per care hour, cost per patient day and average staffing cost
- The continued roll out of the Safecare Module and the inclusion of escalated areas to support monitoring of acuity and dependency and associated staffing levels.

Risks associated with this report

Staffing levels remain a concern across clinical divisions with individual wards being noted on the Corporate Risk Register. Nurse Staffing remains the biggest risk on the risk register.

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☒	People	☐	Partnerships

The WWL Way

Safe Staffing Report – January 2019

1.0 INTRODUCTION

This report provides a monthly summary of Safe Staffing on all in-patient wards across the Trust. It includes exception reports related to staffing levels, related incidents and red flags which are then triangulated with a range of quality indicators.

2.0 SAFER STAFFING EXCEPTION REPORT

The safe staffing exception report (Appendix1), provides the established versus actual fill rates on a ward by ward basis. Fill rates are RAG rated with supporting narrative by exception, and a number of related factors are displayed alongside the fill rates to provide an overall picture of safe staffing.

- Sickness rate and Vacancy rate are the two main factors that affect fill rates.
- Datix incident submissions related to staffing and Red Flags are monitored on a daily basis to act as an early warning system and inform future planning.
- Nurse Sensitive Indicators demonstrate the outcome for patients by measuring harm.
    - Cases of Clostridium Difficile (CDT);
    - Pressure Ulcers Grade 1&2 / Grade 3&4;
    - *Falls resulting in physical harm / not resulting in physical harm;
    - *Medication administration errors resulting in harm / not resulting in harm.

  (*All incidents displayed by: those that resulted in moderate and severe harm / resulted in minor or no harm)
- The impact of Nurse staffing on Patients' Experience is demonstrated by two specific questions from the monthly Real Time Patient Experience Survey. The NICE guidance on safe staffing in hospitals suggests using a number of questions in the form of a patient experience survey. For some of the NICE questions the trust has an equivalent question, or proxy question within the monthly Real Time Patient Experience survey or Always Events Survey, with the two questions matching most closely featuring in this report.

3.0 DISCUSSION

Appendix 1 provides the detail of the safe staffing report.

Throughout January the Undesignated Areas paper was utilised to support escalation of areas associated with increased operational demands. Unless the areas are escalated in a planned manner movement of staff from other areas is required to support care and management of these patients which depletes planned staffing levels. The Board are reminded that the ward establishments are to safe minimum staffing levels only. Staff who have taken advantage of the incentive scheme launched this month have been utilised to support safe staffing across these areas as required to reduce the impact on ward rostered staff. The overall fill rate for registered nurses within the report is 93.67% and reflects the impact of the incentive scheme.

The Board will note that vacancy rates remain high across Scheduled Care in the Division of Medicine despite ongoing recruitment within the division. The number of registered nurse vacancies has increased in January and this is not associated with the development of new nursing roles.

3 areas raised nursing red flags (5 incidents in total) in relation to clinical areas having less than 2 registered nurses per shift in January 2019. These areas were Pemberton (3 occasions) CDW and the Elderly Care Unit (Standish area of the unit). All these incidents occurred at night during periods of escalation. Investigation reports have been requested from

the clinical areas involved to identify learning. The overall reporting of red flags remains low with under-reporting clearly being an issue on Pemberton, Cardio-respiratory Unit, Highfield and Shevington.

Tables 6 and 7 provides information from the Model Hospital for November 2018 with respect to Care Hours per Patient Day (CHPPD) and Nursing Costs. In accordance with NHSI requirements the external reporting of fill rates for registered and unregistered nursing staff has ceased and CHPPD only is being utilised as a comparator for benchmarking purposes.

As demonstrated within the data sets provided the Trust continues to compare favourably for aggregate and non-registered staff CHPPD against both the National and Peer comparative data. Registered staff comparators remain above the peer group but below the national benchmarking data. Costs per patient and costs per care hour are lower than peer and national average.

Despite the ongoing operational challenges and increased patient acuity and dependency there continues to be a low incidence of reports of moderate and severe harm within inpatient areas.

The Trust roll out of the SafeCare module has continued to progress throughout January. 14 wards are currently utilising the system although further work is required to ensure data is captured as required and full functionality of the system is utilised. Areas utilised for escalation have been added onto SafeCare so the acuity and dependency of patients accommodated can be captured alongside the staff required to deliver safe and effective nursing care based on patient need. This data should assist in determining the flexibility required to manage increased inpatient demand within acute inpatient areas.

4.0 SUMMARY

The Trust continues to compare favourably with peers and nationally for CHPPD and for nursing and midwifery staffing costs.

SafeCare continues to be rolled out across the Trust which will assist in determining future staffing requirements.

The Undesignated Areas paper has been utilised during periods of demand to safely accommodate patients requiring inpatient care, and staff allocated to provide safe staffing where required.

The aggregate fill rate for registered nursing staff remains above 90% and is reflective on the impact of the incentive scheme and the specialist nurses working within the ward areas.

5.0 RECOMMENDATIONS

The Board is asked to receive the paper for information and discussion.

Appendix 1
SAFE STAFFING EXCEPTION REPORT – January 2019

Division of Medicine – Scheduled Care

Division of Medicine – Scheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability		Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW											
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Acute Stroke Unit	87.1%	103.3%	2.5	143.0%	120.6%	4.7	4.91%	13.45%	0		0/5			100.0%	100.0%
Cardio and Respiratory	79.7%	66.1%	2.3	101.2%	79.6%	3.6	5.56%	17.38%	1		0/2		0/2	100.0%	**100.0%**
Coronary Care Unit	99.3%	98.7%	7.0	101.2%		2.1	5.00%	4.01%	0		0/1			100.0%	100.0%
Elderly Care Unit	90.9%	89.7%	2.4	105.7%	0.0%	4.0	7.54%	11.86%	one		0/6			95.7%	95.7%
Highfield	83.5%	66.1%	3.7	133.5%	57.9%	4.7			0		0/3		0/1		
Pemberton	84.5%	97.0%	4.6	146.5%	124.5%	5.6	6.52%	18.56%	3		0/5		0/1		
Shevington	86.0%	71.0%	2.6	110.7%	130.4%	4.4	4.33%	20.24%	0		0/3			100.0%	100.0%
Taylor Unit															

Division of Medicine – Unscheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability		Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW											
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
A&E Emg Care	95.6%	104.1%		139.4%	223.4%		5.41%	11.95%			0/3		0/2		
A&E Paeds	92.5%	128.0%					0.00%	10.28%							
CDW	101.3%	96.8%		93.1%	109.5%		4.82%	13.71%			0/2			100.0%	100.0%
Medical Assessment Unit	97.2%	86.7%		121.6%	97.7%		3.52%	7.72%			1/21		1/3	95.7%	95.7%

Division of Surgery

Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	97.4%	93.6%	26.2	96.6%		3.0	7.88%	0.00%	0						
Langtree	83.9%	98.4%	2.5	107.7%	121.2%	2.6	5.17%	13.94%	5		0/4		0/1	100.0%	100.0%
Orrell	103.3%	100.1%	4.4	114.4%	132.9%	4.7	5.26%	6.33%	5		0/1		0/1	87.5%	100.0%
Swinley	96.6%	100.3%	2.7	108.6%	115.3%	2.6	5.66%	11.19%	0		0/5		0/1	100.0%	77.8%
Maternity Unit	98.4%	95.8%	12.0	72.2%	0.0%	3.3	4.60%	0.00%	0		0/1			100.0%	100.0%
Neonatal Unit	100.1%	105.6%	13.1	93.5%		2.5	0.00%	0.00%	0				0/1	100.0%	100.0%
Rainbow	106.5%	91.2%	11.5	82.8%	56.1%	3.0	14.87%	4.00%	0		0/2		0/1	100.0%	100.0%

Rainbow ward: During the reporting period safe staffing has been maintained within the framework set out in the Standard Operational Procedures for the safe running of Rainbow ward and Escalation procedure.

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability		Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW											
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Aspull	97.7%	71.1%	3.7	127.5%	154.3%	5.44	6.03%	6.04%	11		1/1		0/1	60.0%	80.0%
Ward A	90.0%	81.2%	3.6	105.9%	84.1%	3.96	11.04%	7.75%	0				0/1	100.0%	100.0%
Ward B	108.0%	98.3%	3.7	89.7%	92.5%	3.40	11.94%	0.95%	0			1/0		100.0%	100.0%
JCW	103.5%	95.4%	7.1	88.8%	0.0%	3.96	8.89%	0.00%	0		0/1				

	<=84%
	85 - 94%
	95 - 119%
	>=120%

Appendix 2

	December 2018		January 2019	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	7	5	4	5

Table 1. Red Metrics December 2018/January 2019

	December 18		January 2019	
Specialty	Qualified	Qualified	Qualified	Unqualified
Medicine	40.89**	11.58*	40.04**	6.3
Surgery	13.07***		17.41***	1.0
Specialist Services	10.75	3.89	12.91	
Total	**64.71**	**15.47**	**70.36**	**7.3**

*Table 2. Nurse Vacancies December 2018/January 2019 by Division (**6 WTE of these are from uplift for MIU/PCC, 8 WTE new substantively funded posts for Highfield; *3.7 WTE new substantively funded posts for Highfield, *** 1 WTE Bereavement Midwife)*

Month	Qualified WTE	Unqualified WTE
September 17	58.15	28.99
October 17	67.56	13.04
November 17	64.76	16.25
December 17	75.76	17.25
January 18	67.48	14.27
February 18	61.5	23.27
March 18	61.19	13.26
April 18	48.38	9.39
May 2018	55.94	13.03
June 2018	49.21	13.15
July 2018	59.44	10.48
August 2018	56.89	12.89
September 2018	50.78	8.37
October 2018	51.88	9.643
November 2018	67.28	14.83
December 2018	64.71	15.47

Table 3. Nurse Vacancies September 2017 – December 2018 (Trust Wide)

Red Flag Category	**No. of Incidents January 2019**
Shortfall of more than 8 hours or 25% of registered nurses in a shift	21
Delay of 30 minutes or more for the administration of pain relief	1
Delay or omission of intentional rounding	2
Less than 2 registered nurses on shift	5
Vital signs not assessed or recorded as planned	4
Unplanned omission of medication	1
Total	**34**

Table 4. Nursing Red Flags January 2019

Red Flag Category	No. of Incidents January 2019
Unit on Divert	0
Co-Ordinator Unable to Remain Super-numerary	0
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0
Delay of 30 or more between presentation and triage	0
Delay of 2 hours or more between admission for induction and beginning of process	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0
Total	**0**

Table 5. Maternity Red Flags January 2019

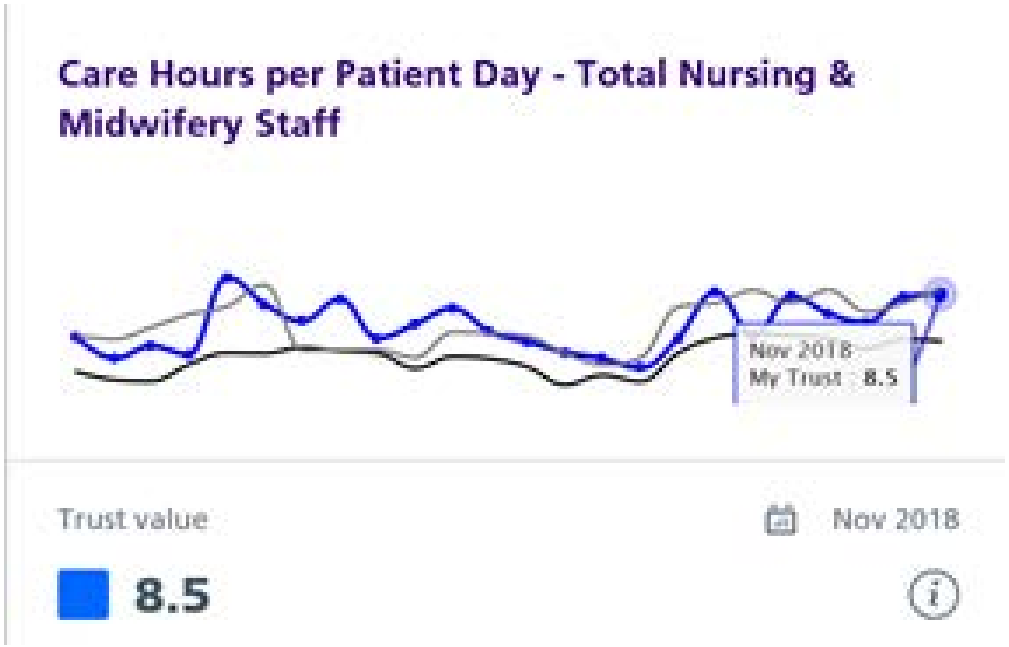

Table 6. CHPPD data November 2018 (Source Model Hospital)

Money & Resources	Data period	Trust value	Peer median	National median	Chart	Actions
Cost per WAU - Substantive Nursing & Midwifery Staff	2017/18	£880	£750	£710		
Total Nursing & Midwifery FTE	2017/18	2,096.0	2,629.8	2,096.6		
Care Hours per Patient Day - Total Nursing & Midwifery Staff	Nov 2018	8.5	8.6	8.0		
Cost per Care Hour - Total Nursing & Midwifery Staff	Nov 2018	£22.55	£27.11	£25.80		
Cost per Patient Day - Total Nursing & Midwifery Staff	Nov 2018	£188.05	£217.24	£207.32		
Average Staff Cost - All Nursing & Midwifery Staff	2016/17	£34,229	£35,565	£35,334		

Table 7.Use of Resources October 2018 (Source Model Hospital)

Patients:

Every patient receives the best possible care

Executive lead(s):	Director of Nursing Medical Director	**Reviewing committee:**	Quality and Safety Committee	**DELIVERY CONFIDENCE** **CURRENT MONTH:**	**WEIGHTED DASHBOARD** **MONTH:** 2.92 **YTD:** 3.27
Strategic importance:	Provision of safe, effective, high-quality and evidence based care is at the heart of everything we do.				
Sources of assurance:	▪ Scrutiny by Quality and Safety Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMC			**ROLLING TREND:** Jan 2019 · Dec 2018 · Nov 2018 · Oct 2018	**ROLLING TREND:** Jan 2019: 2.46 · Dec 2018: 2.68 · Nov 2018: 2.48 · Oct 2018: 2.56

Individual risks	Original Score	Mitigations	Current score
Failure to document patient care through the production and maintenance of accurate and contemporaneous clinical records.	16	Risk escalated and subject to review by REMC	16
There is a risk that patients with infectious conditions may not be able to be appropriately isolated in a timely manner due to a lack of side rooms	20	GM pipeline bid for additional beds including side rooms	20
Inability to recruit to required staffing levels, in particular nurse staffing (numerous entries)	20	Board and Workforce Cttee briefed on this issue, various options being pursued	20
Risk of injury/equipment failure/fire cause by failure of celling pendants in ICH/HDU, as a result of excessive weight, beyond safe	16	Previously escalated to Q&S. Business case and decant plan being prepared	20
Failure to identify the root cause and lessons learned from never events reported during 2017-18 and 2018-19 creates a risk around patient safety, reputational damage and increased regulatory scrutiny	16	Reported to Board. Themed SIRI Panel in Mar 2019 on actions/lessons learned	16
Upgrade to Somerset cancer registry interface on PAS has potential to delay cancer diagnosis	20	New risk, further analysis being undertaken	20
Only 1 maternity theatre available for elective and emergency cases	20	New risk, further analysis being undertaken	20

NARRATIVE

PATIENTS: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Harm free care	%VTE Assessments undertaken within 24 hours of admission (indicative data)	**96.2% M 97.1% Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	1 x 1 = 1	1 x 1 = 1	Perf. Report (Dec 2018)
Harm free care	No. Serious Falls	**0 MTD 6 YTD**	0 (MTD)		1	2 or 3	>3 (YTD)	**2**	1 x 2 = 2	5 x 2 = 10	Perf. Report (Jan 2018)
Patient Safety	% of 'red sepsis' patients receiving antibiotics within 1 hour in A&E	**47.5%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	5 x 1 = 5	---	A&E Monthly Audits
Patient Safety	No. of Never Events	**1 MTD 5 YTD**	0				1	**3**	5 x 3 = 15	5 x 3 = 15	Perf. Report (Jan 2018)
Patient Safety	100% compliance with appropriate frequency of observations	**92.4%**	100%	99-95%	94-90%	89-80%	<80%	**1**	3 x 1 = 3	---	CCOT quarterly Audits
Infection Control	No. of MRSA	**1 MTD 2 YTD**	0				1	**3**	5 x 3 = 15	5 x 3 = 15	Perf. Report (Jan 2018)
Infection Control	No. of C. diff Lapses in Care	**0 MTD 1 YTD**	0 (MTD)	1 (YTD)	2	3	>4	**2**	1 x 2 = 2	2 x 2 = 4	Perf. Report (Jan 2018)
Patient Experience	% of patients recommending WWL for care	**93%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**2**	2 x 2 = 4	---	Monthly FFT (Dec 2018)
Patient Experience	% of patients feeling involved with decisions about their discharge	**89.3%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	3 x 1 = 3	---	Perf. Report (Jan 2018)
Patient Experience	% of complaints responded to within the timescale agreed with the patient	**52% M 72.34% Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	5 x 1 = 5	5 x 1 = 5	Perf. Report (Jan 2018)
Mortality	HSMR	**78.1% M 96.8% Y**	≤100	101-105	106-110	111-115	>115	**3**	1 x 3 = 3	1 x 3 = 3	Perf. Report (Oct 2018)
Mortality	SHMI	**111.9%**	≤100	101-105	106-110	111-115	>115	**1**	4 x 1 = 4	4 x 1 = 4	Perf. Report (June 2018)
Mortality	No. of PFDs	**0**	0	1	2	3	>4	**2**	1 x 2 = 2	1 x 2 = 2	Perf. Report (Jan 2018)
Medicines Management	% of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area	**84%**	100%	99-95%	94-90%	89-80%	<80%	**1**	4 x 1 = 4	---	Pharmacy (Dec 2018)
Medicines Management	% of completed medicines reconciliation within 24 hours	**87%**	100%	99-95%	94-90%	89-80%	<80%	**2**	4 x 2 = 8	---	Pharmacy (Dec 2018)
Total									76(/26)	59(/18)	
Average									2.92	3.27	

People:
Everyone has the opportunity to achieve their purpose

Executive lead(s):	Director of Workforce	**Reviewing committee:**	Workforce Committee	**DELIVERY CONFIDENCE**			**WEIGHTED DASHBOARD**	
Strategic importance:	Every member of staff has the opportunity to achieve their purpose. Safe and effective workforce to meet service needs						**MONTH:** 3.25	**YTD:** 3.25
Sources of assurance:	▪ Scrutiny by Workforce Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC		**ROLLING TREND:**			**ROLLING TREND:**	
				Jan 2019	Dec 2018	Nov 2018	Oct 2018	Jan 2019	Dec 2018	Nov 2018	Oct 2018
								4.00	4.00	4.00	3.38

Individual risks	Original Score	Mitigations	Current score
HR 84 - Ability to recruit and retain to required staffing levels for service delivery and service development plans	20	International recruitment, nursing incentive schemes, return to practice programmes, nursing pipeline	20
HR 86 - Lack of assurance around medical job plans will lead to both negative service and financial impacts for the Trust	12	E-job planning	16
HR93 – Breaching the NHSI agency ceiling	12	Temporary staffing protocols, nursing incentive schemes, international recruitment, Steps 4 Wellness programmes, regional collaboration	20
HR101 – Access to intranet (Wally)	16	Liaison between IT, system provider and staff engagement to resolve Active Directory problems. Single sign on implementation	16
HR102 - Re-building the relationship with E&F staff, the wider organisation and the Unions following WWL Solutions	20	Development of new recognition agreement. Commitment to partnership working. Early engagement regarding E&F CIP schemes and consultations. 1:1's with new regional officer (Unison)	12
HR80 – meeting the Government Apprenticeship targets	10	Prioritisation programme. Workforce Committee discussions and agreement around the apprenticeship strategy – target will not be delivered	15
HR06 – sickness absence above target (and not delivering 20% reduction as specified in BIG scheme)	12	Attendance management policy and Steps 4 Wellness programmes	15

NARRATIVE

The weighted dashboard overleaf has been updated and the month to which data relates has been included.

Since the focus on divisional actions in relation to the October Pulse survey, we have seen significant improvements in the January survey. Further work must continue though to ensure that we act appropriately on staff feedback. Energy levels are concerning, illustrating the continued pressure that staff are under. The proposed well-being pilot, taking initiatives to front line staff is aimed to mitgate this, alongside mental health support directed to unscheduled care staff.

The workforce summit identified a number of Trust wide and speciality specific programmes of work to be explored to facilitate alternative workforce models in response to long standing vacancies and national shortages.

In month scores weighted dashboard scores have improved, and therefore delivery confidence has increased from red amber to amber.

PEOPLE: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Go Engage	Friends and family test (work)	71.59%	≥95%	72-94%	68-71%	64-67%	≤63%	2	3 x 2 = 6	3 x 2 = 6	Workforce team
Employment Essentials	Turnover	8.83%	≤8%	8.01-8.5%	8.51-9%	9.01-9.9%	≥10%	1	3 x 1 = 3	3 x 1 = 3	Workforce team
Employment Essentials	Leavers with less than 12 months' service	14.28%	≤10%	11-14%	15-20%	21-24%	≥25%	1	2 x 1 = 2	2 x 1 = 2	Workforce team
Route Planner	PDR completion	89.4%	≥95%	86-94%	78-85%	73-77%	≤72%	1	2 x 1 = 2	2 x 1 = 2	Workforce team
Steps 4 Wellness	Energy levels	3.45	≥4.00	3.7-3.99	3.61-3.69	3.47-3.6	≤3.46	1	5 x 1 = 5	5 x 1 = 5	Workforce team
Go Engage	Cultural enabler score	33.68	≥36	35.01-35.9	34.01-35	33.61-34	≤33.6	2	4 x 2 = 8	4 x 2 = 8	Workforce team
Total								8	26	26	
Average									3.25	3.25	

Performance:
We aim to be in the top 10%

Executive lead(s):	Chief Operating Officer Director of Finance & Informatics	**Reviewing committee:**	Finance and Performance Committee	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Delivery of operational and finance performance underpins clinical care, facilitates the patient journey and enhances the patient experience, and affects the organisation's financial performance.				**MONTH:** 2.37 **YTD:** 2.11
Sources of assurance:	▪ Scrutiny by Finance and Performance Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMC			**ROLLING TREND:**  Jan 2019 / Dec 2018 / Nov 2018 / Oct 2018	**ROLLING TREND:** 2.11 / 2.63 / 2.89 / 2.20 Jan 2019 / Dec 2018 / Nov 2018 / Oct 2018

Individual risks	Original Score	Mitigations	Current score
Risk of failure/vulnerability of back-end infrastructure resulting in no access to IT systems	20	Reviewed by REMC. Business case being prepared.	20
Delivery of cost improvement programme	20	Reviewed by F&P committee regularly, focus on transformation programme	20
Risk of forecast and recurrent plans for 2018/19 not being achieved	20	Reviewed by F&P on a monthly basis.	20
Numerous IT-related risks	16	Reviewed by REMC.	16

NARRATIVE

Please note that the weightings allocated to the metrics in the weighted dashboard were reviewed in September 2018 and therefore direct comparison with earlier periods is not possible. An additional metric relating to CIP performance was added to the dashboard in October 2018

PERFORMANCE: WEIGHTED DASHBOARD

Performance data as at: **31 JANUARY 2019**

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
4-hour standard	95% of patients should be admitted, transferred or discharged within 4 hours of arrival at A&E	63.65% Mth 83.73% YTD	≥95%	94.9-90%	89.9-80% YTD	79.9-70%	≤70% Mth	2	5 x 2 = 10	3 x 2 = 6	BI (Jan 2019)
12-hour operational standard	No patient requiring emergency admission will wait 12 hours in A&E	0 Mth 0 YTD	0 Mth & YTD				1	2	1 x 2 = 2	1 x 2 = 2	BI (Jan 2019)
Ambulance handover standard	All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m	0 >60m M 644 >60m Y	≤ 15 mins	15-30 mins (M)		30-59 mins	>60 mins (YTD)	1	2 x 1 = 2	5 x 1 = 5	BI (Jan 2019)
Cancer treatment times	85% should wait no more than 62 days from urgent referrer to first definitive treatment	92.79% Mth 89.86% YTD	≥85% Mth & YTD				≤84.9%	2	1 x 2 = 2	1 x 2 = 2	BI (Jan 2019)
18-week RTT	92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks	92.56% Mth 93.45% YTD	≥92% Mth & YTD				≤91.9%	1	1 x 1 = 1	1 x 1 = 1	BI (Jan 2019)
52-week RTT	Zero tolerance for patient waits over 52 weeks on an incomplete pathway	0 Mth 0 YTD	0 Mth & YTD				1	2	1 x 2 = 2	1 x 2 = 2	BI (Jan 2019)
Diagnostic waiting times	99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral	99.37% Mth 99.18% YTD	≥99% (mth)				≤98.9%	1	1 x 1 = 1	1 x 1 = 1	BI (Jan 2019)
Paper switch off programme	By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments	All using	100%				≤99.9%	1	1 x 1 = 1	1 x 1 = 1	Complete
Control total achievement	Forecast position: Achieve finance control total before STP	Forecast 3 quarters	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	2 x 4 = 8	2 x 4 = 8	Forecast
Control total achievement	Forecast position: Achieve A&E control total trajectory	Forecast 3 quarters	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	2	2 x 2 = 4	2 x 2 = 4	Forecast
Use of resources risk rating	Forecast position: Achieve use of resources risk rating as per plan	Forecast 3 quarters	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	2 x 4 = 8	2 x 4 = 8	Forecast
Transformation	CIP delivery against target	Fail40% - M Fail 15% - Y	Achieved	Fail by <10%	Fail by 10-20%	Fail by 20-30%	Fail by >30%	3	5 x 3 = 15	3 x 3 = 9	Finance report
IT	Completion of agreed IT priorities in line with plan	78%	100%	90-99%	80-89%	70-79%	≤70%	2	4 x 2 = 8	4 x 2 = 8	IT department
Total								27	64	57	
Average									**2.37**	**2.11**	

Partnerships:
We work together for the best patient outcomes

Executive lead(s):	Director of Strategy and Planning	**Reviewing committee:**	Board of Directors	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Effective partnership working underpins our strategic direction				MONTH: 2.92 YTD: 2.92
Sources of assurance:	▪ Scrutiny by committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC		ROLLING TREND: Jan 2019, Dec 2018, Nov 2018, Oct 2018	ROLLING TREND: Jan 2019: 2.92; Dec 2018: 3.08; Nov 2018: 2.92; Oct 2018: 2.58

Individual risks	Original Score	Mitigations	Current score
Lack of Tier 4 CAMHS beds	16	Escalated to Q&S	20
Transfer of community services from Bridgewater NHS FT to WWL	20	Risk assessment discussed and risk score agreed. Included on risk register	20
Non-achievement of KPIs relating to cellular pathology	16	Shared Services Board re-established	16

NARRATIVE

Delivery confidence has reduced as a result of board discussions on Healthier Together and the potential consequences of this, together with the temporary suspension of the orthopaedic pilot with Bolton NHS FT.

PARTNERSHIPS: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Transformation	Support to BIG projects	Mild problems	Fully provided	Mostly provided	Mild problems	Moderate problems	Major problems	2	2 x 2 = 4	2 x 2 = 4	Self-assessment
Research	Numbers recruited against target	Ahead of target	Target complete	Ahead of target	On track	Off target	Way off target	1	1 x 1 = 1	1 x 1 = 1	R&D report
Bolton partnership	Progress on 8 key projects	Mod. concern	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	4 x 3 = 12	4 x 3 = 12	Self-assessment
Locality partnership	Locality plan performance matrix	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	3 x 2 = 6	3 x 2 = 6	Self-assessment
Locality partnership	Transformation of hospital care	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	3 x 3 = 9	3 x 3 = 9	Self-assessment
Locality partnership	Healthier Wigan partnership score	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	4 x 2 = 8	4 x 2 = 8	Self-assessment
Locality partnership	Community services transfer	Moderate concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	4 x 3 = 12	4 x 3 = 12	Self-assessment
NW Sector p/ship	Highlight report for NWSP	Major concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	1	5 x 1 = 5	5 x 1 = 5	Self-assessment
GM partnership	Combined theme 3 status	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	4 x 2 = 8	4 x 2 = 8	Self-assessment
GM partnership	Orthopaedic theme 3 status	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	1 x 3 = 3	1 x 3 = 3	Self-assessment
GM partnership	Cardiology theme 3 status	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	1 x 2 = 2	1 x 2 = 2	Self-assessment
Total								24	70	70	
Average									**2.92**	**2.92**	

REPORT

AGENDA ITEM: 8.1

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	27 February 2019
Subject:	7 Day Service Assurance		
Presented by:	Medical Director	**Purpose:**	Approval

Executive summary

The national Seven Day Working programme, covering ten clinical standards, commenced in 2013 and through an audit process performance against several of them has been submitted by provider organisations over the last 3 years. Following a review of the process NHSI have now developed a new system of board assurance via self-assessment and this report sets out the requirements of this (currently in a pilot phase) and the Trust performance against it.

The results show the Trust is compliant against 3 of the 4 priority standards and 5 out of 6 standards for continuous improvement. The Board is asked to note the outcome and confirm the self-assessment for submission.

Risks associated with this report

The Trust is not fully compliant with standard 2 which states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. Whilst performance during the week is continually improving, performance at the weekend has fallen from the last survey. Work is needed to ensure this improves ahead of the next assessment

Link(s) to The WWL Way 4wards

☒	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Seven Day Services Assurance Process

Introduction

The national Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (standard 2), diagnostics (standard 5), interventions (standard 6) and ongoing review every day of the week (standard 8).

To enable providers to track their progress in achieving the four priority 7DS clinical standards, NHSI developed a self-assessment survey. This was an online tool that allowed providers to input data taken from patient case notes to measure achievement of standards 2 and 8, alongside an assessment of the availability of key diagnostics for Standard 5 and interventions for Standard 6

To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients.

Providers have measured their delivery of 7DS using this tool since 2016 but the significant changes and considerable improvements were not always reflected in the survey results due to the quality of source data and validation issues. The survey also placed a significant administrative burden on providers as it involved reviewing many patient case notes.

To resolve these issues and enable provider boards to directly oversee reporting on this work, NHSI are replacing the survey tool with this board assurance framework for measuring 7DS delivery and this paper sets out the new requirements and Trust performance.

A clinical reference group of senior provider clinicians advised on developing a robust board assurance process. Its work was based on agreed design principles for the board assurance model, to ensure that the new measurement system is:

- consistent, both in terms of the product (a single template for all providers) and its contents (assessments of delivery based on evidence aligned with the organisation's planned improvement trajectory)
- robust and accurate, containing independently verifiable information relating to 7DS, allowing for appropriate external scrutiny
- less of an administrative burden than the existing 7DS survey
- linked to developments in urgent and emergency care (UEC) and joint structures that enable network solutions such as sustainability and transformation partnerships (STPs)
- aligned with national-level measurement and reporting against the mandate and planning guidance ambitions for 7DS.

Building on these principles and following the clinical reference group's advice, NHSI developed a single template for providers to record their self-assessments of 7DS delivery. This template enables providers to record their assessments of 7DS delivery in each of the four priority standards for both weekdays and weekends. They can also record progress against the remaining six standards (the 7DS Clinical Standards for Continuous Improvement).

The purpose of the self-assessment template is to ensure providers can produce a single, consistent report of their 7DS delivery, for the dual purpose of assurance from their own boards and national reporting.

As this is a new process the current cycle (this report) is a pilot and is based on data from the previously submitted 7DS submission made in June 2018. NHSI has confirmed that in future this revised submission will be submitted biannually and future cycles will be based on a broader evidence base although case note review will form a part of this.

Four Priority Clinical Standards

The threshold for achieving compliance for all four priority clinical standards is 90%

Standard 2 specifies that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital

Standard 5 covers the availability of six consultant-directed diagnostic tests for patients within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients. The diagnostic tests are as follows

- Computerised tomography (CT)
- Ultrasound (USS)
- Echocardiography
- Upper GI endoscopy
- Magnetic resonance imaging (MRI)
- Microbiology

Standard 6 covers timely 24-hour access seven days a week to nine consultant-directed interventions. The interventions are as follows

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous coronary intervention
- Cardiac pacing

Standard 8 relates to the ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition. In practice this means that patients with high

dependency needs should be reviewed by a consultant twice daily. All other patients admitted in an emergency should be reviewed by a consultant once daily unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway

Standards for Continuous Improvement

All 10 7DS clinical standards are vital to consistently high quality care, and taken as a whole, impact positively on the quality of care and patient experience. In addition to the specific information on the four clinical standards as outlined above providers must draft a commentary on work done relating to the delivery of the remaining six in the board assurance template. These standards are as follows

- **Standard 1 : Patient Experience** - Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends
- **Standard 3 : Multidisciplinary Team Review** - Assurance of written policies for MDT processes in all specialties with emergency admissions, with appropriate members (medical, nursing, physiotherapy, pharmacy and any others) to enable assessment for ongoing/complex needs and integrated management plan covering discharge planning and medicines reconciliation within 24 hours
- **Standard 4 : Shift Handovers** - Assurance of handovers led by a competent senior decision-maker taking place at a designated time and place, with multiprofessional participation from the relevant incoming and outgoing shifts
- **Standard 7 : Mental Health** - Assurance that liaison mental health services are available to respond to referrals and provide urgent and emergency mental healthcare in acute hospitals with 24/7 emergency departments 24 hours a day, seven days a week
- **Standard 9 : Transfer to Community, Primary and Social** Care - Assurance that the hospital services to enable the next steps in the patient's care pathway, as determined by the daily consultant-led review, are available every day of the week
- **Standard 10 : Quality Improvement** - Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that the duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week

Trust Performance

Priority Clinical Standards

For the pilot of the new assurance framework Trusts have been advised to use the results of the previous audits carried out in summer 2018 for the four priority clinical standards. The most recent results of this and all the previous surveys are shown below. The standards covered in each submission varied so previous data is not available for all of them from each survey.

In previous surveys there wasn't a national target although in the final report there was some benchmarking with other providers. The target issued as part of the revised process is 90% as outlined above.

WWL	Weekday results	Weekend results

Results	Standard 2	Standard 5	Standard 6	Standard 8	Standard 2	Standard 5	Standard 6	Standard 8
Mar-16	61%			100%	58%			97%
Sep-16	74%				59%			
Mar-17	81%	100%	100%	98%	84%	68%	89%	64%
Sep-17	82%				94%			
Jun-18	89%	100%	100%	100%	71%	83%	100%	100%

Full details of the current assurance levels and a short narrative are included in Appendix 1 but in relation clinical standard 2 there has been a sustained improvement in performance on week days. The weekend performance dipped significantly but the majority of this is due to the performance on one particular Saturday (the audit is based on a sample from one week of data). In relation to standard 5 at the weekend this is due to echocardiography not being available.

Clinical Standards for Continuous Improvement

The Trust is compliant with all standards except for standard 1 relating to patient experience at weekends versus during the week. This is not something that has previously been specifically reviewed but plans are in place to complete an initial survey before the next self-assessment is completed in the Autumn of 2019 and if this identifies any issues an action plan will be developed accordingly.

Conclusions and Recommendations

The Board is asked to note the contents of the report and approve the self-assessment as outlined. As the new process is a wider exercise covering all 10 standards and will require more evidence in future submissions it is recommended that a 7DS working group is established to ensure that the Trust is able to provide all the necessary evidence and can demonstrate improvement plans where necessary. Once feedback is received on the pilot submission an update will be provided to the Board.

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Acute Internal Medicine 14 fails of 104 cases within the sample Trauma & Orthopaedics 4 fails of 17 cases within the sample Urology 1 fail of 4 within the sample Obs & Gynae 1 fail of 2 cases within the sample General Surgery 1 fail of 18 cases within the sample Other 1 fail of 1 case within the sample • 8 of the 14 fails for Acute Internal Medicine were on the Saturday of the sample week – all afternoon / evening admissions. All 14 fails were afternoon / evening admissions, 12x <20 hours and 2 just over 20 hours. A flagging mechanism is being explored to support prioritisation of new admissions. • Similarly for T&O all 4 fails were <18hours and a similar mechanism to support prioritisation suggested. Each case has been thoroughly investigaed and there were no apparent themes or learning opportunities in particular identified.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	A business case is being completed to provide echocardiography at the weekend by formal arrangement. At the moment this is reliant on good will to deliver.	Echocardiography	Yes available on site	No the test is only available on or off site via informal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Fully compliant with this standard	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients requiring twice daily reviews: 0 patients Patients requiring once daily review: 151 patients • 92% of patients received a once daily review	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Clinical Standard 1 : Patient Experience - the Trust has not previously specifically surveyed patients to investigate differences between weekends and week days but is developing plans to do this before the next survey in the Autumn of 2019. If this identifies any differences an action plan will be developed accordingly Clinical Standard 3 : Multidisciplinary Team Review - The Trust is compliant with this standard Clinical Standard 4 : Shift Handover - The Trust is compliant with this standard Clinical standard 7 : Mental Health - The Trust is compliant with this standard Clinical Standard 9 : Transfer to community, primary and social care - The Trust is compliant with this standard Clinical Standard 10 : Quality Improvement - The Trust is compliant with this standard

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Not applicable

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

REPORT

AGENDA ITEM: 8.2

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	27 February 2019
Subject:	Review of committee terms of reference		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

The terms of reference of a number of committees have been reviewed during February 2019 and are presented for approval. The terms of reference for groups that have not met in February will be reviewed during March 2019.

The board is recommended to approve the updated terms of reference as presented.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

Terms of Reference

Committee Name:	Audit Committee
Chairperson	Non Executive Director
Date:	February 2019
Version:	FTv19
Role of the Committee:	To provide an oversight of the Trust's systems for governance, risk management and internal control.
Reports to:	The Board of Directors, through minutes and Chairs report of key outcomes.
Receives Chairman's reports on the key issues from:	1. Finance & Investment Committee 2. Quality & Safety Committee 3. Workforce Committee 4. Charitable Trust Board 5. Engagement Committee 6. Caldicott Committee
Constitution	The committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.
Meeting and Attendance Frequency:	Minimum of 4 meetings per annum, more frequently if deemed necessary by the Committee, Internal or External Auditors on an ad hoc basis as agreed with the Chairperson. Audit NEDs must attend at least 3 meetings a year
Definition of Quorum:	No business shall be transacted unless Three Non Executive Directors of the committee are present.
Membership including Core Membership:	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than four members. The Chairman of the Trust cannot be a member. All Non-Executive Directors are eligible to attend the Audit Committee with the exclusion of the Chairman. There is a core membership of 4 NEDs. Membership should include a NED with recent and relevant financial experience who would act as Chair of this committee.

Attendance (to support the committee)

Appropriate representatives from the Executive Management Team and appropriate representation from Internal and External Audit and Counter Fraud.

At least once per year the Committee may meet privately with the Internal and External Auditors without any Executive Board members present.

The Chief Executive should be invited to attend to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft internal audit plan and the annual accounts. All other executive directors should be invited to attend, when the Committee is discussing items on the agenda that cover areas of risk or operation that are the responsibility of that particular director.

The Company Secretary or his or her deputy shall attend to take minutes of the meeting and provide appropriate support to the Chairman and Committee Members.

Two Executive Directors, (one of which must be the Director of Finance or his/her nominated deputy and a Director with a clinical background or his/her nominated deputy) and appropriate representatives from External, Internal Audit, the Counter Fraud Team and the Company Secretary (or his/her representative).

Authority	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Audit committee will escalate matters of concern to the Board via the Chair's Report. In particular, where a red risk score has remained unchanged for 3 consecutive months, this should be considered for escalation to the Trust Board or Amber for 6 months this should be considered for escalated to the Trust Board. Time will be set aside as a standing item on each Agenda at the start of Audit Committee meetings to consider any aspects of audit relating to the Charitable Trust as required.

Scope of Responsibility (Duties):	**Governance, Risk Management and Internal Control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee shall: 1. Critically review all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board 2. Review the Trust's process of corporate governance to ensure that due consideration is being given to the process of reviewing the Board Assurance Framework to monitor progress towards the achievement of corporate objectives. 3. Ensure a procedure is in place to identify, manage and measure key risks facing the Trust. 4. Ensure that the Trust has an appropriate frame work in place to review all policies including compliance with relevant regulatory, statutory, legal and code of conduct requirements and guidance relevant to the corporate governance of the Trust. 5. Establish a procedure to report to the Council of Governors and within the Annual Report on the supply of non-audit services provided by the External Auditor to the Trust. 6. Consider the adequacy of policies and procedures covering fraud corruption and bribery as set out by the NHS Protect. Standards for providers in regards to quality and compliance. 7. Consider the Annual Report, Quality Accounts and Financial Statement before recommending acceptance to the Board, focusing particularly on the wording in the Annual Governance Statement and other disclosures relevant to the ToR of the Committee. 8. Advise the Board on any risks or concerns, which might have material effect on the Organisation. 9. Review or consider the Trust Strategy and any issues that may arise in relation to anti-fraud and corruption. 10. Conduct an Annual Review of all aspects of the Board Assurance Framework to ensure that the principles are embedded in the organisation. 11. Review the Trust's processes for monitoring Information Governance and Clinical Audit 12. Conduct a Bi-annual review of the Corporate Risk Register to ensure that the processes for escalation of risks are operating appropriately. 13. Scrutiny of the Trust's Gifts and Hospitality Register, providing appropriate challenge and receiving assurances regarding the processes related to declarations of gifts and hospitality.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it, as well as reference to the Trust's Risk Register.

INTERNAL AUDIT

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal (including involvement in the selection process when/if a provider is changed).
- Review and approval of the Internal Audit strategy, operational plan, reporting system, training for audit committee members, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Consideration of the major findings of internal audit work (and management's response, including monitoring of progress on the implementation of IA recommendations), and ensure co-ordination between the Internal and External Auditors to optimise resources.
- Ensuring that the Internal Audit function is suitably qualified adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of the Internal audit

EXTERNAL AUDIT

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors having taken account of the recommendations of the Audit Committee and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment, costs and performance of the External Auditor, to be overseen by an external audit task and finish sub committee of the COG, chaired by the Audit Committee Chair.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with the other External Auditors in the local health economy
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- In addition the committee will monitor progress against the implementation of External Auditor recommendations.

	Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses **OTHER ASSURANCE FUNCTIONS** The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.) In addition, the Committee will review the function of other committees including key concerns/risks highlighted by that committee, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality and Safety Committee and other sub committees of the Board that are established. In reviewing the work of the Quality & Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on a biannual arrangement of the assurance that can be gained from the CRR and BAF. Review the work and any identified risks relating to the operation of the Legal Services Department by receiving bi-annual reports of activity, to provide assurance on effectiveness of service delivery. **ANTI- FRAUD, CORRUPTION AND BRIBERY** The local anti-fraud function is very important in identifying and preventing fraud and operational risks to the Trust. The Trust has a zero tolerance policy in respect of fraud, corruption and bribery and investigations are carried out if evidence supports this. The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud, corruption and bribery and shall review the outcomes of anti-fraud work. The Local Anti-Fraud Specialist shall respond to the Committee who shall challenge and scrutinise identified fraud risks at the Trust. **MANAGEMENT** The Committee shall request and review reports and positive assurances from the CEO, Directors and managers on the overall arrangements for governance, risk management and internal control, including regular updates on the Trust's Assurance Framework and Risk Register as described above. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. The committee will after each meeting consider the effectiveness of the discussion and assurances received.

	FINANCIAL REPORTING The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal reporting relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other • disclosures relevant to the terms of reference of the Committee • Changes in, and compliance with, accounting policies, practices and estimation techniques • Unadjusted mis-statements in the financial statements • Significant judgements in preparation of the financial statements • Significant adjustments resulting from the Audit letter of representation • Qualitative aspects of financial reporting.
Other Matters	The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance (including quality governance) arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts. The Committee shall be supported administratively by the Trust/Company Secretary, whose duties in this respect will include: • Agreement of agendas with Chair and attendees and collation of papers • Ensuring accurate minutes are recorded • Keeping a record of matters arising and issues to be carried forward • Advising the Committee on pertinent issues/areas • Enabling the development and training of Committee members.
Review Date:	March 2020 (minor changes can be adopted on an ongoing basis i.e. job titles and attendees)
Monitoring ToR	On an annual basis, the Committee will review its own effectiveness by reference to the self-assessment checklist provided within the NHS Audit Committee Handbook 2018.

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Terms of Reference	
Committee Name:	Finance and Performance Committee
Chairperson	A Non Executive Director (other than the Trust Chairperson)
Date:	February 2019
Version:	FT v13
Reports to:	Board of Directors and Audit Committee
Meeting and attendance Frequency:	Monthly except August and December. All members are expected to achieve a minimum attendance of 7 meetings a year.
Definition of Quorum:	3 Executive Directors (one of which must be the Director of Finance or their nominated Deputy & Director of Operations & Performance or their nominated Deputy) and 3 Non Executive Directors.
Membership:	Membership is open to all Board Members.
Core Membership :	All Executive Directors should attend, but may nominate a Deputy to attend on their behalf. This should be by exception and not as a matter of routine. The Deputy must attend should the relevant director not be able to.
Associate Membership:	On an ad hoc basis as required by the content of the agenda.
In Attendance: (to support the committee)	Company Secretariat
Authority:	Authorised by the Board of Directors in accordance with the Trust's Constitution and Standing Orders. Section 8.1 states "The Board of Directors may make arrangements on behalf of the Foundation Trust for the exercise of any of its powers by a formally constituted committee of Directors or the Chief Executive, subject to such restrictions and conditions as the Board of Directors thinks fit." To develop strategic recommendations for approval by the Trust Board including recommendations from the Capital Committee on the following: • 5 Year rolling Capital Planning • In year capital monitoring • In year forecasting The Finance & Performance Committee will escalate matters of concern to the Audit Committee or Board using the approved escalation template. Where a Red risk score has remained unchanged for 3 consecutive months this should be escalated to the Board or amber for 6 months this should be escalated to the Board.

Scope of Responsibilities (duties)	**Strategic** 1. To monitor the financial position of the Foundation Trust, including approving the key financial assumptions to be used in Strategic and Business Planning for recommendation to the Trust Board. 2. To monitor activity and the impact of any major changes in the economic, political and regulatory environment, and the associated financial risks. 3. To consider investment and disinvestment from services 4. To monitor strategic cash flow, cash levels and liquidity 5. To recommend the borrowing strategy for Board approval 6. To identify and review external financing arrangements / vehicles e.g. borrowing, Joint Ventures, PFI 7. To identify, evaluate and recommend for Board approval opportunities for strategic commercial partnerships 8. To review the long term capital investment plans 9. To consider proposals for acquisition and disposal of assets 10. Evaluation of strategic issues related to income e.g. contract negotiations, commissioning, CQUIN, tendering for new services, risks from competition 11. To review the contractual framework relating to any material commercial relationships. 12. Monitoring of the implementation of service and site transformation and investment plans. 13. To consider the definition of core activities and non-core activities 14. To monitor the performance of the Trusts Cost Improvement Programmes **Short term** 1. To recommend the annual I&E /capital investment plans 2. To review the current financial, activity and other performance information, including SLR & SLM 3. To apply learning from previous financial, activity and other performance to ensure performance achieves/surpasses targets 4. To recommend prioritisation of capital investment proposals when appropriate 5. To monitor performance against ST schemes. On those over £50,000, where progress is RAG rated red for 3 months, to require the responsible senior manager/clinician to report on performance and corrective action plans. 6. To review the BAF performance for delegated areas **Statutory / Regulatory** 1. To review the annual financial statement before submission to the Trust Board **Procedural** 1. To keep under review and approve the SFIs for submission to the Trust Board 2. To confirm that the Trust has the legal power to make proposed investments 3. Review the Trust's Investment Policy and recommend changes where necessary 4. To approve the Treasury Policy

Other Matters:	The Finance & Investment Committee reports direct to the Foundation Trust Board and via its minutes to the Audit Committee.
Review Date:	February 2020
Monitoring of T of R:	Monitoring of the Terms of Reference will be on an ongoing basis and subject to annual review.

Terms of Reference

Committee Name:	IM&T Strategy Committee
Chairperson	NED or delegated representative (this should by exception and not be a matter of routine)
Date:	January 2017
Reports to:	Trust Board
Receives reports/ minutes from:	IT Security Working Group Digital Programme Delivery Board Caldicott Committee Data Quality Committee minutes
Meeting and attendance Frequency:	3 scheduled meetings per year, however, as circumstances dictate, the committee may deviate from this and meet more or less frequently. All members must achieve a minimum attendance of 2 meetings a year.
Definition of Quorum:	A quorum shall be formed on the attendance of three members of the committee.
Membership:	Director of Finance Director of Strategy and Planning Director of Community Services Chief Executive Medical Director Director of Nursing Director of Operations and Performance 2 Non-Executive Directors *Other Trust Board Directors may attend any meeting*
In Attendance:	Divisional Medical Director Head of IM&T Head of Production and Modernisation Head of Clinical Coding & Data Quality Head of Business Intelligence Head of IT Services Head of Business Analysis Trust Financial Controller Clinical Director for IT Head of Procurement Trust Board Secretary
Associate Membership: (must attend on an ad hoc basis dependent on the agenda)	Project Leads will attend to report directly to the Board for the major projects they are leading on
In Attendance: (to support the committee)	Company Secretariat

Authority:	• The IM&T Strategy Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Director's meetings. • The IM&T Strategy Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the IM&T Strategy Committee. • The IM&T Strategy Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. • To develop strategic recommendations for approval by the Trust Board. • The IM&T Strategy committee will escalate matters of concern to the Audit Committee or Trust Board using the approved escalation template. Where a Red risk score has remained unchanged for 3 consecutive months this should be escalated to the Trust Board or amber for 6 months this should be escalated to the Trust Board.
Scope of Responsibilities (duties)	• To ensure the executive, clinical and operational divisions are informed of and engaged with the design, content and implementation of the Trust's IM & T Strategy. • To review the clinical and business benefits and risks associated with the strategy. • To provide assurances into how the IM & T Strategy supports the Trust Board's Corporate Objectives in both business and clinical advances. • To formally endorse all IM&T business cases that relate to major areas of investment for approval by the Board • To advise upon, as required, the scope, delivery and performance of all key, critical relationships with external stakeholders. • To approve policies as appropriate under IM&T responsibilities prior to submission to PARC
Other Matters:	The core agenda will be consistent with the agreed work plan of the committee:
Review Date:	Trust Board to review the committee structures as appropriate, including the remit, scope and responsibilities of the IM&T Strategy Committee

Monitoring of Tof R:	Monitoring of the Terms of Reference will be on an ongoing basis and subject to annual review in February 2018

Terms of Reference

Committee Name:	Quality and Safety Committee
Chairperson	A Non Executive Director
Date:	February 2019
Version:	V18
Reports to:	Audit Committee and Board of Directors routinely via minutes and by escalation using the approved escalation template as required.
Receives reports/ minutes from:	a. Divisional Quality Executive Committee Minutes (DQEC) • Corporate • Specialist Services • Surgery • Medicine • Estates and Facilities • Community (once acquired) b. Quality Champion Committee Minutes c. REMC minutes d. Safeguarding Committee minutes e. Infection Prevention Control committee minutes f. Medicine Management Strategy Board minutes and dashboard g. Wigan Borough Palliative Care and End of Life Care Committee h. Harm Free Care Board i. Discharge Improvement Group minutes j. Occupational Safety and Health Committee k. Quality, Safety and Safeguarding Group l. CQC Stakeholder Group m. Mortality Group
Meeting and attendance Frequency:	Monthly excluding August All members must achieve a minimum attendance of 8 meetings a year
Definition of Quorum:	2 Non Executive Directors and 2 Executive Directors of which one must be either the Director of Nursing or Medical Director or their nominated representatives
Membership:	Non Executive Director (Chair of the committee) 3 Non Executive Directors Chief Executive Chief Nurse Medical Director Director of Governance Director of Workforce Director of Finance Chief Operating Officer Director of Strategy & Planning *Nominated Deputies are acceptable but cannot be the norm.* *All NEDs are entitled to attend if they so wish*

In attendance :	Deputy Chief Nurse Compliance Lead Deputy Company Secretary Associate Director Estates and Facilities Public Governors (2) Associate Director of IM&T Divisional Heads of Governance Heads of Nursing Assistant Director of Nursing and Head of Midwifery Divisional Medical Directors (to be present when the deep dive of their relevant DQEC minutes is taking place) *Internal Audit has an open invitation to attend meetings.*
In Attendance: (to support the committee)	Deputy Company Secretary
Authority:	• The Quality and Safety Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Director's meetings. • The Quality and Safety Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Quality and Safety Committee. • The Quality and Safety Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. • To develop strategic recommendations for approval by the Board of Directors. • The Quality and Safety Committee will escalate matters of concern to the Audit Committee or Board of Directors, using the Trust's approved escalation template. • A Task and Finish Group nominated by the Quality and Safety Committee may be established to conduct deep dive exercises when required.

Scope of Responsibilities (duties)	**Role** To act as a scrutiny and assurance committee. The Quality and Safety Committee will receive minutes, reports and escalations as required from REMC. To enable the Board to obtain assurance that high standards of care are provided by the Foundation Trust and in particular that adequate and appropriate governance structures, processes and controls are in place throughout the Foundation Trust to: • Promote safety and excellence in patient care • Monitor compliance with agreed standards, pathways and checklists • Identify, prioritise and manage risk arising from clinical care. • Ensure the effective and efficient use of resources through evidence based clinical practice • Protect the health and safety of foundation trust employees • Ensure consistency is maintained across all quality governance measures • Ensure regulatory compliance, particularly in relation to CQC and NHSI requirements. **Duties** • To receive assurance that all statutory elements of quality governance are adhered to within the Foundation Trust • To assure the Board of Directors on the Foundation Trust's compliance with agreed quality and safety metrics. • To approve the terms of reference and membership of its reporting sub committees (as may be varied from time to time at the discretion of the Quality and Safety Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the Quality and Safety Committee in the sub-committees' Terms of Reference for consideration and action as necessary. • To consider matters referred to the Quality and Safety Committee by its sub-committees • To make recommendations to the Audit Committee concerning the annual programme of Internal Audit work, to the extent that it applies to matters within these Terms of Reference. • To foster quality and safety links with external stakeholders. • To ensure that the Foundation Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

	Safe Effective and Caring **Safe:** • To commission the setting of quality and safety standards by the Board and ensure that a mechanism exists for these standards to be monitored, to assure the Foundation Trust's Quality Strategy of "Safe Effective and Caring"; • To receive quarterly Safe Effective and Caring (SEC) assurance reports; • To undertake monthly reviews of the STEIS log; • To assure that the Foundation Trust has reliable, up to date information about patient experience informing progress against the 90% positive experience target; • To receive quarterly reports on mortality and medicines management; • To ensure that risks to patients are minimised through the application of a comprehensive risk management strategy prior to its presentation to the Board of Directors for approval; • To assure that areas of identified significant risk have set priorities and actions using the Assurance Framework; • To agree the quality strategy and monitor progress against the Trusts annual Quality Account priorities; • To undertake twice yearly reviews of the Corporate Risk Register and monthly reviews of the Corporate Risk Tracker; • To receive annual reports for Incident Management, Infection Prevention and Control, Safeguarding Adults, Safeguarding Children and Health and Safety, Patient Safety; Complaints and the National Maternity Survey. • To undertake scrutiny of service transformation programmes, ensuring that due consideration is given to the safety and quality of services when planning to make changes to clinical services, or to services that provide a direct support function to clinical areas. • To monitor progress to achieve actions identified following the receipt of a Prevention of Future Deaths notification from the Coroner. **Effective** • To ensure that the CQC's Fundamental Standards are complied with to provide relevant assurance to the Board when making the Trust's annual CQC Declaration of Compliance: o Person centred care o Dignity and respect o Need for Consent o Safe Care and Treatment

	○ Safeguarding service users from abuse and improper treatment ○ Meeting Nutrition and Hydration Needs ○ Premises and equipment ○ Receiving and Acting on Complaints ○ Good governance ○ Staffing ○ Fit and proper staff ○ Duty of candour ○ Requirement as to Display of Performance Assessments (CQC ratings) • To ensure the Foundation Trust complies with NHS Improvements Single Oversight Framework in relation to Quality and Safety. **Caring** • To receive patient experience assurance reports twice yearly; • To receive an annual report on Complaints Management; • To promote within the Foundation Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's Being Open/Duty of Candour policy on reporting issues of concern and monitoring the implementation of that policy.
Other Matters:	**Minutes and Reporting** The minutes of all meetings of the Quality and Safety Committee will be formally recorded. The Quality and Safety Committee minutes will be submitted to the Audit Committee and Board of Directors.
Review Date:	February 2020
Monitoring of Terms of Reference:	The terms of reference of the committee shall be reviewed annually as a minimum but changes may be applied as required.

REPORT

AGENDA ITEM: 8.3

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	27 February 2019
Subject:	Cycle of business 2019-20		
Presented by:	Company Secretary	**Purpose:**	Approval

Executive summary

At its last meeting, the board agreed to move towards bi-monthly meetings from the start of the next financial year.

The attached cycle of business sets out the business proposed to be transacted at each meeting. It has been reviewed by executive directors and those whose prepare papers to ensure that the proposed timings are appropriate.

The board is therefore requested to approve the cycle of business as presented.

Risks associated with this report

The purpose of this report is to set out the cycle of business for the coming year, which serves to mitigate the risk of missing regulatory and other deadlines.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☐	People	☐	Partnerships

The WWL Way

Board of Directors
Cycle of business 2019-20

Item	Part	Purpose	Presenter	Prepared by	May 2019	Jul 2019	Sep 2019	Nov 2019	Jan 2020	Mar 2020
INTRODUCTORY ITEMS										
Chair and quorum	1 & 2	Information	Chair	Verbal	✓	✓	✓	✓	✓	✓
Apologies for absence	1 & 2	Information	Chair	Verbal	✓	✓	✓	✓	✓	✓
Declarations of interest	1 & 2	Information	Chair	Verbal	✓	✓	✓	✓	✓	✓
Minutes of the previous meeting	1 & 2	Approval	Chair	Company Secretary	✓	✓	✓	✓	✓	✓
Chair and Chief Executive's report	1 & 2	Information	Chair/Chief Executive	Chair/Chief Executive	✓	✓	✓	✓	✓	✓
Patient experience video	1	Discussion	Chief Nurse	Patient Relations/PALS	✓	✓	✓	✓	✓	✓
ASSURANCE AND GOVERNANCE										
Committee chairs' reports (verbal)	1	Discussion	Committee Chairs	Verbal	✓	✓	✓	✓	✓	✓
Performance report	1	Discussion	COO/CN/MD	Business Intelligence	✓	✓	✓	✓	✓	✓
Finance report	1	Discussion	Director of Finance	Finance Team	✓	✓	✓	✓	✓	✓
Safe staffing report	1	Discussion	Chief Nurse	Deputy Chief Nurse	✓	✓	✓	✓	✓	✓
Board assurance framework	1	Approval	Chair	Deputy Co. Sec.	✓	✓	✓	✓	✓	✓
StEIS reports	2	Information	Chief Nurse	Patient Safety Mgr	✓	✓	✓	✓	✓	✓
Serious incident annual report	2	Information	Chief Nurse	Patient Safety Mgr					✓	
Biannual staffing review	1	Information	Chief Nurse	Deputy Chief Nurse	✓			✓		
Maternity staffing review	1	Information	Chief Nurse	Deputy Chief Nurse	✓					
Mortality report	1	Information	Medical Director	Director of Governance	✓		✓		✓	

Item	Part	Purpose	Presenter	Prepared by	May 2019	Jul 2019	Sep 2019	Nov 2019	Jan 2020	Mar 2020
Review of risk management strategy	1	Approval	Director of Governance	Director of Governance	✓					
CORPORATE GOVERNANCE										
Register of directors' interests	1	Information	Company Secretary	Company Secretary						✓
Review of committee terms of reference	1	Information	Company Secretary	Company Secretary						✓
Review of committee effectiveness	1	Information	Company Secretary	Company Secretary					✓	
Review of well-led action plan	2	Discussion	Company Secretary	Company Secretary	✓			✓		
Use of the common seal	1	Information	Company Secretary	Company Secretary						✓
Data Protection Officer's report	2	Information	Company Secretary	Company Secretary	✓		✓		✓	
NHS Improvement self-certifications	1	Approval	Company Secretary	Company Secretary	✓					
Approval of annual report and accounts *(separate meeting to be convened)*	2	Approval	Chair	Co Sec/DGov/Finance	✓					
Review of Standing Orders	1	Approval	Company Secretary	Company Secretary						✓
Review of Standing Financial Instructions	1	Approval	Director of Finance	Head of Fin. Services				✓		
Internal audit plan	2	Approval	Audit Committee Chair	Internal auditors						✓
Review of cycle of business	1	Approval	Company Secretary	Company Secretary			✓			✓
QUALITY AND PATIENT EXPERIENCE										
In-patient survey results	1	Information	Chief Nurse	Survey provider	✓					
Safeguarding annual report	1	Information	Chief Nurse	Safeguarding Team			✓			
Safe, Effective, Caring (SEC) report	2	Information	Chief Nurse	Compliance Lead		✓	✓	✓		✓
Complaints annual report	1	Information	Chief Nurse	Patient Relations/PALS			✓			
PPI assurance report	1	Information	Chief Nurse	Engagement Team			✓			

Item	Part	Purpose	Presenter	Prepared by	May 2019	Jul 2019	Sep 2019	Nov 2019	Jan 2020	Mar 2020
WORKFORCE										
Medical exclusions and restrictions	2	Information	Director of Workforce	Workforce Gov Mgr	✓	✓		✓	✓	
Guardian of safe working hours report	1	Information	Director of Workforce	Responsible Officer	✓					
Freedom to Speak Up Guardian's report	1	Information	Director of Workforce	Workforce Gov Mgr		✓				
Inclusion and Diversity annual report	1	Information	Director of Workforce	I&D Leads				✓		
Gender pay gap report	1	Information	Director of Workforce	Workforce Team						✓
Staff survey report	1	Information	Director of Workforce	Staff Engagement						✓
FINANCE										
Approval of budget	2	Approval	Director of Finance	Dep Director of Finance						✓
Approval of reference costs	2	Approval	Director of Finance	Dep Director of Finance		✓				
Acceptance of control total	2	Approval	Director of Finance	Dep Director of Finance					✓	
BUSINESS CONTINUITY										
Major incident/business continuity plan	1	Approval	Chief Operating Officer	Head of Resilience		✓				
EPRR core standards report	1	Approval	Chief Operating Officer	Head of Resilience		✓				
7-day services report	1	Approval	Chief Operating Officer	Head of Resilience			✓			✓
STRATEGY AND PLANNING										
Agreement of corporate objectives	2	Approval	Dir. of Strat and Plan	Dep Dir Strat and Plan					✓	
NHSI operational plan 2020-21	2	Approval	Dir. of Strat and Plan	Dep Dir Strat and Plan						✓
Review of NHS operational plan 2019-20	2	Discussion	Dir. of Strat and Plan	Dep Dir Strat and Plan				✓		

REPORT

AGENDA ITEM: 8.3

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To:	Board of Directors	**Date:**	27 February 2019
Subject:	Appointment of Senior Independent Director		
Presented by:	Chair	**Purpose:**	Approval

Executive summary

The NHS Foundation Trust Code of Governance recommends that the board should appoint one of the independent Non-Executive Directors to be the Senior Independent Director. The role of the Senior Independent Director is to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The Senior Independent Director should also be available to governors if they have concerns that contact through the normal channels of Chair, Chief Executive, Finance Director or Company Secretary has failed to resolve, or for which such contact is inappropriate.

The role is currently undertaken by Prof Tony Warne, however he has recently been appointed as the Vice-Chair. Whilst it is possible for both roles to be undertaken by the same individual, it is considered beneficial for the roles to be separate. Having consulted the Council of Governors' Nominations and Remuneration Committee, the board is recommended to appoint Mrs Lynne Lobley as the Senior Independent Director.

Risks associated with this report

There are no risks associated with the content of this report.

Link(s) to The WWL Way 4wards

☐	Patients	☐	Performance
☒	People	☐	Partnerships

The WWL Way

REPORT

AGENDA ITEM: 8.5

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

To	Board of Directors	**Date:**	27 February 2019
Subject:	Changes to Standing Financial Instructions		
Presented by:	Deputy Director of Finance	**Purpose:**	Approval

Executive summary

A number of minor amendments to Standing Orders are presented for the board's approval, as set out in the attached report.

The board will wish to note that the proposed changes have also been reviewed by the Audit Committee and Finance and Performance Committee.

Risks associated with this report

None

Link(s) to The WWL Way 4wards

☐	Patients	☒	Performance
☐	People	☐	Partnerships

The WWL Way

Introduction

The purpose of this paper is to seek approval from the Board of Directors in respect of changes to the Trust's Standing Financial Instructions and Budgetary Control and Delegation Arrangements.

Background

The Code of Conduct: Code of Accountability for NHS Boards issued by the Department of Health requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. The Standing Financial Instructions (SFIs) are issued in accordance with the Code.

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust and are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

The SFIs incorporate the Trust's budgetary control and delegation arrangements which detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions even those delegated to committees, sub committees, individual directors or officers.

Changes

An in-depth review of the SFIs was undertaken during September. Following that review a number further changes have been made and details of these can be found in Appendix 1 attached to this report.

Recommendation

The Board is asked to approve the amendments made to the SFIs.

APPENDIX 1

Standing Financial Instructions –Summary of amendments made January 2019

Section 8.2 Authorisation levels for approval of purchase orders

The national procurement strategy and implementation of Category Towers will result in an increase in expenditure that is being procured through what is currently known as NHS Supply Chain. The weekly invoice value will therefore increase and the approval limits of the Deputy Director of Finance have therefore been increased to support timely approval.

Section 8.2.1 (page 26)

The following table has been updated with a revised limit for the Deputy Director of Finance:

Approval Level	Approval Level - Posts	Approval Limit (inc VAT)
1	Chief Executive / Deputy Chief Executive / Director of Finance	£1,000,000
2	Executive Director / Deputy Director of Finance	£250,000
3	Associate Director of Finance / Deputy Director of Performance	£150,000
4	Head of Department or Service	£20,000
5	Deputy Head of Department / Head of Service	£10,000
6	Senior Department / Service Manager	£5,000
7	Department / Service Manager	£2,500
8	Department / Service Approver	£1,000
9	Requestor Only	N/A

Revised table:

Approval Level	Approval Level - Posts	Approval Limit (inc VAT)
1	Chief Executive / Deputy Chief Executive / Director of Finance	£1,000,000
2	Deputy Director of Finance	£300,000
3	Executive Director	£250,000
4	Associate Director of Finance / Deputy Director of Performance	£150,000
5	Head of Department or Service	£20,000
6	Deputy Head of Department / Head of Service	£10,000
7	Senior Department / Service Manager	£5,000
8	Department / Service Manager	£2,500
9	Department / Service Approver	£1,000
10	Requestor Only	N/A

8.2.3 (page 27)

The table detailing the internal approval limits applicable within the Procurement Department has been updated to include position of Contracts Officer:

Previous table:

Position	PO Approval Limit
Head of Procurement	£25,000,000
Procurement Manager	£250,000
Contracts Officers (Capital)	£100,000
eProcurement Manager	£100,000
eProcurement Officer / Assistant	£50,000

Revised table:

Position	PO Approval Limit
Head of Procurement	£25,000,000
Procurement Manager	£250,000
Contracts Officers (Capital)	£100,000
eProcurement Manager	£100,000
Contracts/eProcurement Officer / Assistant	£50,000

9.3 NHS Supply Chain (page 31)

Amended from:

For goods supplied via the NHS Supply Chain regional stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Director of Finance who shall satisfy him/herself that the goods have been received before accepting the recharge.

To:

For goods supplied via NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Director of Finance or Deputy Director of Finance depending on value, who shall satisfy him/herself that the goods have been received before accepting the recharge.

23.3 Role of the approving entities (page 51)

Amended from:

The Deputies Forum will be responsible for approving all business cases up to the value of £50,000 even where funding is already available to support the expenditure required in the business case.

To:

The Deputies Forum will be responsible for scrutinising business cases, and has the authority to approve:

a. capital only business cases up to the value of £50,000 where funding is already available in the capital programme

b. revenue business cases that are self-funded up to the value of £50,000.

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Standing Financial Instructions

Incorporating Budgetary Control and Delegated Arrangements

The WWL Way

FOREWORD

1. Within the Terms of Authorisation issued by the sector regulator, NHS foundation trusts are required to demonstrate the existence of comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003.

2. The standard requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to all staff and those representing the Trust. Additionally, the Board has drawn up locally generated rules and instructions, including delegation arrangements and financial procedural notes, for use within the Trust. Collectively these comprehensively cover all aspects of (financial) management and control. They set the business rules which directors, employees and the Council of Governors (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

3. SFIs are mandatory for all directors, employees and members of the Council of Governors.

CONTENTS

Further references and financial procedures are retained in the Finance Department section of the intranet.

The following policies are specifically referenced.

- Treasury Management Policy
- Intellectual Property Policy
- Commercial Representatives Policy
- Counter Fraud, Corruption and Bribery Policy and Response Plan
- Gifts and Hospitality Policy
- Disciplinary Policy
- Code of Conduct Policy
- The Charity's Treasury Management Policy
- The Charity's Expenditure Guidance and Fundraising and Income Guidance policy documents.

The Trust's Constitution and Standing Orders, and the Schedule of Matters are also referenced.

1. INTRODUCTION

1.1 Purpose and scope

1.1.1 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

1.1.2 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations including trading units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with detailed departmental and financial procedure notes which must be approved by the Director of Finance.

1.1.3 These SFIs also detail the delegation by the Board of powers and approval limits to officers of the Trust, and as such, contain the Trust's Scheme of Delegation.

1.1.4 The Trust's Schedule of Matters broadly outlines those decisions and duties specifically reserved to the Board of Directors. These matters are not delegated, and as such, the Schedule of Matters represents the Trust's Scheme of Reservation. It is therefore recommended that the Schedule of Matters is read in conjunction with these SFIs and the Scheme of Delegation contained herein.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

1.1.6 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

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

1.1.8 These Instructions are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in the National Health Service Act 2006, National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions.

1.2.2 **"Trust"** means **Wrightington, Wigan and Leigh NHS Foundation Trust.**

1.2.3 "**Accounting Officer"** means the officer responsible to Parliament for the resources under their control. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Services Act (2006) designates the Chief Executive of the NHS Foundation Trust (NHS FT) as the Accounting Officer. The definition of duties and responsibilities of the Accounting Officer are set out within the NHS Foundation Trust Accounting Officer Memorandum.

1.2.4 **"Board"** means the Chairman, Executive Directors and Non-Executive Directors of the Trust collectively as a body.

1.2.5 **"Council of Governors"** means the Council of Governors as constituted within the Constitution.

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

1.2.7 **"Budget holder"** means the director or employee with delegated authority from the Accounting Officer to manage finances (income and expenditure) for a specific area of the organisation.

1.2.8 **"Budget manager**" means an employee directly responsible to a budget holder.

1.2.9 **"Budget operator**" has delegated power from a budget manager to control a particular budget(s). Such delegation of powers shall be within defined parameters and shall be recorded in writing.

1.2.10 **"NHS Improvement"** means the office of the Regulator of Health Services of England.

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

1.2.12 **"Chief Executive"** means the Chief Officer (and the Chief Accounting Officer) of the Trust.

1.2.13 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.2.14 **"Executive Director"** means a Director of the Trust who may also be an officer.

1.2.15 **"Non-Executive Director"** means a member of the Board of Directors who does not hold an executive office of the Trust.

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

1.2.17 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and guidance from NHS Improvement and the Department of Health and Social Care.

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

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

1.2.20 **"Charitable funds"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under s90 of the NHS Act 1977 and the NHS and Community Care Act 1990, as amended.

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

1.2.22 **"SOs"** means Standing Orders, which are contained within the Trust's Constitution.

1.2.23 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

1.2.24 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and delegation

1.3.1 **The Board of Directors** exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within overall income;

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

d) defining specific responsibilities placed on members of the Board and employees as indicated within these Instructions.

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

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

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

1.3.4 The Chairman and Chief Executive must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

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

1.3.6 In line with the requirements of the NHS Act (2006) the Chief Executive and Director of Finance shall monitor and ensure compliance with NHS Counter Fraud Authority standards for Providers for Fraud, Bribery and Corruption, in accordance with the NHS Standard Contract.

1.3.7 The Director of Finance is responsible for:

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

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

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

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

a) the provision of financial advice to the Trust, Directors and employees;

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

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

1.3.7 All Directors and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources; and

d) conforming with the requirements of Standing Orders, the Schedule of Matters, Standing Financial Instructions (including Schemes of Delegation) and financial procedures.

1.3.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure, or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT, FRAUD, CORRUPTION, BRIBERY AND SECURITY

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook and in accordance with the Audit Code for NHS Foundation Trusts issued by NHS Improvement, which will provide an independent and objective view of internal control by:

a) ensuring that there is an effective internal audit function established by management, that meets mandatory Public Sector Internal Audit Standards;

b) reviewing the work and findings of the external auditors;

c) reviewing financial and information systems, monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements;

d) 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;

e) monitoring compliance with Standing Orders and Standing Financial Instructions;

f) reviewing schedules of losses and special payments, making recommendations to the Board; and

g) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions or improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets the NHS foundation trust audit standards;

c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, corruption or bribery; and

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with the current Risk assessment framework issued by NHS Improvement 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) a strategic audit plan covering the coming three years; and

(vi) a detailed plan for the next year.

2.2.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require or 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, members of the Board and Council of Governors or employees of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of the Board or employee's control; and

d) explanations concerning any matter under investigation.

2.3 Role of internal audit

2.3.1 Internal audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data; and

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, or inefficient administration; or

(iii) poor value for money or other causes.

2.3.2 Whenever any audit matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.3 The Director of Internal Audit/Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Director of Internal Audit/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 Director of Internal Audit in the form of an Internal Audit Charter. The Charter will comply with guidance on reporting contained in the Public Sector Internal Audit Standards. The Charter will be reviewed at least every three years.

2.4 External audit

2.4.1 The external auditor is appointed, through a formal process, by the Council of Governors following recommendation from the Audit Committee which should ensure that a cost efficient service is being provided. Where a problem arises in the provision of this service it should be raised with the external auditor and referred on to NHS Improvement if the issue cannot be resolved.

2.4.2 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors, based on recommendations from the Audit Committee. The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by NHS Improvement within the Audit Code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

2.5 Fraud, corruption and bribery

2.5.1 Under the NHS Standard Contract for 2017/2018 and 2018/19, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements. In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance on fraud, corruption and bribery as set out in NHS Counter Fraud Authority Standards for providers.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter-Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Manual and guidance.

2.5.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Counter-Fraud Manual.

2.5.4 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. In addition, a Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

2.6 Security management

2.6.1 Under the NHS Standard Contract for 2017/2018 and 2018/19, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management, and NHS Counter Fraud Authority Standards for providers.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Chief Executive has overall responsibility for controlling and coordinating security.

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

3.1 Preparation and approval of plans and budgets

3.1.1 The appropriate Executive Director will compile and submit to the Board a Business Plan, which takes into account capacity and demand, and HR, estates and financial targets. The Business Plan will contain:

a) a statement of the significant assumptions on which the plan is based; and

b) details of major changes in workload, delivery of services, or resources required to achieve the plan.

The Business Plan will be submitted to NHS Improvement in line with their deadlines, guidance and requirements.

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

a) be in accordance with the aims and objectives set out in the Business Plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds; and

e) identify potential risks.

3.1.3 The Trust shall submit information in respect of its financial plans to NHS Improvement, once approved by the Board of Directors.

3.1.4 The Director of Finance will monitor actual financial performance against plan and report variances and risks to the Board.

3.1.5 All budget holders must provide information as required by the Director of Finance to enable income and expenditure plans to be compiled.

3.1.6 Budget holders, with divisional responsibility, will electronically sign up to their allocated income and expenditure plans at the commencement of each financial year via the Trust's devolved financial management system, DFM.

3.1.7 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 delegated financial performance successfully.

3.2 Budgetary delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) the value of the delegated budget;

b) the purpose(s) of each budget heading;

c) whole time equivalents (WTEs) in respect of pay budgets;

d) individual and group responsibilities;

e) authority to exercise virement;

f) achievement of planned levels of service; and

g) the provision of regular reports.

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

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

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

3.3 Budgetary control and reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control and reporting. These will include the following.

a) Monthly financial reports to the Board, including:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan; and

(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.

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

c) Investigation and reporting of variances from financial, workload and manpower budgets.

d) Monitoring of management action to address variances.

e) Arrangements for the authorisation of budget transfers.

f) Advice to the Chief Executive and the Board on the consequences and economic and financial impact on future plans and projects of a change in policy, pay awards and other events and trends affecting budgets.

3.3.2 Each budget holder is responsible for ensuring that:

a) they remain within their budget allocation;

b) any planned reduction in income or overspending on expenditure, which cannot be addressed by virement, are reported to the Board of Directors;

c) the amount provided in an approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

d) recruitment of a fixed term or permanent employee to a post, not covered by funded establishment, must be approved beforehand by following the Trust's current recruitment policy. Approval must be gained prior to engaging services of any and all agency workers.

e) no permanent employees are appointed without following the Trust's approval process other than those provided for within the available resources and manpower establishment as approved by the Board;

f) they identify and implement cost improvements and income generation initiatives in accordance with the requirements of the approved budget; and

g) any proposal to increase revenue spending has an appropriate funding stream identified and that this has been agreed by the Chief Executive. Proposals to increase revenue spending should also be signed off by the Director of Finance. This applies to all revenue developments whether part of Annual Business Plan discussions or separate business case initiatives, however funded.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business Plan.

3.4 Budget Transfer -Virement

3.4.1 The facility of virement is available to Divisional Chairmen and to budget holders/managers of other budgets. Virement can involve the following different types of transfers:

(i) Transfers between non-pay budgets.
(ii) Transfers between staff budgets.
(iii) Transfers from staff to non-pay budgets.

NB Transfers from non-pay to staff budgets is not allowable.

3.4.2 There is no financial ceiling limiting the amount of any one virement transfer. In all cases, the Divisional Accountant shall be consulted. It is paramount that virement changes do not undermine the integrity of the budgets.

3.6.3 To proceed with budget virements the agreement of both parties should be sought by the Divisional Accountants.

3.5 Capital expenditure

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.6 Monitoring of performance

3.6.1 The Chief Executive is responsible for ensuring that

a) the appropriate monitoring returns are submitted to NHS Improvement in line with the Risk Assessment Framework;

b) financial performance measures have been defined and are monitored and reasonable targets have been identified for these measures;

c) a robust system in in place for managing performance against the targets; and

d) reporting lines are in place to ensure all performance is managed and arrangements are in place to manage/respond to adverse performance.

3.7 Emergency Expenditure

3.7.1 In instances which are deemed as critical the Chief Executive can approve unbudgeted revenue expenditure up to a value of £10,000 (per instance) and with the additional agreement of the Chairman up to £20,000 (per instance). Applications for such an approval must be submitted to the 'Head of Financial Services and Payroll' who will then forward to the Finance Director for final submission to the CEO and Chairman.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will

a) keep accounts, and in respect of each financial year

b) prepare annual accounts, in such form as NHS Improvement and Department of Health and Social Care may, with the approval of the Treasury, direct;

c) ensure that, in preparing annual accounts, the Trust complies with any directions given by NHS Improvement and Department of Health and Social Care with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

d) ensure that a copy of the annual accounts, and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHS Improvement.

e) submit financial returns to NHS Improvement for each financial year in accordance with NHS Improvement's timetable.

4.2 The Trust's audited annual accounts must be presented to the Board for approval and received by the Council of Governors at a public meeting.

4.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented at a public meeting and made available to the public.

4.4 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 Group Accounting Manual. .

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The Director of Finance is responsible for negotiating the Trust's banking contracts, establishing any associated mandates and naming personnel to be signatories for banking transactions.

5.1.3 No employee may open or hold a bank account in the name and/or address of the Trust or of its constituent hospitals/departments. Any employee aware of the existence of such an account shall report the matter to the Director of Finance.

5.2 Bank and GBS accounts

5.2.1 The Director of Finance is responsible for:

a) bank accounts and Government Banking Service (GBS) accounts;

b) establishing separate bank accounts for the Trust's charitable funds;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board of any external borrowing requirements; and

e) ensuring that procedures are maintained that document all transaction processing relating to Trust bank accounts.

5.3 Banking procedures

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

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

b) the limit to be applied to any overdraft; and

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

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

5.4 Banking tendering and review

5.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every five years, unless the Board determines otherwise. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

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

6.1 Income systems

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

6.1.2 Credit note authorisation will be determined for each manager depending on their role/responsibility and a list of managers who are set up to undertake such approvals is maintained within Oracle.

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

6.2 Fees and charges

6.2.1 The Trust shall follow NHS Improvement's guidance in setting prices for NHS Service contracts, where services are not covered by a mandatory National Tariff. The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England (such as Payment by Results National Tariffs), HM Treasury or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.2 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the NHS Commissioning Board – Standards of Business Conduct shall be followed.

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

6.3 Debt recovery

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

6.3.2 Income which is deemed due, but possibly uncollectable, should be dealt with in accordance with debt recovery procedures, and reported as a write-off loss (SFI 14.2) where appropriate.

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

6.4 Security of cash, cheques and other negotiable instruments

6.4.1 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Trust cash shall not under any circumstances be used for private transactions such as the encashment of private cheques, bank to bank transfers or temporary loans.

6.4.3 Trust accounts should not be used for ad hoc temporary banking of employee funds or other monies unrelated to Trust business and income, except patients' monies held in trust.

6.4.4 Trust credit cards should not be used for personal expenditure, even if there is an intention to reimburse the Trust.

6.4.5 Trust credit cards should not be used to pay employee expenses, as these should be reimbursed via Payroll.

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

6.4.7 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.

6.4.8 During the absence (whether sickness or annual leave etc.) of the authorised safe key holder, the officer who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be a written discharge of the safe and/or cash box contents on the transfer of responsibilities, with the discharge document authorised by the relevant senior officer, and retained for audit inspection.

6.4.9 The opening of incoming post shall be undertaken by two officers except where authorised in writing by the Director of Finance. All cash, cheques, postal orders and other forms of payment received shall be entered in an approved form of remittance register. All cheques and postal orders shall be crossed "Not Negotiable Account Payee Only – Wrightington, Wigan and Leigh NHS Foundation Trust". The remittance register should be passed to the cashier from whom a signature should be obtained.

6.4.10 All unused cheques and GBS orders will be held as controlled stationery and issued in accordance with controlled stationery procedures.

6.4.11 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy and Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures.

7. TENDERING AND CONTRACTING PROCEDURE

7.1 General

7.1.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions.

7.1.2 The approval of business cases prior to the procurement process is covered in SFI 23.

7.1.3 In all instances, the intended expenditure should be reflective of the total life cycle costs of provision of the goods and / or services.

7.1.4

7.2 EU Directives governing public procurement

7.2.1 Directives by the Council of the European Union promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

7.3 Competitive quotations

7.3.1 Competitive quotations are required where the intended expenditure or income is equal to, or is reasonably expected to exceed £5,000 but not exceed £50,000 ex VAT.

a) Quotations should be obtained from at least three suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

b) Quotations should be submitted by email or via electronic sourcing software, as deemed appropriate by the Procurement Department.

c) All quotations should be treated as confidential and should be retained for inspection.

d) The Chief Executive or his/her 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 not 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.

7.3.2 Contract and tendering procedures within these SFIs should be applied to quotations as best practice.

7.4 Competitive tendering

7.4.1 Competitive tenders are required where the intended expenditure or income is equal to or is reasonably expected to exceed £50,000, but not exceed the relevant European Union threshold ex VAT.

7.4.2 The Trust shall ensure that competitive tenders are invited for:

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

b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

d) disposals of Trust property or goods (unless specified in SFI 7.24).

7.4.3 Formal tendering procedures need not be applied where:

a) the estimated expenditure or income does not, or is not reasonably expected to exceed £50,000 excluding VAT.

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

c) the Trust is disposing of Trust assets, as set out in SFI 7.24

d) the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS e.g. NHS Supply Chain); or

e) there is a national or regional sole supplier agreement in place.

7.5 Non–competitive waivers

7.5.1 In exceptional instances where competitive quotations and tenders are not deemed possible, Trust officers should seek the approval of the Trust to waive these requirements.

7.5.2 Quotation and tendering procedures may only be waived in the following circumstances:

(i) very exceptionally, where the Chief Executive decides that formal tendering procedures would not be appropriate, however in such instances the benefits and rationale must be clearly demonstrated;

(ii) timescales - 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;

(iii) sole supplier - where specialist expertise is required and is available from only one source;

(iii) maintaining continuity – when there is a clear benefit to be gained from maintaining continuity with an earlier project and/or engaging a different supplier 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 (financial evidence must be provided in support); or

(iv) standardisation where the requirement is an addition to a previously tendered range of goods and services and clearly supports the Trust policy for standardisation.

7.5.3 The waiving of competitive quotation or tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

7.5.4 Where it is decided that a competitive quotation/ 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.

7.6 Authorisation of waivers

7.6.1 Where competitive tendering or a competitive quotation process is to be waived, the authorisation limits stipulated are as follows.

Amount	Authorisation
Less than £5,000 ex VAT	No waiver required
£5,000k - £25,000 ex VAT	Associate Director of Finance
Up to £50,000 ex VAT	Deputy Director of Finance
Up to EU Threshold ex VAT	Director of Finance
Up to and over EU Threshold ex VAT	Chief Executive (or Deputy)

7.6.2 Expenditure exceeding the relevant European Union threshold may not be waived, unless specified in the European Regulations. The Trust Procurement Department will advise in these circumstances.

7.7 Frameworks and approved supplier lists

7.7.1 The Trust shall use contracts established by the Crown Commercial Service (CCS), NHS Supply Chain (NHSSC), Shared Business Service Collaborative Procurement Service (SBS) or another applicable organisation with appropriate frameworks, for the procurement of goods and services unless the Chief Executive or nominated officers deem it inappropriate.

7.7.2 If the Trust does not use frameworks as mentioned in SFI 7.7.1, and where tenders or quotations are not required because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

7.7.3 The Trust shall ensure that the suppliers invited to tender for estates-related contracts (and where appropriate, quote) are among those on approved lists such as North West Consortium, ProCure22 or the latest DHSC framework providing design and construction services or those outlined in SFI 7.7.

7.7.4 All firms who have applied for permission to tender must satisfy the Trust as to their technical and financial competence. All suppliers must adhere, where appropriate, to the standard NHS Terms and Conditions.

7.8 Exceptions to using approved contractors

7.8.1 If, in the opinion of the Chief Executive and either the Director of Finance or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved suppliers (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

7.9 Contracting/tendering procedure

7.9.1 The Trust has adopted an "e-tendering" system to issue and receive all tenders electronically.

7.9.2 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders, and no tender will be considered for acceptance unless submitted through the e-tender system, as instructed within the tender documentation.

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

7.9.4 Every tender for goods and services shall embody the NHS Terms and Conditions and, as appropriate, the contract form required for the specific goods and services.

7.9.5 Where the Trust is tendering to undertake the provision of goods/services for another organisation then a full financial appraisal must be undertaken and approved by Executive Communication Cell (ECC) prior to any invitation to tender being submitted. Where approval has been granted a full business case must be completed and approved in accordance with the business case approval process during the period in which the contract is being agreed.

7.10 Receipt and safe custody of tenders

7.10.1 All tenders must be issued and managed via the Trust's, or other approved, electronic tendering systems e.g. Crown Commercial Services. No hard copy tenders will be accepted.

7.10.2 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

7.11 Opening tenders

7.11.1 The electronic tendering system is a fully automated, auditable system which seals bids until the response deadline has passed. Therefore the originating Contract Manager will be deemed authorised to access the electronic tenders and release them once the sealed date and time has passed.

7.11.2 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

7.12 Admissibility of tenders

7.12.1 In considering which tender to accept, if any, the designated officer(s) shall have regard to whether value for money will be obtained and whether the number of tenders received provides adequate competition.

7.12.2 Tenders received after the due time and date may be considered only if the tenders received on the due date have not been opened and the designated officer(s) decide that there are exceptional

circumstances, e.g. where significant financial, technical or delivery advantages would accrue, being satisfied that there is no reason to doubt the bona fides of the tenders concerned.

7.12.3 The Chief Executive or the Director of Finance shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

7.12.4 Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) will be regarded as having arrived in due time.

7.12.5 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

7.12.6 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

7.12.7 Necessary discussions with a tenderer regarding the contents of their tender, in order to elucidate before the award of a contract, need not disqualify the tender.

7.12.8 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

7.12.9 Where only one tender/quotation is received, the designated officer(s) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

7.12.10 A tender other than the most economically advantageous tender shall not be accepted unless for good and sufficient reason and a record of that reason be created and approved by the Chief Executive and held with the appropriate tender documentation.

7.12.11 Where the form of contract includes a fluctuation clause, all applications for price variations must be submitted in writing by the tenderer and shall be approved by either the Chief Executive or the Director of Finance.

7.12.12 All Tenders should be treated as confidential and should be retained for inspection.

7.13 Acceptance of tenders

7.13.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

7.13.2 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless the Chief Executive determines that there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;

(ii) understanding of client's needs;

(iii) feasibility and credibility of proposed approach; and

(iv) ability to complete the project on time.

7.13.3 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

7.13.4 Post tender negotiations on price shall not be entered into without the specific prior approval of the Director of Finance in writing, and must be in accordance with UK and EU Procurement Regulations. Such approvals shall not be given without prior consultation with the Chairman of the Audit Committee or the Chairman of the Finance & Investment Committee. Such negotiations are to be carried out by a senior manager specifically designated by the Director of Finance, witnessed by a second manager, and approved by the Chief Executive. The range and scope of the negotiations are to be determined by the Director of Finance on each and every occasion.

7.13.5 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions, except with the authorisation of the Chief Executive.

7.13.6 The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate/price current at the time the contract was awarded, and that best value for money was achieved.

7.13.7 All tenders should be treated as confidential and should be retained for inspection.

7.14 Signing of contracts

7.14.1 In all instances, the Trust's Procurement Team must be engaged in the tender procurement process prior to an official order being raised.

7.14.2 Section 7.14 – 7.16 refers specifically to circumstances where a contract needs to be signed (see DHSC guidance document available on the www.gov.uk website).

7.14.3 Contracts should be approved as follows:

Amount	Contracts on NHS T&Cs	Contract on Non-NHS T&Cs
Less than £5,000 ex VAT	Head of Procurement	Head of Procurement
£5,000k - £25,000 ex VAT	Head of Procurement	Associate Director of Finance
Up to £50,000 ex VAT	Deputy Director of Finance	Deputy Director of Finance
Up to EU Threshold ex VAT	Director of Finance	Director of Finance
Over EU Threshold ex VAT	Chief Executive (or Deputy)	Chief Executive (or Deputy)

7.15 Tender reports to the Board of Directors

7.15.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

7.16 Fair and adequate competition

7.16.1 The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and, unless not practicable, in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.17 Expenditure to be within financial limits

7.17.1 No tender or 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.

7.18 Reverse e-auctions

7.18.1 Where appropriate, the Trust will use e-auctions, and partner organisations to conduct e-auctions on its behalf, and will determine throughout the year the most appropriate product areas that will achieve the best value by being managed through an e-auction.

7.18.2 The results of the e-auction will be made available for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the submissions in full.

7.19 Health care services

7.19.1 Where the Trust elects to invite tenders for the supply of health care services, these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

7.20 Items which subsequently breach thresholds after original approval

7.20.1 Items estimated to be below the limits set in these Standing Financial Instructions for which formal tendering procedures are not used, which subsequently prove to have a value above such limits, shall be reported to the Audit Committee on a quarterly basis and be recorded in an appropriate Trust record.

7.21 Authorisation of tenders and competitive quotations

7.21.1 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 in line with section 7.14.

7.21.2 In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

7.22 Private finance for capital procurement

7.22.1 When considering PFI funding the Trust should normally market-test. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

b) a business case must be referred to the Department of Health and Social Care, NHS Improvement, or as per current guidelines;

c) the proposal must be specifically agreed by the Board of the Trust; and

d) the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.23 Compliance requirements for all contracts

7.23.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a) the Trust's Standing Orders and Standing Financial Instructions;

b) EU Directives and other statutory provisions;

c) any relevant directions including the Capital Investment Manual, Health Building Note 00-08: Estatecode and guidance on the Procurement and Management of Consultants;

d) such of the NHS Standard Contract Conditions as are applicable; and

e) appropriate NHS guidance regarding the form of contracts with foundation trusts.

7.23.2 Where appropriate, contracts shall be in, or embody, the same terms and conditions of contract as the basis on which tenders or quotations were invited.

7.23.3 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all available systems in place.

7.23.4 Commercial negotiations and the establishment of a contract management framework may only be undertaken by members of the Procurement Department, unless otherwise authorised by the Chief Executive or Director of Finance.

7.24 Disposals

7.24.1 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/her nominated officer;

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

c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

d) land or buildings subject to compliance with DH guidance.

7.25 In-house services and benchmarking

7.25.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering. This will be undertaken adopting a two stage process.

7.25.2 The process for undertaking the Best Value Review is set out below.

(i) Establish a cross-functional project team, to include senior representatives from the department which is the focus of the exercise, Finance, Procurement, staff-side and HR, with project management responsibility residing with the Head of Procurement.

(ii) The project team will be responsible for the scope and specifics of the departmental review. This should include quality targets and innovations, as well as cost analysis. Specific metrics would include the range of services offered, head count, and comparison of KPI data, with the aim of providing the Trust with a holistic view of the value received from the existing in-house service provider. For benchmarking, at least one comparator must be an external provider.

(iii) The project team are responsible for the production of a report in which improvements/opportunities are identified. The department or service in question is then given a period of 3 months to make any necessary improvements to the in-house service provision, to align itself to the 'best in class' targets. Where improvements are not achieved, escalation to a full 'market testing' exercise is an executive decision.

7.25.3 On the basis of the outcome of the benchmarking exercise, the Trust may determine that in-house services should be market tested by competitive tendering.

7.25.4 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) specification group, comprising the Chief Executive or nominated officer(s) and specialist;

b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

c) evaluation team, comprising normally a specialist officer, a Procurement officer and a representative of the Director of Finance.

7.25.5 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.

7.25.6 The evaluation team shall make recommendations to the Board.

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

7.26 Applicability of SFIs on tendering and contracting to funds held in trust

7.26.1 These Instructions shall equally apply to expenditure from charitable funds.

8. NON-PAY EXPENDITURE

8.1 Delegation of authority

8.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

8.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

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

8.2 Authorisation levels for approval of purchase orders

8.2.1 The below table details the internal approval levels and limits applicable for the procurement of goods and services through the Trust's procurement order processing system (Oracle).

Approval Level	Approval Level - Posts	Approval Limit (inc VAT)
1	Chief Executive / Deputy Chief Executive / Director of Finance	£1,000,000
2	Deputy Director of Finance	£300,000
3	Executive Director	£250,000
4	Associate Director of Finance / Deputy Director of Performance	£150,000
5	Head of Department or Service	£20,000
6	Deputy Head of Department / Head of Service	£10,000
7	Senior Department / Service Manager	£5,000
8	Department / Service Manager	£2,500
9	Department / Service Approver	£1,000
10	Requestor Only	N/A

8.2.2 In cases where expenditure is over £1,000,000, the Chief Executive's limit will be increased to allow electronic authorisation in instances where the business case has been approved by the Board and evidence can be shown of this.

8.2.3 The table below details the internal approval limits applicable within the Procurement Department for the approval of purchase orders once authorisation has been given to expenditure

Position	PO Approval Limit
Head of Procurement	£25,000,000
Procurement Manager	£250,000
Contracts Officers (Capital)	£100,000
eProcurement Manager	£100,000
Contracts/eProcurement Officer / Assistant	£50,000

8.2.4 The Head of Financial Services and Payroll will have the authority to override the approval process for invoices in respect of Locum Doctors provided by Brookson. This applies only in instances where due to timing an approval has not been provided by Divisional Managers, but timesheets have been verified.

8.2.5 The procurement process for goods, services or works depends upon whether expenditure is incurred from capital or revenue budgets, and refers to expenditure not already covered by existing NHS national or local contracts.

8.2.6 The limits below refer to whole life cost of the contract (i.e. an annual contract value of £70,000 over 3 years requires OJEU tender in respect of revenue) to incur non-pay expenditure (ex VAT).

8.2.7 Revenue

1. Below £5,000 — Purchase order
2. £5,000 - £49,999 — Official quotations
3. £50,000 – EU threshold for goods/services — Official tender exercise
4. Over current EU threshold for goods/services — European tender exercise (OJEU)

8.2.8 Capital

5. Below £5,000 — Purchase order
6. £5,000 - £49,999 — Official quotations
7. £50,000 – EU threshold for works — Official tender exercise
8. Over the current EU threshold for works — European tender exercise (OJEU)

8.3 Choice, requisitioning, ordering, receipt and payment for goods and services

8.3.1 Requisitioning

To ensure best value for money all purchases of goods and services must be made utilising the advice and services of the Trust's Procurement Department. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

All requisitions shall be priced and include the relevant financial code.

8.3.2 System of payment and payment verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

8.3.3 The Director of Finance will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated in these SFIs and regularly reviewed;

b) prepare procedural instructions or guidance within these SFIs on the procurement of goods, works and services incorporating the thresholds;

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

d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, with the only exceptions set out in SFI 8.3.4 below; and

e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for the following.

(i) A list of Directors/employees authorised to certify invoices.

(ii) Certification that:

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

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

8.3.4 Prepayments

Prepayments are only permitted where exceptional circumstances apply.

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

b) The appropriate authorised staff member 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 their commitments.

c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold).

d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

8.3.5 Official orders

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.

They may be transmitted by a system of Electronic Data Interchange (EDI) approved by the Director of Finance.

8.3.6 Duties of managers and staff

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and the relevant staff must ensure that:

a) all contracts (except as otherwise provided for in these SFIs), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Department in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

d) all intellectual property (IP) benefits, such as copyright, patents, design rights, trademarks and confidentiality are protected and applied in all cases via the Trust's authorised representatives, (as established in the Trust's Intellectual Property Policy);

e) discussions with suppliers in respect of commercial terms must not be undertaken other than by members of the Procurement Department;

f) 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;

g) all goods, services, or works are ordered on an official order except purchases from petty cash and purchases from suppliers identified on the agreed list of non-PO suppliers/services maintained by Financial Services and Procurement.

h) verbal orders must only be issued very exceptionally and be accompanied by a purchase order number - 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";

i) requisitions/orders/petty cash requests are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

k) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

m) petty cash records are maintained in a form as determined by the Director of Finance; and

n) the Gifts and Hospitality Policy must be adhered to at all times, with no orders issued to or business transacted contrary to this policy

8.3.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current guidance.

8.3.8 In the case of contracts for building or emergency works which require payment made on account during progress of the works, the Director of Finance shall make payment upon receipt of a certificate from the appropriate technical consultant or works officer appointed to a particular building or engineering contract.

9. STORES AND RECEIPT OF GOODS

9.1 General position

9.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stock take; and

c) valued at the lower of cost and net realisable value, or a weighted average in the case of Pharmacy.

9.2 Control of stores, stocktaking, condemnations and disposal

9.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel oil and coal shall be the responsibility of a designated estates manager.

9.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as Trust property.

9.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

a) All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note should be obtained from the supplier at the time of delivery/service and signed by the staff member receiving the goods/service.

b) Particulars of all goods/services received shall be registered on the day of receipt, with unsatisfactory goods returned to the supplier within the set timescales.

c) Stock shall only be issued/released upon receipt of an authorised requisition.

9.2.4 All stock records shall be in such form and shall comply with such systems of control as the Director of Finance may require.

9.2.5 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.

9.2.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

9.2.7 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 14 Disposals and condemnations, losses and special payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

9.3 Goods supplied by NHS Supply Chain

9.3.1 For goods supplied via the NHS Supply Chain regional stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Director of Fince/Deputy Director of Finance, depending on value, who shall satisfy him/herself that the goods have been received before accepting the recharge.

10. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

Commissioner-related contracts

10.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

a) costing and pricing of services;

b) payment terms and conditions; and

c) amendments to contracts and extra-contractual arrangements.

10.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with NHS Improvement's and NHS England's National Tariff Guidance.

10.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

Non commissioner-related contracts

10.4 Where the Trust enters into a relationship with a non-NHS body or another NHS organisation for the supply or receipt of other services, either clinical or non-clinical, or collaborative arrangements and non-financial contracts, the responsible contracting officer should ensure that an appropriate Service Level Agreement (SLA) is in place and has been signed by both parties. SLAs must be signed off as follows:

a) For corporate SLAs, the Lead Executive (or nominated deputy)

b) For divisional SLAs, the Divisional Director of Operations.

Plus, in all circumstances:

a) Director of Operations and Performance (or nominated deputy)

b) Director of Finance (or nominated deputy)

c) Either: Director of Nursing, or Medical Director(or nominated deputies)

10.5 This contract should incorporate:

a) a description of the service and indicative activity levels;

b) the term of the agreement including termination arrangements;

c) the value of the agreement;

d) the operational lead;

e) performance and dispute resolution procedures; and

f) risk management and clinical governance arrangements.

10.6 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

10.7 Copies of signed SLAs should be retained on file by the contracting officer and, where the contract specifies financial information, a copy should be issued to the appropriate Divisional Management Accountant within Finance.

10.8 Electronic copies of the SLA and sign off schedule should be submitted to the Head of Legal Services with summary details of the SLA expiry date and any review dates which occur during the term of the SLA.

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE AND EMPLOYEES

11.1 Remuneration and terms of service

11.1.1 The Board shall establish a Remuneration Committee comprised of non-executive directors. Such Committee shall have clearly defined terms of reference which specify which posts fall under its remit as well as its composition and the arrangements for reporting.

11.1.2 The Committee will undertake the following.

a) Decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors and any other senior employees under its remit, including:

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

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

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

b) monitor and evaluate the performance of the executive directors and any other senior employees under its remit; and

c) oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

11.1.3 When deciding the remuneration, allowances and the other terms of service of the executive directors and any other senior employees under its remit, the Committee shall ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

11.1.4 The allowances paid to the non-executive directors shall be determined by the Council of Governors**.**

11.2 Funded establishment

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

11.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive unless in accordance with an establishment control procedure approved by the Board.

11.2.3 All budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

11.3 Staff appointments

11.3.1 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by the Chief Executive; or

b) unless the changes are within the limit of their approved budget and funded establishment; or

c) the change is temporary and within the delegated powers of the Workforce Expenditure Panel.

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

11.4 Processing payroll

11.4.1 The Director of Finance is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

11.4.2 The Director of Finance will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee and officers;

h) procedures for payment by cheque or bank credit to employees and officers;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) segregation of duties in preparing records and handling cash; and

m) a system to ensure the recovery of sums of money and property, from those leaving the employment of the Trust, due by them to the Trust.

11.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

11.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.4.5 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

11.4.6 Expenses should only be reimbursed via payroll. There should be no reimbursement for Trust purchases via payroll.

11.5 Contracts of employment

11.5.1 The Board shall delegate responsibility to the Director of Workforce for:

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

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

Local pay variations require the written approval of the Director of Workforce.

11.5.2 The Director of Finance will be responsible for maintaining up-to-date procedures, to ensure that assurance can be obtained from off-payroll workers to determine that the correct tax and NI contributions are being paid to HMRC.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 Public Dividend Capital

12.1.1 On authorisation as a foundation trust, the public dividend capital (PDC) held immediately prior to authorisation continues to be held on the same conditions.

12.1.2 Additional public dividend capital may be made available on such terms the Secretary of State for Health (with the consent of HM Treasury) decides.

12.1.3 Draw down of additional public dividend capital will be authorised by the Chief Executive or Deputy Chief Executive, and by the Director of Finance or the Deputy Director of Finance.

12.1.4 The Trust shall be required to pay annually to the Department of Health and Social Care a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

12.2 Commercial borrowing and investment

12.2.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, or repay principal on, borrowings held, and will advise the Board on any proposed new borrowing. The Director of Finance is responsible for reporting periodically to the Board concerning all loans and overdrafts.

12.2.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

12.2.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.2.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the Director of Finance.

12.2.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Director of Finance.

12.2.6 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

12.3 Investments

12.3.1 Temporary cash surpluses must be held only in such public or private sector investments as approved and authorised by the Board in line with the Trust's Treasury Management Policy.

12.3.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.3.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital investment

13.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) that a business case 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;

(iii) appropriate project management and control arrangements; and

b) that the Director of Finance has certified professionally the costs and revenue consequences detailed in the business case.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Health Building Note 00-08: Estatecode.

13.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

13.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall delegate to the manager responsible for any scheme:

a) specific authority to commit expenditure;

b) authority to proceed to tender; and

c) approval to accept a successful tender.

13.1.6 The Director of Finance shall issue procedures for the regular reporting of capital expenditure and commitment against authorised capital expenditure.

13.2 Asset registers

13.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a rolling programme of physical checks of assets against the asset register.

13.2.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Department of Health and Social Care Group Accounting Manual and IFRS accounting standards.

13.2.3 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, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

13.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.2.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.2.6 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..

13.2.7 The Director of Finance shall calculate and pay public dividend capital charges as specified in the Department of Health Group and Social Care Accounting Manual.

13.3 Security of assets

13.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.3.2 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; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.3.3 The up-to-date maintenance and checking of asset records shall be the responsibility of designated budget holders for all items for which the initial purchase or replacement is within their service area.

All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Director of Finance.

13.3.4 Whilst each employee has a responsibility for the security of Trust property, it is the responsibility of 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 Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

13.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

13.3.6 The Director of Finance shall be the authorised officer to be responsible for the disposal of assets surplus to requirements.

13.3.7 Where practical, assets should be marked as Trust property and have a bar coded tag correlating to the record held on the asset register.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and condemnations

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will notify the Director of Finance to determine the asset's current valuation and the impact the disposal may have on the Trust's finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and

b) recorded by the condemning officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

14.1.4 The condemning officer shall satisfy him/herself 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.

14.2 Losses and special payments

14.2.1 The Director of Finance must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments, with regard to HM Treasury's Managing Public Money, and NHS-specific guidance and directions.

14.2.2 Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery, must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then inform the Director of Finance and/or Chief Executive.

14.2.3 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

14.2.4 Where property loss/damage is suspected, including theft of or criminal damage (including burglary, arson, and vandalism) to staff, patient or NHS property or equipment, the Director of Finance must immediately inform NHS Protect.

14.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify the Board.

14.2.6 Any employee discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud or corruption, must inform the Trust's Local Anti-Fraud Specialist (LAFS).

14.2.7 The LAFS and/or Director of Finance must report all frauds in accordance with the provisions of the Trust's Local Protocol on the Conduct of Investigations and Application of Sanctions and Redress in Respect of Fraud and Corruption.

14.2.8 The Director of Finance will

a) refer any novel, contentious or repercussive cases to the Department of Health and Social Care for approval, including extra-statutory and extra-regulatory payments, in accordance with HM Treasury direction; and

b) refer severance payments on termination of employment (not including Treasury-approved MAS scheme payments) to NHS Improvement, who will deal directly with HM Treasury to get the necessary approval.

NHS Improvement and the general public are informed of specific individual losses and special payments which exceed £250,000 via the Annual Reports and Accounts process.

14.2.9 The Board's delegated limits for the approval of losses are set out below.

Categories of losses and special payments	Approval delegated to	Delegated checklist* signatories *– for all individual losses over £1,000*
LOSSES		
1. Losses of cash (a) Theft, fraud, arson etc. (b) Overpayments of salaries, wages, fees and allowances (c) Other causes, including unvouched or incompletely vouched payments overpayments other than those included under 1b loss of cash by fire (other than arson) physical losses of cash, cash equivalents and stamps other than those covered by 1a	Director of Finance up to £25,000 Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Director of Finance or nominated deputy and Executive Director or nominated deputy in the relevant directorate
2. Fruitless payments and constructive losses *(including abandoned capital schemes, except where work is purely exploratory)*		
3. Bad debts and claims abandoned (a) Private patients (b) Overseas visitors (c) Cases other than 3a & 3b		
4. Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use (a) Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness (b) Stores losses (c) Other causes e.g. weather damage or accidental fire		
***Checklists are available from Finance**		

14.2.10 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in respect of bankruptcies and company liquidations. This shall include the requirement for parent company guarantees or banker's bonds in circumstances where a review of company financial credit ratings requires further guarantees to be made prior to awarding contracts.

14.2.11 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.12 The Board's delegated limits for the approval of special payments are set out below.

Categories of losses and special payments	Approval delegated to	Delegated checklist* signatories *– for all individual losses over £1,000*
SPECIAL PAYMENTS		
5. Compensation payments made under legal obligation *(such as court order or arbitration award for personal injury, property damage or unfair dismissal)*	Director of Finance / Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Not applicable
6. Extra-contractual payments to contractors *(such as payments for non-contractual obligations which might arguably have been upheld in court)*	Chief Executive up to £50,000 Audit Committee and Board of Directors over £50,000	Director of Finance or nominated deputy and Executive Director or nominated deputy in the relevant directorate
7. Ex-gratia payments (a) Loss of personal effects (b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied (c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied (d) Other clinical negligence cases and personal injury claims (e) Other employment payments (f) Patient referrals outside the UK and EEA guidelines (g) Other (h) Maladministration, such as bias, neglect, or delay	Trust Legal Department up to £10,000 Director of Nursing from £10,000 to £50,000 Audit Committee and Board of Directors over £50,000	Executive Director or nominated deputy in the relevant directorate and One other Executive Director or nominated deputy
8. Severance payments on termination of employment *(beyond contractual obligations and not including Treasury-approved MAS)* **9. Extra statutory and extra regulatory payments**	See 14.28 above.	
***Checklists are available from Finance**		

14.2.13 The Director of Finance shall maintain a Losses and Special Payments Register, which is completed on an accruals basis.

14.2.14 All losses and special payments must be reported to the Audit Committee each quarter, as a minimum.

15. INFORMATION TECHNOLOGY AND GOVERNANCE

15.1 Responsibilities and duties of the Director of Finance

15.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware, for which the Director of Finance is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director of Finance may consider necessary are being carried out.

15.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.2 Responsibilities and duties of other directors and officers

15.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

a) details of the outline design of the system;

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirements; and

c) support arrangements for the system including business continuity and disaster recovery plans.

15.3 Contracts for computer services with other health bodies or outside agencies

15.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.4 Risk assessment

15.4.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk.

15.5 Requirements for computer systems, which have an impact on corporate financial systems

15.5.1 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;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) only appropriate staff have access to such data; and

d) computer audit reviews are carried out, as considered necessary.

15.6 Freedom of information

15.6.1 The Trust 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 our Trust that we make publicly available.

15.7 Information governance – "principle 7 compliance statement"

The NHS holds the most sensitive and confidential information about individuals and is bound by the Data Protection Act 1998 (DPA). When sharing data with external parties or data are processed by a third party, we must adhere to DPA Principle 7 which states that:

"Appropriate technical and organisational measures shall be taken against unauthorised and/or unlawful processing of personal data, and against accidental loss or destruction of, or damage to, personal data."

Therefore all data processors acting on behalf of the Trust or under instruction from the Trust must adhere to the Data Protection Act 1998 and afford the appropriate security to the information they may hold/process where the Trust is the Data Controller. Measures include: statements regarding information security; implementation of physical security and access controls, and business continuity measures; information governance training for staff; and incident reporting procedures. Failures may lead to the Trust seeking damages if a breach/data loss occurs.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are notified before or at admission that 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.

This notification is through:

- notices and information booklets;
- hospital admission documentation and property records; and
- the oral advice of administrative and nursing staff responsible for admissions.

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money.

16.4 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.

16.5 Patient lockers are available for use by patients, and those wishing to use these facilities may do so following an assessment of competence and capability. For patients who have property that needs to be handed in for safekeeping, and who are unable to use the lockers provided, a Patient Property Record, in a form determined by the Director of Finance, shall be completed in respect of the following:

a) property handed in for safekeeping by any patient (or guardian as appropriate); and

b) property taken into safe custody having been found in the possession of:

- mentally ill patients;
- confused and/or disoriented patients;
- unconscious patients;
- patients dying in hospital;
- patients found dead on arrival at hospital; or
- patients severely incapacitated for any reason.

A record shall be completed in respect of all persons in category (b) including a nil return if no property is taken into safe custody.

16.6 The Patient Property Record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient or their personal representative, where practicable. The record shall then be signed by both members of staff and the patient, except where the latter is restricted by mental or physical incapacity.

16.7 Property and money handed over for safe keeping shall be placed immediately into the care of the cashier or designated member of the General Office staff except where there are no administrative staff available, in which case the property shall be placed in the care of the most senior member of nursing staff on duty.

16.8 Except as provided in SFI 16.10 and 16.11 below, refunds of cash handed in for safe custody will be dealt with in accordance with written instructions from the Director of Finance. Property other than cash that has been handed in for safe custody shall be returned to the patient as required. The return shall be receipted by the patient (or guardian as appropriate) and witnessed. The receipts are then retained by the hospital cashier for audit inspection.

16.9 The disposal of the property of deceased patients shall be effected by the hospital cashier, or the staff member who has had responsibility for its security. Particularly where cash and valuables have been deposited, they shall only be released after written authority given by the Director of Finance. Such authority shall include details of the lawful kin or other persons entitled the deceased's property.

16.10 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.

16.11 In respect of a deceased person's property, if there is no will and no lawful kin, the property vests in the Crown and the Director of Finance shall notify the Duchy of Lancaster.

16.12 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. No other expenses or debts shall be discharged out of the estate of a deceased patient.

16.13 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.

17. CHARITABLE FUNDS

17.1 The charity framework and the applicability of standing financial instructions to the Charity

17.1.1 The Trust's SFIs are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

17.1.2 The Standing Financial Instructions state the Board of Directors responsibilities as a Corporate Trustee for the management of charitable funds and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, Corporate Trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission. The Trustee must ensure compliance with the Charity Commission's latest guidance and best practice, and charity law, including the Charities Act 2011.

17.1.3 The discharge of the Board of Directors 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. The Charitable Trust Board is a Committee of the Trust Board with delegated powers to administer charitable matters and authorise expenditure.

17.1.4 Within these Standing Financial Instructions, 'charitable funds' are defined as the total net assets of Wrightington, Wigan and Leigh Health Services Charity (also known as 'Three Wishes'), which is a registered charity in support of purposes relating to the National Health Service. These chiefly represent the cumulative cash donated and bequeathed to the Charity, net of charitable expenditure to date. Management of the funds is governed by charity legislation.

17.2 Approvals

17.2.1 The Director of Finance must prepare procedural guidance for raising, handling, and accounting for charitable income, and for the proper expenditure of charitable funds, and shall ensure that each charitable fund is managed appropriately with regard to its purpose, the Charity Commission's latest guidance and best practice, and charity law.

17.2.2 No new fund or fundraising activity (except those 'for the general purposes of the Charity', and not undertaken during work-time) shall be established without first obtaining the written approval of the Charitable Trust Board.

17.2.3 As Corporate Trustee, the Board has delegated limits for the approval of expenditure as follows.

Type of charitable fund	Approval delegated to
DIVISIONAL FUNDS AND RESTRICTED FUNDS (SUCH AS APPEALS FUNDS)	Divisional Fund Committee: up to and including £20,000, including VAT and carriage); Amounts over the above limits will be referred to Charitable Trust Board via the Trust business case process.
FUNDRAISING EXPENDITURE	Head of Financial Services and Payroll: up to £5,000 (including VAT and carriage). Director of Finance £5,001 to £20,000 (including VAT and carriage) Amounts over the above limits will be referred to Charitable Trust Board via the Trust business case process.
The Charitable Trust Board reserves the privilege to veto expenditure approved by Divisional Fund Committees and to recharge Divisional Funds for administrative / governance or other costs.	

17.3 Fund management and expenditure

17.3.1 All Divisional Fund Committees shall be responsible for the management of funds held within their areas of responsibility including the implementation of initiatives to increase donations.

17.3.2 Divisional Fund Committees will be responsible for ensuring that all expenditure incurred through charitable funds meets the public benefit test as outlined in the Charity Act 2011; and that such expenditure is timely, without the unnecessary accumulation of funds.

17.3.3 All expenditure must be for 'appropriate charitable purposes', in accordance with the Charity's Expenditure Guidance policy document. Exceptionally, strategic and governance expenditure is approved by the Charitable Trust Board.

17.3.4 In the first instance, it is the responsibility of a Divisional Fund Committee or equivalent to ensure that all commitments against a charitable fund represent the best available value for money in terms of direct patient benefit, and are consistent with 'appropriate charitable purposes' as defined by

a) the fund's objectives;

b) Charity policies; and

c) patient benefit criteria set out in charity law.

17.3.5 Under no circumstances shall a fund be allowed to go into deficit. It is a responsibility of the Divisional Fund Committee to ensure this does not occur.

17.3.6 Where possible, the use of exchequer funds to discharge charitable fund liabilities should be avoided, and any indebtedness to exchequer should be discharged by the charitable fund at the earliest possible time.

17.4 Income

17.4.1 All charitable gifts, donations and fundraising activities are governed by the Charity's Fundraising and Income Guidance policy document. All charitable proceeds must be handed immediately to the Director of Finance via an authorised Cash/General Office, to be banked directly to the Charity's charitable fund bank account. All gifts received shall be confirmed to the donor in the Trust's authorised form of receipt that will ensure the donor's wishes are observed without unnecessarily creating new trusts.

17.4.2 Gifts which are intended to personally and directly benefit staff, such as 'thank-you' presents, flowers or contributions to staff recreation are not charitable donations, as they have no link to public or patient benefit, but are, rather, gifts to individuals. As such, they are expected to be modest, and are covered by the Trust's Gifts and Hospitality Policy.

17.4.3 Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash/General Office is closed. Where a donation occurs at night or at weekends, the income shall be retained in a secure environment, with an internal receipt given to the donor at the time the donation is made. In the event of this occurring, the income shall be deposited with a Cashier at the next earliest opportunity.

17.4.4 All gifts and income accepted shall be administered in accordance with the relevant fund's charitable objectives, subject to the terms of specific trusts. As the Charity can only accept cash or non-cash donations for all or any purpose related to the Health Service, officers shall, in cases of doubt, consult the Director of Finance before accepting gifts of any kind.

17.4.5 In respect of legacies and bequests, the Director of Finance shall be kept informed of all enquiries regarding legacies and bequests, which should be filed on a case-by-case basis. Where required, the Director of Finance shall:

a) provide assistance covering any approach regarding the wording of wills and the receipt of funds/other assets from executors; and

b) where necessary, obtain grant of probate, or make application for grant of letters of administration.

17.5 Banking

17.5.1 The Director of Finance shall be responsible for ensuring that appropriate banking services are available in respect of administering the charitable funds.

17.6 Investment management

17.6.1 The Director of Finance shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the Charity's approved Treasury Management Policy. The issues on which the Director of Finance shall be required to provide advice to the Charitable Trust Board include:

a) the formulation of a Treasury Management Policy, which meets statutory requirements and Charity Commission guidance with regard to income generation and the enhancement of capital value;

b) the appointment of advisers, brokers and, where appropriate, investment fund managers;

c) pooling of investment resources in line with Charity Commission legislation;

d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds; and

e) the review of investment performance and of brokers and fund managers.

17.7 Asset management

17.7.1 Donated assets in the ownership of, or used by, the Trust as Corporate Trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure that:

a) appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; and

b) appropriate measures are taken to protect and/or to replace assets. These are to include decisions regarding insurance, inventory control, and the reporting of losses.

17.8 Reporting

17.8.1 The Director of Finance shall:

a) ensure that regular reports are made to the Charitable Trust Board with regard to, inter alia, fund balances, investments, expenditure, expenditure approvals, and any policies in line with Department of Health and Social Care and Charity Commission guidance;

b) prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Board within agreed timescales;

c) prepare an annual Trustee's report and required returns for the Charity Commission for adoption by the Board;

d) prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds; and

e) maintain such accounts and records as may be necessary to record and protect all transactions and funds of the charitable funds.

18. ACCEPTANCE OF GIFTS HOSPITALITY AND COMMERICAL SPONSORHSIP BY STAFF

18.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy, the Gifts and Hospitality Policy should follow the guidance contained in the NHS England model policy document. This policy guides officers and should be adhered to in all business dealings with organisations and people outside of the Trust.

18.2 The Trust will publish on its website, its Register of Interests and Register of Gifts and Hospitality on a bi-annual basis and Registers of Interests and Registers of Gifts and Hospitality will be discussed at each Audit Committee meeting.

18.3 Gifts to staff, including cash, intended to benefit individual staff members or teams, are not charitable donations to the Trust's charity.

18.4 Staff should not ask for or accept gifts, rewards or hospitality that may affect, or be seen to affect, their professional judgement. Gifts of cash or cash equivalent should always be declined.

18.5 Hospitality includes offers such as transport, refreshments, meals, accommodation etc, and should only be accepted where it is secondary to a business event i.e. there is a legitimate business reason. Hospitality must be appropriate and not out of proportion to the occasion i.e. subsistence only.

18.6 Commercial sponsorship agreements must always be declared. Before entering into a commercial sponsorship agreement written approval should be sought from the individual's line manager.

18.7 Sponsored post holders must not promote or favour the sponsor's products.

18.8 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored post.

19. RETENTION OF RECORDS

19.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines NHS Records Management Part 1 and Part 2.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records shall only be destroyed in accordance with latest Department of Health and Social Care guidance and a record shall be maintained of those records so destroyed, together with the date of their destruction.

20. RISK MANAGEMENT AND INSURANCE

20.1 Programme of risk management

20.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS Improvement's Risk Assurance Framework, which must be approved and monitored by the Board.

20.1.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) promotion 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, and health and safety review;

f) a clear indication of which risks shall be insured; and

g) arrangements to review the risk management programme.

20.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by Department of Health and Social Care Group Accounting Manual..

20.1.4 The Director of Finance shall ensure that appropriate insurance arrangements exist in accordance with Department of Health and Social Care guidance. This will be a mixture of NHS Resolution cover and in some instances commercial insurance.

20.1.5 The 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 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.

20.1.6 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

a) insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

b) private finance initiative (PFI) contracts where the other consortium members require that commercial insurance arrangements are entered into;

c) pressure vessels such as boilers and other associated risks; and

d) income generation activities – if not related to normal business activity, these should normally be insured using commercial insurance. If the income generation activity is an activity normally carried out by the Trust for an NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

20.1.7 All other commercial, or alternative insurance policies, are to be approved by the Director of Finance.

20.2 Arrangements to be followed by the board in agreeing insurance cover

20.2.1 Where the Board decides to use the risk pooling schemes administered by 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.

20.2.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed to the Trust.

20.2.3 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.

21. INTELLECTUAL PROPERTY

21.1 Intellectual property (IP)

21.1.1 The Trust has an approved Intellectual Property Policy.

21.1.2 It is appropriate therefore to include IP references in the Standing Financial Instructions.

21.2 Definition of intellectual property

21.2.1 Intellectual Property can be defined as products of innovation and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images. IP can be given legal recognition of ownership through intellectual property rights (IPR) such as patents, copyright, design rights, trademarks or "know how."

21.2.2 Examples of IP that may be developed in the NHS include: training manuals, clinical guidelines, books and journal articles, PowerPoint presentations, inventions, new or improved designs, devices, equipment, new uses for existing drugs, diagnostics tests, and new treatments.

21.3 Ownership of intellectual property

21.3.1 Ownership of IP will, in most cases, rest with the Trust. This applies to all IP produced by Trust employees in the course of their employment, specifically when undertaken on Trust premises, using Trust equipment and in contact with Trust patients. IP developed by an employee outside the course of their employment, not utilising Trust assets or Trust patients will usually belong to the employee, subject to agreement.

21.3.2 This is in accordance with the Patent Act 1977, and the Copyright, Designs and Patent Act 1988.

21.3.3 IP ownership can vary according to the circumstances under which the IP was generated. Such circumstances include:

a) joint/honorary appointments/trainees;

b) externally funded work;

c) commissioned work; and

d) collaborative projects.

21.4 Disputes of ownership

21.4.1 If the ownership of IP is disputed, dated written records relating to the IP in question will be assessed to establish the inventor(s), and their proportionate contribution. If such material is not available, the Chief Executive of the Trust will make a final decision, taking professional advice if necessary.

21.4.2 Persons covered by the Intellectual Property Policy include:

a) all staff that are full time or part time employees of the Trust;

b) full-time or part-time staff who are self-employed (e.g. private practice);

c) trainee professionals (e.g. Specialist Registrars);

d) staff seconded to other organisations; and

e) staff with joint or honorary contracts with another organisation.

21.5 Intellectual property management

21.5.1 The Trust should use an appointed NHS Innovation Hub as its IP expert company to give advice and assistance in the protection, management and commercial opportunities of IP initiatives.

21.6 Staff obligations

21.6.1 All employees, including those covered by the Intellectual Property Policy, have an obligation to inform the Trust's R&D manager about identified or potential IP activities, and must not, under any circumstances, sell, assign, license, give or otherwise trade IP without the Trust's approval.

21.6.2 The Trust brand and logos should not be used unless in connection with Trust business.

21.7 Monitoring intellectual property

21.7.1 The R&D manager will provide to the Board updates with regards to;

a) the risks and rewards in respect of approving IP initiatives; and

b) potential and ongoing IP initiatives.

22. DECLARATION OF INTERESTS

22.1 General

22.1.1 Staff at Band 8 & above, are required to declare on an annual basis, any interest, including partners or spouse, which may be relevant to the work of Wrightington Wigan and Leigh NHS Foundation Trust or their work within the organisation. A declaration of interest must be submitted in the event where a relationship exists when entering into, or negotiating, the procurement of goods and services. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

22.1.2 A declaration of interest must be submitted in the event where a relationship exists when entering into, or negotiating, the procurement of goods and services.

22.1.3 Where a new interest arises during the course of the year, then staff are required to declare that interest at the earliest opportunity and must notify their line manager that such an interest exists.

22.2 Bribery Act 2010

22.2.1 Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

22.2.2 The offences of bribing another person or being bribed carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

22.2.3 This Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees, contractors and agents are aware of the standards of behaviour expected of them contained in this policy.

22.2.4 It is the duty of Trust employees, including all agency and contracted staff, who have the powers to enter into transactions on behalf of the Trust, not to influence or enter into negotiations or purchases with an individual or entity where a relationship with the other party exists. For

clarification relationships include, but are not limited to, spouse, parent, child, brother, sister (and relations of any of these). Relationships also include friendships, and are deemed to exist when the employee has any financial interest in the other party.

22.2.5 If in doubt, Trust employees and representatives must inform their line manager and in all circumstances should declare his/her interest by completing a declaration of interest form which can be found in the Trust's Code of Conduct Policy, and should not take any part in the negotiation process.

22.3 Declaration of interest

22.3.1 An annual completion of declarations of interest exercise will be undertaken as part of the Trust's annual accounts process and is mandatory for all staff on band 8 and above. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

.

23. BUSINESS CASE AND TENDER PROCESS

23.1 Introduction

23.1.1 This summary document outlines the business case process that must be followed for all service changes/developments which have either revenue or capital financial implications. The Trust's business case process has thus been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

23.2 Business case process summary

23.2.1 The following overview summarises the business case process.

1. Any service changes/developments that have been incorporated in the revenue and capital plans previously agreed by the Board of Directors will require a business case.
2. Any service changes/developments that emerge in year (i.e. proposals which, if approved, would have financial implications over and above capital and revenue plans previously agreed by the Board) require a business case.
3. All items of capital expenditure will require a business case.

23.2.2 The business case process does not replace the Trust's tendering process which must be followed when purchasing goods or services. The values in the table below represent the total value of expenditure covered by the business case, which includes both the total capital spend and the full-year effect of revenue expenditure.

	Value (inclusive of VAT)					
	£0-£24,000	£0 - £50,000	£50,001 - £250,000	£250,000-£500,000	£500,000 - £1M	Above £1M
Capital Medical Equipment Group C*apital Equipment only*	✓					
Deputies Forum		✓				
Executive Communication Cell (ECC)			✓			
Management Board				✓		

Finance & Investment (F&I) Committee					✓	
Board of Directors						✓

23.3 Role of the approving entities

23.3.1 The capital medical equipment group will be responsible for approving business cases up to the value of £24,000 where funding for capital medical equipment has already been included within the capital programme for the year. The total value of business cases approved by the group must not exceed the total balance available for capital medical equipment in the year. Monitoring of spend against this balance will be managed through the Capital Committee.

23.3.2 The Deputies Forum will be responsible for scrutinising business cases, and has the authority to approve:

a. capital only business cases up to the value of £50,000 where funding is already available in the capital programme

b. revenue business cases that are self-funded up to the value of £50,000.

Business cases in excess of £50,000 will be presented at the Deputies Forum for review before being presented to the appropriate committee as outlined in the above table for approval.

23.3.3 The Deputies Forum will be responsible for ensuring that all business cases contain valid assumptions, detailed and accurate financial information and that the sponsor has liaised with all relevant parties, i.e. internal and external organisations prior to the business case being submitted.

23.3.4 ECC, Management Board, F &I and the Board of Directors will take the decision to approve a business case taking in to consideration strategic direction, priorities and affordability