NHS
South Tees Hospitals
NHS Foundation Trust

Board of Directors Meeting (to be held in PUBLIC)

Tuesday, 6 November 2018 at 1pm in the Boardroom

Murray Building, James Cook University Hospital

		Enclosure	Led By
1.	**Opening Items**		
1.1	Welcome and Apologies for Absence (*information*)	*Verbal*	Chairman
1.2	Declarations of Interest (*information*/**approval**) *(Any new conflict of interest and any actual or potential conflict of interest in relation to any matter to be discussed*)	*Verbal*	Chairman
1.3	Minutes of Previous Meeting (**approval**)	***3***	Chairman
1.4	Matters Arising (*discussion/information/***approval**)	*Verbal*	Chairman
1.5	Action Log (*information*) - no open actions to report	*Verbal*	Chairman
1.6	Chairman's Report (*discussion/information*)	*Verbal*	Chairman
1.7	Chief Executive Report (*discussion/information*)	*Verbal*	Chief Executive
2.	**Strategy and Planning**		
2.1	Medical Education Strategy (*discussion*/**approval**)	***9***	MD Medical Education, Research and Innovation
2.2	Information Technology Strategy (*discussion*/**approval**)	***19***	Director of Estates. ICT and Health Records
2.3	Emergency Preparedness Resilience and Response Core Standards (*discussion/information*)	***53***	Director of Estates. ICT and Health Records
3.	**Quality, Safety, Performance and Finance**		
3.1	Quality, Safety, Performance and Finance Assurance Report by Exceptions (*discussion/information*)	***67***	Deputy Chief Executive/ Director of Nursing/ Medical Directors/ Director of Finance
3.2	Learning from Deaths Q2 Report (*discussion/information*)	***81***	MD Medical Education, Research and Innovation
3.3	Healthcare Associated Infection Report (/*information*/**approval**)	***89***	Director of Nursing

3.4	Safe Staffing Monthly Report (*discussion/information*)	***97***	Director of Nursing
3.5	Nurse Establishment Review (*discussion/information*)		Director of
3.5.1	Adult In-patient	***103***	Nursing
3.5.2	Paediatrics In-patient	***125***	
4.	**Governance/Assurance**		
4.1	Revised Board Corporate Governance Structure (*information*/**approval**)	***135***	Chief Executive/ Chairman
4.2	Standing Financial Instructions and Corporate Policies (**approval**)	***143***	Director of Finance
4.2.1	Standing Financial Instructions	***145***	
4.2.2	Standing Orders	***193***	
4.2	Decisions Reserved for the Board – Scheme of Delegation	***219***	
5.	**Closing Items**		
5.1	Any Other Business	*Verbal*	Chairman
5.2	*Risks* *Any Risks discussed during meeting for consideration of adding to Corporate Risk Register or Board Assurance Framework (discussion/**approval**)*	*Verbal*	Chairman
5.3	Evaluation of Meeting (*discussion*)	*Verbal*	Chairman
5.4	Date and Time of Next Meeting (*information*) The next meeting is scheduled to take place on Tuesday, 6 November 2018 (*information*)		

South Tees Hospitals NHS
NHS Foundation Trust

APPROVED Board of Directors Meeting (held in PUBLIC)
held on 4 September 2018
Boardroom, Murray Building, James Cook University Hospital

Present:

Mr A Downey	Chairman
Ms A Hullick	Non-executive Director/Deputy Chair
Mrs M Rutter	Non-executive Director/Senior Independent Director
Mr R Carter-Ferris	Non-executive Director
Mr M Ducker	Non-executive Director
Mr D Heslop	Non-executive Director
Mr J Tompkins	Non-executive Director (*to item BoDC/10/17 only*)
Mrs S McArdle	Chief Executive
Mr D Chadwick	Medical Director (Planned and Specialist Care)
Mr A Clements	Deputy Chief Executive/Medical Director (Urgent and Emergency & Friarage)
Mrs G Hunt	Director of Nursing and Quality
Dr S Nag	Medical Director (Community Care)

In attendance:

Mrs H Edwards	Director of Communications
Ms L Hughes	Company Secretary
Mr G MacDonald	Deputy Director of Finance
Mr S Kendall	Medical Director (Clinical Diagnostics and Support Services/Responsible Officer)
Mr K Oxley	Director of Estates, ICT and Health Records (item
Mr A Adair	Consultant in Accident and Emergency/Chief Clinical Information Officer (*item BoDC/10/8.5 only)*
Mr I Willis	Mr I Willis Head of Digital Programmes (*item BoDC/10/8.5 only)*
Mrs A Arundale	Elected Public Governor (Middlesbrough Constituency) (observing)
Mr I Nwokoro	Patient (*item BoDC/10/6 only)*
Ms D McKeown	Nursing Sister in Therapeutic Care (*item BoDC/10/6 only)*
Ms H Rodgers-Shaw	Commercial Business Manager for Johnson and Johnson (observing)
Mrs D Reape	Shadowing Non-executive Directors (observing)
Mrs A Seward	Lead Governor (Rest of England) (observing)
Mrs H Smithies	Head of Safeguarding (*item BoDC/10/13 only)*

BoD/9/01 **Apologies for Absence**

1.1 Apologies for absence were received from Mr M Ducker, Non-executive Director and Mr S Mason, Director of Finance.

BoD/9/02 **Declaration of Interests**

2.1 The Chairman requested that Directors declared any actual or potential conflict of interest relevant to their role as a member of the Board of Directors and in particular to any matter to be discussed at the meeting. There were no interests declared in relation to open items on the agenda.

BoDC/9/03 **Minutes of Previous Meeting**

3.1 **Resolved:** the minutes of the previous meeting held on 4 July 2018 were accepted as a true record.

BoD/9/04 **Matters Arising**

4.1 There were no matters arising in addition to those included on the agenda.

BoD/9/05 **Action Log**

5.1 The completed actions were noted.

BoD/9/06 **Patient Story**

6.1 Mr I Nwokoro attended the meeting and presented his patient story from experience. He explained that following a serious accident he was paralysed from the shoulders downwards and had been both an inpatient and outpatient at the Trust since 2010. He described his experience at the Spinal Unit, High Dependency Unit and Physiotherapy service which he held in high regard. He explained that he felt he had been supported like a family member and now volunteers at the Trust to support patients who have found it difficult to adjust following a major trauma experiencing.

6.2 The Board thanked Mr I Nwokoro for attending the meeting and for sharing his life changing story with them. They also paid tribute to his support as a volunteer at the Trust

6.3 **Resolved:** the patient story was noted.

BoD/9/07 **Chairman's Report**

The Chairman reported on the following items:

7.1 **Governor Group meetings** – he explained that he had met with Governor groups with the final meetings now been held with the appointed Governors and he planned to report on the key issues raised at the next Council of Governors meeting in October 2018.

7.2 **Meetings with Regional Chairs** – he provided an update on his one to one meetings with a number of Chairs from the acute sector in the Cumbria and North East region since the last Board meeting.

7.3 **Mr I Dalton CBE, Chief Executive of NHS Improvement Visit to the Trust** – he reported on the visit by Mr Dalton who met with the Trust's Chief Executive, Director of Finance and him on 10 August 2018 which had proved most productive. They discussed the Trust's challenges and innovative plans. Mr Dalton, the Chief Executive and him then visited the Trust's Accident and Emergency department and met with a number of staff.

7.4 **Secretary of State for Health Letter regarding No Deal Brexit** – he explained that the Secretary of State for Health had issued a letter to all NHS organisations with regards to the No Deal Brexit which was noted.

7.5 **Resolved:** the Chairman's report was noted.

BoD/9/08 **Chief Executive Report**

8.1 The quality, safety, finance and operational performance by exception for the period ending 31 July 2018 was noted with reference drawn to:

8.1.2 Accident and Emergency 4 hour performance was reported as 95.88% against the 95% target with the Trust ranked third in the region. Increase in activity had been noted in comparison to the same period in 2017.

8.1.3 Referral to Treatment was reported below trajectory at 89.61% against the 92% target with the Trust ranked ninth out of 12 local Trusts. It was noted that work continued to drive forward improvements to meet the RTT recovery target

by 31 March 2019.

8.1.3.1 M Rutter, Non-executive Director queried if an increase in activity had been noted across all speciality levels. In response to that the Chief Executive explained that widespread growth had been noted and the Trust's Business Intelligent unit were looking further into this to gain a greater understanding.

8.1.4 Cancer 62 Day Standard was reported at 83% which was below the 85% target with underlying issues noted to be attributable to tertiary referrals and work continued to drive forward improvements via closely monitoring of the cancer wall. The Board were pleased to note that a Cancer Delivery Group was planned to be formed which would be chaired by the Medical Director (Specialist and Planned Care).

8.1.5 It was noted that the Medical Director (Community Care) and the Director of Nursing had reported to Operational Management Board on the work undertaken as part of the Model Hospital which enabled a greater understanding on the Trust's length of stay position.

8.1.6 Delayed Transfer of Care was noted to be closely monitored with meetings held with partners across the local health and social care system. The Chief Executive explained that the Unplanned Care Group would drive improvements across the elective pathway.

8.1.7 With regards to Patient Outcome and Experience it was noted that three trust-apportioned cases of Clostridium difficile cases in August 2018 against the Trust's objective for 2018/19 is to have no more than 54 trust-apportioned cases among patients aged over 2 years.

8.1.8 Sickness absence was reported at 4.55% against the 3.5% target in July 2018. It was noted that work continued within the Centres and Corporate divisions to drive down sickness absence levels.

8.1.9 Financial performance as at 31 July 2018 was noted as £0.4m ahead of the Trust's control total plan; £0.9m ahead for Pay and £0.5m behind plan for Non-Pay. The Board were pleased to note that the significant progress had been made against the Trust's productivity and efficiency savings plan with £13.6m achieved against the £35.6m year-end plan.

8.2 **Sir Ian Carruthers Independent Review** had commenced which covered the Cumbria and North East Integrated Care System (ICS) for the southern area of the Integrated Care Partnership. It was noted that the ICS covered seven local authorities; five CCGs; North Tees and Hartlepool NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust; and South Tees Hospitals NHS Foundation Trust. It was noted that the Chief Executive had been appointed as the provider lead for the ICS.

8.3 **Friarage Hospital Northallerton update** - the Medical Director (Urgent and Emergency Care and FHN)/Deputy Chief Executive confirmed that the Trust was in a positon to submit its *Preferred Clinical Model for Friarage Hospital Northallerton*' to Hambleton and Richmond CCG and was hopeful that the formal consultation would commence in the near future.

8.4 **Carillion Facilities Management Transition update**
It was noted that the Carillion Facilities Management had successfully transferred to Serco on in July 2018.

8.5 **Electronic Patient Records Update**
The Director of Estates, ICT and Health Records provided an update on the Trust's intention to carry out a joint procurement exercise with County Durham and Darlington NHS Foundation Trust with regards to an Electronic Patient Records system. It was noted that a capital bid was planned to be submitted to the ICS later that month.

8.6 **Resolved:** the Chief Executive report was noted.

BoD/9/09 Healthcare Associated Infection Report

9.1 The Director of Nursing spoke to the Healthcare Associated Infection Report. In addition to the Clostridium difficile update provided within the Chief Executive's report above she explained that there had been zero MRSA bacteraemia trust-assigned cases this financial year; and two trust-apportioned MSSA bacteraemia cases in July 2018 which totalled 14 for April to 31 July 2018.

9.2 **Resolved:** the Healthcare Associated Infection Report as at 31 July 2018 was noted.

BoD/9/10 Safe Staffing Monthly Report

10.1 The Director of Nursing spoke to the Safe Staffing Report for July 2018. She highlighted that the Trust was committed to ensure that levels of nursing staff, including registered nurse (RN), midwives (RM) and health care support workers (HCSW) matched acuity and dependency needs of patient within the Trust to ensure that an appropriate level of skill mix of staff was in place to provide safe, effective, high quality care. The fill rate was noted to be 91.4% day shift, 94.3% night shift for RN and RM; and 92.3% day shift; 107.3% night shift for HCSW.

10.2 **Resolved:** the Board noted the report and were assured that staffing levels were sufficient to deliver safe, high quality care with systems and processes in place should staffing levels fall below those planned.

BoD/9/11 Learning from Deaths Quarter 1 Update

11.1 The national Learning from Deaths policy requires all Trusts to publish details of how they learn from deaths in care. The Board noted the Quarter one update report on mortality for the period ending 30 June 2018. Data included: count of deaths; SHMI January 2017 – December 2017 (111 'as expected'); HSMR April 2017 – March 2018 (114'higher than expected'); and lower than expected rates of palliative care and comorbidity coding.

11.2 The Board noted that the Learning from Deaths Dashboard included the number of deaths, the number of deaths reviewed or investigated and the number of those judged to be potentially preventable; and data was provided separately for patients with learning disabilities.

11.3 It was noted that the data from the Mortality Surveillance Reviews for June 2018 confirmed that of the 20 deaths reviewed in the reporting period 75% were regarded to have received good care with no preventability.

11.4 The Board were pleased to note that the Medical Examiner Service was now fully operational.

11.5 M Rutter, Non-executive Director, Chair of the Quality Assurance Committee explained that a deep dive exercise was being carried out to gain a greater understanding on the higher than expected HSMR and issues of reduced

Palliative Care activity. The outcome of the exercise was planned to be presented to a future Quality Assurance Committee meeting.

11.6 **Resolved:** the Learning from Deaths Quarter 1 update report was noted.

BoD/9/12 Report of the use of Trust Seal

12.1 **Resolved:** the documents affixed under seal between 1 June 2018 and 31 July 2018 were noted which were in line with the Trust's Standing Orders.

BoD/9/13 Freedom to Speak Up Report

13.1 The Director of Nursing presented the report. It was noted that the report had been prepared to support the guidance received from NHS Improvement in May 2018 for NHS Trust Board on Freedom to Speak Up requirements. Arrangements had been put in place to meet the revised requirements with two new Freedom to Speak Up Guardians appointed to support the Board in ensuring it had in place a culture that encouraged freedom to speak up. The Board noted that as part of the Care Quality Commission assessment it would assess organisations' speaking up culture under the key line of enquiry as part of the well-led question.

13.2 The Board welcomed Helen Smithies, Assistant Director of Nursing, Safeguarding who is one of the Trust's new Freedom to Speak up Guardians alongside Laura Mills, Head of Facilities. The Board were supportive of the plans in place with approval granted to deliver the action plan with the support of Board FTSU leads. The Chief Executive explained that Freedom to Speak Up Champions would help to support the Freedom to Speak Up Guardians in carrying out their role and improving the speaking up culture at the Trust.

13.3 **Resolved:** i) the Freedom to Speak up Report was noted and supported; and
ii) the action plan to improve the Trust's freedom to speak up culture and reporting process going forward was approved.

BoD/9/14 Doctors Revalidation Report

14.1 The Medical Director (Clinical Diagnostics and Support Services/Responsible Officer spoke to the Board and provided assurance that recommendations for the revalidation of Doctors were being made in accordance with GMC guidance for Doctors holding a prescribed connection to South Tees Hospitals NHS Foundation Trust and Teesside Hospice Care Foundation.

14.2 The next steps required from the Revalidation Team were noted to include:

- Ensuring appraisals are undertaken appropriately and in accordance with national and local policies, procedures and guidelines;
- Checking that appraisals and supporting information are sufficient for the RO to make a positive recommendation for revalidation to the GMC;
- Optimising the reporting mechanisms within the Allocate Software
- Explore new ways of working to further enhance the Trust's revalidation and appraisal processes;
- Building and maintain working relationships with Doctors, Managers and Directors across the organisation; and
- Seeking feedback from service users to improve upon current working practices.

14.2 **Resolved:** i) the Doctors Revalidation Report was received and noted; and

ii) approval was granted for the Chief Executive to sign the Statement of Compliance on behalf of the Board for submission to NHS England

BoD/9/15 EPRR Annual Report

15.1 The Emergency Preparedness, Resilience and Response (EPRR) Annual Report for the period ending 31 March 2018 was received and noted. The Board noted that the work plan for 2018/19 had been approved by Operational Management Board which they were supportive of.

15.2 **Resolved:** the EPRR Annual Report for 2017/18 was received and the 2018/19 work plan was received and supported by the Board.

BoD/9/16 Finance and Improvement Committee Chair's Log

16.1 The Finance and Improvement Committee Chair's log from the meeting held on 19 July 2018 was noted.

BoD/9/17 Quality Assurance Committee Chair's Log

17.1 The Quality Assurance Committee Chair's log from the meeting held on 24 July 2018 was noted.

BoD/9/18 Any Other Business

18.1 There was no other business.

BoD/9/19 Date and Time of Next Meeting

19.1 The Board meeting to be held in Public was arranged to take place on Tuesday, 6 November 2018

Board of Directors	
Agenda item	2.1
Title of Report	Medical Education Strategy
Date of Meeting	6 November 2018
Presented by	Professor Andrew Owens, Medical Director, Medical Education, Research and Innovation
Author	David Macafee, Director of Medical Education
Approved by	Professor Andrew Owens, Medical Director, Medical Education, Research and Innovation
Previous Committee/Group Review	Operational Management Board
Purpose	Approval √ Decision ☐ Discussion ☐ Information ☐
Alignment to Trust's Strategic Objectives	☐ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements	GMC
Recommendation(s)	The Board is asked to: • Support for the Medical Education Strategy • Endorsement of "Eight high impact actions to improve the working environment for junior doctors" • Support for development of new Educational facilities at Friarage for Hull York Medical School Undergraduates, Trust Postgraduates and the wider North Yorkshire health service

South Tees NHS Hospitals Trust
Medical Education Strategy
2018-2021

Our mission:

To provide an educational environment which facilitates the delivery of excellent clinical care, with trainee focussed high quality training within an inclusive and supportive culture

Our vision:

To be recognised as a centre of excellence in the provision of medical education

Strategic context:

The Medical Education teams (Undergraduate and Postgraduate) will:

- Continue to attract, train and retain talented doctors, as evidenced by our excellent GMC survey results
- Deliver high-quality training so enabling trainees to meet their training needs and outcomes while facilitating the provision of high quality care by teams
- Recognise the changing structure and needs of clinical teams, and provide flexible training to meet these needs
- Empower a culture of continuous safety improvement and dissemination of learning
- Promote compassionate care for patients, and a stable, supportive environment for trainees
- Focus on the "Eight high impact actions to improve the working environment for junior doctors"

The challenges to meeting these aims:

- Increasing numbers of complex and frail patients entering the acute care system requiring specific skills to treat and discharge
- A primary-secondary care divide, with discontinuity in clinical care, leading to unplanned admissions to hospital
- Increasing patient and societal pressure for "consultant only" rather than "consultant led" care
- A more diverse workforce with increased training and pastoral needs
- Under-fill in our rotas leading to a poorer training experience for the remainder
- Clinical and managerial pressures affecting training and culture
- A generational "gap" with regard working attitudes

The opportunities it realises:

- Facilitating working across boundaries to provide more effective and integrated care for patients
- Delivering need-specific training to trainees and non-specialists across the Trust via an established training infrastructure
- Promoting innovative partnerships with neighbouring institutions to solve current workforce and training gaps
- Recruiting and retaining high quality staff as future consultant colleagues
- Enhancing consultant's leadership and educational roles for their health care teams, patients and carers
- Using digital learning to meet the changing needs of the workforce
- Up-skilling all staff and remunerating them for the extra skills and resilience they bring to the organisation

Our strategic goals

Strategic goal 1: Foster and retain talent

This means we recognise talent in our trainee workforce, and strive to nurture those individuals into future leadership roles

- Provide high quality placements for students and trainees, recognising these people as our future workforce
- Continue to deliver outstanding medical training as evidenced by excellent GMC feedback from trainees
- Recognise, recruit, train and retain gifted postgraduate medical supervisors
- Increase student numbers overall
- Use our reputational success to attract new technologies or expand our secondary and tertiary services (e.g. robotic surgery, centralised vascular and cardiological services)
- Re-establish Trust led Consultant induction where educational and research opportunities can be highlighted

Strategic goal 2: Right team, right skills

This means promoting team-working, team-building and a positive workforce culture

- Recognise that education of staff is the best way to raise the quality of clinical care delivered
- Develop inter-professional learning to promote the most effective team to deliver a patient-centred approach to care
- Shared values
- Recognise and utilise the skills of postgraduate trainees in improving our Trust through quality improvement, leadership and management opportunities

Strategic goal 3: Digital literacy

This means using technology to deliver education, up-skilling staff where necessary

- Work as a whole Trust to up-skill the workforce, and utilise technology so that each member can reach their highest potential
- Use technology to enable postgraduate trainees and senior medical staff to best utilise their skills for the service of patients, our Trust and the local health economy
- Utilise trainee's experiences from other Trusts to improve our processes and use of digital technologies
- Using IT and local governance to harvest the best educational resources from the internet (webinars, videos) while protecting Trust infrastructure
- Investing in e-learning, in situ simulation and gamification techniques
- Reduce the service elements of trainee posts using technology and well designed administrative approaches
- Maximise the use of social media, Trust communications and the internet to highlight our strategic goals, our future events and our achievements

Strategic goal 4: Culture of continuous learning and safety improvement

This means that we endorse an environment where highlighting and learning from mistakes is not only the norm, but part of our core values

- Foster a culture where learning from mistakes and sharing knowledge are actively encouraged
- Work towards delivering safe, harm free care, consistently
- Positive educational culture to learn constructively from poor patient care, serious untoward events and never events
- Collaborative working with the clinical intelligence unit, medical examiners, the safeguarding team and others to share learning both with trainees and anonymously with the whole Trust
- Using technology to reduce human error and to ensure trainees and consultants are trained in the use of these systems

Strategic Goal 5: Working across boundaries

This means promoting and engaging in relationships with neighbouring and distant institutions to deliver workplace solutions

- Continue to build on our strong links with the Tees Valley and North Yorkshire GP schemes, via quality improvement, educational events, research collaboration and educational placements
- Increased presence of Newcastle University at South Tees site following expansion of student numbers and changes in the undergraduate curriculum
- Establish Friarage Hospital as a Hull-York Medical School hub, with North Yorkshire GP engagement for Longitudinal Integrated Clerkships (2019) and undergraduate Phased teaching (2021)
- Establish 2 week rural GP medical placements for year 3 undergraduate medical students from Imperial College London
- Establish Friarage Hospital as a training hub for healthcare staff throughout North Yorkshire, Hambleton and Richmond

Strategic goal 6: Flexible and innovative training and working

This means recognising the changing nature of both the workforce and the patients whom we serve

- Delivering inter-professional education to nurse practitioners, physician associates, registered nurses, allied health professionals and other non-medical staff
- Recognising the importance of community based care, and providing increased educational opportunities for undergraduates and postgraduates
- Increasing provision of small group teaching, with a focus on simulation as a highly effective method of learning for multidisciplinary groups of learners

Strategic goal 7: A friendly, supportive and resilient learning environment

This means providing a fun and supportive place to work, increasing morale and thus patient care

- Maintain current clinical team structures to avoid “ward assigned” working isolation
- Provide pastoral as well as educational opportunities for trainees
- Create an educational structure which is resilient to changes in the local health economy, and a source of stability for trainees
- Support trainers in their own educational development

Our strategy for delivering quality medical education

Our medical education strategy builds on the three key domains from the NHS report, *High quality care for all*. These are:
• **Patient safety** (consistently delivering safe, harm-free quality care to all patients)
• **Patient experience** (providing an excellent quality health experience for patients, carers and visitors)
• **Clinical Effectiveness and Outcomes** (providing high quality evidence based care that is effective to ensure the best possible outcomes)

Why do we need a strategy?

Our mission is to be recognised as a national centre of excellence in medical training, with the aim of providing an outstanding training experience. This will not only benefit our patients today, but future patients by retaining talented professionals. Our strategy sets the direction, in order to help us to focus time and resources on the areas that will enable delivery of these goals.

What do we mean by quality?

We believe that high quality medical education should

- Be effective - trainees should improve in knowledge, skills, attitudes and resilience during their training time with us
- Reduce error and instances of poor care
- Provide a wealth of training opportunities across tertiary, secondary and primary care
- Provide new ways to learn, including digital technologies
- Ensure our trainees feel supported – and inspire them to work with us in the future

How will we measure quality?

Our quality goals include:

1. Trainee feedback
    - Trainee feedback is collected annually via the GMC survey nationally and our aim is to remain in the top quartile
    - We aim for consistently positive feedback from Your School Your Say Foundation feedback annually
    - We aim to expand medical student numbers on both sites by ongoing collaboration with Newcastle University and future collaboration with Hull-York Medical School

2. Trainer feedback and recruitment
    - Encourage GMC trainer survey feedback to increase our contact with trainers through directorate meetings and Trainer updates
    - We should as a Trust re-affirm the importance and value we hold for “shop floor” clinical trainers and high quality supervisors
    - We provide spoken and written feedback to trainers through the year – most concentrated around ARCP times locally after trainee assessments.
    - Our aim is to recruit an additional 30 clinical and educational supervisors across the Trust over the next three years.

3. Patient and carer feedback
    - Patient feedback is collected via 1000 voices and we aim for an increase in compliments for trainees and their trainers
    - Aim for a reduction in complaints involving trainees and improved support for them through clinical incidents, never events, safeguarding issues or coronial attendances

4. Clinical effectiveness
    - We will measure clinical effectiveness by increased adherence to national guidelines
    - We wish to introduce “Positive Reporting” to recognise consistently high quality or excellent care
    - We aim to increase reporting of patient safety incidents over the next three years
    - We also aim to see a decrease in severity of incidents over the next three years, indicating organizational and learning.

Our plan

We will work as a Trust to develop a workforce with the right skills, forming the right teams, in the right place at the right time for patients. With the support of medical teams, our undergraduate and postgraduate teams will help the up-skilling of other members of the workforce to build resilience and increase capacity within teams (Nurse Practitioners, Physician associates, Registered nurses, Allied Health teams). Undergraduate and postgraduate curriculums are also recognising the increased importance of community based care so our increased interdependency and involvement in community provides increased educational opportunities for our trainees.

We need to be reactive to changes in the experience and confidence of our trainees. Our planned and emergency rotas may be affected by new guidelines established by Health Education England, Medical Royal Colleges or the General Medical Council such as altering the content, contract or levels of independent practice enabled by a trainee level. This includes the Shape of Training changes planned.

A positive educational culture provides the best opportunity to learn constructively from poor patient care, serious untoward incidents and never events. We will work collaboratively with other clinical and management groups (e.g. Clinical Intelligence Unit, Medical Examiners, Safeguarding) to support trainees who have been involved and ensure positive lessons are learnt by them and their teams and then shared anonymously to the Trust as a whole. We would commend the funding of a Positive reporting tool to counterbalance the Datix reporting system as approximately 90% of the care we deliver as a Trust is either of acceptable or reaching exceptional standards - but such care regularly goes unrecorded and unrecognized.

Trainees are and will be increasingly encouraged to involve themselves in quality improvement projects. Their experiences from other Trusts can improve our processes, approaches and use of technologies. Their digital capabilities will be crucial in developing aspects of our clinical IT developments (e.g. electronic records). We will also provide opportunities from undergraduate and postgraduate groups to learn and collaborate with all healthcare colleagues and healthcare management teams. This includes dentists, nurses including specialist nurses, midwives, pharmacists, dieticians, occupational therapists, operating department and surgical care practitioners, physician associates, radiographers and phlebotomists

We look forward to increasing our collaboration with Higher Education Institutions (HEI's) such as Newcastle University, Hull-York Medical school, Imperial College and Teesside University. We will continue to support the work in the LRI towards Preferred Provider status so we can provide increased, in house, bespoke training that is of a higher quality and lower cost in terms of money and time.

We will work with the events team to increase the number of locally delivered courses to highlight the secondary and specialist tertiary services available at South Tees. This will include events to attract local school leavers to our Trust and other innovations such as the Social Mobility Foundation residential course.

We must continue to develop the infrastructure to support inspiring, effective and efficient learners. This includes IT and governance to gain the best educational use out of the internet via webinars, social media, video links - whilst also protecting our Trust infrastructure from IT threats or inappropriate use. Learning increasingly comes from self-direction, E-learning, simulation including in situ approaches, applications and potentially gamification techniques. We must ensure we use educational income to invest in such learning techniques. We must also have increased financial oversight of educational funds – we are a leader in this from an undergraduate (SIFT) perspective but Health Education England will require similar transparency for Postgraduate (MADEL) budgets also.

Much work is needed over the next few years in order to realize these goals but we begin from a very strong educational position. We will provide reports of our ongoing progress.

David Macafee, Director of Medical Education, GMC 4529105

Board of Directors	
Agenda item	2.2
Title of Report	Information Technology Strategy
Date of Meeting	6 November 2018
Presented by	Kevin Oxley, Director of Estates, ICT and Health Records
Author	Andrew Adair/Ian Willis
Approved by	Kevin Oxley, Director of Estates, ICT and Health Records
Previous Committee/Group Review	Operational Management Board Digital Strategy Group
Purpose	Approval [√] Decision [ ] Discussion [ ] Information [ ]
Alignment to Trust's Strategic Objectives	[ ] 1. We will deliver excellence in patient outcomes and experience [ ] 2. We will drive operational performance to deliver responsive, cost effective care [ ] 3. We will deliver long term financial sustainability to invest in our future [ ] 4. We will deliver excellence in employee experience to be seen as an employer of choice [ ] 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements	GMC
Recommendation(s)	The Board is asked to approve the ICT Strategy and support the commitment for the implementation of an Electronic Patient Record.

Executive Summary

The previous ICT Strategy (2014 – 2019) focused on maximising the use of current systems in place while providing small scale improvements in clinical systems and the underlying infrastructure.

A number of key systems were implemented during this time, including VitalPAC for bed side observations, Symphony in Accident and Emergency and an upgrade to the Trust network including the entire wireless estate. However, a number of key systems were not implemented, most notably Electronic Prescribing. This has limited our ability to support business transformation and means that the Trust is regarded as being less "digitally mature" compared to many of its peers.

Regional and National drivers are now focused on the ability to share patient records across all healthcare settings, giving access to patient records whenever and wherever they are needed. Initiatives such as the Great North Care Record and the Five Year Forward View require organisations to have fully interoperable Electronic Patient Records in order to participate in record sharing.

The Trust must therefore move away from the previous strategy of "Best of Breed" and move towards a single integrated record. The heart of this strategy is the implementation of an Electronic Patient Record. This will give the Trust a fully integrated health record which spans the entire Trust, reaches out into the community and patient's homes and integrates the Trust, supporting units and the population, locally and regionally.

Recommendation

Board is asked to approve this strategy noting the ambition to procure an Electronic Patient Record. A business case for an Electronic Patient Record will be presented at the next Trust Board for discussion/approval.

South Tees Hospitals NHS

NHS Foundation Trust

ICT Strategy

2018-2022

Reference	ICT Strategy Final Ver 1.0	ICT Strategy
Owner	Ian Willis	
Version	1.0	
Authors	Ian Willis, Kevin Ryott, Michelle Harrison, Mike Jackson	
Date	19th October 2018	

Contents

1 Executive Summary

1.1 Background

At the heart of this strategy is an Electronic Patient Record (EPR). An EPR is a fully integrated health record which spans the entire Trust, reaches out into the community and patients' homes, ultimately fully integrating the Trust, supporting units and the population regionally. It offers many significant patient safety benefits and is key to enable the Trust to move towards the vision of a paperless NHS.

There have been a number of previous EPR programmes that for several reasons have not reached the final business case stage. Our previous strategy (2014-19) was designed to put the Trust into a holding position whereby the use of current systems would be maximised, functional gaps would be plugged and core infrastructure would be upgraded. Despite a challenging financial landscape, some progress was made in the last four years, including:

- Implementation of the VitalPAC solution with automatic calculation of early warning scores and cascading escalation
- An upgrade of the entire Trust network infrastructure including the wireless network
- Roll out of the EMIS Symphony A&E solution along with Dragon voice recognition software to enable a paperless A&E.

Despite this progress, the decision not to invest in an EPR has limited our ability to support business transformation and new ways of working. The Trust continues to rely on "point solutions", systems designed to perform a single task very well but with little or no integration. This has resulted in silos of information and a proliferation of systems, all with separate passwords and different user interfaces.

Continuing as we are is no longer an option. We have a number of systems which are now nearing their end of life, including the CaMIS Patient Administration System (PAS) which is over 25 years old and can no longer be developed and a theatre management system nearly 20 years old which does not support current working practices. These core systems alone are costly to change but would offer little or no benefit over the current systems in place.

At the same time there continues to be fundamental gaps in functionality, including, most significantly, electronic prescribing. The benefits of electronic prescribing solutions are well documented with clear evidence that indicates serious incidents can be reduced significantly with their introduction. This lack of functionality has a severe impact on our Digital Maturity, ranking us 105 out of 150 and putting us the second lowest in the region.

Rank	Trust	Score
1	Newcastle Upon Tyne	95
1	North Tees and Hartlepool	95
1	County Durham & Darlington	95
23	City Hospital Sunderland	90
32	Gateshead Health	87
42	York Teaching Hospital	85
45	Northumbria Healthcare	84
85	South Tyneside	73

105	South Tees	69
115	Leeds Teaching Hospitals	67

CDMI index – September 2018

This shows starkly why we must, as a leading provider with tertiary services, have up to date technology that will enable greater business transformation, safer care and release many benefits we are currently unable to realise.

The emerging ICS's Digital Care Strategy identifies EPRs, to improve capture and share patient records, as a priority. With an EPR, patient information will be recorded electronically allowing it to be shared securely and seamlessly across all our service teams and healthcare settings at the point of need; enabling multi-disciplinary teams to work collaboratively to better support the care of our patients.

Interoperability will be the cornerstone to enable delivery of the national Integrated Care requirements and is essential for participating in the Great North Care Record (GNCR). Key priorities for the GNCR include a Health Information Exchange where patient records can be shared across and between multiple care providers, and a population health analytics platform for modelling patient information to provide data driven decisions across the whole health system. Without an EPR the Trust would not have the tools to support and contribute to the GNCR.

Additionally and importantly, interoperability will support the safe and effective transfer of care throughout our clinical pathways as they develop and change; and will allow our clinicians to work across the system as appropriate.

Finally, our patients and citizens will benefit from an EPR by providing secure access to their own health care records electronically, to allow them to book appointments on line and to enable them to participate and contribute to their own health and care management.

1.2 Recommendation

OMB is requested to note the strategic context of this paper and support the commitment for the implementation of an EPR.

2 Our Trust

This section outlines information about the Trust and its vision, values and strategic objectives and how ICT can support these.

2.1 Organisational Overview

The role of South Tees Hospital NHS Foundation Trust is to provide high quality health care to patients and to ensure the services it delivers are safe, meet national clinical standards and can be sustained in the long term. The Trust operates from two main hospital sites:

- The James Cook University Hospital in Middlesbrough, a tertiary site with a major trauma centre, and
- the Friarage in Northallerton, which provides district general hospital services.

It also provides a range of community and district nursing services and covers a local population of 435,000 which extends to a 1.5 million catchment area for its specialist services.

Our vision

Our vision is to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement.

Our values

- Putting patients at the centre of everything we do.
- Continuously improving quality
- Using our resources to the benefit of the wider community

Our strategic objectives:

- We will deliver excellence in patient outcomes and experience
- We will deliver excellence in employee experience to be seen as an employer of choice
- We will drive operational performance to deliver responsive, cost effective care
- We will deliver long-term financial sustainability to invest in our future
- We will develop clinical and commercial strategies to ensure our long term sustainability

We will demonstrate that this ICT strategy will support the overall strategic objectives as follows:

Strategic Objective	Achieved through
We will deliver excellence in patient outcomes and experience	Seamless joined up patient records giving clinicians access to the information they need at their fingertips enabling them to deliver the best care possible.
We will deliver excellence in employee experience to be seen as an employer of choice	By maintaining hardware and infrastructure and employing the latest technologies we will attract and retain staff that appreciate the benefit technology brings to their working lives.
We will drive operational performance to deliver responsive, cost effective care	By having access to real-time or near real-time performance data available through reports and dashboards we will be able to drive transformational change informed by rich

	information.
We will deliver long-term financial sustainability to invest in our future	Modern technologies will drive out inefficiencies within processes, reduce duplication and hand-offs saving both time and money which can be invested elsewhere.
We will develop clinical and commercial strategies to ensure our long term sustainability	Data shared across the whole health economy through technologies such as the Great North Care Record will provide "big data" which can be leveraged to provide forward-thinking strategic planning across all services.

3 ICT within the Trust – where are we now?

This section provides detail on the current ICT situation of the Trust.

3.1 Current systems in place

The current major clinical systems in place within the Trust and their functionality are shown in Appendix A. In addition to these systems there are a range of smaller systems and databases in use giving in excess of 100 systems involved in clinical care either directly or indirectly.

A number of systems have been in use for over 20 years and have a number of limitations that are now holding back development of a patient centred electronic record, require data manipulation off line or alternative workaround processes, including the following:

- Acute PAS (CaMIS)
- Theatres (TheatreMan)
- Maternity (EuroKing)

In addition, the Pathology and PACS/RIS systems are now nearly end of their contracts and need to be re-procured.

The above list also illustrates the system and information silos that exist across the organisation and the difficulty in providing information at the point of care to meet clinical and operational need.

3.2 Current links/ interfaces between systems

The diagram in Appendix B shows the main information flows between the systems used in hospital based care and the complexity in maintaining transfer of patient information and a limited amount of clinical information between systems.

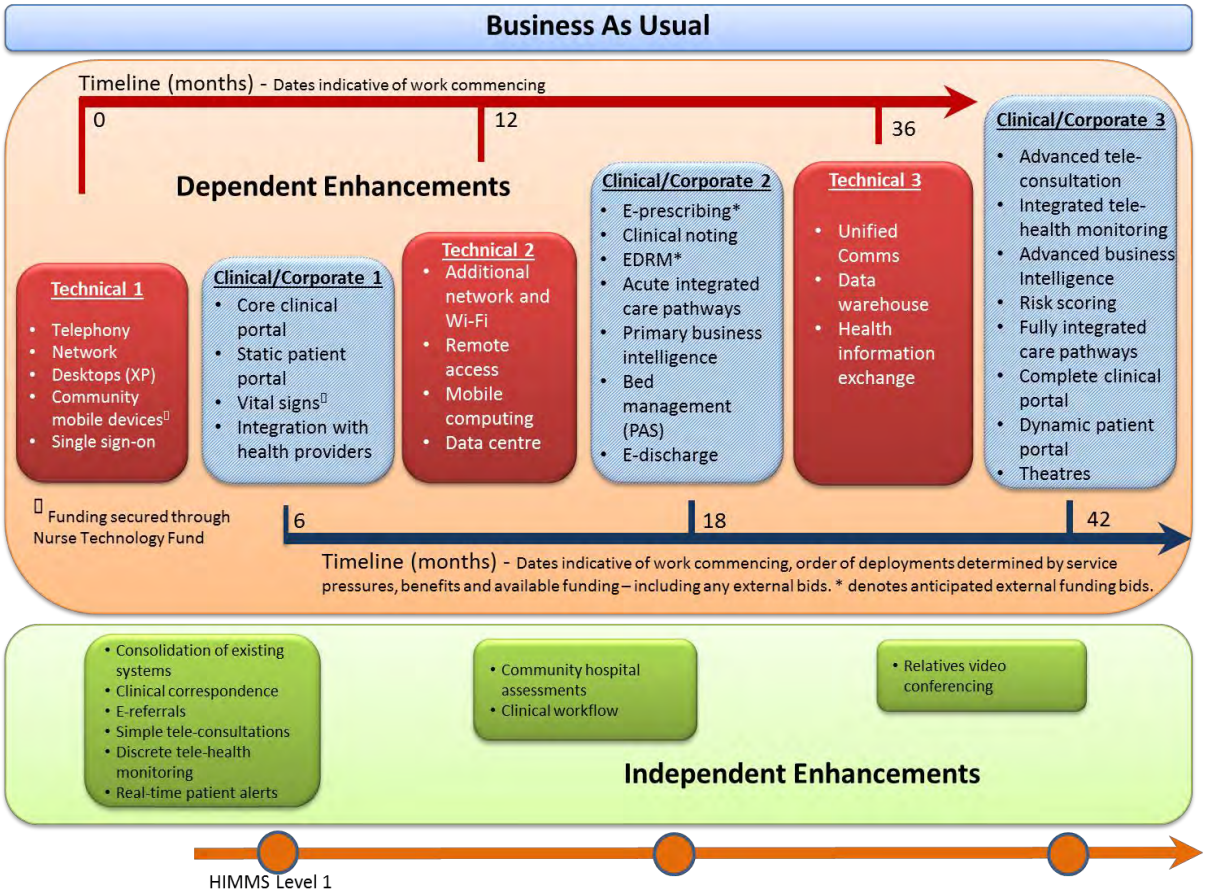
Whilst there is some interfacing to pass basic information between systems this is limited to a large degree by the technical ability of the linked systems. From a clinical experience perspective the key systems are all separate, requiring separate log-ins, and a very different user interface to navigate in each one. This leads to duplication of data collection, wastes clinical time and potentially increases clinical risks through mis-identification of patients or poor access to key information when it is needed.

3.3 ICT Strategic Programme – 2014 - 2019

The overall strategic approach in the last ICT strategy could be described as 'best of breed'. The strategic aim was to:

1. Maximise what we already have
2. Improve core ICT functionality
3. Deliver new mobile functionality

Our existing strategic programme consisted of two workstreams running in parallel; one to improve the overall infrastructure capability and the second to improve the overall digital maturity of the clinical solutions.



On reflection and given the position of the Trust at the time, the strategy has proved to be sound and has delivered a number of new capabilities including:

- Implementation of the VitalPAC solution with automatic calculation of early warning scores and cascading escalation
- An upgrade of the entire Trust network infrastructure including the wireless network
- Roll out of the EMIS Symphony A&E solution and Dragon voice recognition software to enable a paperless A&E.

Appendix C contains details of all the systems and solutions that have been implemented during the last four years.

However, a number of enhancements were not implemented during the last strategic cycle, most notably:

- E-prescribing
- Clinical portal
- Patient portal
- Health Information Exchange (HIE)

The delivery of this best of breed approach was correct against our previous strategic intentions; however, as the current strategy comes to an end and with current regional and national drivers shifting the emphasis to integrated shared records, this approach is no longer sustainable. The introduction of multiple point systems has presented greater levels of information silos and challenges regarding interoperability.

4 Drivers for change

This section discusses the drivers for change within the organisation, from a local and national level as well as ICT specific drivers.

Despite the improvements outlined above, South Tees NHS Foundation Trust as a healthcare provider is not as digitally mature as most of its peers. There are a number of key clinical functions, such as E-prescribing, electronic patient pathways and decision support which prevent the Trust from improving its digital maturity further. There are a number of national, local and ICT specific drivers which will have a significant impact on the direction the trust takes with its ICT service.

4.1 National Drivers

4.1.1 Personalised Health and Care 2020

Published in 2014, NHS England has committed to making patient-facing digital services a requirement by 2020. The National Information Board's Personalised Health and Care 2020 framework is a set of requirements, proposals and case studies intended to ensure the delivery of digital health and care information by 2020.

4.1.2 Local Digital Roadmap

In September 2015 a three-step process began to enable local health and care systems to produce Local Digital Roadmaps (LDRs), setting out how they will achieve the ambition of Paper-free at the Point of Care by 2020. The first step was the organisation of local commissioners, providers and social care partners into LDR footprints. The second step was for NHS providers within the LDR footprints to complete a Digital Maturity Self-assessment.

The LDRs include the following elements:

- A five-year vision for digitally-enabled transformation
- A capability deployment schedule and trajectory, outlining how professionals will increasingly operate 'paper-free at the point of care' over the next three years
- A delivery plan for a set of universal capabilities, detailing how progress will be made in fully exploiting the existing national digital assets
- An information sharing approach

It is now the responsibility of the Integrated Care Systems (ICS) to adopt and deliver on the LDR.

4.1.3 NHS Standard Contract

NHS England will be using the National NHS Standard Contract terms to enforce compliance with the details outlined within the Personalised Health and Care 2020 document.

An example of this is the "Transfer of Care" initiative to improve quality and continuity of patient care by making all patient records accessible across the system. Key steps identified to achieve this are standardising headings, coding and electronic transmission of correspondence. This requirement is detailed in the NHS England Standard Contract with a deadline of 1st October 2018.

4.1.4 Information and Technology for Better Care

The Health and Social Care Information Centre (now NHS Digital) was established in April 2013 by the Health and Social Care Act 2012. It is responsible for collecting, transporting, storing, analysing and disseminating the nation's health and social care data.

NHS Digital is responsible for providing a trusted, safe haven for some of an individual's most sensitive information. It is also responsible for building and delivering the technical systems that enable that data both to be used to support that individual's care and to deliver better, more effective care for the community as a whole.

The 'Information and Technology for Better Care' document is NHS Digital's Strategy for 2015 – 2020, and sets out how NHS Digital are going to fulfil these responsibilities.

4.1.5 NHS England Digital Maturity Index

NHS England has developed an informatics maturity model that supports the strategic direction of delivering an Integrated Digital Care Record across the NHS.

The methodology for assessing digital maturity has been recently re-developed. The Trust was required to complete the organisation's digital maturity via self-assessment in March 2018.

Key development areas outlined within this strategy have also been identified as assessment measures within the revised DMI, these now include: security of data centres, utilisation of GS1 barcode technology, access to information at the point of care and patient access to information.

Currently (as of September 2018), the Trust is ranked 105 out of 150 acute Trusts on the Digital Maturity Index with a score of 69. The main gaps in functionality are:

- E-prescribing, including ward/inpatient prescribing, outpatient/TTO prescribing and clinical decision support
- Scheduling, such as a clinical workflow engine and electronic integrated pathways
- Clinical noting and document management
- Simple Business Intelligence, such as data warehousing and dashboards

The national score enables us to look at our position and situation regionally and the following represents regional ranking and scoring when looking at all trusts, not just acute:

Rank	Trust	Score
1	Newcastle Upon Tyne	95
1	North Tees and Hartlepool	95
1	County Durham & Darlington	95
23	City Hospital Sunderland	90
32	Gateshead Health	87
42	York Teaching Hospital	85
45	Northumbria Healthcare	84
85	South Tyneside	73
105	South Tees	69
115	Leeds Teaching Hospitals	67

This clearly shows that we are below our regional peers for most areas of the DMI. This strategy looks to increase our score in most areas of the DMI, to ensure compliance with national and local standards and to future proof the Trust's investments.

4.1.6 Simon Stevens [1] 'Five Year Forward View'

The NHS Five Year Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. There will be a focus on self-care and providing both staff and those individuals with the tools needed to support new processes to manage their own health, staying healthy, make informed choices for treatment, managing conditions and avoiding complications. The view will require agile systems and technology in order to adapt to the new models of working. New models of care including Primary and Acute Care Systems (PACS) will need to be underpinned with appropriate information systems and date sharing. The view stipulates the need for fully interoperable electronic health records so that patients' records are largely paperless and they will need to be compliant with standards under the governance of the National Information Board.

4.1.7 The future of healthcare: our vision for digital, data and technology in health and care[2]

This policy paper, published in October 2018, outlines a vision which has a number of challenges to overcome around:

- legacy technology and commercial arrangements
- complex organisational and delivery structures
- a risk-averse culture
- limited resources to invest
- a critical need to build and maintain public trust

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf page 12; 31-34;

[2] https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care

It also sets out the guiding principles by which the NHS should operate by:

- User need
- Privacy and security
- Interoperability and openness
- Inclusion

And the priorities for infrastructure, digital services, innovation, skills and culture, which are to:

- put in place the right infrastructure
- buy the best technology
- ensure that digital services meet people's needs
- enable health-tech and innovation
- develop the right skills and capabilities
- build an open culture

4.2 Local Drivers

The case for change is predicated on the recognition by the Trust that it requires an integrated digital care record for patients to support:

- Delivery of its strategic plans and objectives to meet the requirements of the Health & Social Care Act 2012 and Government Mandate commitments, focusing on:
    - Patient safety
    - Service effectiveness
    - Patient and staff experience
    - Unscheduled care
    - Integration and care closer to home
    - Sustaining and developing Women's and Children's services
    - Developing specialist services and centres of excellence
- The provision of integrated care across Acute and Community services and boundaries with primary and social care
- Delivery of an ICT Plan supporting both local and national strategic Informatics developments
- Provision of patient access and involvement in their care decisions and delivery
- Realising the many benefits and improvements resulting from deployment, including accelerated delivery of benefits associated with other projects e.g. clinical noting
- Addressing key risks to future strategic development and operational performance
- To enhance and improve its performance and ratings against CQC and NHS Improvement standards

5 Our Principles

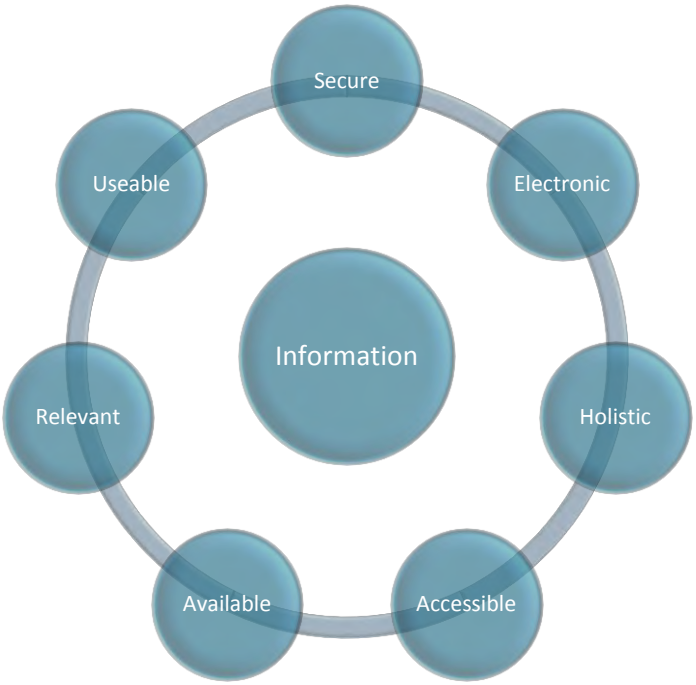
This section outlines the ICT Principles.

It has been noted that the NHS has:

…a great deal of data, but a lack of meaningful information and knowledge…

This strategy has been developed with information at the core – the way in which we record, access, use, manage and share information is central to the way in which the organisation operates both currently and moving forward.

The diagram below outlines the key principles for information in taking this strategy forward:



- Our information must be **secure**. Staff and citizens will have confidence in the protection of their information through secure networks and robust monitoring. Patients will willingly share their records, knowing that this is only done so for their benefit and that during this process the information is confidential and secure.
- Our information must be **electronic**. As much as possible, paper based processes are removed from the organisation, both internally and externally.
- Our information must be **holistic**. The record outlines the patient journey as a whole, providing health care professionals with 'the whole story', including information from partner organisation's systems.
- Our information must be **accessible**. Relevant, real-time information available at the point of care, across multiple sites - whether that is at Trust premises or in the patient's home.
- Our information must be **available**. Clinical service continuity through high availability of systems through the development and implementation of resilient networks and infrastructure.
- Our information must be **relevant**. A single source of information with tailored views depending on role and requirement; appropriate information pushed to care providers for action.
- Our information must be **useable**. Information is recorded once and used many times; removing duplication and improving quality of information.

6 Our Strategy

This section considers the themes of the ICT Strategy.

The development of the strategy follows a thematic approach, aligned to the principles of information outlined above and the requirements of our stakeholders.

This thematic approach helps us to move away from thinking of the composite functions that ICT comprises of and take a more holistic view of the developments and initiatives required to complete the implementation of the strategy.

The themes of this strategy are represented below:

Working Together	By 2020 we will have shared resources across the local health economy, supporting **access to relevant information across partner organisations** and facilitating partnership working. Information flows across **multiple organisational boundaries** will be supported and facilitated through ICT provision. We will implement a common digital platform, based on **standardisation** and common rules supporting seamless integrated care. Everything we do will be **clinically driven**, working in conjunction with the ICT service and others to realise the benefits and remove obstacles to progress.
Working Smarter	By 2020 care professionals will have access to **complete contemporanous records**, analysis and decision support that they need to deliver safe, effective and quality care. We will have a **single source** of high quality information which fit the requirements of both clinical records and organisational management and performance analysis. Technology will be used as an **enabler for innovative ways of working**, including health 'apps' and devices developed in partnership with the Trust; supporting specific illnesses and pathways as identified as local priorities. Workflows throughout the organisation will be supported through the use of **mobile technology**, providing care providers with access to contemproaneous information at the point of care and enabling real-time record keeping and management. We will ensure staff across the organisation have the **right skills and capability** to implement and use new technologies with confidence.
Working Securely	In 2020 we will continue to **protect our information**, systems and technology from the impact of cyber attacks; we will be able to effectively monitor the status of all systems and proactively manage threats. Access to information will be via a continuous secure platform, both from within the organisation and externally.

Citizen Access	By 2020 our patients, carers, families and citizens who want it will have access to relevant national and local data services which will help them **to see and manage their own record**s. Enable them to undertake transactions with the Trust to support the management of their health and wellbeing in a variety of digital and electronic channels, such as through the internet, email, text messaging, and smartphone apps. Wherever, and as practical as possible, digital will be the preferred method of communication.
Paper-heavy to Paper-light	We will **exploit the benefits** achieved through the utilisation of the systems we currently have in place, to maximise the investment already made by the Trust. By 2020 we will **reduce paper** based processes from the organisation, replacing them as required with secure digitised workflows.

6.1 Working Together

Working together is critical to the consistent delivery of safe, effective and quality care, whether that is within the Trust or working in partnership with other health providers and partners.

Information sharing throughout patient pathways within the Trust will be supported through the implementation of an **Electronic Patient Record**; a single record across the organisation for the entirety of the patient pathway. Existing information silos will be removed through the replacement (where appropriate) of existing systems as they reach the end of their lifespan.

The Trust has well established working partnerships in place; facilitating this partnership working and information sharing through the use of technology and systems is key to service provision moving forward.

Providing the platform on which information can be shared between organisations is central to the safeguarding agenda, both locally and nationally; provision of collective data as part of the patient journey will be available through the implementation of an integrated health record, building on the foundation of the Trust's EPR.

What we will do:

- Work in collaboration with suppliers to establish an EPR solution to fit the information requirements of the Trust
- Interoperability and communication between the Trust and partner organisations will be developed with suppliers to ensure the required information flows are supported in line with appropriate open standards
- Develop a roadmap outlining the technical interfaces necessary from partners to support true partnership working
- Encourage local initiatives and innovations that support the adoption of standards to improve interoperability

6.2 Working Smarter

The Trust has recognised the benefit of enabling processes through the use of technology; the short-term focus of this strategy is to ensure that the organisation continues to realise the benefits of the technologies currently in place and get the most out of investments already made.

Without doubt, technology is an enabler for service transformation; through the implementation of this strategy the Trust will need to develop a culture where all health and care professionals take responsibility for recording, sharing and using information to improve the quality and safety of the patient care we deliver.

For example the Trust has invested in a number of voice recognition technologies such as Nuance Dragon which works with Symphony and has transformed A&E into a completely paperless environment . The

Trust is now exploring options for using this technology outside of A&E to support other clinical areas as an alternative to the historical data collection processes.

NHS organisations are often cited to be data rich and information poor; the implementation of a single system supporting the multiple information requirements of the organisation aims to overcome this concern. The principle is to collect data once to use many times, whether that is throughout clinical care or providing activity data for statistical analysis and planning tools.

Clinical and non-clinical staff are expected to use complex tools as part of their everyday job; the work of the Trust and its partners takes place in various locations. Working smarter means greater workforce mobility supported by the use of technology, smarter use of the information we hold and standardisation of working processes to release efficiencies.

What we will do:

- Ensure our workforce have the knowledge and skills required to facilitate smarter ways of working and ensure they are confidence to implement and use new technologies as they emerge
- Provide a platform from which clinical and operational processes can be standardised
- The ICT strategy proposes a range of technical, infrastructure and governance goals. The successful achievement of the core vision and transformational change however, will only be realised by strong Board and clinical leadership working together with ICT professionals to remove obstacles and achieve a common aim.

6.3 Working Securely

The Trust has a sustained focus on information governance for a number of years. Information governance is a framework that brings together all the statutory requirements, standards and best practice that apply to securing and handling of information. The focus on information governance will be continued over the period of the strategy as we seek to increase public confidence in how we obtain, hold, use, record, share and secure their information.

It is critical that we maintain public trust in how we hold, share and use data. Clear and mandated standards, guidance and frameworks for this underpin the delivery of the best services and outcomes that meet user need and are based on the General Data Protection Regulation (GDPR) and consent where appropriate. GDPR contains stringent transparency requirements in Articles 13 and 14 to support people being properly informed of the use of their personal information and of their rights, before or at the time their information is collected.

We will maintain a safe and secure data infrastructure that protects health and care services, patients and the public. The digital architecture of the health and care system needs to be underpinned by clear and commonly understood data and cyber security standards, mandated across the NHS, to ensure we are secure by default.

We, and the healthcare sector overall, will continue to be assessed against the way in which we manage and care for the information with which we are entrusted.

This strategy proposes more information flows within, and outside of, the organisation and identifies a need for a balance between managing the security of information and providing those with a legitimate need for access to the data they require.

Improvements to the management of Cyber Security will be implemented as part of this strategy.

What we will do

- Working with with IG colleagues continue to provide assurance through the completion of Data Protection and Security Toolkit (DPST) and other national standards
- Working with IG colleagues, ensure staff know their responsibilities; continue training delivery and development to improve awareness of Information Governance and Data Protection and Security.
- Completion of the network refresh; implementation of monitoring and alert tools regarding network security
- Reduce the risk of information losses associated with paper based processes through digitisation

6.4 Citizen Access

The National Information Board (NIB) has set out plans for citizens to be empowered through access to their health records by 2020.

The Trust recognises the importance of patient access to information and has made some progress in making this a reality for our patients, e.g. with limited Telehealth capabilities. And being open with people about how their information is used so that they have confidence that it is legal, safe and secure. Every patient must have full, frictionless access to all of their health records to use in our growing ecosystem of health-tech solutions and services.

The Trust will continue to build on the developments already made in terms of Telehealth and Telecare; supporting patient self-management of key illnesses through the use of technology such as HealthCall. Support for this innovation will continue through the developments of health 'apps' and devices. Information will be drawn from and input to the overarching EPR, supporting the holistic view of records.

A patient view of the record will be available through the use of portal as part of the EPR development.

What we will do:

- Continue to work with suppliers to develop solutions supporting self-management for key pathways
- Establish a testbed platform for the development of health 'apps' in partnership with other Trusts
- Explore the extension of access to the EPR through a patient portal
- Communicate with patients and citizens through a variety of digital and electronic channels, such as through internet, email, text messaging, and apps, adopting a "digital by default" approach wherever practical
- Ensure that information is presented in an accessible way, and where appropriate in a range of languages and formats that are easily used and understood by the intended audience.

6.5 Paper-heavy to Paper-light

The organisation is recognised as being less digitally mature than many of its peers; the implementation of the 'best of breed' approach of the previous strategy has begun the journey of removing paper from the system and digitising the record e.g through the use of VitalPAC on wards. However, there is still much to be done for the Trust to be truly paper-less or even paper-light.

The implementation of the EPR will begin the process of removing the requirement for paper processes within the organisation as part of clinical practice. However, the organisation will still continue to work with historical paper case-notes and this mixed economy of paper and electronic will hamper any benefits the EPR will bring.

The Trust must therefore look to scan any paper case notes so that they can be viewed alongside the electronic record within the EPR. Options for scanning paper notes will need to be explored, but the recommendation would be to operate a "scan-on-demand" solution whereby historic notes are only scanned when required, for example for up coming appointments or procedures. The benefits of scanning records for patients attending A&E particularly out of hours would need to be evaluated within the process. It would be recommended that the Kainos Electronic Document Management (EDM) solution is used as the repository for scanning paper case notes but this would need to also be explored along side the EPR solution.

What we will do:

- Work in collaboration with suppliers to establish an EPR solution to fit the information requirements and clinical processes of the Trust
- Interoperability and communication between the Trust and partner systems will be developed with suppliers to ensure the required information flows are supported
- Look to maximise the investment in the Kainos Electronic Document Management (EDM) solution and explore options for scanning paper case notes

- Support initiatives and innovations that encourage the adoption of standards to improve information flows

7 What this strategy means to the Trust

This section looks at what the strategy means for the Trust as a whole.

An EPR will be the enabler for many of the benefits associated with the delivery of this strategy, building on those already achieved from existing investments, key benefit areas include support for various quality, safety and efficiency gains.

Modest potential cash releasing benefits are available, plus a far larger equivalent value as a direct result of improved access to a single comprehensive clinical record.

The implementation of this strategy within the Trust will enable the following strategic benefit objectives:

- Enhanced patient pathway support and improved management of end-to-end patient journey.
- Comprehensive digital record, supplemented by local / national guidelines / protocols, Clinical Decision Support (CDS) and pathway support that will reduce net care risks
- Comprehensive digital record, supplemented by local / national guidelines / protocols, CDS and pathway support will reduce unnecessary diagnostic tests (either repeat tests avoided or tests not clinically required)
- Comprehensive digital record will improve information availability for audit and research and reduce data duplication and data collation effort
- Comprehensive digital record will improve information availability for care and reduce operational data duplication
- Comprehensive digital record will improve integrated working between Acute and Community based staff
- Patient / carer access to their own clinical record will improve understanding of options, improve care plan compliance, support early escalation of concerns / queries to "virtual health team", reducing lengths of stay, crises and avoidable hospitalisation.
- Improved information quality
- Enhanced communications via patient-centred record leading to more ‘joined up’ care

Apart from operational benefits, the model also notes that data collected and available in the integrated care record will provide a rich source of care pathway information, enabling analysis of condition specific resources consumed, for example consultations, diagnostics, treatments and procedures. This information will improve analysis of health outcomes and aid future planning / costing at both service and patient level.

It should be noted that all benefits outlined in this strategy are potential and cannot be achieved without full implementation of the strategy and full business change support and commitment from the Trust.

8 Strategic Delivery Plan

This section outlines the plan for the delivery of this Strategy.

8.1 Enabling the Vision

Reviewing our current status and drivers, it is apparent that significant change is required to deliver the desired vision outcome.

It remains our strategic goal across the Trust to deliver an integrated care record system, with the capability of connecting all accredited clinical stakeholders with the right clinical information. The approach that the Trust must undertake to achieve this goal is now significantly different to the previous, 'best of breed' approach. Due to the time constraints from key drivers, the Trust must now re-evaluate options available to deliver the desired EPR functionality.

In order to reach the system and information goals outlined within this strategy, it is proposed that the Trust replace multiple existing systems (as appropriate) with a single, enterprise-wide EPR solution.

8.2 Electronic Patient Records (EPR)

The deployment of a fully Electronic Patient Record (EPR) is the keystone of the strategy and will deliver the following strategic aims: -

- To achieve fully automated business and clinical functions.
- To have a paper-light electronic medical records environment where clinical records can be shared across the health community.
- To have efficient and effective business and clinical intelligence reporting tools.
- To enhance information sharing, staff productivity and task management.

A modern EPR would allow the Trust to expand its ICT capability to deliver real benefits to patients, staff and the wider NHS.

8.3 System Replacements

The Trust has a number of systems approaching end of contract within the timescale of this strategy, for which there is no identified funding for the required replacements. Consideration has to be given to whether the contracts are extended, the systems are replaced or the functionality is incorporated as part of an EPR. Options for which will be detailed in the supporting Business Case.

The key systems and the dates for their contract renewal can be seen in Appendix A.

8.4 Using Current Systems to their Best Capacity

A development roadmap for existing systems will be produced as part of the supporting strategic delivery plan, in line with existing Trust priorities, emerging financial targets (such as development to support CQUIN targets) and aligned to the chosen electronic records delivery option.

All development requests for existing systems and digital health initiatives will progress through the Digital Strategy Group (DSG).

DSG will use the follow principles in the continuation of system provision and development:

- Using existing systems to the end of their life, in line with contractual agreements
- Maximise investment and exploit benefits already achieved

- Align developments to Trust strategic objectives
- Remove paper from the system wherever possible
- Review replacement options, in line with the delivery of an EPR solutions

8.5 ICT Infrastructure and Support Requirements

ICT is responsible for the support and maintenance of the Trust's technical infrastructure along with ICT support for nearly 9,000 users.

There are 3 key technology areas covered by ICT Infrastructure;

- Client support, covering the desktop estate installs and faults,
- Networks including telecoms and security,
- Operations including application support.

8.5.1 Client Support

8.5.1.1 *PC Estate*

The Trust's PC estate consists of approximately 5454 desktops and 769 laptops. Historically, the ICT department has relied on the ICT discretionary fund to replace broken and faulty kit on a "break fix" basis, rather than relying on an ongoing refresh policy. While this has enabled the organisation to maximise the lifespan of equipment, a proportion of devices are now coming to their end of life and will need replacing in the next few years. As we move forward with the EPR programme and the additional desktops and laptops that will be required to access and use the system, a more structured and formal refresh policy will be needed to ensure equipment remains fully operational and available, particularly in the clinical areas.

8.5.1.2 *Licensing*

All software in use within the Trust is appropriately licenced for use within an enterprise environment. Strict controls are in place to ensure all non-standard software is tested and certified prior to joining the corporate network.

8.5.1.3 *Microsoft Licensing*

The Department of Health and Social Care has recently agreed a deal with Microsoft which now enables all NHS organisations to use Windows 10. The current operating system, Windows 7 will be end of support in January 2020; therefore, the Trust is now undertaking a project to update all appropriate equipment to Windows 10 over the next 12 months.

Aside from Windows 10, each computer that connects to the Trust network and has capability of accessing Microsoft technologies must be licenced accordingly, e.g. Windows SQL databases. This means each new PC incurs costs which can exceed that of the hardware. The Trust must adopt a much stronger control over Microsoft licences management to ensure all equipment is fully and legally licenced but at the same time avoids over licencing of equipment.

8.5.1.4 *Device Encryption*

All capable mobile devices are provided with full disk encryption so that in the event of loss or theft any data is fully protected and inaccessible. The encryption process is fully automatic and all mobile devices are encrypted by default policy. Some mobile devices, such as basic mobile telephones and hand held devices do not support encryption. Further strengthened policies are enforced on these devices.

8.5.1.5 *Mobile working*

Staff increasingly want to use mobile devices to access clinical and non-clinical systems. The ICT department already supports a large number of mobile devices which are predominately Apple iPhones, iPads and iPods. Until such time that the Trust has a robust Bring Your Own Device (BYOD) the use of staff own devices to access Trust networks and resource will not be permitted, unless staff are prepared for their device to have the Trust's Mobile Device Management (MDM) software installed. The ICT department will endeavour to provide staff with a Trust purchased and maintained device in order for them to fulfil their requirements. Specific needs and requirements are evaluated before a decision is made on suitability, whilst keeping the device estate as standard as possible to allow ease of support.

8.5.1.6 *Printer consolidation*

The Trust will continue with the programme of replacing all Ricoh printers and identified desktop printers with Canon network printers. This provides additional benefits around secure printing through a PIN – ensuring confidential prints are only printed when the PIN is entered. The strategic intention is to remove paper from within the system as much as practicably possible; when devices reach end of life consolidation and reduction strategies will be put into place.

8.5.2 Network and Comms

The network forms the fundamental foundation for successful delivery of all the ICT strategy. Due to recent technology developments such as VitalPAC, the dependency on the wireless network in terms of resilience and availability is greater than ever. This will result in a shift from conventional fixed device types to a combination of fixed and wireless.

8.5.2.1 *Recent COIN developments & Changes*

The Trust has recently awarded a contract for the supply of the Health and Social Care Network (HSCN) which will replace the current N3 network. This includes the Community of Interest Network (CoIN) which connects the Trust to all community sites and other Health and Social care partners within the network, e.g. North Tees.

8.5.2.2 *Network refresh*

Since 2016 the Trust has embarked on a complete refresh of the core network infrastructure including the Wi-Fi. In total this it has refreshed the network with:

- 5930 Core switches
- 5700 Data centre switches
- 2920 Edge switches
- 2 x Aruba 7220 Mobility Controllers at the James Cook site, and 2 x Aruba 7210 Mobility Controllers at Friarage site.
- Over 700 access points across the James Cook and Friarage Hospital sites.

8.5.2.3 *Guest Wi-Fi*

The Trust is mandated to provide patient and public WiFi by December 2018. It has secured funding to implement this and a procurement process is underway. A specification and tender document has been produced and the Trust will be using the prescribed frameworks to purchase a suitable solution to support public, carer and staff Wi-Fi.

8.5.2.4 *Voice Communications*

The Trust has standardised on a Mitel Voice over IP (VoIP) telephony platform. This will provide a robust, adaptive and expandable platform replacing the aging analogue solution which has been in the Trust for over 30 years. Between now and the end of 2018 the majority of the estate (barring a number of

analogue phone lines which will need to remain such as in lifts etc.) will be moved onto the VOIP technologies.

8.5.2.5 *Alternative Communications*

There are number of users in the Trust who still heavily rely upon fax technologies. In order to remove fax machines from service, a software based solution has been provided. This will allow users to receive faxes in a secure manner directly to their NHS mail accounts. Where a requirement to send a fax exists, capability will be added to PCs, using NHS mail addresses to send documents in a facsimile format.

Longer term it is still the aim to reduce and subsequently remove fax as a method of communication.

8.5.3 Operations and Application Support

It is recognised that the clinically preferred solution for an EPR will determine the overall data centre requirements; a firm direction cannot be provided until the supplier and their requirements are known. We will remain flexible with our approach up to this point.

8.5.3.1 *Data centre physical and environmental*

The Trust has two main datacentres, with a number of smaller data centres across the James Cook and Friarage Hospital sites. All key clinical services are running live out of one site with failover to a secondary site.

8.5.3.2 *Virtualisation and High Availability*

The Trust has invested heavily in virtualisation technologies, and has highly-resilient virtualisation platforms located in both of the Trust's datacentres. High resilience to failure and short recovery time objectives for these systems in the event of a disaster at a system or a site level are key to the Trust's performance as a healthcare provider. We have standardised on HP equipment which offers high performance scalable hardware to reduce the number of devices to purchase, deploy and maintain. All new systems will continue to be delivered as virtualised servers where possible giving the flexibility of management and support. Deployment on the Trust's virtual platform means a quick turnaround on providing services and platforms for suppliers to implement their solutions.

High availability is configured both locally and cross site via replication to ensure that services have significant uptime. Ensuring critical business and clinical systems are available to clinicians at all times is the key focus of the Operations team, and will be the number one priority when considering deployment of new services.

8.5.3.3 *Storage*

Data growth is a large feature of every organizations ICT strategy. Data is growing at an exponential rate due to more reliance on technology and systems. Particularly in a healthcare environment where more aspects of patient records are being converted to electronic formats the growth of data needs addressing. An efficient storage environment is critical to the ability of the Infrastructure department to support the existing workloads, along with the future developments of the Trust.

The growth in the storage of electronic data and images continues to increase beyond predicted levels as a consequence of the procurement of new systems and also the technical upgrades to hardware and peripherals. A continued emphasis on staff being responsible for managing their data has not resulted in better housekeeping practices or a reduction in storage requirements. A solution needs to ensure

compliance with data retention periods and Information Governance policies, in particular those relating to the storage of data on file shares rather than on removable media or devices such as laptops.

Data growth is estimated to increase by approximately 15 – 20% per annum. However, due to the increased use of images, videos, audio files, training videos and material and also advanced cameras with high definition images using more storage space this will continue to grow at an unpredictable rate.

Additionally, the organisation has moved towards a centralised digital data system and the scanning of case notes is adding to the storage capacity and the need for a robust and secure storage solution.

Data retention and the need to keep certain records for up to 25 years has also impacted the growth of data and the need to have a robust backup and restore facility available is critical.

Therefore, the Trust must have a flexible and agile solution for data storage that is capable of easy expansion when the demand for storage increases. However, the Trust cannot continue to grow storage indefinitely and staff must be made take responsibilities to manage data storage and perform routine housekeeping tasks to remove data and information in line with retention policies.

Efficient data management and discovery means that we should store data once – usually where it is created – and make it available where appropriate.

8.5.3.4 *Data Management (Back-ups)*

All data on Trust servers must be backed up on a daily basis and be recoverable in the eventuality of system or data loss within reasonable timescales. A system backup review was carried out and has identified that the Trust's current backup solution is rapidly running out of storage space and would be unable to restore data older than 3 weeks.

The situation has arisen due to large increases in the volume of data stored on the Trust servers over the last 18 months. The run time to back up the current servers is now 24 hours, seven days a week. Ideally backups should be undertaken only during the evening when there is less impact on the network and system performance. This would also provide a day time window for recovery purposes.

A business case has recently been written to increase the capacity of the current backup solution to allow for planned data growth and system expansion over the next 3 years.

8.5.3.5 *Cyber Security Compliance*

We need to build on the existing safeguards in legislation, security standards, toolkits and independent advisory bodies, and ensure that data is shared across the system in a safe, secure and legal way.

GDPR is the basis of our legal framework for data protection and consent. In addition, the National Data Guardian for Health and Social Care is an independent voice for individuals in how their data is used in the health and care system.

NHS Digital's Data Security and Protection Toolkit describes the 10 data security standards that all organisations with access to NHS patient data and systems must adhere to. These standards are specific in nature and range from access control systems to the management of obsolescent technology and supplier management.

Trusts are asked to implement best practice around information and technical security with respect to cyber-attacks identified in the media. They are also asked to review incident management capability with defined plans to isolate incidents; implementing timely and effective repairs and ensuring the ability to recover data are all within the ten steps guide.

The government launched the '10 steps to cyber security'3 which provides updated practical guidance for organisations to improve the security of their networks and the information carried on them.

The key gaps identified against this guidance are:

Gap	Response
Monitor Use intrusion monitoring tools and regularly audit activity logs.	This area has also been identified as an audit recommendation that the Trust need to proactively monitor activity logs. The Trust has purchased Nagios to undertake this but this is not yet implemented.
Access control	The management of user accounts is a significant problem. There are a number of generic accounts in use, password strength is poor, people share usernames and passwords and users often do not have the correct access levels for their roles.
Up to date software	Whilst patching of operating systems and software does take place it is not always timely. There are a number of systems with old software which run the risk of attack.
Obsolete hardware	There are a number of Trust systems which are running on old or obsolete hardware. This hardware runs the risk of failure and must be replaced.

The Trust subscribes to the Care Cert program which identifies current and growing threats. This allows the Trust to apply fixes, where appropriate prior to an incident. However, not all cyber threats are identified in this manner. This type of threat is managed on a reactive basis once a threat is exposed.

With the need to provide services outside of the organisations boundaries the need to protect the Trust and its data is paramount whilst at the same time making the user experience, either staff or patient, easy.

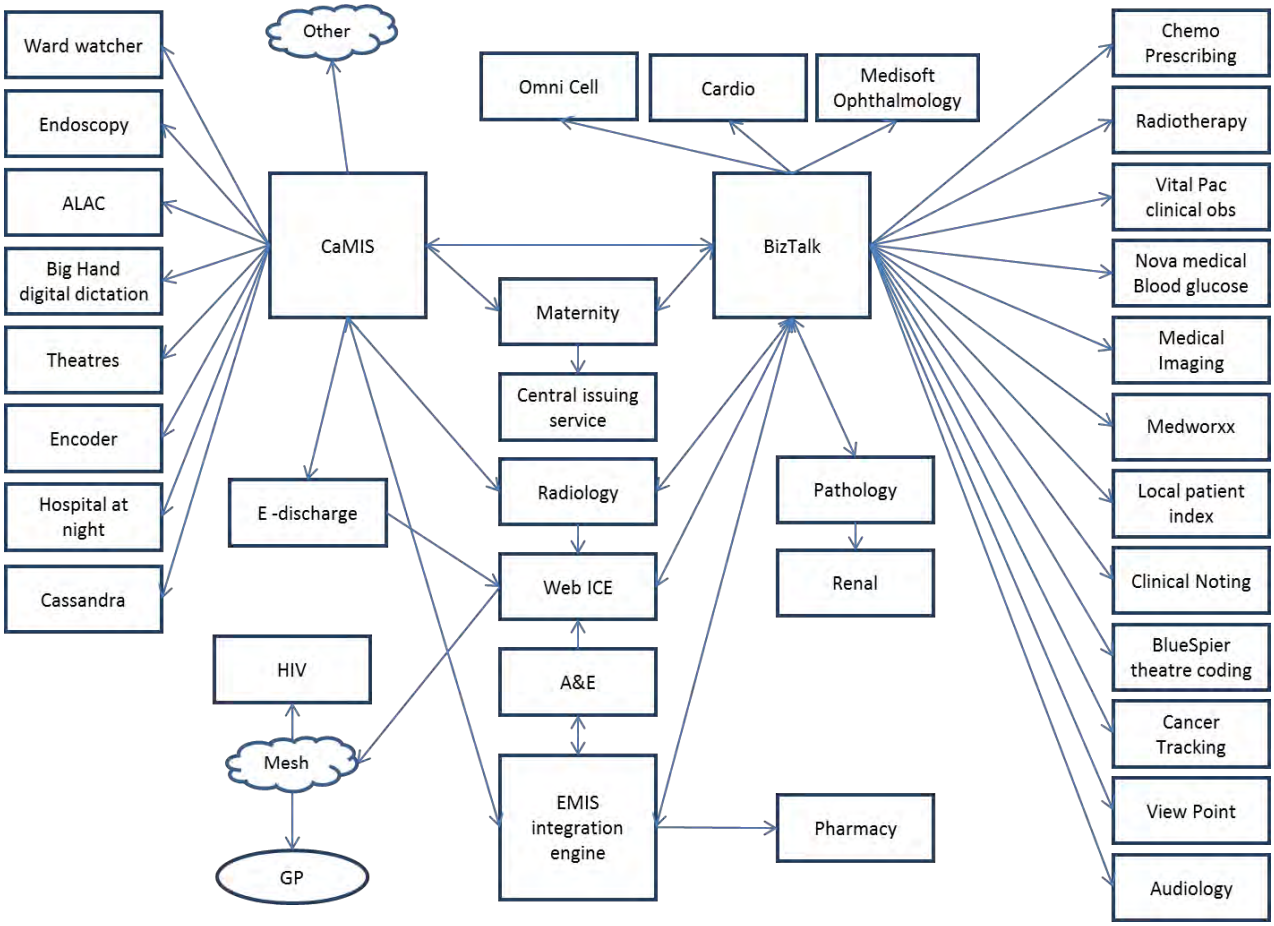
The cyber security threat is growing and the Trust needs to develop its defences, not just through technology but through the people who use it.

[3] https://www.gov.uk/government/publications/cyber-risk-management-a-board-level-responsibility

9 Appendix A – Current major clinical systems with Contract start and Renewal dates

System / Functionality	Supplier	Original install date/contract date	Renewal Date
Patient Administration System (PAS)	EMIS	1993	31/03/2019*
A&E (Symphony)	EMIS	2016	31/03/2019*
Pharmacy	Ascribe	1998	31/03/2021
Renal (Proton)	VitalPulse	2003	28/02/2019
Retinopathy	Digital Healthcare	2005	-
Critical Care (Ward watcher)	Critical Care Audit Ltd	2007	31/03/2019
Audiology (Audit base)	CSW	-	31/12/2018
Cancer Information System	Infoflex	1998	31/03/2020
Chemo prescribing	Clinisys	2005	31/05/2018
Colposcopy	Cyres	-	-
Theatres Management	Trisoft	1999	31/03/2019
Central Sterile Services Department (CSSD)	Trisoft	1999	31/03/2021
Laboratory Information System (Pathology)	DxC	1996	31/03/2018
Requesting/Reporting (Web ICE)	Sunquest	2001	01/04/2021
Picture Archive & Communication (PACS)	Agfa	2011 (original 2003/4)	07/04/2019
Radiology Information System (RIS)	Agfa	2011 (original 2003/4)	07/04/2019
Endoscopy reporting	Endosoft	2004	31/10/2019
Disablement services System	Best	2003	09/12/2018
Maternity Information System	EuroKing/Wellbeing	1998	31/05/2019
Maternity Foetal Management	Clevermed/Badger	2008	-
Spinal Injuries Electronic Patient Record	IMS Maxims	2003	31/03/2019
Observations and vitals recording (VitalPAC)	TLC/SystemC	2014	01/04/2021
Electronic Records/Documents (Evolve)	Kainos	2016	2020
Cardio Imaging	Philips	2018	2023
HIV record management system	Climate	2016	
ViewPoint (Maternity Ultrasound reporting)	HealthNetConnections	2006	31/03/2018
Digital Dictation	BigHand	2012	31/12/2018

10 Appendix B – Current Interfaces



11 Appendix C – System implementations in the last 4 years.

eObservations (VitalPAC)	Using funding secured from the Nurse Technology fund, real-time capture of patient data was introduced along with the supporting mobile technology. This allows clinical staff to update information whilst at the patient bedside; electronic recording of patient observations and calculation of the National Early Warning Score (NEWS) with automated cascading escalations ensure that acutely ill or deteriorating patients are quickly identified. The system now also alerts patients with suspected sepsis and acute kidney injury (AKI).
NHS Mail Migration	Provision of a single, enterprise wide solution to support the secure transfer of information through electronic communication replacing the Trust managed mail solution and ensuring the Trust met the NHS digital secure email standard (DCB1596).
Telephony	The analogue telephone system has been replaced with a modern digital network that can support telephony, instant messaging and video conferencing facilities across the whole of the James Cook and Friarage estates. Replacement of analogue phones with the digital handsets continues and is due to finish in December 2018.
Single sign-on	Although not successfully rolled out across the whole of the estate, the single sign-on solution in conjunction with proximity readers has proved key in the implementation of secure electronic patient status at a glance boards (PSAG) across the organisation.
Windows upgrade	All PCs, barring a few specialist PCs connected to clinical equipment, were upgraded from Windows XP to Windows 7. This includes all community laptops.
Mobile access in the community	Funding secured as part of the nurse technology fund enabled all community staff to be issued with a suitable laptop with remote access to SystmOne, removing the requirement to retain paper notes or return to base to complete records etc.
Bed Management/Electronic PSAG boards	The introduction of the bed management module for E-CaMIS along with electronic PSAG boards have enabled better management of patient flow improving the admission, discharge and transfer process.
Electronic Document Management (E-notes)	With funds from the safer wards, safer hospitals technology initiative, the Trust was able to purchase the Evolve clinical documentation solution from Kainos. So far it has been rolled out to paediatrics and therapies only but the solution provides electronic patient documentation available at the point of care.
Network Refresh including Wi-Fi	The core network infrastructure for the James Cook and Friarage sites has been completely upgraded and replaced over a two year programme. This includes all core and network switches along with an entirely new Wi-Fi infrastructure, remote access and firewalls etc.
Service Desk	The in-house developed service desk and requesting solutions were replaced with a single ITIL (Information Technology Infrastructure

	Library) compliant service desk which now includes an online self-service portal, electronic access forms and customer feedback surveys.
A&E	The A&E solution which was part of the CaMIS PAS platform was replaced with the EMIS Symphony solution. Along with the use of the Dragon Voice recognition platform this has introduced a completely paperless A&E department which is recognised nationally as an exemplar in the use of Symphony to improve patient flow through the department.
Server Estate & Back ups	Investment was made in the overall server estate, in particular with the Trust's virtual platform. The Trust now has a robust virtual platform with fail over between a number of primary and secondary data centres.
Printers – Multi-function devices	The aging Ricoh printing estate has now been replaced with Canon Multi-Function Devices (MFDs). These offer additional benefits, such as centralised print function with secure printing via PIN, automatic toner ordering and automatic call out of engineers. They offer a much reduced price per print cost compared to the older Ricoh and desktop printers.

Board of Directors	
Agenda item	2.3
Title of Report	2018/19 Emergency Preparedness, Resilience and Response (EPRR) Core Standards
Date of Meeting	6th November 2018
Presented by	Kevin Oxley, Director of Estates, ICT and Healthcare Records
Author	Diane Hurley, Head of EPRR
Approved by	Kevin Oxley, Director of Estates, ICT and Healthcare Records
Previous Committee/Group Review	Operational Management Board (25th October 2018)
Purpose	Approval ☐ Decision ☐ Discussion ☐ Information ☑
Alignment to Trust's Strategic Objectives	☑ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	NHS England EPRR Framework (2015) Civil Contingencies Act 2004 NHS Act 2006 (as amended)
Recommendation(s)	The Board is asked to receive this report and note the submission to NHS England of 'substantial compliance' with the 2018/19 EPRR Core Standards

1. Executive Summary

NHS Trusts are required to undertake an annual self-assessment against the NHS England EPRR Core Standards and provide a statement of compliance to the Board.

Following the self-assessment review of the 2018/19 EPRR Core Standards, it was identified that 6 of the 64 standards were amber (not compliant but evidence of progress and in the EPRR work plan for the next 12 months) and therefore the Trust has declared **substantial compliance** in line with the national reporting levels.

An action plan is in place to continue to address the areas of partial compliance.

2. Recommendation

The Board is asked to receive this report and note the submission to NHS England of 'substantial compliance' with the 2018/19 EPRR Core Standards

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Emergency Preparedness, Resilience and Response (EPRR) Core Standards 2018/19

Background
The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect services or patient care. These could be anything from loss of power or extreme weather conditions to an infectious disease outbreak, major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended), which requires NHS organisations to demonstrate that they can effectively respond to such incidents while maintaining services to patients.

Under the CCA the Trust is designated as a category 1 responder which means that it must be able to provide an effective response in emergencies whilst maintaining services. It is subject to the full range of civil protection duties as follows:

- Assessing the risk of emergencies occurring and using this to inform planning
- Putting in place emergency and business continuity plans
- Putting in place and maintaining arrangements to warn, inform and advise the public
- Sharing information and co-operating with other local responders

This work is referred to as 'emergency preparedness, resilience and response' (EPRR) and requires NHS organisations to develop plans, policies and procedures, provide training for staff on their role in an incident, exercise these plans to ensure they are fit for purpose and support any response and recovery efforts when an incident occurs.

National core standards for EPRR
The NHS England Core Standards for EPRR are the minimum standards which NHS organisations must meet. The Trust is required to undertake an annual self-assessment against the core standards and produce a statement of compliance for presentation to the Board of Directors. In the event that the Trust is not compliant with any of the standards, an action plan will be developed and monitored through the EPRR governance arrangements.

In 2017/18 the Trust reported non-compliance with the standards, as there were a number of areas rated as amber (*not compliant but evidence of progress and in the EPRR work plan for the next 12 months*). An action plan was developed to address these and substantial progress has been made over the past 12 months.

2018/19 assessment
This year there are 64 standards that the Trust is required to report against, split into 10 domains. In addition, there is a separate 'deep dive' into command and control.

The self-assessment was undertaken by the Director of Estates, ICT and Healthcare Records and the Head of EPRR in liaison with relevant personnel across the Trust. Following this, 58 of the standards have been assessed as green (fully compliant) with the remaining 6 standards assessed as amber (partially compliant), plus full compliance with the deep dive.

Overall, this means that the Trust can report **substantial compliance** for 2018/19.

The table below gives an overview of the areas identified as partially compliant; an action plan has been developed to address these and can be found within the embedded self-assessment spreadsheet (annex A).

The Trust was required to submit their completed submission and statement of compliance to NHS England, Cumbria and the North East by 24th September 2018. This was reviewed and externally validated at a moderation session held on 2nd October 2018 during which it was compared with other Trusts across the North Cumbria and North East area. No changes were required following this session.

Domain	No of standards	Compliance
Governance	6	All fully compliant
Duty to assess risk	2	All fully compliant
Duty to maintain plans	14	13 fully compliant; 1 partially compliant • Mass countermeasures plan
Command and control	2	All fully compliant
Training and exercising	3	All fully compliant
Response	7	All fully compliant
Warning and informing	3	2 fully compliant; 1 partially compliant • EPRR media strategy
Co-operation	4	3 fully compliant; 1 partially compliant • Mutual aid arrangements
Business continuity	9	6 fully compliant; 3 partially compliant • Business continuity management system scope and objectives • Business impact analysis • Assurance of suppliers BCPs
CBRN	14	Full compliance
Total	**64**	**58 fully compliant; 6 partially compliant**
Deep Dive – command and control	8	Full compliance

A regional assurance visit is being undertaken in October to review progress since 2017/18. This will be led by the Regional Head of EPRR for NHS England, supported by NHS Improvement and the lead Clinical Commissioner. A report will be produced following the visit and will form part of the overall regional assurance at the end of the year.

Conclusion
The Board is asked to receive this report and note the submission to NHS England of 'substantial compliance' with the 2018/19 EPRR Core Standards. A detailed action plan will be developed to further address the areas of partial and shared with SLT.

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement

7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff

30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings

41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans

55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control										
Domain: Incident Coordination Centres										
1	**Incident Coordination Centres**	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y		Fully compliant				
2	**Incident Coordination Centres**	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Up to date training records of staff able to resource an ICC	Fully compliant				
3	**Incident Coordination Centres**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Post test reports Lessons identified EPRR programme	Fully compliant				
4	**Incident Coordination Centres**	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				
Domain: Command structures										
5	**Command structures**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				
6	**Command structures**	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	EPRR policy statement and response structure	Fully compliant				
7	**Command structures**	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				
8	**Command structures**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				

Overall assessment:			Substantially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
17	**Duty to maintain**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	SOP to be developed regarding distribution of mass countermeasures In EPRR workplan for 2019/20	Head of EPRR	2019/20 workplan	Access to countermeasures referenced in CBRN SOPs Additional SOP to be developed
39	**Warning and info**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Partially compliant	EPRR media strategy to be developed and media spokespersons to be identified. Media training to be commissioned if required	Director of Communications	By March 2019	Media strategy in place but needs updating Not specific to EPRR
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Partially compliant	Internal arrangements to be developed as part of 2019/20 workplan CNE mutual aid SOP to be developed (led by NHS England)	Head of EPRR	2019/20 workplan	To be developed
48	**Business Contin**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Partially compliant	Business continuity management document to be developed to include detailed information around scope, objectives, risk management and business impact analysis process	Head of EPRR	By March 2019	Referenced in EPRR strategy but not in detail Further work to be carried out to develop more detailed BCM document
49	**Business Contin**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Partially compliant	Business continuity management document to be developed to include detailed information around scope, objectives, risk management and business impact analysis process	Head of EPRR	By March 2019	Referenced in BC plans but more detailed arrangements to be developed
55	**Business Contin**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Partially compliant	Arrangements to be developed in conjunction with Procurement / contract leads to seek assurance from suppliers in respect of business continuity	Head of EPRR	2019/20 workplan	To be developed

South Tees Hospitals
NHS Foundation Trust

Quality, Performance, Safety & Finance Exception Report

Board of Directors Meeting

6 November 2018

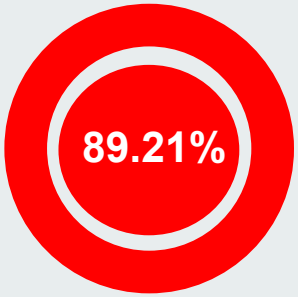
Must Do's

Must Do's 2018/19 – September 2018

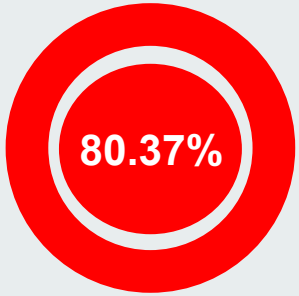
Deliver Excellence in Patient Outcome and Experience….

A&E
4hr Target

RTT
18 Week Target



Cancer
62 Day Target



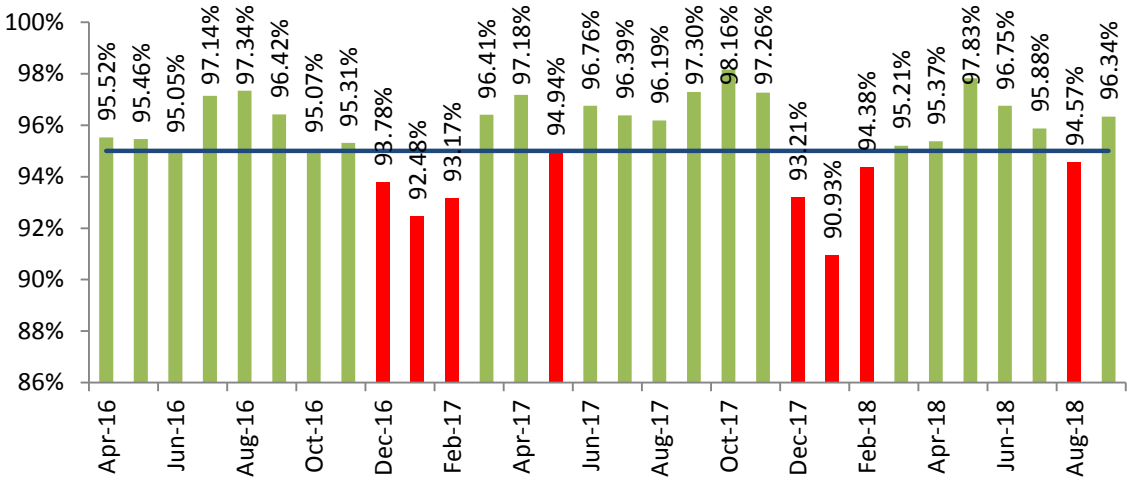
CDiff
HCAI Threshold

* Indicative

…and ensure our long term financial sustainability

Operating Surplus

Performance - A&E



95% TARGET

Sep 18
96.34%

Quarter 1:
96.69%

Quarter 2*:
95.60%

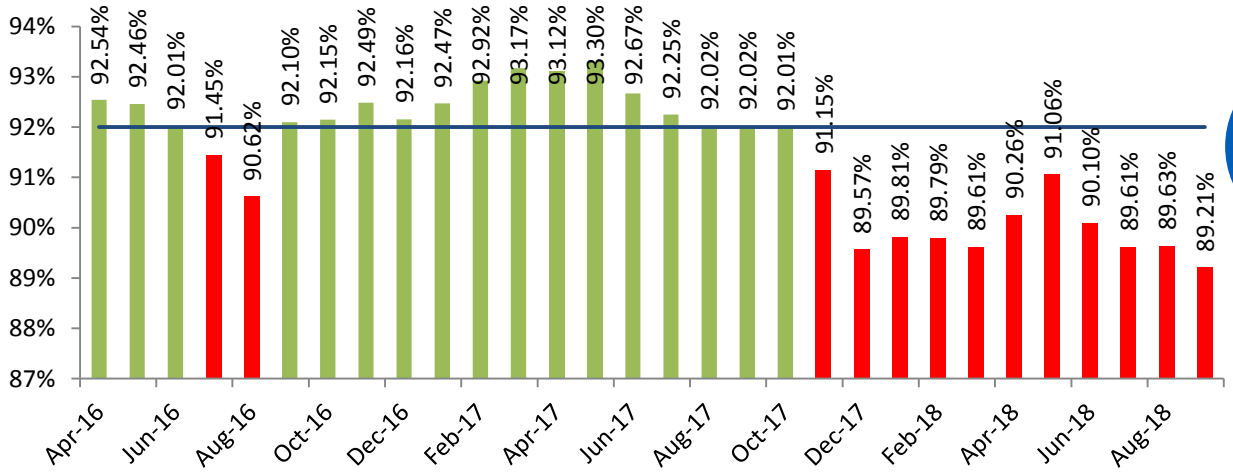
**Q2 position 18/10/2018*

Regional Rank	Trust	Sept
1	North Tees and Hartlepool NHS Foundation Trust	97.26%
2	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	96.57%
3	South Tyneside NHS Foundation Trust	96.46%
4	**South Tees Hospitals NHS Foundation Trust**	**96.34%**
5	Gateshead Health NHS Foundation Trust	96.21%
6	Harrogate and District NHS Foundation Trust	95.23%
7	Northumbria Healthcare NHS Foundation Trust	95.07%
8	North Cumbria University Hospitals NHS Trust	94.01%
9	City Hospitals Sunderland NHS Foundation Trust	90.95%
10	York Teaching Hospitals NHS Foundation Trust	90.34%
11	County Durham and Darlington NHS Foundation Trust	88.58%
	ENGLAND	**88.94%**

September 18 Ranked 4th in the region

October to Date = 95.78% (Position 18/10/2018)

Referral to Treat



92% TARGET

Sep 18
89.21%

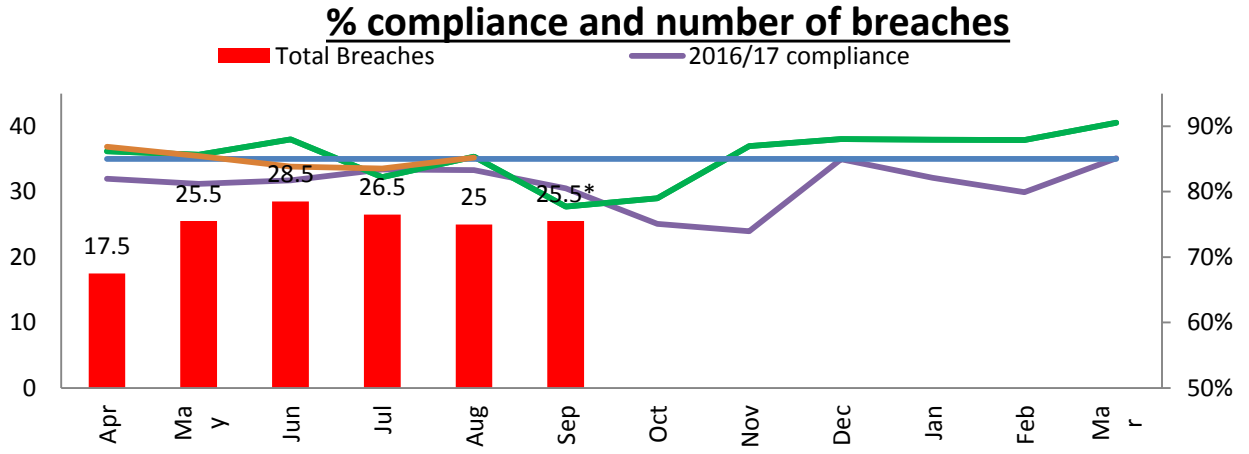
Quarter 1: 90.47%
Quarter 2: 89.48%

**Q2 position 18/10/2018*

Regional Rank	Trust	Aug
1	South Tyneside NHS Foundation Trust	96.00%
2	City Hospitals Sunderland NHS Foundation Trust	94.60%
3	North Tees and Hartlepool NHS Foundation Trust	94.50%
4	Northumbria Healthcare NHS Foundation Trust	94.40%
5	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	94.20%
6	County Durham and Darlington NHS Foundation Trust	93.00%
7	Gateshead Health NHS Foundation Trust	92.90%
8	Harrogate and District NHS Foundation Trust	91.10%
9	**South Tees Hospitals NHS Foundation Trust**	**89.63%**
10	York Teaching Hospital	87.50%
11	North Cumbria University Hospitals NHS Trust	86.50%
	ENGLAND	**87.24%**

Aug 18 Ranked 9th in the region

Performance – 62 Day Cancer Standard



% compliance and number of breaches

*** Indicative**

Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18*
86.84%	85.43%	83.81%	83.54%	85.21%	82.5%

Regional Rank	Trust	Aug
1	County Durham and Darlington NHS Foundation Trust	87.90%
2	North Cumbria University Hospitals NHS Trust	86.70%
3	Harrogate and District NHS Foundation Trust	85.60%
4	**South Tees Hospitals NHS Foundation Trust**	**85.21%**
5	Gateshead Health NHS Foundation Trust	82.81%
6	North Tees and Hartlepool NHS Foundation Trust	82.11%
7	York Teaching Hospitals NHS Foundation Trust	81.07%
8	City Hospitals Sunderland NHS Foundation Trust	80.85%
9	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	80.24%
10	Northumbria Healthcare NHS Foundation Trust	78.42%
11	South Tyneside NHS Foundation Trust	75.00%
	ENGLAND	**79.36%**

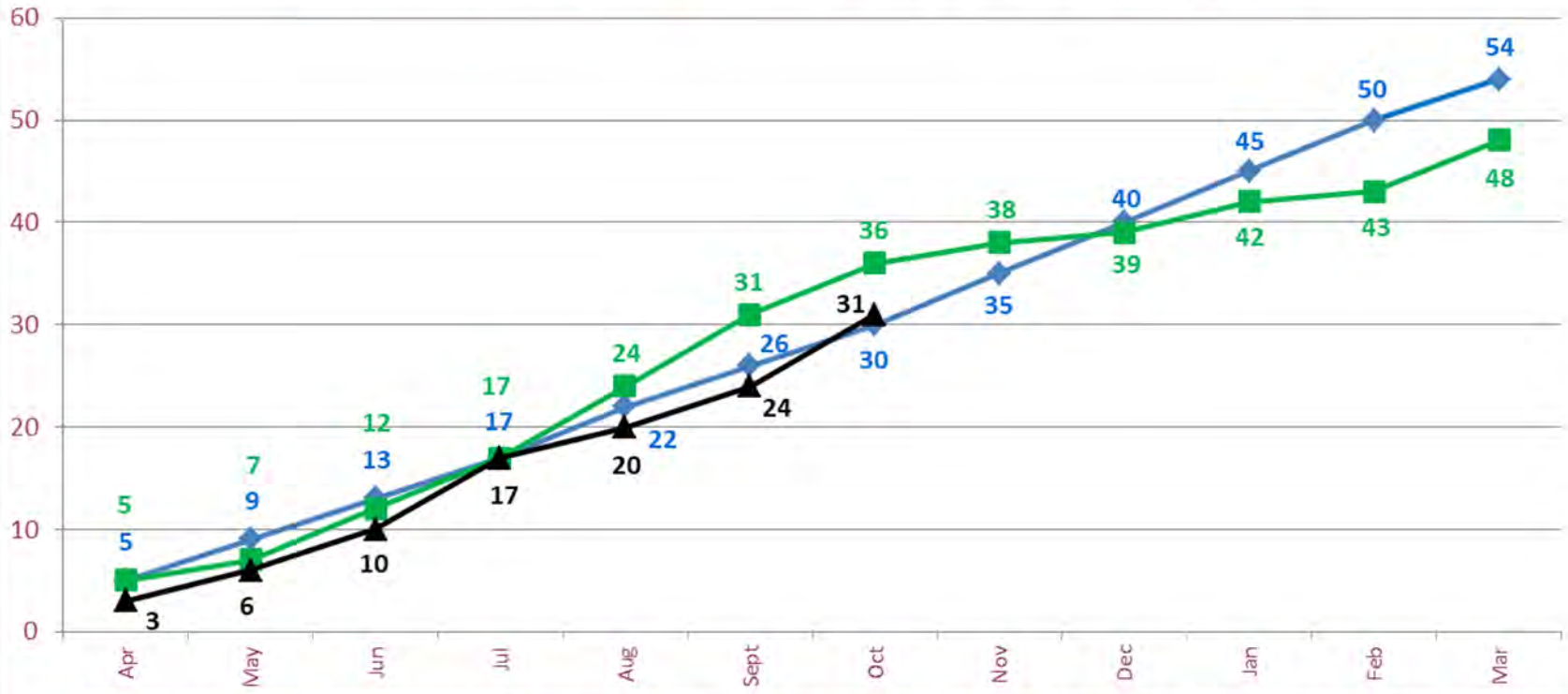
August 18 Ranked 4th in the region

Best performing cancer centre in the Region

South Tees Hospitals
NHS Foundation Trust

Patient Outcome and Experience

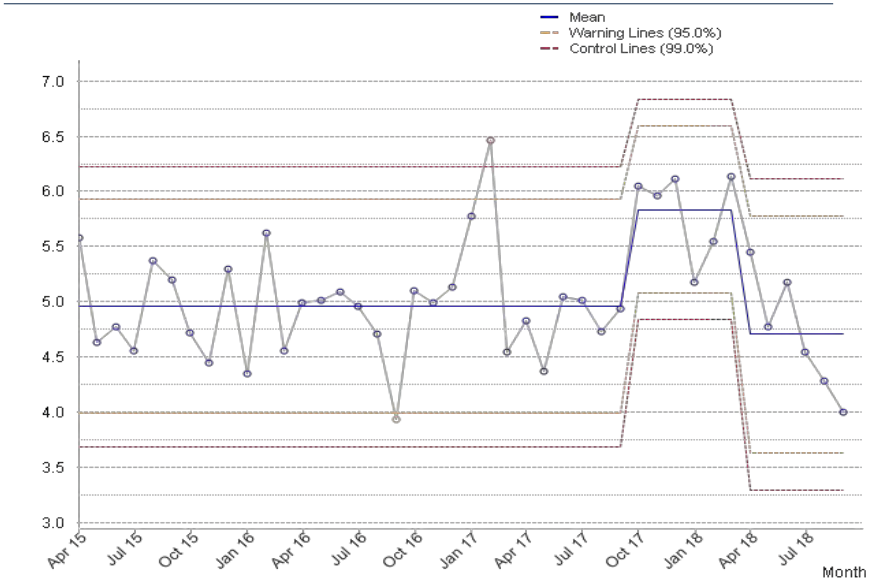
Trust apportioned Clostridium difficile



Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
JC24	JC31	ECTO	JC06	Friary	JC35	JC12					
JC14	JC14	FHGara	FHGara	JCITU3	JC33	JC14					
JSIRU	JC08	JC33	Zetland	JCGHDU	JCGHDU	JC06					
		JC34	ITU FHN		JC07	JC03					
			JC12			JC05					
			JC11			JC33					
			JC27			ZETLAND					

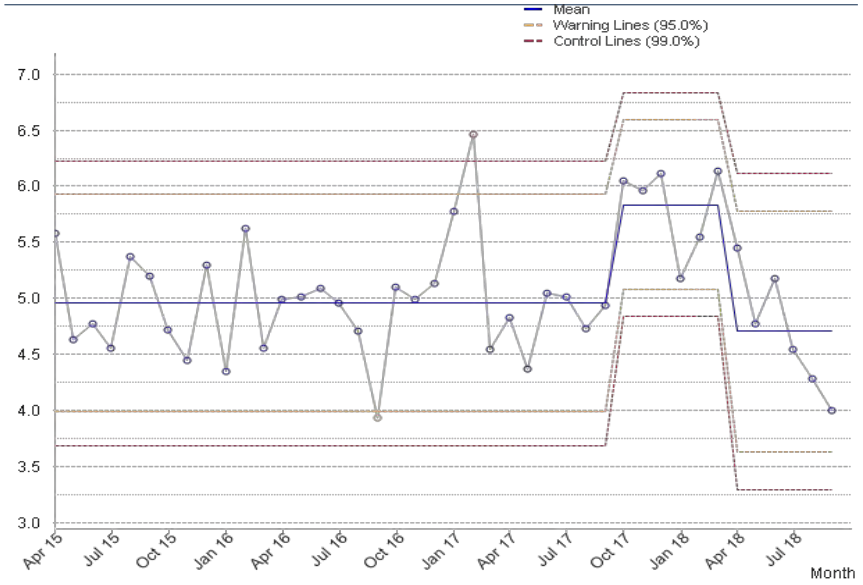
Delivering Safe Care 18/19

Trust attributed category 2 pressure ulcers September 2018



Rate 1.8 per 1000 bed days. Rate within normal variation

Falls September 2018



4.0 per 1000 bed days. Rate within normal variation and lowest rate since Oct 16

Continued Focus on Falls Prevention Strategies

Patient Experience

Trust

How do patients rate us out of 10…?

NHS
South Tees Hospitals
NHS Foundation Trust

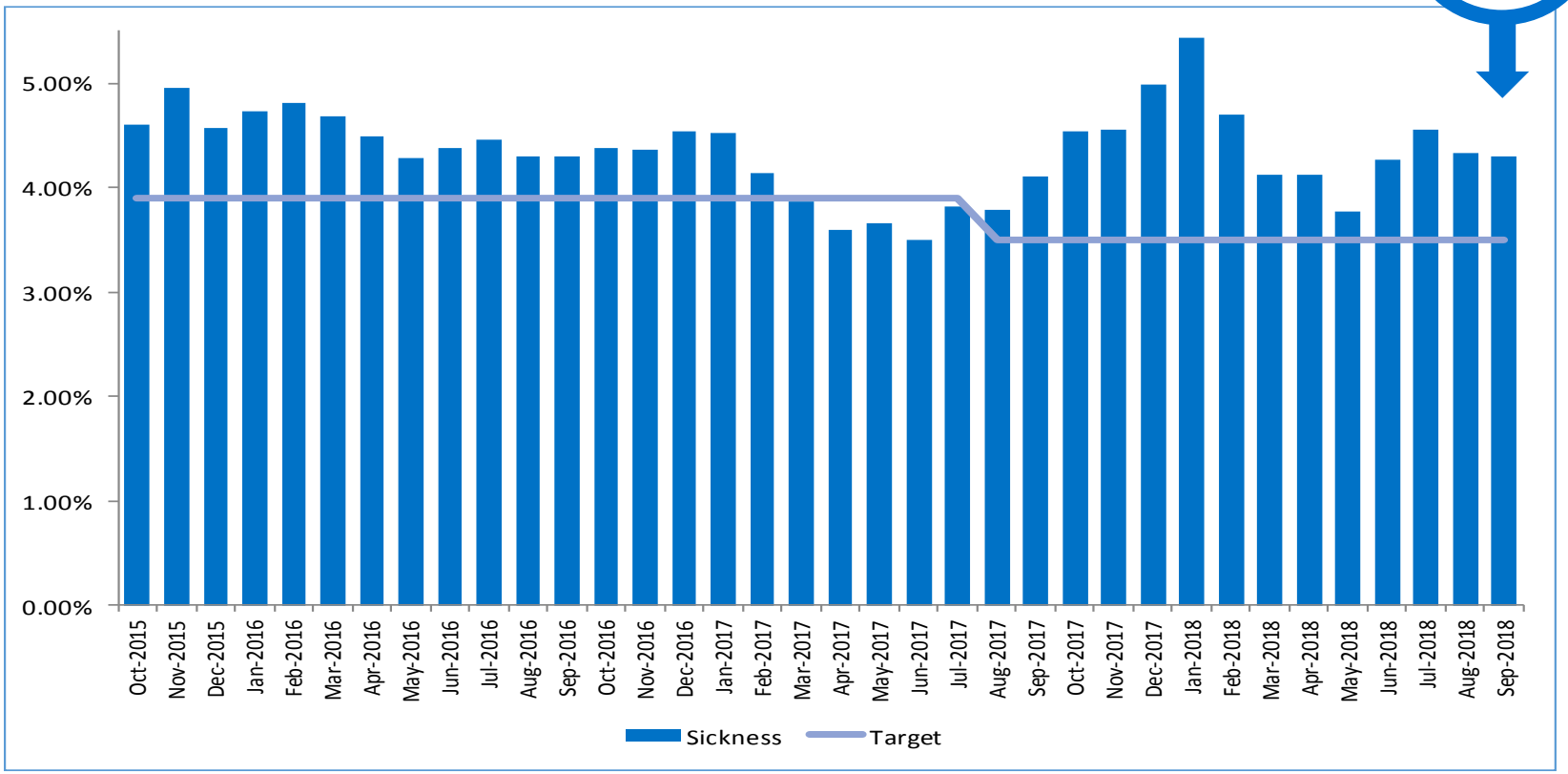
In September 2018 patients gave us an overall rating of... **9.65 out of 10**

% of patients surveyed would highly likely or likely recommend this ward to their families and friends	98%	No of patients on new medication	161	No of respondents	342

People

People

Sickness % Rate



SDR % Rate - 76.61% (Target 80%)

2015/16	2016/17	2017/18	2018/19
68.58%	71.27%	84.70%	80.85%

Training % Rate 89.64% (Target 90%)

2015/16	2016/17	2017/18	2018/19
79.75%	89.35%	92.38%	90.93%

South Tees Hospitals
NHS Foundation Trust

Finance

Summary Financials by Centre – September 2018

Summary Financials	Year to Date		
	Plan £'000	Actual £'000	Variance £'000
Community Care			
Income	61,523.8	62,355.6	831.8
Pay expenditure	(36,441.2)	(35,242.9)	1,198.3
Non-Pay expenditure	(11,898.4)	(11,830.3)	68.1
EBITDA	**13,184.2**	**15,282.4**	**2,098.2**
Clinical Support			
Income	21,138.8	21,083.0	(55.8)
Pay expenditure	(34,425.4)	(33,523.7)	901.7
Non-Pay expenditure	(12,580.0)	(12,484.0)	96.0
EBITDA	**(25,866.6)**	**(24,924.7)**	**941.9**
Urgent and Emergency Care			
Income	38,479.2	41,434.5	2,955.3
Pay expenditure	(30,699.1)	(31,361.7)	(662.6)
Non-Pay expenditure	(2,910.7)	(2,761.2)	149.5
EBITDA	**4,869.4**	**7,311.6**	**2,442.2**
Specialist and Planned Care			
Income	153,847.1	152,735.8	(1,111.3)
Pay expenditure	(59,844.9)	(60,656.8)	(811.9)
Non-Pay expenditure	(45,398.0)	(45,277.0)	121.0
EBITDA	**48,604.2**	**46,802.0**	**(1,802.2)**
Corporate	**(50,655.7)**	**(54,259.5)**	**(3,603.8)**
Control Total	**(9,864.5)**	**(9,788.2)**	**76.3**

Trust Headlines Month 6 YTD

Control Total

£0.07m ahead of plan

Productivity and Efficiency savings

£18.8m YTD Plan
£21.7m YTD Actual

£35.6m Plan for year

Board of Directors	
Agenda item	3.2
Title of Report	Learning From Deaths Monthly Dashboard Quarter 2 Report
Date of Meeting	6 November 2018
Presented by	Professor Andrew Owens, Medical Director for Education, Learning and Innovation
Author	Jo Raine, Data Analyst Mortality Surveillance and Tony Roberts, Deputy Director (Clinical Effectiveness)
Approved by	Professor Andrew Owens, Medical Director for Education, Learning and Innovation
Previous Committee/Group Review	Operational Management Board Quality Assurance Committee
Purpose	Approval ☐ Decision ☐ Discussion ☐ **Information** ☒
Alignment to Trust's Strategic Objectives	☒ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	NHS Improvement Care Quality Commission
Recommendation(s)	The Board is asked to note that mortality indicators will continue to be monitored. Issues around the recording of comorbidities and specialist palliative care coding are being addressed through relevant departments of the Trust.

Learning From Deaths Monthly Dashboard September 2018

1 Responding to Deaths

1.1 In March 2017 the National Quality Board published *Guidance on Learning from Deaths* (LFD)[1] and a national work programme has been established for LFD. NHS Improvement hosted a conference on 14 December 2017 LFD: One Year On and have published case studies[2].

1.2 The Trust published it's *Responding to Deaths* Policy (in line with the national LFD requirements) in September 2018. It sets out the Trust's approach to learning from deaths in care: https://www.southtees.nhs.uk/about/trust/responding-deaths-policy/ There are broadly three opportunities to learn:

- at the time of certification of death. The Trust has established a Medical Examiner Service which commenced work in May 2018. All deaths receive some scrutiny and for those deaths not referred to the Coroners this includes a 'stage one' case record review, discussion with the attending team and a discussion with the bereaved family

- at a 'stage two' case record review, usually conducted within weeks of a death, any death identified by a 'stage one' case record review plus all deaths of patients with learning disabilities, serious mental illness, where an incident or complaint has been reported, within 30 days of a surgical procedure or where a 'mortality alert' from a range of sources has occurred.

- at the time of investigation when a death has occurred where an incident has been reported through the Trust's incident reporting system (Datix).

1.3 The Learning From Deaths dashboard has been redesigned to make it more easily interpreted and reports the number of deaths, the number deaths with 1st stage reviews (by Medical Examiners), number of deaths with 2nd stage reviews or investigations and the number of those deaths judged to show evidence of preventability. Numbers are reported separately for patients with learning disabilities. For the year to end of September 2018, there were 2,027 deaths, of which 736 received a review or investigation (379 1st stage only) and 4 deaths were considered to be potentially avoidable. In the same period there were 15 deaths in patients with learning disabilities, of which 11 received a review or investigation and 0 deaths were considered to be potentially avoidable. For patients with a mental health issue, 177 were identified of which 40 have been reviewed, with 0 deaths considered potentially avoidable. Potential learning from both good care and from problems in care are outlined. Changes that are being implemented relate to better coordination and documentation of care and these will be easier to address as enhancement to the use of electronic patient records occur and the impact of these changes will also become easier to assess from digital records.

2 Mortality indicators

2.1 The dashboard includes the number deaths from April 2008 to September 2018. Since the winter peak the number of deaths per month has averaged 150 – about what would be expected for the Trust at this time of year.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
[2] https://improvement.nhs.uk/uploads/documents/Learning_from_deaths_case_studies_Web_version.pdf

2.2 Two risk-adjusted mortality indicators are included in the dashboard. The Summary Hospital-level Mortality Indicator (SHMI) includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis (including 12 months of data in each release) by NHS Digital and is an official government statistic. Current reporting is April 2017 – March 2018. The SHMI is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). The SHMI is 111 and is 'as expected' (ie within the variation expected statistically). The Hospital Standardised Mortality Ratio (HSMR) includes approximately 80% of in-hospital deaths and uses different risk adjustment methods. Current reporting is July 2017 – June 2018. The HSMR is 114 and is 'higher than expected'.

2.3 SHMI and HSMR risk-adjust deaths in diagnostic groups based on the primary diagnosis coded in the first Finished Consultant Episode (FCE), risk-adjusted for age, sex, method of admission and comorbidities (ie other clinical conditions coded in secondary positions). The Comorbidity score for South Tees and England is shown in quarters from January 2015 to March 2018. This shows the broadly static coding level for South Tees and the higher and rising rate for England. The relative difference is adversely affecting the HSMR and accounts for part of the difference in value between the SHMI and HSMR (as HSMR is more sensitive to this issue than SHMI). HSMR (but not SHMI) also adjusts for specialist palliative care coding and the chart for Palliative Care Coding for January 2016 to June 2018 shows that the number of cases with the relevant codes is static or falling slightly. This is adversely affecting the HSMR by about 3.6 points.

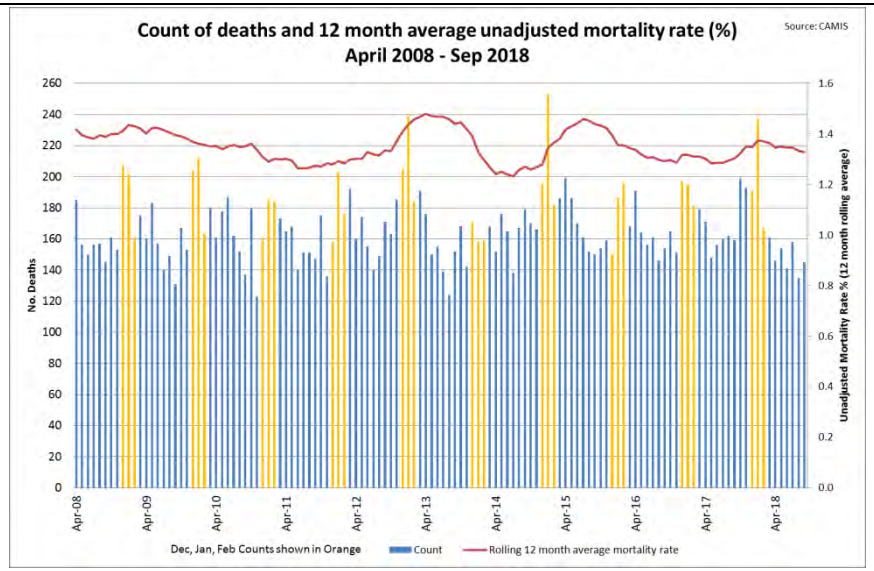
3 Next steps

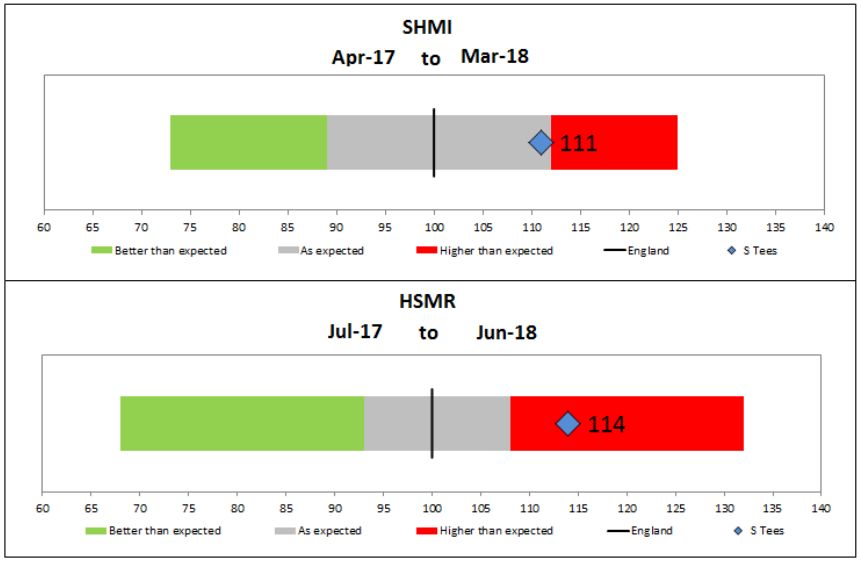
3.1 The Learning From Deaths work was reported in the annual Quality Account which was published in June 2018.

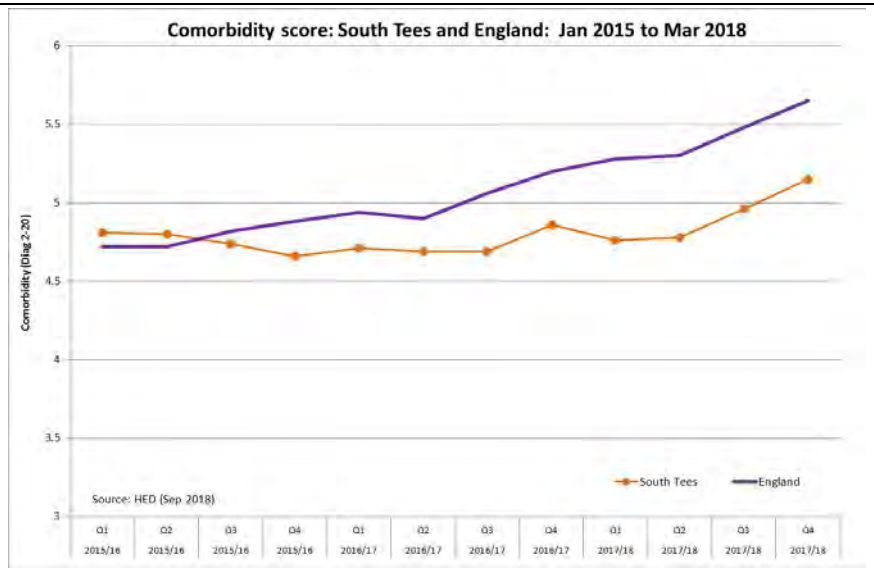
3.2 The Medical Examiner Service is now operational, and 68% of deaths have received a stage one review with 55 deaths being recommended for 2nd stage review. The new service will also impact on the number of second stage reviews completed and this will be monitored through the Learning From Deaths dashboard.

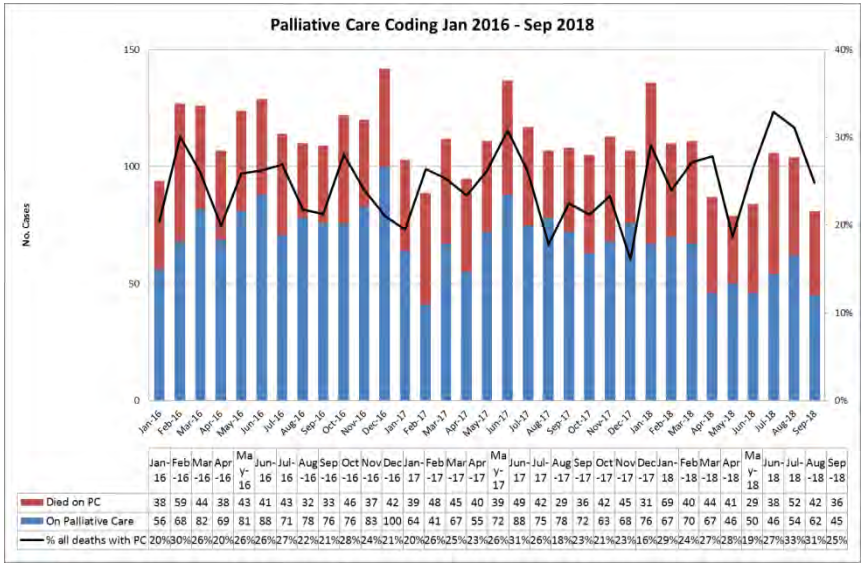
3.3 Mortality indicators will continue to be monitored. Issues around the recording of comorbidities and specialist palliative care coding are being addressed through relevant departments of the Trust.

3.4 This Learning From Deaths Quarterly Dashboard is a development of previous Board reporting and will continue to evolve. A longer report is considered by the Patient Safety Group who report to the Quality Assurance Committee (QAC) who report to the Board of Directors.









	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Died on PC	38	59	44	38	43	41	43	32	33	46	37	42	39	48	45	40	39	49	42	29	36	42	45	31	69	40	44	41	29	38	52	42	36
On Palliative Care	56	68	82	69	81	88	71	78	76	76	83	100	64	41	67	55	72	88	75	78	72	63	68	76	67	70	67	46	50	46	54	62	45
% all deaths with PC	20%	30%	26%	20%	26%	26%	27%	22%	21%	28%	24%	21%	20%	26%	25%	23%	26%	31%	26%	18%	23%	21%	23%	16%	29%	24%	27%	28%	19%	27%	33%	31%	25%

Learning from Deaths Monthly Dashboard - September 2018

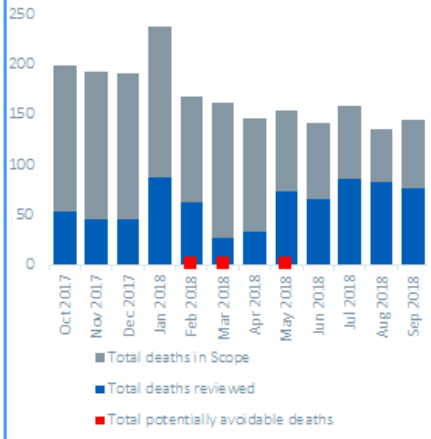
South Tees Hospitals NHS Foundation Trust

Total number of deaths reviewed and deaths deemed preventable
(includes patients with identified learning disabilities)

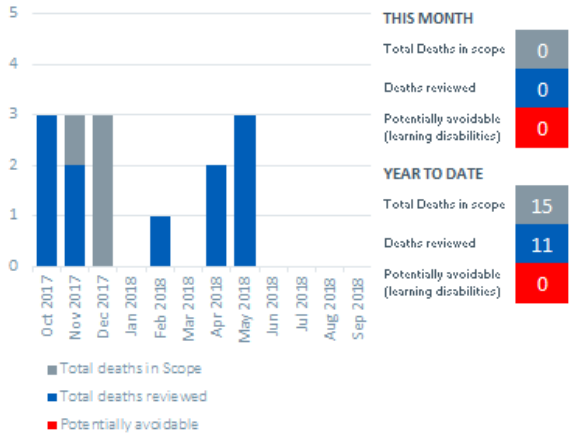
	Total deaths in scope	Total deaths Reviewed	1st stage review only	Definitely not Preventable	Slight evidence of preventability	Possibly preventable (<50:50 but close call)	Possibly preventable (>50:50 but close call)	Strong evidence for preventability	Definitely Preventable	Total potentiallly avoidable deaths
This month	145	77	74	2	1	0	0	0	0	0
Previous 12 months	2027	736	379	328	18	7	1	3	0	4

2nd Stage Review

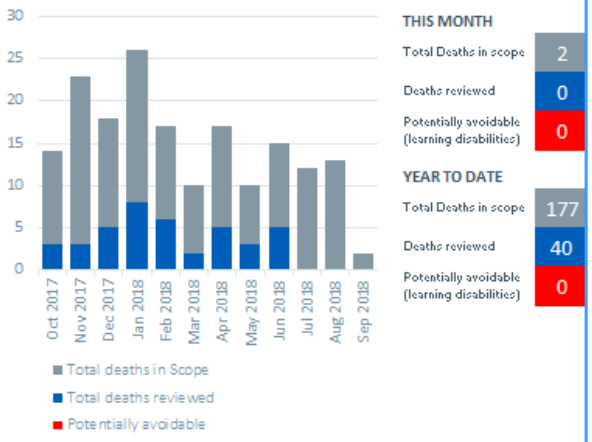
All patients:
Mortality over time, total deaths and deaths considered potentially preventable

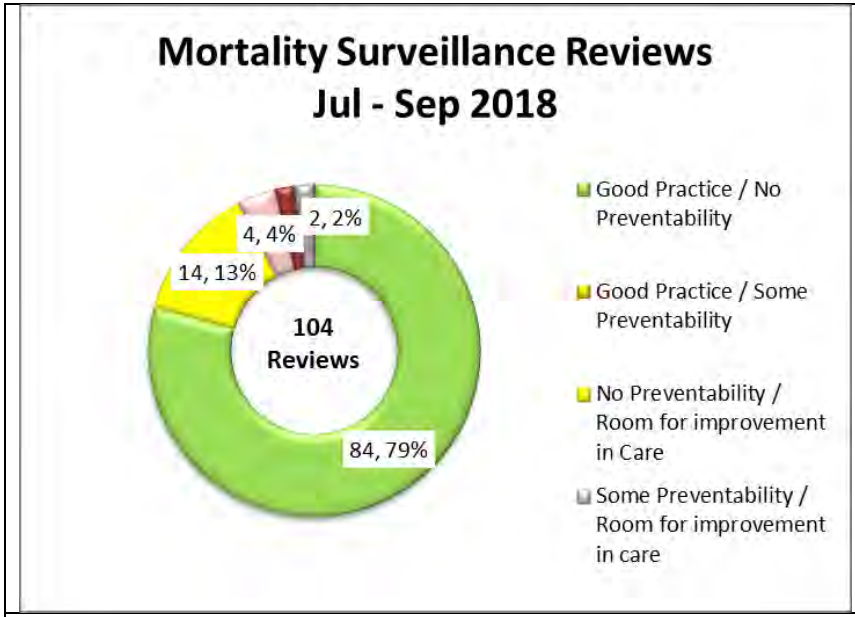


Patients with learning disabilities:
Mortality over time, total deaths and deaths considered potentially avoidable



Patients with a mental health issue:
Mortality over time, total deaths and deaths considered potentially avoidable





Of the 104 deaths reviewed in July-September 2018, 79% of patients were judged to have received good care with no preventability. 14 cases (13%) were judged to have had care which showed room for improvement without evidence of preventability Six cases (6%) showed room for improvement with evidence for preventability (in two cases, strong evidence)

28 cases were highlighted as identifying learning from good care (cases can appear in more than one category) and 32 cases were highlighted as identifying learning from problems in care.

Positive lessons were around good coordination of clinical care with multi-team involvement, good communication with family and good SPCT involvement (including out of hours). Negatives reflected observations not being undertaken as often as mandated with failure to escalate deterioration in a timely fashion, lack of advanced decision making and poor quality of documentation (missing information, poor filing)..

REVIEWS IDENTIFYING LEARNING FROM GOOD CARE	28
Good coordination of clinical care / senior input / advanced decision making	20
Good communication with family	15
Palliative care instituted appropriately	7
Good documentation	4
Patient's stated wishes were followed	2
Capacity assessment recorded	1
High quality treatment	1
Test results / tests being undertaken appropriately	1
Treatment of complex patient in appropriate ward,	1

REVIEWS IDENTIFYING LEARNING FROM PROBLEMS IN CARE	32
Incomplete physiological observations / deterioration not escalated	17
Poor coordination of clinical care / lack of senior input / advanced decision	11
Poor quality of documentation	11
DNACPR not in place or invalid or ignored and CPR undertaken	3
Inappropriate admission from nursing home / community hospital /	3
Lack of ICU Bed	3
Medication Error	3
Availability of appropriate bed (nonICU) compromising care	2
Delay in instituting palliative care	2
Delay in treatment/surgery due to staff shortages/equipment failure	2
Mis- or Missed Diagnosis	2
Delayed or poor clerking	1
Inappropriate Referral to Coroner / query need for PM	1
Inappropriately aggressive treatment	1
Patient fall not escalated properly	1
Poor communication with family	1
Rapid readmission following earlier (inappropriate?) discharge	1
Treatment of complex medical patient on surgical ward	1

Board of Directors	
Agenda item	3.3
Title of Report	Healthcare-associated infection report for September 2018
Date of Meeting	6 November 2018
Presented by	Gill Hunt, Director of Nursing and Quality / DIPC
Authors	Richard Bellamy, Infection Control Doctor, JCUH Judith Connor, Assistant Director of Nursing / Deputy DIPC Gill Hunt, Director of Nursing and Quality/ DIPC
Approved by	Gill Hunt
Previous Committee/Group Review	Operational Management Board
Purpose	Approval ☑ Decision ☐ Discussion ☐ Information ☑
Alignment to Trust's Strategic Objectives	☑ 1. We will deliver excellence in patient outcomes and experience ☑ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	BAF 2.1
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to note the current position in respect of HCAI and for their support for the actions being taken.

1. Executive Summary

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, MRSA and MSSA bacteraemia, bacteraemia due to glycopeptide-resistant enterococci, E.coli, ESBL-producing coliform infections and other important healthcare-associated infections for the month of September 2018.

- The *Clostridium difficile*-associated diarrhoea objective for 2018/19 is to have no more than 54 trust-apportioned cases among patients aged over 2 years. There were 4 trust-apportioned cases in September 2018. In the first 6 months of 2018/19 there have been 24 trust-apportioned cases, which is under trajectory.

- There is no official MRSA bacteraemia target for 2018/19. There were 0 trust-assigned cases in September 2018. In the first 6 months of 2018/19 there has been 1 trust-assigned case.

- There is no official MSSA bacteraemia target for 2018/19. There were 4 trust-apportioned cases in September 2018. In the first 6 months of 2018/19 there have been 22 trust-apportioned cases.

2. Recommendation

The Board is asked to note the current position in respect of HCAI and for their support for the actions being taken.

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1. SURVEILLANCE DATA

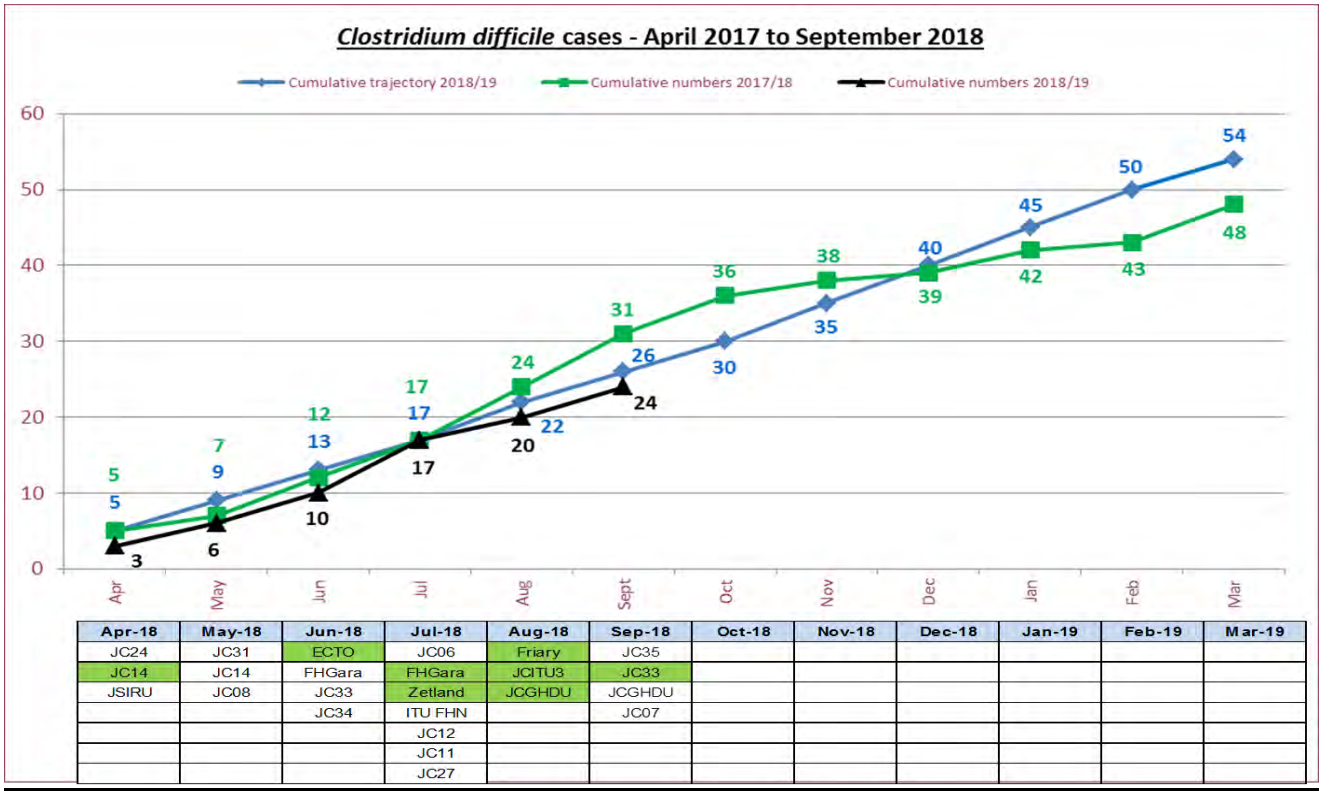
1.1 Clostridium difficile

C diff	Total 2017/18	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Total 2018/19 to date	Target for 2018/19
Total cases	125	11	8	4	10	6	8	8	11	12	14	8	11	64	NA
Not trust apportioned	77	6	6	3	7	5	3	5	8	8	7	5	7	40	NA
Trust apportioned	48	5	2	1	3	1	5	3	3	4	7	3	4	24	**54**
- JCUH	45	3	2	1	2	1	5	3	3	2	4	2	4	18	
-FHN	3	2	0	0	1	0	0	0	0	1	2	0	0	3	
-Carters	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Redcar	0	0	0	0	0	0	0	0	0	0	1	0	0	1	
-East Cl	0	0	0	0	0	0	0	0	0	1	0	0	0	1	
-Guis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Rutson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
-Friary	0	0	0	0	0	0	0	0	0	0	0	1	0	1	
-Lambert	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

There were 11 cases of *C. difficile* infection in September 2018, 4 of which were classed as trust-apportioned. The annual objective is to have no more than 54 trust-apportioned cases. There have been 24 trust-apportioned cases in the first 6 months of 2018/19. All actions to ensure robust controls are in place are monitored through both IPAG and the monthly 'Performance Wall' held with Matrons to ensure continued focus.

Deaths within 30 days after *C. difficile* diagnosis: for August 2018, 3 patients died during this period. Since April 2009, 288/1584 patients (18%) have died during the 30 day follow-up period.

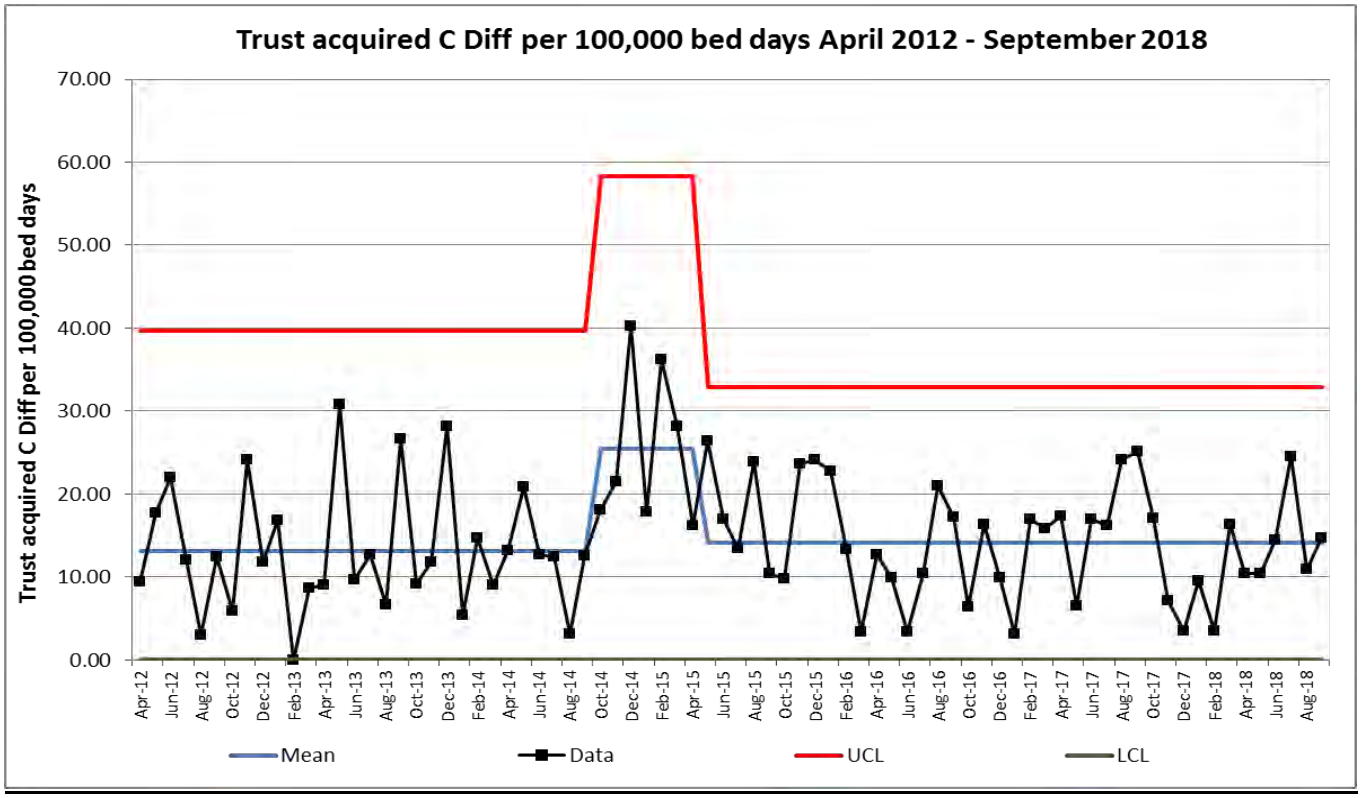
Graph 1: Cumulative Trust-apportioned *C. difficile* cases 2018/19 compared to 2017/18 & 2016/17 trajectory:

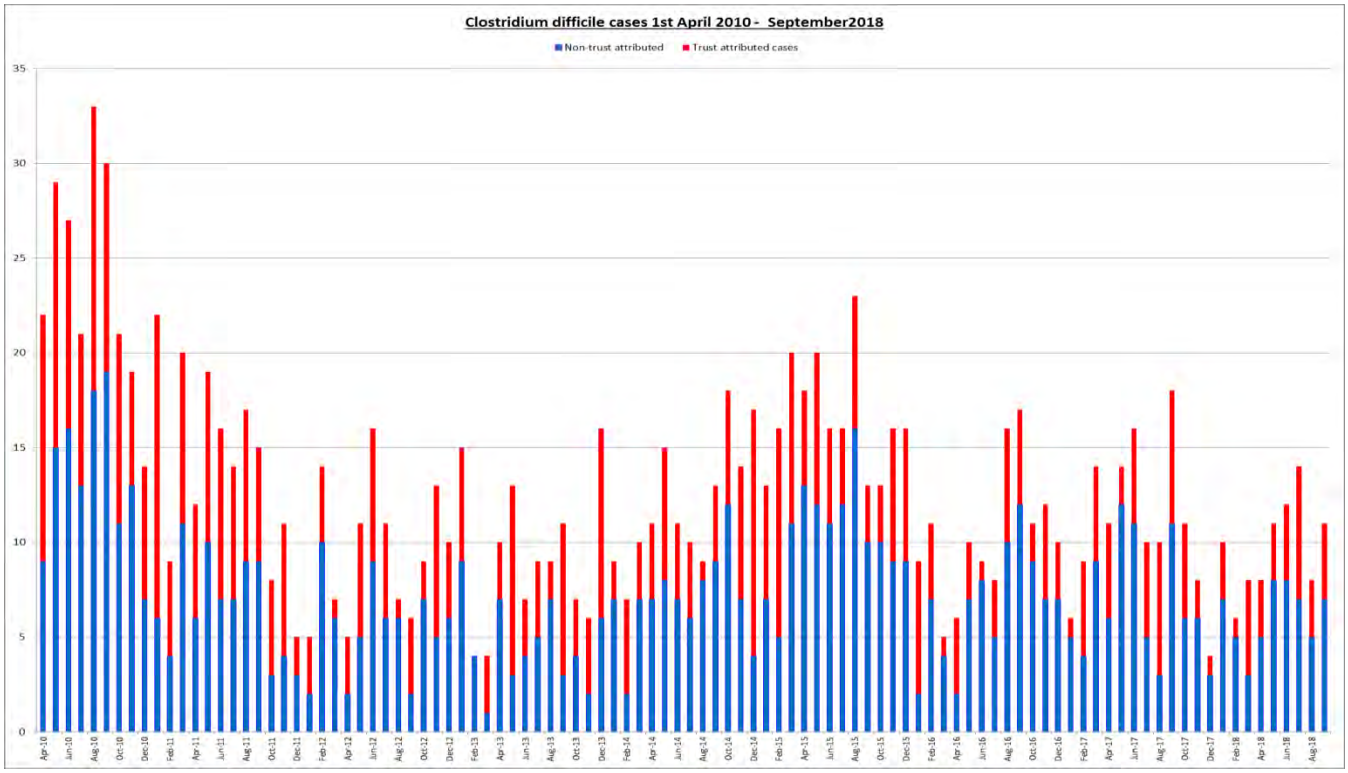


Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
JC24	JC31	ECTO	JC06	Friary	JC35						
JC14	JC14	FHGara	FHGara	JCITU3	JC33						
JSIRU	JC08	JC33	Zetland	JCGHDU	JCGHDU						
		JC34	ITU FHN		JC07						
			JC12								
			JC11								
			JC27								

Requested appeal	

Graph 2: Rate of Clostridium *difficile* infection per 100,000 bed days.





Root Cause Analysis (RCA) and panel reviews are undertaken for all trust-apportioned *C. difficile* cases. Panel reviews are chaired by the DIPC or Deputy DIPC and attended by CCG colleagues. There have been no episodes of linked cases by ribotype identified since June/July 2017.

The average hand hygiene self-assessment score in September 2018 was 93.57% and the peer review average was 94.74%. Installation of the refreshed hand hygiene product and associated campaign was re-commenced from 24 September, with theatres, ITU 2 and 3 being completed as well as a number of non-clinical areas.

Antimicrobial Stewardship

The trust is continuing with a number of antimicrobial stewardship initiatives including the ARK project. The antibiotic guidelines are being developed into a user-friendly app in conjunction with North Tees Hospitals. Jessica Martin, consultant microbiologist is leading this project.

Environmental Cleaning

The average cleaning scores by month are as follows:

The James Cook Site:

Risk Category	NSC Target	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18
High Risk	**95%**	98%	98%	98%	98%	99%	98%	99%	99%	99%	98%	98%	98%
Significant Risk	**85%**	98%	98%	97%	98%	98%	98%	97%	98%	97%	97%	97%	97%
Low Risk	**75%**	95%	95%	95%	95%	96%	96%	95%	95%	96%	95%	94%	94%

Cleaning scores have been maintained on the JCUH site. No areas failed the C4C inspection in August 2018 on the James Cook site. Maintaining cleaning standards remains an area of continued focus in conjunction with our new service provider SERCO. The monthly cleaning standards review meetings continue to be led by the Director of Estates and cleaning scores continue to be monitored via IPAG.

The Friarage, Friary, East Cleveland and Redcar Primary Care Hospital:

Risk Category	NSC Target	FHN Site	Friary	East Cleveland	Redcar PCH
Very High Risk	**98%**	97.82%	95%		99.3%
High Risk	**95%**			97%	98.0%
Significant Risk	**85%**	98.88%		95%	96.8%
Low Risk	**75%**	98.11%		95%	96.2%

1.2 MSSA bacteraemia

MSSA	Total 2017/18	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Total 2018/19 to date	Target for 2018/19
Total cases	130	17	13	10	10	9	21	9	23	8	13	13	10	76	NA
Not trust apportioned	96	11	11	7	5	6	17	6	16	6	11	9	6	54	NA
Trust apportioned	34	6	2	3	5	3	4	3	7	2	2	4	4	22	NA

There were 10 cases of MSSA bacteraemia cases in September 2018; 4 of which were classed as trust-apportioned. There have been 22 trust-apportioned cases in the first 6 months of 2018/19.

Whilst there is no external target for MSSA or MRSA bacteraemia, the trust has set an internal target to maintain the 15% reduction of Staphylococcus aureus infections based on the 16/17 baseline, meaning no more than 35 combined MRSA and MSSA trust-apportioned cases in total. The trust is not currently on trajectory in achieving this ambition.

To support our continued focus the trust has recently purchased an e-learning package to support ‘aseptic no touch technique’ for the management of intravenous lines. The IPC team will therefore work in collaboration with the trusts clinical skills team to incorporate this training into the current education programmes as well as rolling out a full education programme. High risk areas such as haematology and oncology will be targeted first.

A working group to be chaired by Dr Oliver to explore improvements in intravenous line care will meet early November to establish the first steps in developing a trust line registry to support surveillance in infections related to intravenous lines, this will exclude peripheral venous catheters and arterial lines.

1.3 MRSA bacteraemia

There were 0 cases of MRSA bacteraemia cases in September 2018. There has been 1 trust-assigned case in the first 6 months of 2018/19. A case review was held for this case although no lessons to be learnt were identified.

MRSA	Total 2017/18	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Total 2018/19 to date	Target for 2018/19
Total cases	4	0	0	0	2	0	0	0	2	0	2	1	0	5	NA
Not trust assigned	3	0	0	0	2	0	0	0	2	0	2	0	0	4	NA
Trust assigned	1	0	0	0	0	0	0	0	0	0	0	1	0	1	NA

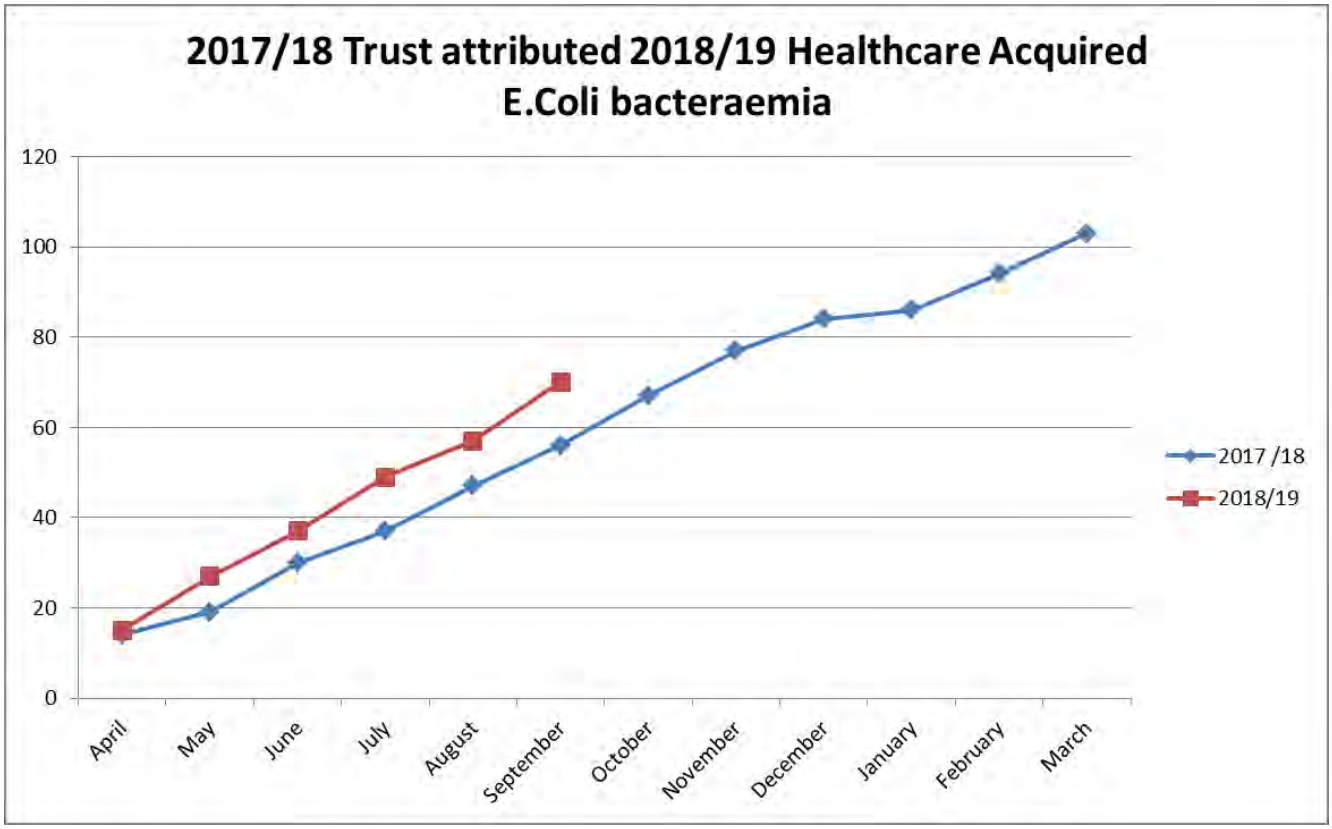
1.4 Surveillance for other healthcare-associated infections

	Total for 17/18	September 2018	Total 18/19
Bacteraemia due to glycopeptide-resistant enterococci	7	1	6
Bacteraemia due to E. coli	500	47	280
• Trust-apportioned	106	13	70
• Not trust-apportioned	394	34	210
ESBL producing coliform infections	798	82	458
• sample taken in community	490	50	283
• sample taken in our trust	304	32	175
• bacteraemias	25	2	13
Bacteraemia due to Klebsiella species	131	18	73
• Trust-apportioned	41	7	23
• Not trust-apportioned	90	11	53
Bacteraemia due to Pseudomonas aeruginosa	41	10	21
• Trust-apportioned	19	6	10
• Not trust-apportioned	22	4	11
Other alert organisms	1	0	0
• invasive group A streptococcus			

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction of healthcare associated infections by 2021.

In September 2018 the trust reported a total of 75 cases of the 3 GNBSI organisms which are part of national surveillance (E.coli, 47; Klebsiella sp. 18; Pseudomonas aeruginosa 10). Of these, 26 cases were classed as trust-apportioned (34%) as defined by the Department of Health definition. This demonstrates the need to provide further support to the wider community in order to reduce these infections.

The trust is taking part in the second wave of the national GNBSI urinary tract infection collaborative hosted by NHS Improvement / NHS England with the second meeting taking place in October. The focus of this improvement programme will be hydration in both the community setting in the older population and care home setting with a number of resources being made available as well as a specific hydration campaign within 2 care homes. This work is being led by the IPC post currently hosted by the trust but funded through health and social care funding the 'Better Care Fund'.



The trust continues to work with partner organisations as part of the Tees-wide collaborative which supports a number of initiatives within the community setting.

2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 17/18	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Total 18/19 to date
Total number	*3*	1	0	0	0	0	2	0	0	0	0	0	0	0
Total number of patients affected	*42*	11	0	0	0	0	31	0	0	0	0	0	0	0
Total number of staff affected	*15*	2	0	0	0	0	13	0	0	0	0	0	0	0

There were no significant outbreaks of diarrhoea and vomiting in the trust in September 2018.

3. OUTBREAK OF GES – CARBAPENEMASE-PRODUCING MULTI-DRUG-RESISTANT PSEUDOMONAS AERUGINOSA INFECTION IN ICU2/3, GHDU, WARD 4 AND 24HDU AND OTHER AREAS

There have been no new patients identified with GES carbapenemase-producing Pseudomonas aeruginosa since October 2017. There were no further cases detected in September 2018, however, we will continue with our surveillance for this organism.

In total there have been 21 patients identified who are colonised or infected with a GES carbapenemase-producing strain of Pseudomonas aeruginosa in our trust since November 2014.

4. OXA-48-CARBAPENEMASE-PRODUCING KLEBSIELLA PNEUMONIAE

Acute trusts in Teesside have seen an increase in patients affected by a single strain of oxa-48 carbapenemase-producing Klebsiella pneumoniae. We had no new cases in September 2018.

5. DECONTAMINATION

A monthly report is prepared by the Lead for Decontamination and presented to IPAG. Key points from the most recent report are as follows:

- Life cycle works have been completed for ITU 2 and 3. This work will include a deep clean of both clinical areas.

Board of Directors	
Agenda item	3.4
Title of Report	Safe Staffing Report – Nursing and Midwifery
Date of Meeting	6 November 2018
Presented by	Gill Hunt, Director of Nursing and Quality
Author	Eileen Aylott, Assistant Director of Nursing, Workforce
Approved by	Gill Hunt
Previous Committee/Group Review	Operational Management Board
Purpose	Approval ☐ Decision ☐ Discussion √ Information √
Alignment to Trust's Strategic Objectives	√ 1. We will deliver excellence in patient outcomes and experience √ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future √ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	BAF – 5.2
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to receive and note the content of this report.

1. Executive Summary

South Tees Hospitals NHS Foundation Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses (RN), Midwives (RM) and Health Care Support Workers (HCSW), matches the acuity and dependency needs of patients within the organisation. To ensure there is an appropriate level and skill mix of staff to provide safe and effective high quality care.

The requirement to publish nursing and midwifery staffing levels on a monthly basis is explicit and is one of the ten expectations specified by the National Quality Board (2013).

The fill rate against planned rosters for the month of September at an overall level was:

- RN / RM day shift – 93.7%, night shift 95.6%
- HCSW day shift 92.4%, night shift 109.4%

2. Recommendation

The Board are asked to note the content of the report and to be assured that staffing levels are sufficient to deliver safe, high quality care with systems and processes in place should staffing levels fall short of those planned.

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1. UNIFY Safe Staffing Return

The Trust's safer staffing submission to UNIFY for September 2018 was submitted on 15 October 2018 with the summary of overall fill rate in the table below with the full report in Appendix 1.

Table 1 – Overall UNIFY Return fill Rate

2017/2018	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
April 2017	92.7%	99.0%	95.3%	111.9%
May 2017	91.0%	97.4%	95.0%	109.5%
June 2017	91.5%	98.3%	93.5%	109.1%
July 2017	88.7%	97.4%	93.9%	111.0%
August 2017	87.2%	96.9%	92.1%	113.1%
September 2017	88.3%	100.3%	91.7%	113.9%
October 2017	88.7%	96.6%	93.1%	116.0%
November 2017	88.5%	95.1%	93.6%	109.6%
December 2017	87.1%	92.8%	92.6%	107.9%
January 2018	90.7%	91.2%	93.0%	109.1%
February 2018	89.4%	89.2%	93.1%	107.4%
March 2018	91.1%	92.6%	94.2%	109.2%
April 2018	91.0%	94.7%	96.4%	110.9%
May 2018	92.1%	91.4%	96.2%	112.1%
June 2018	92.7%	93.1%	94.6%	109.5%
July 2018	91.4%	92.3%	94.3%	107.3%
August 2018	91.3%	91.3%	94.5%	108.1%
September 2018	93.7%	92.4%	95.6%	109.4%

Centre Associate Directors of Nursing lead the twice daily SafeCare meetings Monday to Friday with Clinical Matrons providing weekend leadership in this area. Temporary staffing requirements are reviewed daily together with acuity, dependency and clinical judgement to ensure safe and efficient staffing.

Specialist Nurses, Critical Care Outreach and Corporate Nurses have all supported wards with complex patients and those with higher acuity and dependency with both full and part shifts. Clinical Matrons provide oversight and assurance across their areas addressing red flags and supporting decision making.

Paediatric and Midwifery teams meet daily to review staffing across the floor and move staff accordingly. Unavailability is adjusted to meet the needs of the service with managers working clinically as required to maintain safe staffing. These areas are not currently on SafeCare and changes may not always be captured on the roster.

Ward 21 and Paediatric ICU had an RN fill rate of less than 80% during September. The bed occupancy on ward 21 was 72% (18 children) and PICU was 50% (3 Babies). As mentioned

previously staff are deployed on a daily basis to accommodate the numbers of children across the centre to provide safe staffing.

2. Temporary Staffing

The temporary staffing fill rate during September was 74.4% which remains 18% above the National Average bank fill rate and 11% above the next leading trust. Daily review of all shifts continues to take place during the morning SafeCare meeting with ADoN's to ensure both safe and efficient allocation of staff.

3. Red Flag Reporting

A total of 90 red flags have been reported during September. These are investigated by Clinical Matrons prior to the morning SafeCare meeting on a daily basis and action to address taken in real time. The predominant themes are a shortfall in RN hours (51) and opening of 'amber' beds (21) action taken to mitigate risk is captured on the system providing an audit trail or response to the alert.

Amber beds are used as part of routine escalation during surge and are managed within planned staffing levels. The system alerts the clinical matron to the opening of amber beds which ensures they can support patient flow as required.

Row Labels	Count of Shift
AMBER Beds Open	21
Delay in providing pain relief	2
Less than 2 RNs on shift	5
RED Beds Open	10
Shortfall in RN time	51
Unplanned omission in providing medications	1
Grand Total	**90**

4. Redeployed staff

SafeCare gives the Trust the ability to redeploy staff from an area with excess hours to one which is short using the acuity and dependency calculation to support patient care and ensure effective use of resource. During the month of September 1,120 hours were redeployed across adult inpatient areas via SafeCare.

5. Care Hours Per Patient Day (CHPPD)

CHPPD is a national measurement recorded monthly through the UNIFY safe staffing report and is a Model Hospital metric. Triangulation between hours planned vs hours worked in this report should be considered with CHPPD and professional judgement to ensure areas have safe and efficient levels of staffing. The Model Hospital metric also provides the Trust with a peer review option to enable us to compare with hospitals of a similar size and complexity as well as the National trend. At a macro level our CHPPD is relatively consistent with peers, the latest published data was in July 2018 during which time we were in line with our peer group of with an overall CHPPD at South Tees Hospitals NHS Foundation Trust of 8.6 CHPPD (Peer 8.9 and National Ave 8.1).

6. Staff Retention

The retention of nurses and midwives is as important as the recruitment activity undertaken to fill vacant posts. The Trust is working with NHS Employers and NHSI on a retention work stream focused on our flexible working and retirement strategies. The second work stream the Trust has joined in the RePAIR project during which we will look at transition shock of student nurses to help reduce attrition and end of career choices linking to the first work stream above.

7. Band 5 Vacancy Rate and Recruitment Activity

Five nurses arrived from the Philippines during September and were deployed on wards 1 (RAFU), 9, 12, SAU and the Spinal Injuries Unit, they are currently on the OSCE preparation programme. All ten nurses from the previous groups have successfully passed their OSCE exams and are now live on the NMC register and working as Band 5 Staff Nurses.

The Nursing and Midwifery turnover rate remains fairly static at 9.5%. The number of unfilled Band 5 RN posts as of 1 October is 54 Wte.

Eileen Aylott
Assistant Director of Nursing Workforce
October 2018

Appendix 1 JCUH

staffing report for UNIFY Sep 2018.xlsx

References

Department of Health (2016) **Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles**
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

National Quality Board (2016) **How to ensure the right people, with the right skills are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.** London

Safe, sustainable and productive staffing in maternity services
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Maternity_final_2.pdf

Safe, sustainable and productive staffing for neonatal care and children and young people's services
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_Neonatal_mYLJCHm.pdf

Safe, sustainable and productive staffing in urgent and emergency care
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/Safe_Staffing_urgent_and_emergency_care.pdf

Board of Directors	
Agenda item	3.5.1
Title of Report	Nurse Staffing Review (Adult Inpatient Areas)
Date of Meeting	6 November 2018
Presented by	Gill Hunt, Director of Nursing and Quality
Author	Eileen Aylott, Assistant Director of Nursing, Workforce
Approved by	Gill Hunt
Previous Committee/Group Review	Operational Management Board
Purpose	Approval √ Decision √ Discussion √ Information √
Alignment to Trust's Strategic Objectives	☐ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to approve the Nurse Staffing Review for Adult Inpatient Areas

1. Executive Summary

This paper provides assurance to the Board of safe staffing levels across all adult inpatient bed holding areas. Each centre Associate Director of Nursing (ADoN) has reviewed their own data from this report and have contributed to actions resulting from this information.

Critical care areas are staffed in line with mandatory staffing levels of 1:1 for Intensive Care (ICU) and 1:2 for High Dependency Units (HDU). A staffing review is planned in line with the critical care strategy.

Care Hours per Patient Day (CHPPD) are within mid-range of our model hospital peer group at a median of 8.7 (range 6.9 – 10.6)

Work is ongoing with Allocate as part of the Insights package to be able to drill into the data sets provided for roster efficiencies and SafeCare metrics including acuity and dependency scoring and CHPPD in line with the Lord Carter NHSI recommendations to improve efficiencies and reduce variation and waste.

2. Recommendation

The Board is asked to approve the Nurse Staffing Review for Adult Inpatient Areas

1. Purpose

The purpose of this report is to share the results of the patient acuity and dependency data collected between 1 January and 31 March 2018 in adult inpatient areas for both the acute and community hospital sites, to discuss the findings and make recommendations.

2. Background

The requirement to ensure nurse staffing levels are safe and sufficient to meet patient need is clearly an imperative. The Francis enquiry (2013) and subsequent government response 'Hard Truths' (2014) have emphasised the need to get staffing levels right, with recent seminal papers from Keogh (2013) and Berwick (2013) clearly linking nurse staffing levels to patient safety, outcome and experience. Inadequate nurse staffing has been a recurring theme in organisations where patient care has been found to be substandard.

Board ownership is very clear with the National Quality Board (NQB 2013) setting out explicit expectations in terms of Board ownership and public visibility advocating public Board level discussion to ratify and agree nurse staffing levels. The NQB was revised in June 2016 to include recommendations from the Five Year Forward View and the Carter Review (2016).

A recommendation in the NICE guideline is the assessment and review of staffing levels based on average nursing hours per patient. Subsequently this has emerged as a key recommendation from the Carter report (Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. February 2016) described as Care Hours per Patient Day (CHPPD).

The recommendation from the Carter review (2016) for a single measurement that captures effective staff deployment has now been developed into Care Hours per Patient Day and included as a key metric in the development of the model hospital nursing and midwifery dashboard and will be published on My NHS and NHS Choices from September 2018 for acute trusts. The latest published data from April 2018 records STEES establishment Care Hours per Patient Day (CHPPD) at 8.6 (5.5 for RN/RM and 3.2 HCA) which is in line with our peer hospital group (8.8) and against a national average of 7.9.

Care Hours per Patient Day (CHPPD) can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions. It can be broken down by grade – initially registered nurses and healthcare support staff, but ultimately bands/grades within these groups and all other staff groups contributing to ward-based care, including AHPs will be included.

$$\text{Care Hours Per Patient Day} = \frac{\text{Hours of registered nurses} + \text{Hours of healthcare support workers}}{\text{Total number of inpatients}}$$

This is about much more than numbers however with skill mix, capacity and competence being critical in terms of establishing appropriate staffing levels. The impact of the both the number and qualification of the nurse has recently been suggested with reduced mortality found when care is delivered by graduate nurses caring for fewer patients (Aiken et al, 2014).

Ensuring we have the right staff, with the right skills in the right place is Action Area 5 within Compassion in Practice (2012). The document clearly set out the expectation that evidence-based, patient need-driven staffing levels in all care settings should be established.

The Safer Nursing Care Tool (Shelford Group, 2013) is currently the most commonly used method (previously known as the AUKUH Acuity and Dependency Measurement Tool)

The Safer Nursing Care Tool (SNCT) is:

> An evidence based tool which allows nurses to assess patient acuity and dependency. The data is collected and matched with pre-set staffing multipliers to ensure that nursing establishments reflect patient needs.
>
> Recommended staffing levels are based on an analysis of the actual patient acuity and dependency on the ward at the time of data collection and extrapolated to the funded bed base.
>
> The tool is appropriate for use in any acute hospital.

No national workforce tool can incorporate all factors and therefore triangulation is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide balanced assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT.

There are also a minimum number of nurses required to deliver safe care regardless of ward size, 11.5 whole time equivalent (Wte) Registered Nurses (RN's) are required to provide 2 nurses 24/7. The SNCT may indicate that smaller wards are over established however the reality is reductions in staffing levels would be inappropriate. Therefore caution is advised when interpreting results from smaller areas.

In January 2017 the Trust began to roll out the newly purchased SafeCare module across all adult inpatient areas as part of a rapid implementation programme to enable real time staffing to be viewed on a daily basis. This was completed at the end of March and went 'live' at the beginning of April 2018.

SafeCare uses the SNCT (Shelford Group) Acuity and Dependency Measurement Tool and calculates the staffing requirement for each ward based on this information. Data is provided as CHPPD and hours and is reviewed by the Senior Nursing Team to ensure that the right staff are in the right place to provide safe care.

3. Methodology

The SNCT (Shelford Group) Acuity and Dependency Measurement Tool was used as part of the daily SafeCare census entry by each ward.

- Data was extracted from the system for the full 3 month period (January - March 2018)
- Acuity and dependency data was inputted by staff between 06:00 – 08:00, 13:00 -15:00 and 18:00 – 20:00 hours daily using the SafeCare system. (SNCT Levels of Care Criteria appendix 1)
- All staff with the take charge competency were trained to use the system and input data for their own shift.
- Numbers of Register and Unregistered staff were collected using the UNIFY planned versus actual monthly staffing return.
- Red flag reporting was extracted from SafeCare.
- Sickness rates, NHSP (Nurse Bank) temporary staffing hours, funded and contracted staff hours were provided by the appropriate teams.
- SafeCare data was reviewed daily by a combination of Centre Associate Directors of Nursing (Monday – Friday) Clinical Matrons and Patient Flow and staff were redeployed appropriately to match patient need with demand.

4. Results

- The results are displayed by Centre and the figures follow the format below

Figure 1.

This table details:

- funded bed base
- average number of patients on the ward during data collection
- average staffing levels on a shift by shift basis
- average ratio of RN's to patients
- percentage sickness rate

The RN to patient ratio has been considered in respect of a minimum 1:8 (day time) which has a clear evidence base to indicate that as this ratio increases so does the risk of harm to patients in general acute wards. Whilst the evidence base for RN: patient ratio overnight is lacking a 1:12 ratio has been internally agreed as a minimum requirement. Areas above this ratio have been highlighted in red.

Figure 1b

Care Hours per Patient Day (CHPPD) displayed as number of hours required and number of actual hours worked. The number of tasks recorded during this period together with nurse sensitive indicators (falls and hospital acquired pressure ulcers) and red flags raised.

Figure 1c

Summary of Red Flags Reported during the three month period broken down by type

Figure 2.
Pie charts illustrating the actual percentage of acuity and dependency score by ward during the time of data collection

Figure 3.
This table provides analysis using the SNCT multipliers. The variance column provides a figure of whether the funded establishment is considered appropriate for the funded bed base, over or under resourced in respect of acuity and dependency needs of the patients. There is also a column where contracted staff (Wte) and NHSP usage (Wte) relating to the period of data collection is shown.

Specific comments providing context which needs to be considered are also included within the table (e.g. monitored beds, direct admissions, closed beds etc.) As part of the analysis 0.8 Wte has been allocated to allow for a supervisory ward sister / charge nurse (the multipliers allow for 0.2 Wte). Specific comments providing context which needs to be considered are also included in the Centre analysis in the following section.

Community Care Analysis and Action Plan

Figure 1.Staffing Averages and Ratio

		Funded Bed Base	Average of Beds	Average of RNs Day	Average of HCAs Day	Average of RNs Night	Average of HCA Night	Ratio of Beds to RNs Days	Ratio of Beds to RNs Night	Sickness	Comments
Community Care	**Ward 3**	28	27	3.9	4.2	2.2	3.0	6.9	12.2	4.56%	
	Ward 9	28	27	4.1	3.8	2.9	3.3	6.5	9.3	4.45%	4 bedded RSU requiring 1:2 staffing
	Ward 10	24	24	3.5	3.3	3.0	3.0	6.8	8.0	3.18%	
	Ward 11	30	29	4.9	3.9	2.5	3.9	5.9	11.6	4.45%	
	Ward 12	24	29	3.7	4.9	2.6	3.9	7.8	11.1	8.71%	Escalation beds
	Ainderby	21	21	3.1	2.5	2.0	1.9	6.7	11.0	0.93%	
	Romanby	21	21	2.8	3.0	2.0	1.8	7.5	11.0	2.86%	
	Rutson	15	15	2.4	3.1	2.0	1.8	6.2	7.5	4.15%	
	Tocketts	30	25	3.8	4.1	2.5	3.2	6.5	7.8	6.06%	
	Friary Hospital	18	15	2.6	2.5	2.0	0.8	5.7	7.5	1.61%	
	Zetland	31	27	3.7	2.5	2.6	3.5	7.2	10.3	9.41%	Mostly single rooms

Figure 1b - Care Hours per Patient Day (CHPPD) January – March 2018

Wards	Average of Req'd CHPPD	Average of Actual CHPPD	Average % Temp staff	Sum of Task Total	Total No. of Falls	Hospital Acquired PU Grade 2	Hospital Acquired PU Grade 3	No. Red Flags
Ward 3	6.42	5.93	8.67%	11	26	0	0	0
JC09	7.00	6.42	11.49%	53	6	8	0	20
Ward 10	6.14	9.94	10.01%	2	25	2	0	6
Ward 11	6.14	6.27	14.38%	1	30	12	0	7
Ward 12	6.45	6.27	16.20%	10	35	9	0	61
Ainderby	6.94	5.24	6.87%	99	11	3	0	31
Romanby	6.39	5.28	2.59%	13	9	2	0	35
Rutson Rehab	7.23	7.55	0.09%	97	6	0	0	0
Tocketts Ward ECH	7.11	6.27	15.70%	58	15	5	2	0
Friary Hospital	6.66	6.16	0.99%	2	4	0	0	0
Zetland Ward RPCH	7.61	6.74	13.34%	80	13	0	0	0
Grand Total	**6.73**	**6.23**	**9.24%**	**426**	**180**	**41**	**2**	**160**

Summary of Red Flags Reported January – March 2018

Row Labels	AMBER Beds Open	Less than 2 RNs on shift	RED Beds Open	Shortfall in RN time	Grand Total
JC09	0	0	0	20	20
Ward 10	2	1	3	0	6
Ward 11	1	1	3	2	7
Ward 12	6	1	52	2	61
Ainderby	22	0	9	0	31
Romanby	28	0	7	0	35
Grand Total	**59**	**3**	**74**	**24**	**160**

Figure 2 Acuity and Dependency Scores

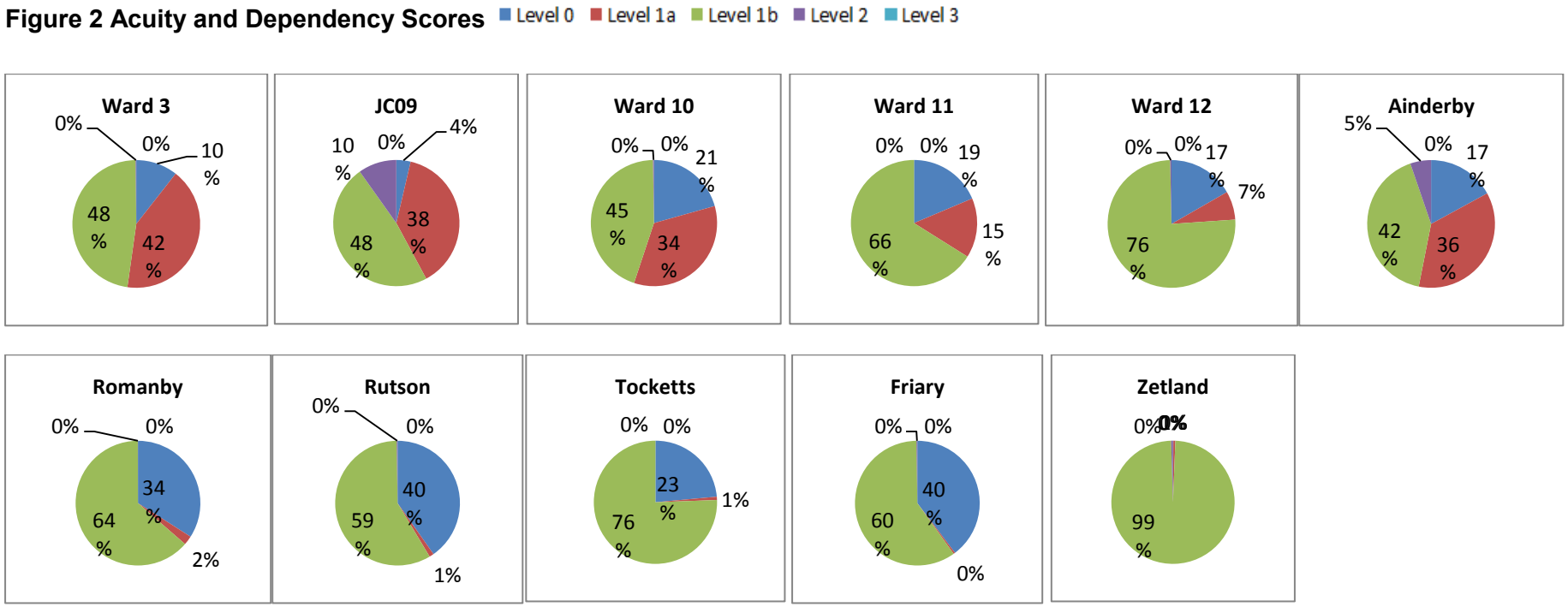


Figure 3 Establishment and Acuity Analysis

		Funded Bed Base	Average of WTE nurses recommended by multipliers	Funded WTE	Variance	Variance minus supervisory ward sister / charge nurse 0.6	Contracted staff WTE	NHSP used WTE	Sickness %	Comments
Community Care	**Ward 3**	28	42.01	39.13	- 2.88	-3.48	40.29	4.8	4.56%	
	Ward 9	28	38.64	47.13	8.49	7.89	42.52	6.2	4.45%	4 NIV beds requiring 2 staff
	Ward 10	27	49.10	42.71	-6.39	- 6.99	38.56	3.0	3.18%	x1 NP and 6 beds closed
	Ward 11	30	45.90	46.64	0.74	0.14	38.04	6.2	4.45%	X1 NP with Therapy model
	Ward 12	24	47.87	44.19	-3.68	- 4.28	34.65	3.3	8.71%	
	Ainderby	21	31.54	34.85	3.31	2.71	31.56	2.2	0.93%	
	Romanby	21	30.68	35.85	5.17	4.57	29.97	1.7	2.86%	
	Rutson	15	30.28	35.69	5.41	4.81	29.93	0.0	4.15%	Stroke Rehab
	Tocketts	30	46.49	44.35	- 2.14	- 2.74	40.28	7.0	6.06%	6 GP beds x1 NP
	Friary	18	25.55	24.92	- 0.63	- 1.23	23.16	0.1	1.61%	Small community hospital
	Zetland	31	53.32	53.16	0.16	- 0.76	50.98	4.8	9.41%	Mostly single rooms x1 NP
			441.38	448.62	7.56	0.61	**399.94**	**39.30**		

Discussion

The minimum ratio of RN to Patients (1:8 for days and 1:12 for nights) is satisfactory for both day and nights in all but one area. Ward 3 night ratio is at 12.2 and has been supplemented by 3 health care assistants to maintain patient safety.

CHPPD scores are reviewed as part of SafeCare with ADoN's and Matrons. There remains inconsistency in the recording of task types within SafeCare which does affect the required CHPPD. Wards 10, 11 and in particular ward 12 had extra beds open during the first 3 months of the year and staffing assistance was provided by both corporate nursing and military colleagues to ensure safe staffing levels.

Establishment and acuity figures across the whole centre are generally aligned with the funded WTE recommended by the multipliers. Ward 10 has since closed and staff relocated to other wards and departments to fill vacancies. Ward 3 establishment warrants monitoring, albeit the contracted and NHSP used more closely reflects SNCT recommendations. Ward 11 and 12 have since amalgamated as a single older peoples ward.

Actions to be overseen by the Centre Associate Director of Nursing

1. Closure of ward 10 and redeployment of staff across the centre into vacant posts increasing substantive fill rate - complete
2. Ensure 3 RN's on night duty for ward 3 – auto roster templates to be reviewed with e-roster team - complete
3. Bed reconfiguration of older people's inpatient beds on the JCUH site to include co-location to a more appropriate estate – by end of 18/19
4. Staffing establishment review for new co-located ward to RCN older people's safe staffing levels (1:6) – complete
5. Reduced the bed base within the co-located ward to eliminate amber and red beds. Work to be undertaken around effective estimated date of discharge (EDD) and discharge before noon. – Clinical Director / Matron by Q3 18/19
6. Dedicated work is required around sickness and promoting a healthy workplace which can be addressed through the Managers Development Programme - current
7. Ensure effective redeployment of staff is undertaken through SafeCare as required and monitor resource utilisation both within centre and externally to other centres - current
8. Staff to attend a CHPPD workshop with Allocate and e-rostering to ensure full understanding of the acuity and dependency scoring process (30th June 2018) - complete
9. Peer acuity and dependency audits to take place during July 2018 – complete

Figure 1.Staffing Averages and Ratio

		Funded Bed Base	Average of Beds	Average of RNs Day	Average of HCAs Day	Average of RNs Night	Average of HCA Night	Ratio of Beds to RNs Days	Ratio of Beds to RNs Night	Sickness	Comments
Emergency Care	Ward 1 (RAFAU)	22	24	5.6	4.1	2.8	3.2	4.2	8.5	5.34%	Frailty Unit
	Ward 15 (AAU)	24	19	5.4	3.2	3.8	3.2	3.5	5.0	5.25%	Acute Assessment Unit
	Ward 37 (AMU)	30	22	6.0	3.6	4.9	3.2	3.6	4.4	3.10%	Acute Medical Unit
	FHN CDU	21	16	3.9	3.6	2.8	1.9	4.1	5.7	4.22%	Clinical Decisions Unit

Figure 1b - Care Hours per Patient Day January – March 2018

Wards	Average of Required CHPPD	Average of Actual CHPPD	Average of % Temp staff	Sum of Task Total	Falls	Hospital Acquired PU Grade 2	Hospital Acquired PU Grade 3	Red Flags
Ward 1 (RAFAU)	8.28	7.01	9.48%	5	28	5	0	47
Ward 15 (AAU)	8.83	9.7	5.69%	704	12	0	0	1
Ward 37 (AMU)	8.36	8.97	11.79%	234	9	1	0	1
FHN CDU	8.98	8.48	24.46%	1201	18	0	0	0
Grand Total					**78**	**17**	**0**	**51**

Summary of Red Flags Reported January – March 2018

Row Labels	Queueing ambulances	RED Beds Open	Shortfall in RN time	Grand Total
RAFAU	0	46	1	47
Ward 15 (AAU)	0	0	1	1
Ward 37 (AMU)	1	0	0	1
CDU FHN	0	0	2	2
CHDU	0	0	1	1
Grand Total	**1**	**46**	**5**	**52**

Figure 2 Acuity and Dependency Scores

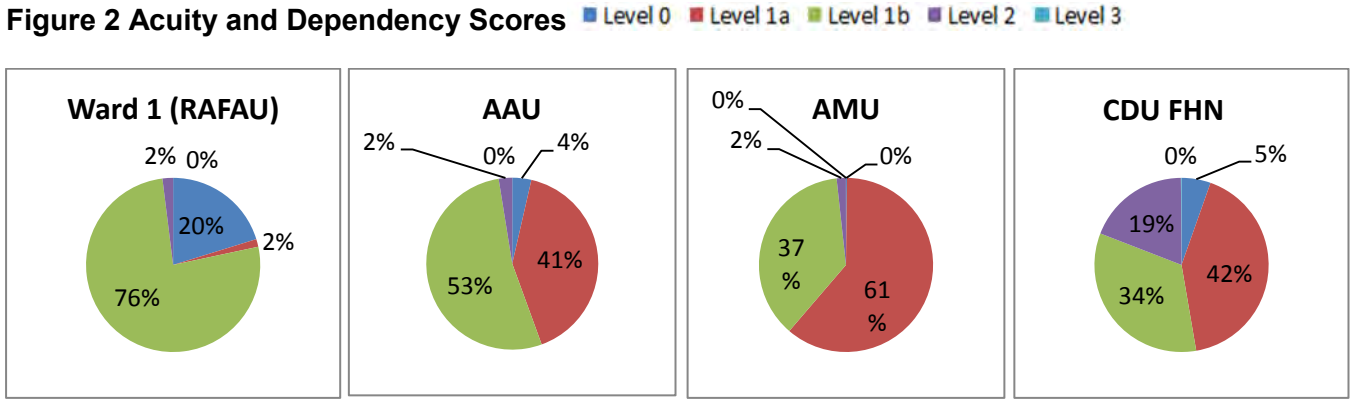


Figure 3 Establishment and Acuity Analysis

		Average of Beds	Average of WTE nurses recommended by multipliers	Funded WTE	Variance	Variance minus shift co-ordinator 2.8 WTE	Variance minus supervisory ward sister / charge nurse 0.6	Contracted staff WTE	NHSP used WTE	Sickness	Comments
Emergency Care	**Ward 1 (RAFAU)**	22	42.10	48.50	6.40	3.60	3.00	42.84	4.4	5.34%	* See notes below
	Ward 15 (AAU)	24	44.61	51.40	6.89	4.09	3.49	59.88	0.1	5.25%	** See notes below re Ambulatory Care
	Ward 37 (AMU)	30	55.02	49.78	-5.24	- 8.04	- 8.64	55.88	0.3	3.10%	
	FHN CDU	21	33.42	37.93	4.51	1.71	1.11	33.71	5.4	4.22%	*** See notes below
		Totals	**175.15**	**187.61**	**12.56**	**1.36**	**-1.04**	**292.44**	**12.4**		

* Ward 1 (RAFA) X 3 Nurse Practitioners removed from funded Wte . **Ward 15 (AAU) X 6.4 Nurse Practitioners removed from funded Wte Ambulatory Care area staffed by ward 11.2 Wte.
***CDU - 7Wte Nurse Practitioners removed from 44.93 funded Wte.

Discussion

Figure 1 demonstrates that there were no areas within the centre that breached the safe staffing ratios for their speciality. RAFU had less CHPPD than required and as they maintained one amber bed and some red beds during the audit period. Professional judgement was used to triangulate data provided by the roster and SafeCare to ensure patient safety. CDU at the Friarage Hospital Actual CHPPD has been affected by the tasks recorded on SafeCare and requires review.

There are military staff attached to wards 15 and 37 who have both committed (planned into the roster) and non-committed shifts (excess to planned). The non-committed shifts worked have not been included in the calculations as they do not form part of the budget or establishment setting which this report informs and may be in a supernumerary / preceptorship capacity. Funded FTE appears appropriate

Actions to be overseen by the Centre Associate Director of Nursing

1. Undertake a review of critical care establishments to maximise the total critical care capacity required to meet demand, enabling Trust objectives in relation to elective and non-elective activity. – Q3 18/19
2. Transfer of specialist critical care services to UECC – determine the service model to ensure the staffing model reflects demand and agree transfer of budget. Q3 18/19
3. Consider critical care nursing establishment in totality to maximise the benefits of critical care redeployment to reduce extra expenditure - current
4. Work with military colleagues to ensure transparency of all non-committed shifts worked on 15, 37 and critical care. Q3 18/19
5. Ensure effective redeployment of staff is undertaken through SafeCare as required and monitor resource utilisation both within centre and externally to other centres - current
6. Staff to attend a CHPPD workshop with Allocate and e rostering to ensure full understanding of the acuity and dependency scoring process (30th June 2018) – complete

Figure 1.Staffing Averages and Ratio

		Funded Bed Base	Average of Beds	Average of RNs Day	Average of HCAs Day	Average of RNs Night	Average of HCA Night	Ratio of Beds to RNs Days	Ratio of Beds to RNs Night	Sickness	Comments
Planned Care	PCAU	12	8	2.2	2.1	2.0	1.1	3.6	4.2	5.94%	New Admissions Unit
	Ward 6	24	23	3.2	3.5	2.0	2.3	7.1	11.5	2.69%	
	Ward 7	30	29	4.3	4.4	2.5	3.0	6.7	11.6	2.90%	
	Ward 8	30	29	4.5	4.0	2.6	2.5	6.4	11.1	5.23%	AP on nights
	Ward 25	21	19	2.6	2.6	2.0	1.2	7.3	9.5	3.51%	
	Ward 34	32	25	3.3	4.9	2.0	4.3	7.5	12.5	4.51%	6 beds closed extra HCA on Nights
	Ward 35	26	24	4.9	3.4	2.1	2.4	4.8	8.2	4.14%	
	Ward 36	32	30	4.9	4.6	2.9	3.2	6.1	10.3	2.85%	
	Allerton	26	26	3.6	2.7	2.0	1.8	7.2	13.0	7.21%	
	Gara	21	16	2.4	1.7	2.0	0.9	6.6	8.0	4.39%	

Figure 1b - Care Hours per Patient Day January – March 2018

Row Labels	Average of Required CHPPD	Average of Actual CHPPD	Average of % Temp staff	Sum of Task Total	Falls	Hospital Acquired PU Grade 2	Hospital Acquired PU Grade 3	Red Flags
PCAU	6.03	9.43	15.72%	118	3	0	0	3
JC06	6.04	5.66	3.30%	96	16	3	0	1
Ward 7	5.99	5.91	14.97%	0	9	6	0	28
Ward 8	6.10	5.87	8.58%	197	15	2	0	19
Ward 25	6.66	5.52	1.95%	79	3	4	0	16
JC34	7.51	6.97	11.24%	210	11	8	0	36
JC35	6.22	6.26	3.42%	49	12	2	0	0
JC36	6.67	5.65	9.96%	55	14	4	0	47
Allerton Ward	6.30	5.53	7.13%	326	13	3	0	23
Gara	5.36	5.54	9.76%	0	9	4	0	14
Grand Total	**6.33**	**6.22**	**8.36%**	**1130**	**102**	**36**	**0**	**187**

Summary of Red Flags Reported January – March 2018

Row Labels	AMBER Beds Open	Delay in providing pain relief	Less than 2 RNs on shift	Missed 'intentional rounding'	RED Beds Open	Shortfall in RN time	Vital signs not assessed or recorded	Grand Total
PCAU	0	0	3	0	0	0	0	3
JC06	0	0	0	0	0	1	0	1
Ward 7	12	2	0	0	4	10	0	28
Ward 8	7	0	0	1	4	7	0	19
Ward 25	0	0	0	5	0	7	4	16
JC34	28	0	0	1	5	2	0	36
JC36	47	0	0	0	0	0	0	47
Allerton Ward	0	0	0	12	0	11	0	23
Gara	11	0	2	0	1	0	0	14
Grand Total	**105**	**2**	**5**	**19**	**14**	**38**	**4**	**187**

Figure 2 Acuity and Dependency Scores

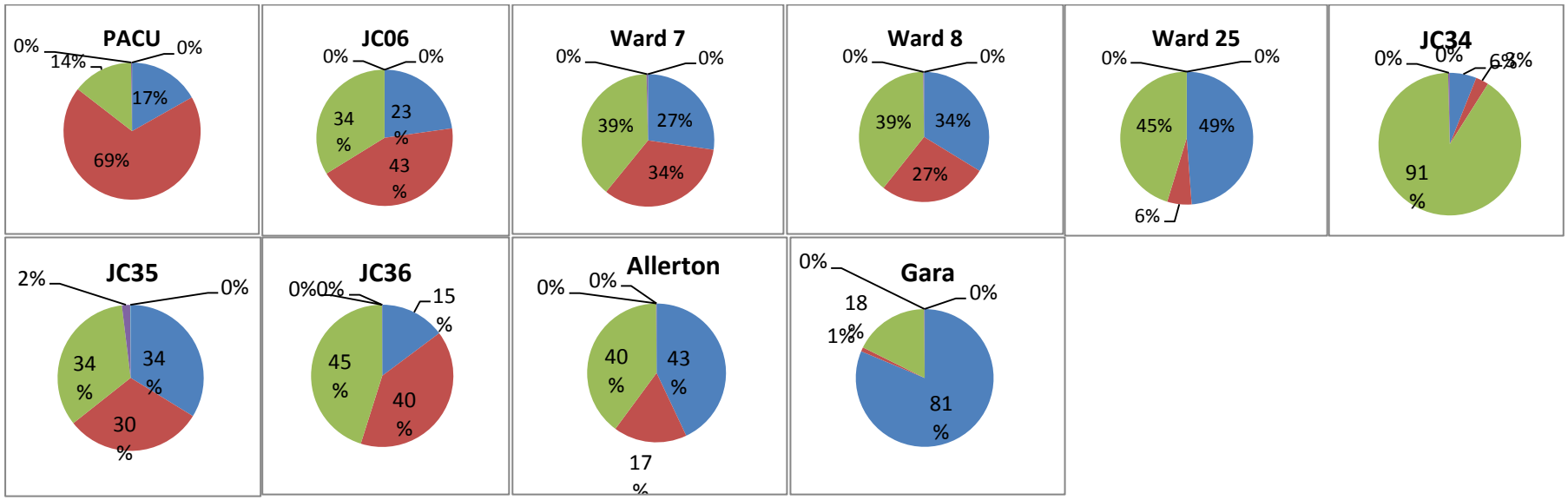


Figure 3 Establishment and Acuity Analysis

		Funded Bed Base	Average of WTE nurses recommended by multipliers	Funded WTE	Variance	Variance minus supervisory ward sister / charge nurse	Contracted staff WTE	NHSP used WTE	Sickness	Comments
Planned Care	**PCAU**	12	19.98	23.81	3.83	3.23	22.36	3.8	5.94%	AAU multipliers used
	Ward 6	24	36.71	32.47	- 4.24	-4.84	34.88	1.5	2.69%	
	Ward 7	30	42.46	42.49	0.03	0.63	39.93	5.2	2.90%	
	Ward 8	30	41.66	41.83	0.17	-0.43	37.52	11.4	5.23%	
	Ward 25	21	28.17	31.33	3.16	2.56	23.88	4.6	3.51%	
	Ward 34	32	53.25	46.88	- 6.37	-6.97	42.42	3.8	4.51%	6 beds closed
	Ward 35	26	35.51	40.31	4.80	4.20	36.93	1.6	4.14%	* 8 x 12 hour shifts per week when high risk surgery takes place requiring 1:1 care
	Ward 36	32	47.10	41.27	-5.83	-6.43	43.11	4.7	2.85%	
	Allerton	26	35.37	33.62	-1.75	-2.35	30.77	2.1	7.21%	
	Gara	21	23.44	28.12	4.68	3.68	26.98	0.9	4.39%	
			363.65	**362.13**	**-1.52**	**-6.72**	**338.78**	**39.6**		

Discussion

A review of night time RN: patient ratio is required for wards 34 and Allerton as they exceed the Trust maximum ratio of 1:12. Ward 34 already has more HCA's rostered to work nights to support RN's and ensure bay nursing can be delivered due to the dependent nature of the patient group, specifically to minimise patient falls.

Assurance regarding acuity and dependency scoring is required to ensure consistency across the surgical footprint is maintained. Whilst the funded Wte across the planned care wards in totality is generally appropriate some re-alignment between wards may be warranted.

Actions to be overseen by the Centre Associate Director of Nursing

1. Ward 35 to reduce to 20 beds with 6 Black Beds (winter escalation beds = 2.71 WTE Band 5 RN's to staff) – Complete Sep 18.
2. Ward 34 to work with the Therapeutic Care Team to pilot an alternative falls prevention approach during the summer 2018 – complete and evaluation pending
3. Ensure effective redeployment of staff is undertaken through SafeCare as required and monitor resource utilisation both within centre and externally to other centres - ongoing
4. Staff to attend a CHPPD workshop with Allocate and e-rostering to ensure full understanding of the acuity and dependency scoring process (30th June 2018) - complete
5. Peer acuity and dependency audits to take place between July and August 2018 - complete

Figure 1.Staffing Averages and Ratio

		Funded Bed Base	Average No. of Beds	Average of RNs Day	Average of HCAs Day	Average of RNs Night	Average of HCA Night	Ratio of Beds to RNs Days	Ratio of Beds to RNs Night	Sickness	Comments
Specialist Care	Ward 4	24	16	4.1	3.0	2.8	2.1	3.9	5.7	7.40%	
	Ward 5 (Vas)	19	17	2.6	3.7	2.0	2.1	6.5	8.5	4.24%	
	Ward 14	23	23	4.1	3.4	2.7	2.1	5.6	8.5	2.17%	
	Ward 24	23	16	2.2	3.4	2.9	2.8	7.2	5.5	7.57%	
	Ward 26	18	18	2.9	3.5	2.0	2.1	6.2	9.0	1.20%	
	Ward 27	15	15	3.5	3.8	2.0	3.0	4.2	7.5	3.69%	
	Ward 28	30	19	4.7	3.0	3.6	2.0	4.0	5.2	8.22%	Includes Monitored Bay (6 beds closed)
	Ward 29	27	22	3.8	3.0	2.8	1.2	5.7	7.8	4.03%	
	Ward 29 MB	9	8	2.0	1.0	2.0	0.0	4.2	4.0	1.77%	
	Ward 31	30	26	5.0	3.2	2.9	2.2	5.2	8.9	6.31%	
	Ward 33	19	18	3.6	3.6	2.8	2.1	5.0	6.4	3.51%	
	Spinal Rehab	19	19	4.4	3.9	2.0	2.0	4.3	9.5	5.12%	
	CCU	14	10	5.4	0.9	4.8	0.0	1.8	2.0	6.68%	

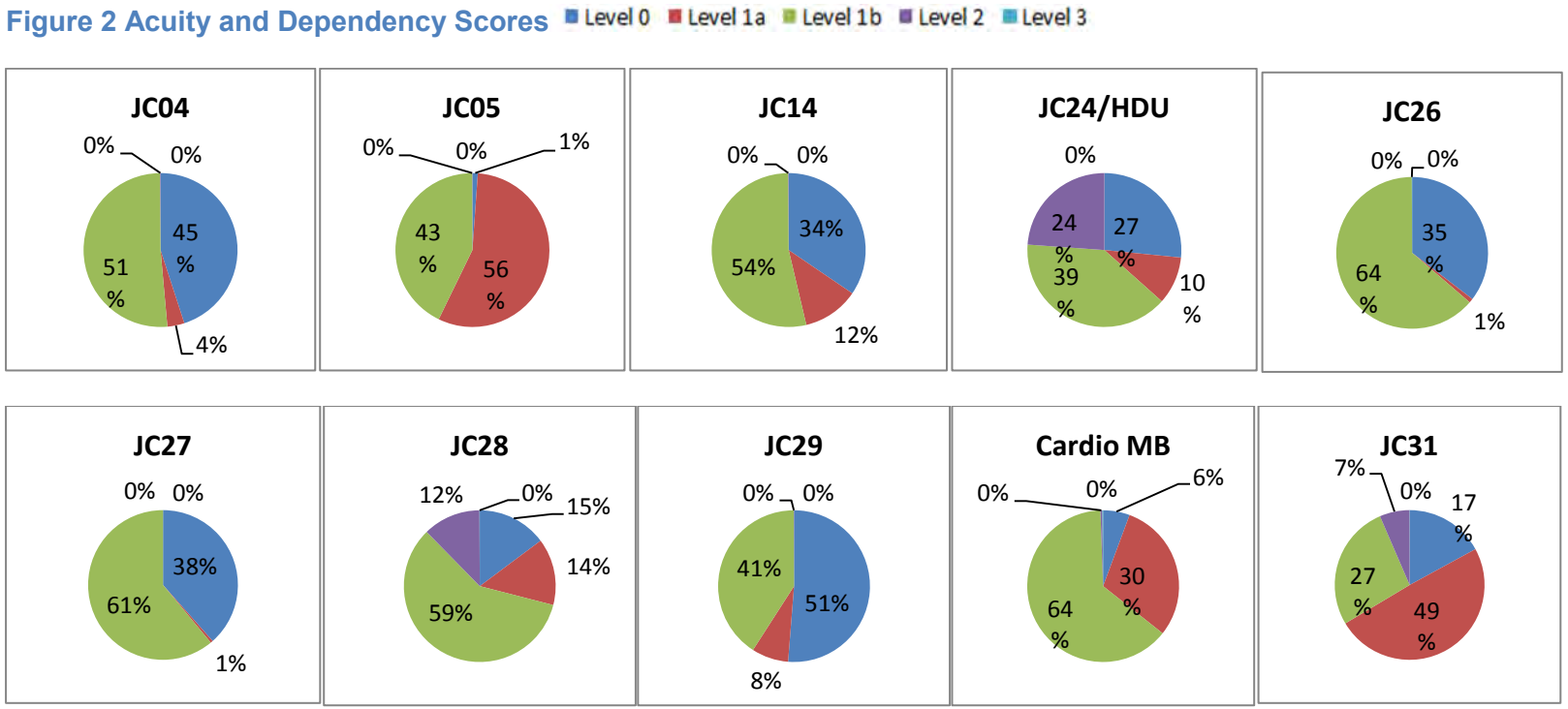
Figure 1b - Care Hours per Patient Day January – March 2018

Row Labels	Average of Required CHPPD	Average of Actual CHPPD	Average of % Temp staff	Sum of Task Total	No. of Falls	Hospital Acquired PU Grade 2	Hospital Acquired PU Grade 3	No. of Red Flags Raised
JC04	6.86	6.08	33.73	562	11	2	0	0
JC05 Vas	6.49	6.35	21.65	59	14	4	0	18
JC14 Oncology	6.92	6.47	19.49	633	17	0	0	64
JC24	7.61	9.15	17.55	260	16	4	0	1
JC26	6.48	7.40	19.09	0	10	1	0	34
JC27 Neuro	7.99	7.35	12.22	567	12	0	0	21
JC28	7.65	8.09	5.00	283	17	2	0	0
JC29 /Cardio MB	6.56	5.53	12.79	121	19	0	0	37
JC31	6.47	5.41	14.11	266	10	0	0	4
JC33 Specialty	7.07	7.93	5.43	1077	12	1	0	0
Spinal Injuries	9.78	8.26	5.11	1	2	0	0	0
CCU	11.25	12.55	0.0	4343	16	1	0	1
Grand Total	**7.26**	**7.09**		**3829**	**140**	**14**	**0**	**199**

Summary of Red Flags Reported January – March 2018

Row Labels	AMBER Beds Open	Delay in providing pain relief	Less than 2 RNs on shift	Missed 'intentional rounding'	RED Beds Open	Shortfall in RN time	Unplanned omission in providing medications	Vital signs not assessed or recorded	Grand Total
Cardio HDU	0	0	0	0	0	1	0	0	1
Cardio MB	0	0	12	0	4	1	0	0	17
CCU JCUH	0	0	1	0	0	0	0	0	1
JC05 Vas	0	0	5	1	2	10	0	0	18
JC14 Oncology	39	7	0	1	3	12	1	1	64
JC24	0	0	0	0	0	0	0	1	1
JC26	5	0	5	6	0	18	0	0	34
JC27 Neuro	19	0	1	0	0	0	0	1	21
JC29	0	0	14	0	1	22	0	0	37
JC31	0	0	0	0	0	4	0	0	4
Grand Total	**63**	**7**	**38**	**8**	**10**	**69**	**1**	**3**	**199**

Figure 2 Acuity and Dependency Scores



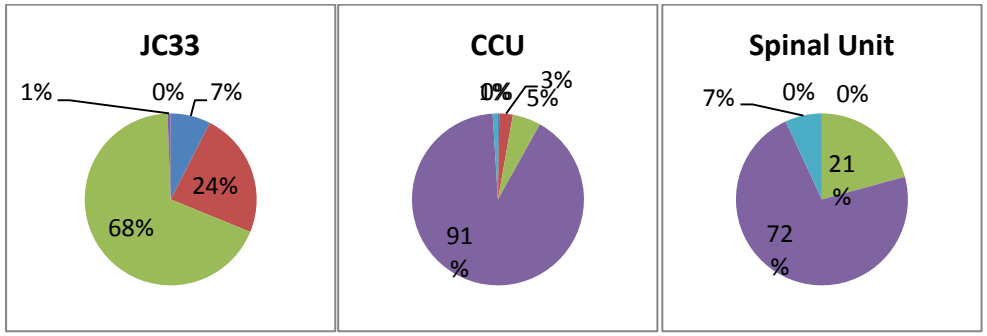


Figure 3 Establishment and Acuity Analysis

		Funded Bed Base	Average of WTE nurses recommended by multipliers	Funded WTE	Variance	Variance minus shift co-ordinator	Variance minus supervisory ward sister / charge nurse	Contracted staff WTE	NHSP used WTE	Sickness	Comments
Specialist Care	**Ward 4**	24	32.92	38.03	5.11		4.51	32.84	4.5	7.40%	Requires x1 RN (1.28Wte) 4 days per week to staff the Dialysis bay.
	Ward 5 (Vas)	19	29.05	33.84	4.79		4.19	29.17	3.3	4.24%	
	Ward 14	23	32.07	37.45	5.38		4.78	36.76	2.8	2.17%	Telephone Support Line Nights + Weekends which reduce admissions
	Ward 24	23	32.91	36.23	3.32		2.47	33.44	6.1	7.57%	
	Ward 26	18	26.58	22.58	-4.00		-4.60	22.55	0.7	1.20%	
	Ward 27	15	21.09	30.77	9.68		9.08	26.64	4.7	3.69%	Day Unit staff included in budget x1 RN and 1 HCA 5 days (3.2 Wte)
	Ward 28	30	48.36	53.62	5.26		4.66	43.91	2.7	8.22%	Monitored bay requiring 1:2 staffing. 6 beds closed
	Ward 29	27	35.56	30.79	-4.77		-5.37	30.55	1.6	4.03%	
	Ward 29 MB	9	14.09	13.55	-0.54		-0.54	13.72	0.0	1.77%	Small unit
	Ward 31	30	43.50	37.20	-6.30		-6.90	37.60	0.5	6.31%	
	Ward 33	19	29.90	40.65	10.75		10.15	36.13	2.0	3.51%	Telephone Support Line Nights + Weekends which reduce admissions
	Spinal Rehab/HDU	23	48.04	52.51	4.47	1.67	1.07	55.52	0.4	5.12%	Nationally mandated staffing levels
	CCU	14	26.75	32.29	5.54	2.74	2.14	35.26	0.0	6.68%	X1 RN to hold Cardiac Arrest Bleep and field admissions from across the region
	Total		**420.82**	**459.51**	**38.69**	**4.41**	**25.64**	**434.09**	**29.3**		

Discussion

No areas across the centre breached the safe staffing ratios but did trigger for CHPPD shortfalls. Professional judgement has been used to triangulate planned vs actual roster templates together with CHPPD on a daily basis through SafeCare to ensure patient safety.

Extra activity outside of the SNCT data collection for direct patient care is undertaken across the centre to support admission avoidance and tertiary activity. A National piece of work has been undertaken regarding spinal unit staffing across the country led by our Spinal Unit Lead Nurse which demonstrates the funded WTE to be in line with these recommendations. The recommended staffing levels for ward 33 and 27 appear anomalous and not consistent with CHPPD recommendations or national benchmark, further work in relation to data capture to be undertaken with the ward managers.

A review of acuity and dependency scoring should be undertaken together with another discussion around the use of tasks to give assurance across the centre

The funded WTE appears appropriate across the centre taking into consideration the extra activity listed in the comments section

Actions to be overseen by the Centre Associate Director of Nursing

1. Review task type recording on wards 4, 27 and CCU to ensure accuracy and understanding as this is affecting required CHPPD significantly – Q3 18/19
2. Reduced bed base on ward 29 to 21 beds and plan for 6 Black Beds during winter surge(=2.71 WTE Band 5 RN to staff)
3. Reduced bed base on ward 28 to 24 beds and plan 6 Black Beds during winter surge (=2.71 WTE Band 5 RN to staff)
4. Work with military colleagues to ensure transparency of all non-committed shifts worked across wards 5, 35 and 36 – Q3 18/19
5. Ensure effective redeployment of staff is undertaken through SafeCare as required and monitor resource utilisation both within centre and externally to other centres.
6. Staff to attend a CHPPD workshop with Allocate and e-rostering to ensure full understanding of the acuity and dependency scoring process (30th June 2018) – complete
7. Peer acuity and dependency audits to take place during July and August 2018 – complete

Conclusion

This review has utilised 3 months data extracted from SafeCare and other data systems to provide a robust review of staffing across centres.

Sickness across the nursing workforce is higher than the national average and work is continuing in conjuction with the Human Resources team to help ward managers support their staff back into work.

Results have been discussed with Centre ADoN's and action plans created, which will be monitored via the Nursing and Midwifery workforce group.

In conclusion the Board can be assured of safe staffing levels across all inpatient bed holding areas of the Trust. A daily review of staffing is undertaken by Centre ADoN's and Clinical Matrons 7 days per week with staff redeployment actioned to match patient acuity and dependancy.

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South Tees Hospitals NHS
NHS Foundation Trust

Board of Directors	
Agenda item	3.5.2
Title of Report	Nurse Staffing Review (Paediatric Inpatient Areas)
Date of Meeting	6 November 2018
Presented by	Gill Hunt, Director of Nursing and Quality
Author	Eileen Aylott, Assistant Director of Nursing, Workforce Cathy Brammer, Matron for Children's Services Yasmin Scott, Service Manager, Children's Services
Approved by	Gill Hunt
Previous Committee/Group Review	Operational Management Board
Purpose	Approval √ Decision √ Discussion √ Information √
Alignment to Trust's Strategic Objectives	☐ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	• Care Quality Commission • NHS Improvement • NHS England
Recommendation(s)	The Board is asked to approve the Nurse Staffing Review for Paediatric Inpatient Areas.

1. Executive Summary

This paper provides the first staffing establishment review of the inpatient paediatric wards on the James Cook University Hospital site using the newly published Children and Young People's Safer Nursing Care Tool (CYP SNCT, Shelford Group 2018).

This report provides assurance to the Board of safe staffing levels across the paediatric ward areas (Ward 21 and 22 JCUH) during the time of data collection (June 2018).

2. Recommendation

The Board is asked to approve the Nurse Staffing Review for Paediatric Inpatient Areas.

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1. Purpose

The purpose of this report is to share the results of the patient acuity and dependency data collected between 1 and 30 June 2018 in the inpatient paediatric wards on the James Cook University Hospital site, to discuss the findings and make recommendations.

2. Background

The requirement to ensure nurse staffing levels are safe and sufficient to meet patient need is clearly an imperative. The Francis enquiry (2013) and subsequent government response 'Hard Truths' (2014) have emphasised the need to get staffing levels right, with seminal papers from Keogh (2013) and Berwick (2013) clearly linking nurse staffing levels to patient safety, outcome and experience. Inadequate nurse staffing has been a recurring theme in organisations where patient care has been found to be substandard.

Board ownership is very clear with the National Quality Board (NQB 2013) setting out explicit expectations in terms of Board ownership and public visibility advocating public Board level discussion to ratify and agree nurse staffing levels. The NQB was revised in June 2016 to include recommendations from both the Five Year Forward View and the Carter Review (2016).

In 2018 The Shelford Group published The Children's & Young People's Safer Nursing Care Tool (C&YP SNCT) which is an adaptation of the SNCT for adult inpatient wards developed in 2006 and updated in 2013. It was devised to inform evidence-based decision making on staffing in all Children and Young Peoples in-patient wards (appendix 1).

The C&YP SNCT is based upon, but not aligned to, the Paediatric Intensive Care Society classifications (Paediatric Intensive care Society 2010). These classifications have been adapted to support measurement across a range of C&YP wards/specialties.

No national workforce tool can incorporate all factors and therefore triangulation is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide balanced assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT.

Wards 21 and 22 are acute paediatric medical and surgical wards within the Community Care Centre and have 25 and 17 beds respectively. Ward 21 is an acute 25 bedded inpatient area for children requiring medical inpatient care. The beds often flex particularly in the winter to manage patient demand. Children have typically been through a triage assessment before admission to the ward area with the usual route of admission being from the Accident and Emergency Department or the Paediatric Day Unit.

The nature of the specialty does however mean that there are patients who do not need to stay overnight but do require reassessment and a period of observation and pre or post treatment. Children can improve or deteriorate over short periods of time and for this reason the unit does cater for children with a zero length of stay.

Ward 22 is a multi-specialty surgical ward catering for children requiring emergency trauma care and elective surgery. There are a variety of orthopaedic, general surgical, ENT, plastics, urology, spinal and neuro-surgery patients with multiple theatre lists each day. The unit as a whole

accommodates children from 0 to 18 years of age with a dedicated young person's area and flexes between beds and cots depending on patient need.

As well as the standards for staffing as set by the SNCT, the Royal College of Nursing staffing guidance (RCN 2013) for Paediatric areas is available to benchmark against. This guidance stipulates a set of Core standards to be applied in services providing health care for children and young people.

3. Challenges

The average bed occupancy is based on midnight occupancy which does not take into account multiple attendances throughout the day and shorter lengths of stay. The tool guidance stipulates that the patient with the highest acuity during the period should be recorded for each bed. This is the same principle as in the adult areas where multiple patients may be admitted and discharged through each bed space.

There is increased activity during the winter period (up to a 35% increase) with a requirement to flex resource to meet demand, this can be challenging and the SNCT will be invaluable to support decision making and safe and effective use of nursing resource.

There is a perception that children have carers present at all times, however this is not the reality on the JCUH site. Generally, 25% of patients are aged less than 2 years and children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Highly complex social and child protection issues are managed daily and often account for children being unaccompanied on the wards. This also generates a need for ward based staff to attend meetings and coordinate pathways as there is not a dedicated discharge coordinator / social worker for paediatric patients and this may be an area for future work.

A number of children have significant complex conditions which require higher ratios of nursing care regardless of age due to acuity e.g. tracheostomy, respiratory support, neuro disability. There is a focus on family centred care and teaching and supporting parents and carers to look after children affected by illness to enable safe discharge home also impacts on nurse time. There is also a need for calculation of medication doses based on a child's weight and a system of two registered nurses checking dosage and administering all medications jointly in line with best practice guidance.

4. Methodology

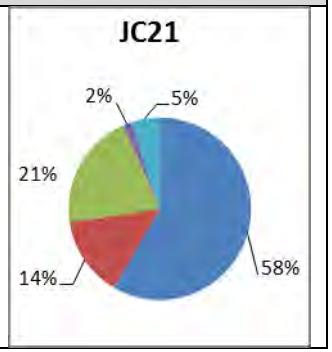
During development of the SNCT staffing recommendations were evaluated for a 28 day Monday - Sunday period and a 20 day Monday - Friday period. This demonstrated no statistical significant difference in the results. Therefore a minimum of 20 days is the recommended timeframe for data collection.

Data for this report was collected each day Monday – Friday for a total of 20 days.

- Acuity and dependency data was scored by staff at 3pm daily using the data collection sheets provided (C&YP SNCT Levels of Care Criteria appendix 1)
- Three senior staff members were trained to use the tool to ensure consistency in data submission
- Sickness rates, NHSP (Nurse Bank) temporary staffing hours, funded and contracted staff hours were provided by the appropriate teams.
- Tasks were recorded daily to include admissions and discharges, transfers on and off site
- RN, HCA and Student numbers were recorded by shift.

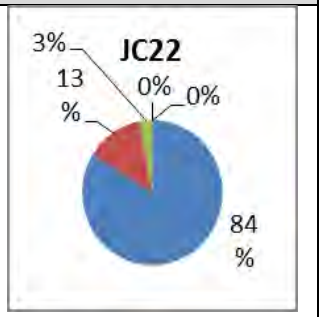
CYP SNCT Results June 2018 (21% Headroom) Ward 21 – 25 Beds

Average midnight bed occupancy for June was 17.6. Staffing actual and required based on this number of occupied beds is below

Staff role	Current budget	CYP SNCT staffing results based on June Occupancy	Variance	Acuity of patients
Ward Manager	1	0.6 (as tool allows 0.2)	+ 0.2	
Coordinator band 6	2		+ 2	
RNs	30.2	27.9	+ 2.3	
HCA 2/4	7.23	12	- 4.77	
Play staff	1.2 excluded in requirements			
Totals	40.43 Wte (excluding play staff)	40.5 Wte	- 0.27	

CYP SNCT Results June 2018 (21% Headroom) Ward 22 – 17 beds

Average midnight bed occupancy for June was 11.5 . Staffing actual and required based on this number of occupied beds is below

Staff role	Current Budget	CYP SNCT staffing results based on June Occupancy	Variance	Acuity of patients
Ward manager	0.91	0.6 as tool allows 0.2	- 0.09	
Coordinator band 6	0.91		+ 0.91	
RNs	16.04	15.08	+ 0.96	
HCA's 2/4	5.73	6.8	- 1.07	
Play staff	0.8 (excluded in requirements)			
Totals	23.59 wte (excluding play staff)	22.48 Wte	+ 1.11	

Conclusion

This is the first review in the C&YP inpatient ward areas using the SNCT and provides a baseline assessment. The review has been undertaken during the summer months and demonstrates that staffing levels matched patient numbers, acuity and dependency. Clearly consideration needs to focus on the expected winter demand and ensuring a flexible and responsive workforce able to meet patient need.

The ward staff are supported by the Therapeutic Care Team who provide an apprentice (TCSW) to ward 21 for 4 days per week between the hours of 9am and 3pm. Therapeutic Volunteers also attend both wards morning and afternoon (minimum of x 2) to support children by playing games, sitting with unaccompanied children and providing help to bottle feed if required. Extra support may be provided when the team receive a telephone call from either ward for help when the number of unaccompanied children increases.

There is a professional view that a Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team, to advise on clinical nursing issues relating to children across the organisation 24-hours a day, this is a recommendation in the Royal College of Nursing staffing guidance for children and young people (RCN 2013). The Service Manager and Matron will produce an options paper to be considered initially within Centre.

To ensure safe staffing, daily staffing meetings are held to incorporate all areas of paediatrics and neonates and staff are redeployed across the floor according to patient need. Escalation prompts have been written and are in place to manage this process with beds used flexibly to respond to demand.

Actions

- Options to support a B6 co-ordinator role to be presented through Centre Board – Action Yasmin Scott / Cathy Brammer by December 18.
- Ensure sufficient HCA's are signed up with NHSP to provide flexibilty if needed during winter surge – Cathy Brammer by November 18.
- Use SNCT to inform staffing decisions on a daily basis when Allocate Software agree a contract to input the multipliers into SafeCare – TBC.
- Repeat data collection during January 2019 – Eileen Aylott / Cathy Brammer.

Appendix 1.

Children's & Young Peoples Safer Nursing Care Tool - Decision Matrix

Levels of Care	Descriptor
Level 0 Child/young person requires hospitalisation - needs met through normal inpatient care	**Care requirements may include the following** • Oxygen therapy less than 40% and patient stable • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care – observations recorded half hourly initially then 4-hourly. • Regular observations 2 – 4 hourly • Basic fluid Management • Intravenous Medication Regimes – (NOT requiring prolonged preparation/ administration/post-administration care) • **Early Warning Score** is within normal threshold.
Level 1a Child /young person is acutely ill requiring close supervision and monitoring, or is **unstable** with a **greater potential** to deteriorate usually available through normal inpatient care	**Care requirements may include the following** • Oxygen therapy greater than 40% +/- Chest Physiotherapy six hourly • Respiratory care requiring two hourly nebulised medicine • Stable nasopharyngeal airway • Post op care following complex trauma/surgery in acute phase • Patient within 24 hour of returning from PICU/ICU • Instability requiring increased level of observation and therapeutic intervention or continual observation • Patient on PCA/NCA/Epidural • Emergency Admissions requiring immediate therapeutic intervention. • **Early Warning Score** - trigger point reached and requiring escalation.
Level 1b Child/young person is **stable** but dependent on nursing care interventions/ intensive therapy to meet most or all their care.	**Care requirements may include the following** • Unaccompanied children • Established High Humidity, High Flow Nasal Cannula (HHHFNC) • Recurrent apnoea-self resolving • Stable patient requiring two hourly blood sampling • Post op care following complex trauma/surgery in rehab phase • Complex wound management requiring more than 1 nurse or takes more than 1 hour to complete. • Spinal Instability/Spinal Cord injury – rehab phase • Mobility or repositioning difficulties requiring two staff • Complex Intravenous Drug Regimes – (including those requiring prolonged preparation/administration/post-administration care) • Patient and/or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome or high level of emotional support • End of life care • Confused children/young people who are at risk or requiring constant supervision • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse • High level Safeguarding input • Tracheostomy – post seven-days.

Level 2 Child/young person who may require closer observation & monitoring than is usually available through normal inpatient care.	**Care requirements may include the following** • CPAP/ BiPAP • Unstable nasopharyngeal airway • Tracheotomy- initial seven days • Instability requiring a range of therapeutic interventions and invasive monitoring • Respiratory care requiring IV therapy • Unstable diabetic ketoacidosis • Single organ monitoring and support • Exchange transfusions • Chest drains • Hypovolaemic/neurogenic shock • Complex fluid +/or electrolyte management • Glasgow coma scale 8-12 • Prolonged seizures requiring intervention • Recurrent apnoea requiring intervention • Patients requiring NIV/respiratory support as a step down from level three care or acute illness phase
Level 3 Child/young person is unstable and requires advanced respiratory and therapeutic support for multiple organ problems.	**Care requirements may include the following** • Monitoring and Supportive Therapy for Compromised/Collapse of two or more Organ/Systems • Respiratory or CNS depression/compromise requires Invasive ventilation • Children requiring advanced respiratory support whilst awaiting transfer i.e. PICU admission. • CPAP/BiPAP Tracheotomy- initial seven days in a single room facility • Active resuscitation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/ haemorrhage/sepsis or neuro-protection • Child/Young person receiving 1:1 nurse 'specialing'

Board of Directors	
Agenda item	4.1
Title of Report	Corporate Governance Board and Board Committee Structure Review
Date of Meeting	6 November 2018
Presented by	Chief Executive/Chairman
Author	Company Secretary
Approved by	Chief Executive
Previous Committee/Group Review	Operational Management Board
Purpose	Approval √ Decision ☐ Discussion ☐ Information √
Alignment to Trust's Strategic Objectives	☐ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	NHS 2006 Act as amended by the 2012 Health and Social Care Act NHS Improvement - Trust's Licence Care Quality Commission
Recommendation(s)	The Board is asked to approve the changes to the Trust's Corporate Governance Policies.

1. Executive Summary

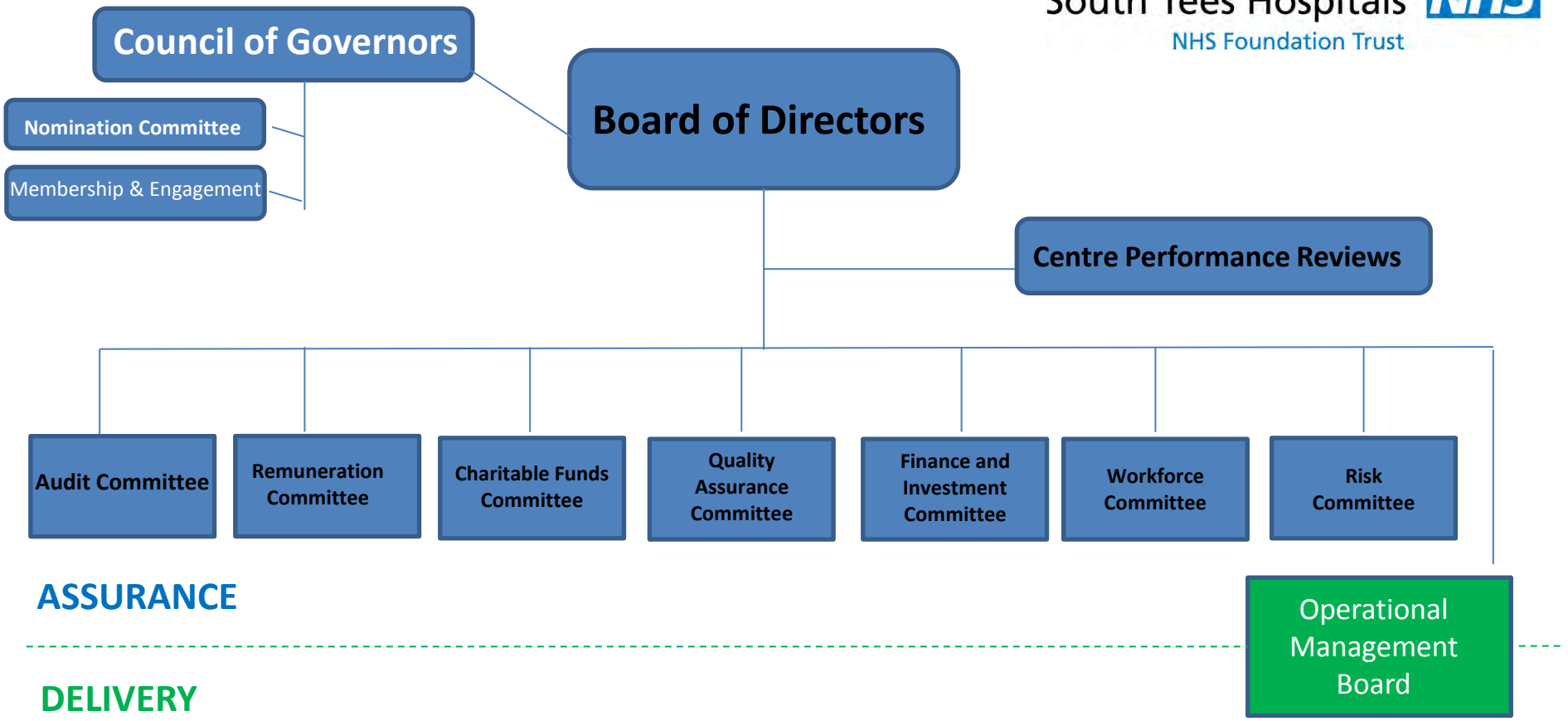
Following a review of the Trust's corporate governance structure changes have been made to the reporting lines to clearly define Operational Management Board's oversight and management of operational delivery groups. The operational groups will continue to provide assurance to Board Committees.

The diagrams appended aims to display the reporting arrangements which are supported by revised Terms of Reference. The Terms of Reference for the Board Committees and Operational Management Board will be presented to the next meeting for endorsement following their review and approval by individual Committees.

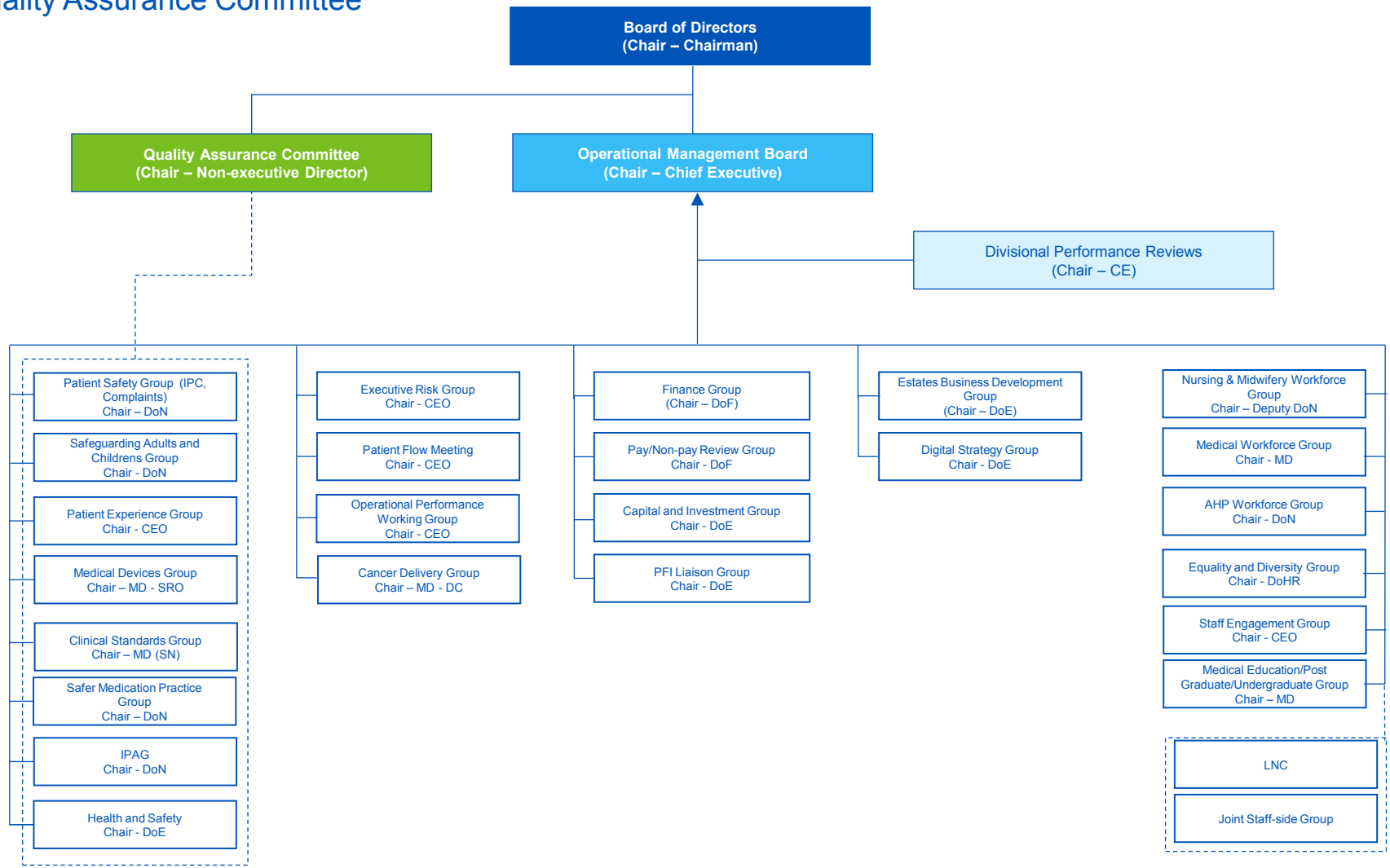
2. Recommendation

The Board is asked to approve the revised Trust's corporate governance structure.

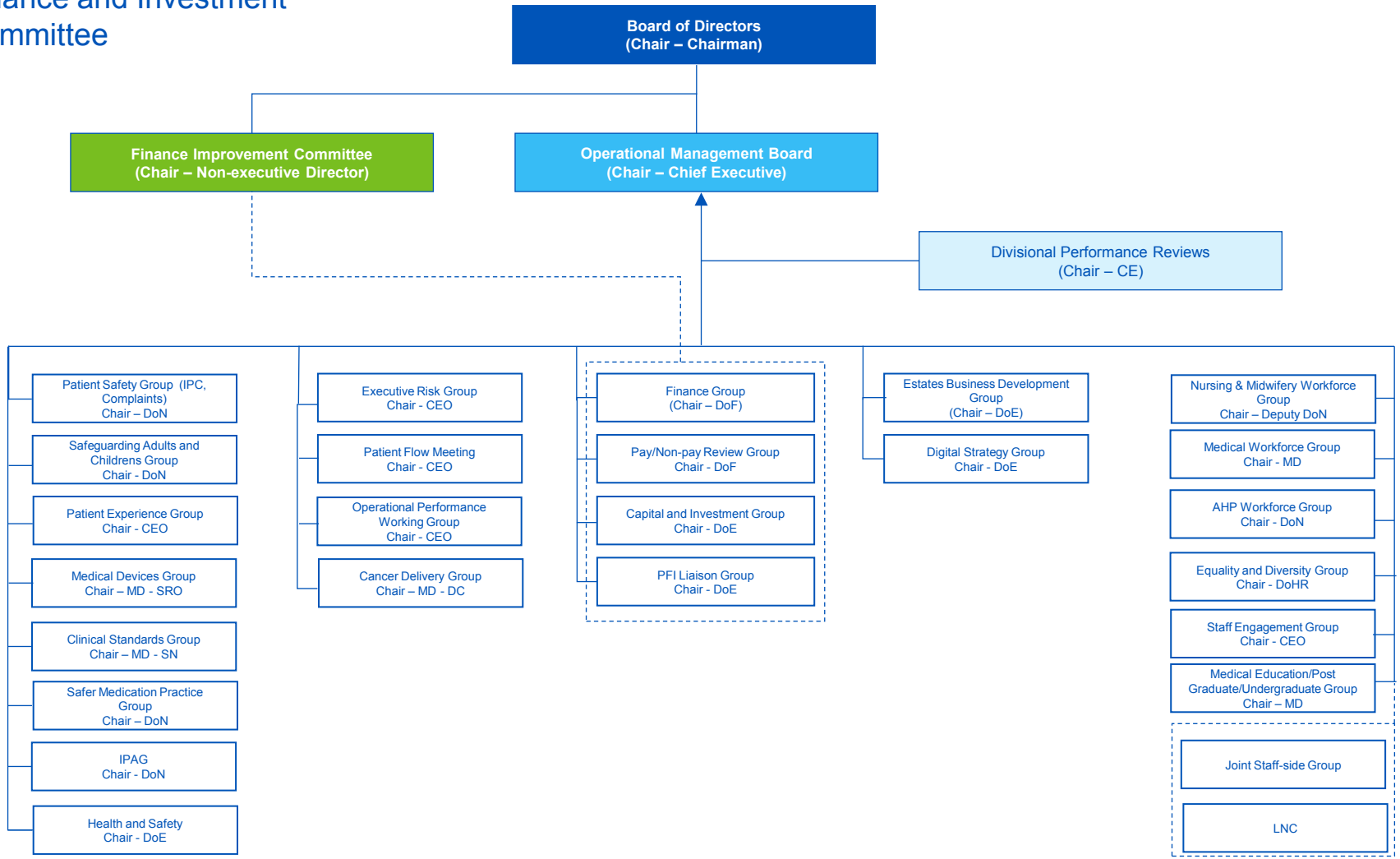
South Tees Hospitals NHS
NHS Foundation Trust



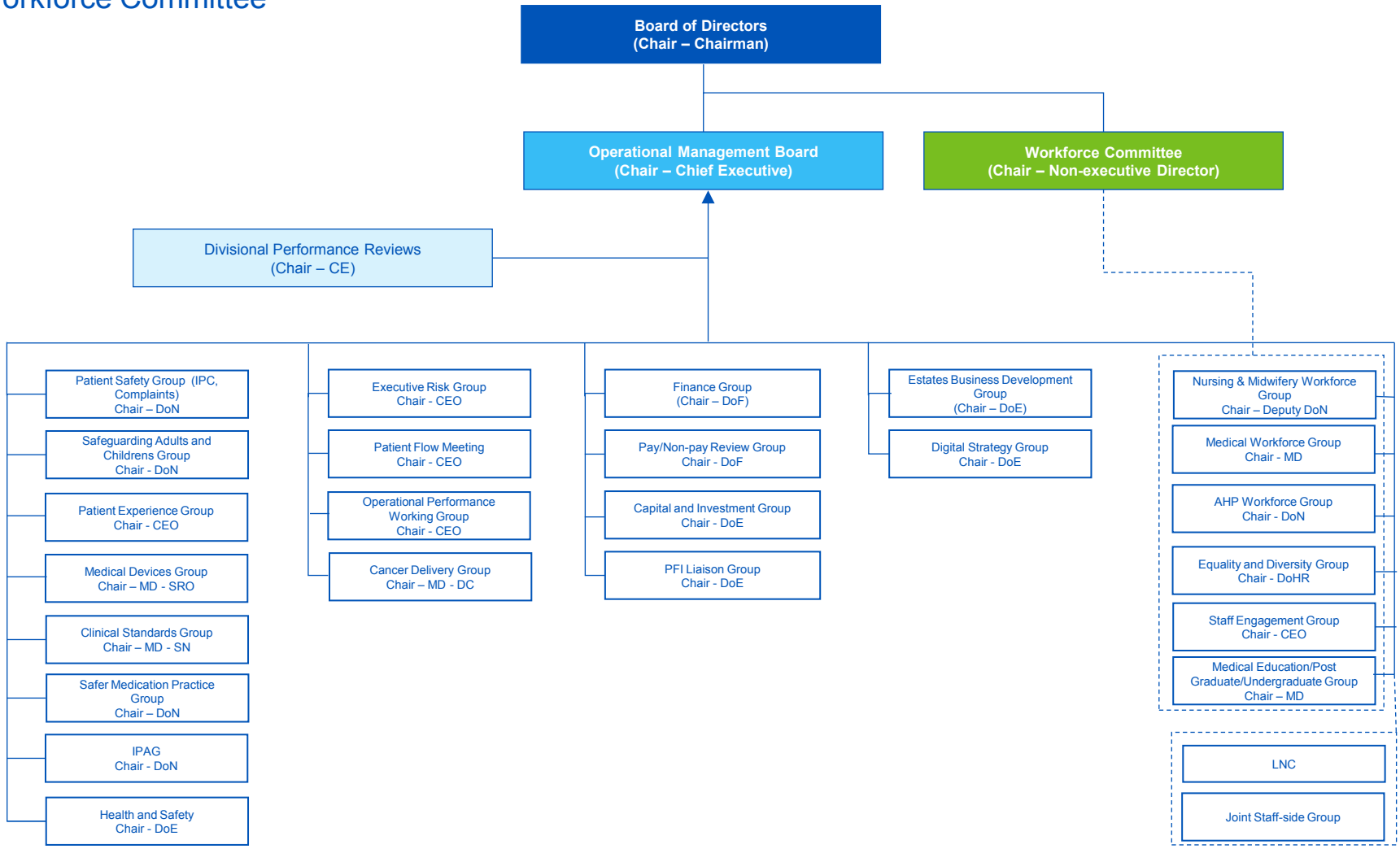
Quality Assurance Committee



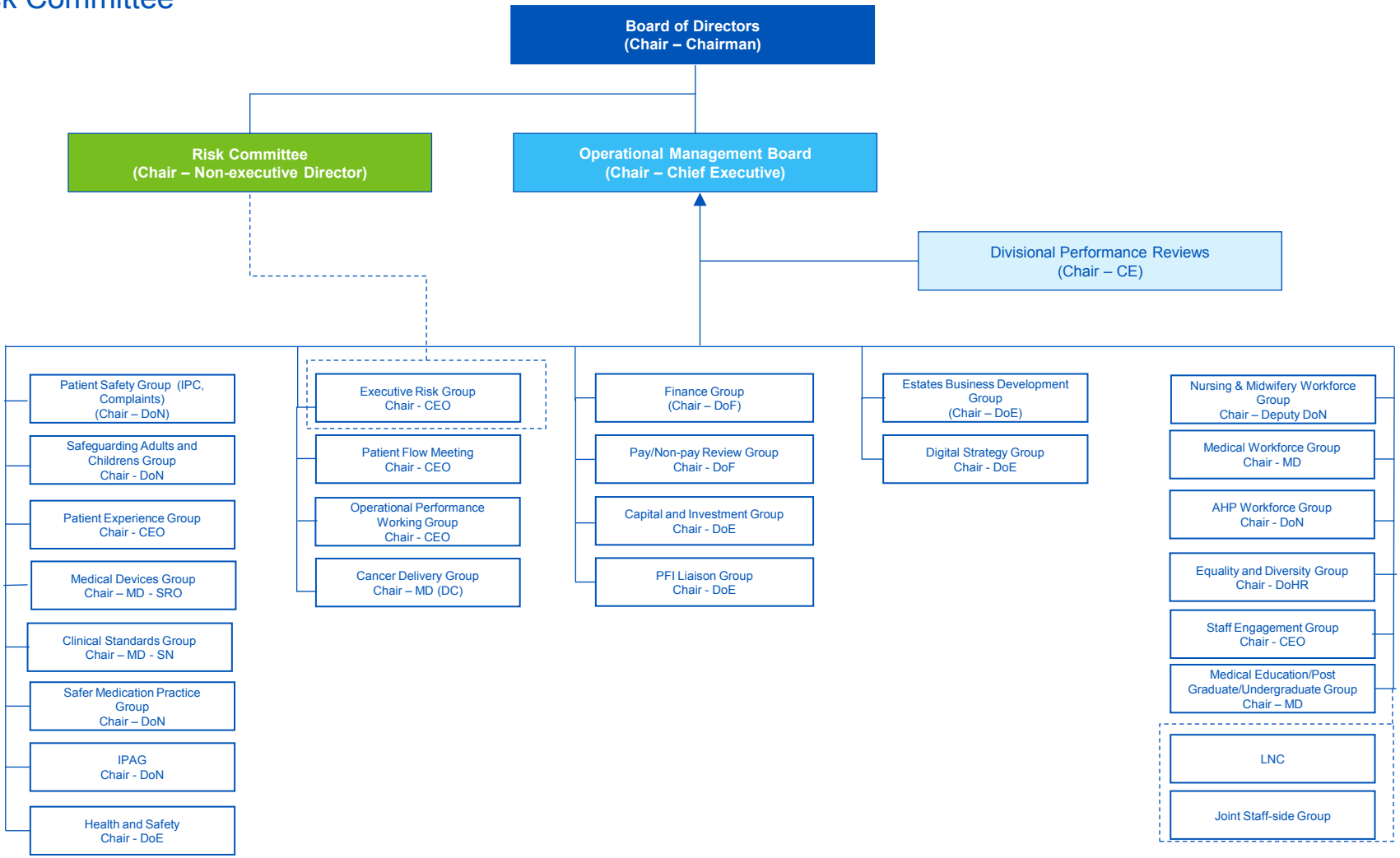
Finance and Investment Committee



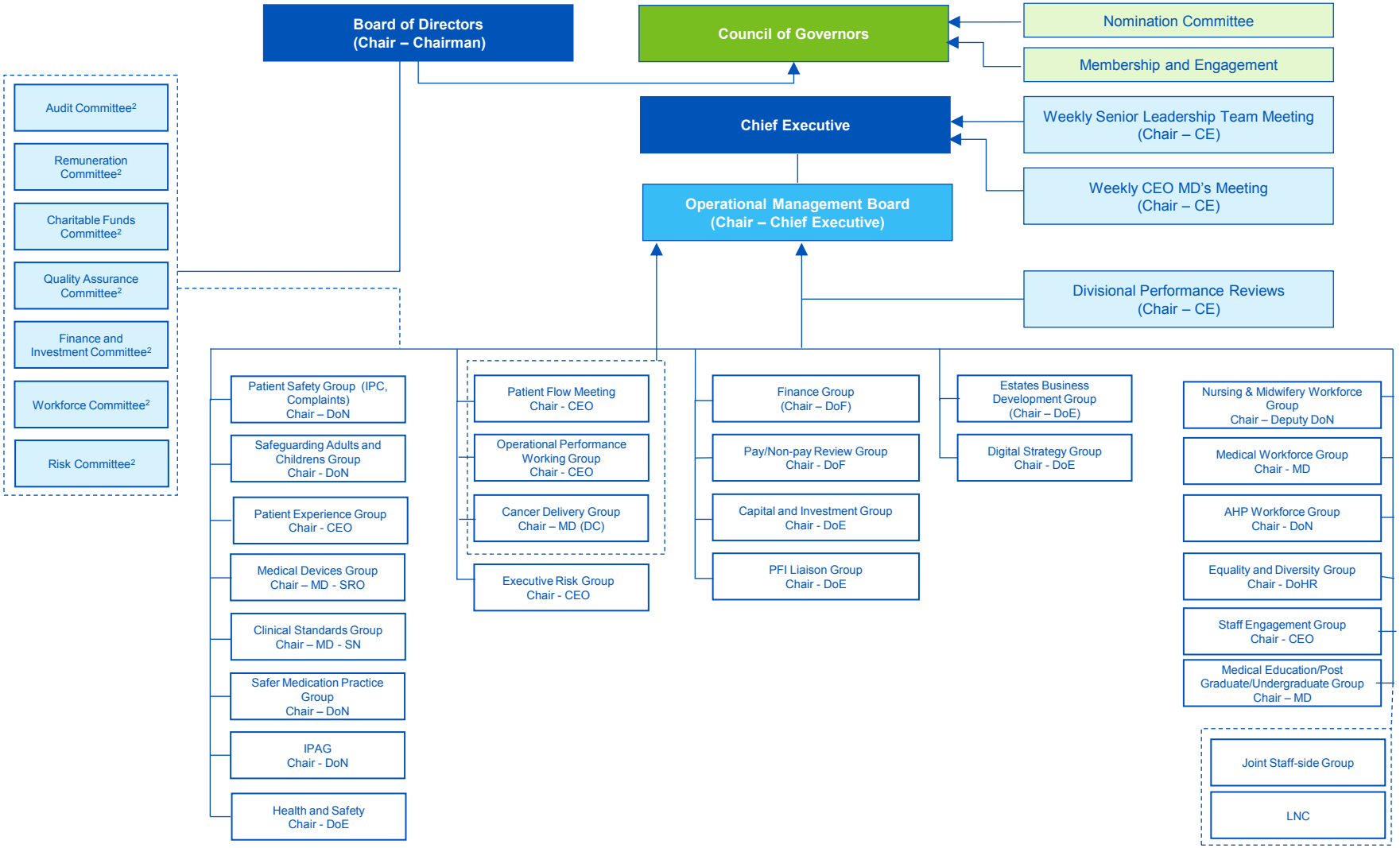
Workforce Committee



Risk Committee



Operational Management Board



Board of Directors	
Agenda item	4.2
Title of Report	Standing Financial Instructions and Corporate Governance Policies
Date of Meeting	6 November 2018
Presented by	Steven Mason, Director of Finance
Author	Luke Armstrong, Finance Business Partner
Approved by	Steven Mason, Director of Finance
Previous Committee/Group Review	Audit Committee
Purpose	Approval √ Decision ☐ Discussion √ Information √
Alignment to Trust's Strategic Objectives	☐ 1. We will deliver excellence in patient outcomes and experience ☐ 2. We will drive operational performance to deliver responsive, cost effective care ☐ 3. We will deliver long term financial sustainability to invest in our future ☐ 4. We will deliver excellence in employee experience to be seen as an employer of choice ☐ 5. We will develop clinical and commercial strategies to ensure our long term sustainability
Alignment to Board Assurance Framework	-
Legal/Regulatory Compliance Requirements (if applicable)	NHS Act 2006 NHS Improvement - Trust's Licence
Recommendation(s)	The Board is asked to approve the changes to the Trust's Corporate Governance Policies.

1. Executive Summary

The purpose of this report is to provide an update on the review of the Trusts Standing Financial Instructions and Corporate Governance policies and procedures. The recommendations are detailed below with all changes previously considered and endorsed by the Trust's Audit Committee and Senior Leadership Team. Provided attached are the key documents which include tracked changes to highlight changes to the original versions.

2. Recommendation

The Board is asked to approve the changes to the Trust's Corporate Governance Policies.

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1. Summary of Losses and Special Payments

The Trust's three key Corporate Governance policies are due for review the key documents are outlined below along with the key changes made to each. Other minor amendments have been completed to job titles and Committee Names.

Standing orders of the Board of Directors

- Update regarding the Trusts revised constitution to align to the Health and Social Care Act 2012 and mirror the constitution approved by the Trusts Board in June 2018.

Standing Financial Instructions & Decisions reserved for the Board and scheme of Delegation

- Revised business case approval process. All business cases for both capital and revenue to be presented and approved by the below committees based upon the value of the business case.
    - <£100k Capital and Investment Group
    - £100k - £2.0m Finance and Investment Committee
    - >£2.0m Board of Directors

- Alignment of procurement ordering approval values to those in operation as outlined below
    - <£5k – Service Manager
    - £5k - £50k Operations Director
    - £50k - £100k – Medical Director / Executive Director
    - £100k - £250k Director of Finance
    - >£250k Chief Executive

- Requirement to tender for purchases reduced from £50k to £25k to align with Public Sector Tendering requirements. When tendering requirements are not followed under a single tender action this will be approved by the Director of Finance and Chief Executive it will no longer require approval of the Chair.
- Approval to recruit to posts outside the Trusts establishment required to be approved by the Director of Finance and Director of HR.
- Approval to engage with Agency staffing now references to adhere to current NHSI price caps.
- Approval to engage with Management Consultancy references NHSI requirements for a business case if the value is in excess of £50k.
- Requirement for redundancy payments to be approved by the Director of Finance and Director of HR below £100k, over this value approval is required by the Chief Executive and Remuneration Committee.
- The purchasing of shares is required to be approved by the Board.

South Tees Hospitals NHS
NHS Foundation Trust

CORPORATE GOVERNANCE POLICY

Document No: CG02
***All Sites**

STANDING FINANCIAL INSTRUCTIONS

TITLE	Standing Financial Instructions
Version:	3~~2~~
Final Approval by: Board of Directors **Date:**	~~06/12/2016~~
Author/lead responsible for policy:	Chairman and Chief Executive
Date issued:	~~December 2016~~
Review date:	September 2020~~March 2018~~
Target audience:	Board Members Trust Senior Staff
Amendments and Additions	Updates for Trust Constitution Revision of financial approval limits ~~Updated to reflect new committee structures, revised tendering and quotation authorisation levels, new Centres and job title changes.~~Updates to job titles
Replaces/supersedes:	Version 2~~1~~
Associated Policies:	Standing Orders of the Board – CG01

Issued by:

Chief Executive

Standing Financial Instructions

Contents

1. Introduction

1.1 General

NHS Improvement sets the terms of authorisation for South Tees Hospitals NHS Foundation Trust (the Trust), that require compliance with the principles of best practice applicable to corporate governance within the NHS/Health Sector, relevant codes of practice and guidance issued by NHS Improvement .

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

1.1.2 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. These are~~-~~ **not** detailed procedural advice notes. These standards should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

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

1.1.4 Failure to comply with Standing Financial Instructions and Standing Orders is a disciplinary matter that could result in dismissal.

1.2 Overriding standing Financial Instructions

If for any reason the Standing Financial Instructions are not complied with, full details of the non-compliance, 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. All members of the Board of Directors, known as 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.

2. Definitions

2.1 Any expression, to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions.

Trust	South Tees Hospitals NHS Foundation Trust
Board	The Board of Directors of the South Tees Hospitals NHS Foundation Trust.
Budget	A resource, expressed in financial terms, sanctioned by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Budget holder	The Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
Chief Executive	The Accountable Officer of the Trust.
Director of Finance	Chief Finance Officer of the Trust.
Executive Director	A person appointed as a director in accordance with the constitution with day-to-day operational responsibility for the Trust. Executive Directors are voting members of Board.
Funds held on Trust	Funds held in the name of the Charity separately from the Trust arising from donations, gifts, legacies and endowments which have been made in line with charitable legislation. These funds are managed in accordance with the objectives of the fund.
Legal adviser	A person qualified in law and appointed by the Trust to provide legal advice.
NHS Improvement	The independent regulator of NHS Foundation Trusts (Monitor merged with the TDA and the merged bodies is called NHS Improvement from April 2016).

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

2.3 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.

3. Roles and Responsibilities (Duties)

Role	Responsibilities
Chief Executive	a) Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as the Accountable Officer to NHS Improvement. The Chief Executive is~~, also~~ accountable for ensuring that the Board meets its obligation within the available financial resources. b) The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control. c) The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control. It is a duty of the Chief Executive to ensure that members of the Board and employees are notified of and understand their responsibilities within these instructions.
Board of Directors	The Trust shall at all times remain a going concern (assessment that the Trust will continue in operation for the foreseeable future and not go into liquidation and cease trading) as defined by the relevant accounting standards in force. The Board exercises financial supervision and control by: a) formulating the financial strategy; b) requiring the submission and approval of the Annual Plan; c) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation; d) Developing strong budgetary control, cash and treasury management procedures. The Board has resolved that certain powers and decisions may only be exercised by a formal session of the Board. These are set out in the decisions reserved to the Board document. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of

	Delegation adopted by the Trust.
Director of Finance	The Director of Finance is responsible for: a) Developing, implementing, maintaining and updating the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies; (The SFIs themselves do not provide detailed procedural advice. These statements should be read in conjunction with the detailed departmental and financial procedure notes for which the Director of Finance is also responsible for development and maintenance). b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time. The duties of the Director of Finance include: a) the provision of financial advice to other members of the Board, Council of Governors and employees; b) the design, implementation and supervision of systems of internal financial control and the preparation and maintenance of such accounts, estimates, models, programmes, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
Board members and employees	All directors and employees, individually and collectively, are responsible for: a) the security of the property of the Trust; b) avoiding loss; c) exercising economy and efficiency in the use of resources; d) conforming to the requirements of Standing Orders, Standing Financial Instructions, financial procedures and the Scheme of Delegation.
Contractors and their employees	Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to

	expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this. For any directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

4. Audit

4.1 Audit Committee

4.1.1 In accordance with Standing Orders, the Board has formally established an Audit Committee, of a minimum of three non-executive directors to monitor the exercise of the financial auditor's function, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

a overseeing internal audit, external audit and counter fraud services;

b reviewing financial and information systems, monitoring the integrity of the financial statements and reviewing significant financial reporting judgements;

c review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

d monitoring compliance with Standing Orders and Standing Financial Instructions;

e reviewing schedules of losses and compensations and making recommendations to the Board;

f Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

The Board shall satisfy itself that at least one member of the Audit Committee is a qualified accountant with a recognised CCAB professional body with recent and relevant financial experience.

4.1.2 Where the Audit Committee considers there is evidence of an inappropriate transaction, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board, exceptionally, the matter may need to be referred to NHS Improvement (unless there are counter fraud or criminal issues (see section 15), the matter should be raised with the Director of Finance before Board).

4.1.3 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 an Internal Audit service provider is changed.

4.2 Fraud and corruption

4.2.1 In line with their responsibilities, the Chief Executive and Director of Finance will monitor and ensure compliance with Secretary of State directions on fraud~~-~~, bribery and corruption which are replicated in the Department of Health's base model contract for Foundation Trusts.

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

4.2.3 The LCFS shall report to the Director of Finance and shall work with NHS Protect staff as required, in accordance with the NHS Protect Anti-Fraud Manual.

4.2.4 Security management

a The Chief Executive will monitor and ensure compliance with directions issued by the Secretary of State for Health on NHS security management.

b 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 and the NHS Security Management Manual.

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

d The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated by the Chief Executive to the Director of Estates, Facilities and ICT ~~Nursing~~ responsible for security management and the appointed (LSMS).

4.3 Director of Finance

4.3.1 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 and the coordination of other assurance arrangements;

b ensuring that the Internal Audit function is adequate and meets the Audit Code for NHS Foundation Trusts;

c deciding at what stage to involve the police in cases of misappropriation and other irregularities;

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 statement on the effectiveness of internal control;

ii major internal financial control weaknesses discovered;

iii progress on the implementation of Internal Audit recommendations;

iv progress against plan over the previous year;

v strategic audit plan covering the coming 3 years; and

vi a detailed plan for the coming year.

4.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b access at all reasonable times to any land, premises or members of the Board, Council of Governors or employee 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.

4.4 Role of Internal Audit

4.4.1 Internal Audit will review, appraise and report upon:

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

b The adequacy and application of financial and other related management controls;

c The suitability of financial and other related management data;

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

i fraud and other offences;

ii waste, extravagance, inefficient administration;

iii poor value for money or other causes.

e Independently verify the assurance statements in accordance with guidance from the Department of Health or NHS Improvement.

f Reporting on the standards for better health in accordance with guidance from the Care Quality Commission (CQC).

4.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the

exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

4.4.3 A Director from the provider of Internal Audit services 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. The Director of Internal Audit services 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 services. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

4.5 External Audit

4.5.1 The External Auditor is appointed by the governing body and paid for by the Trust.

4.5.2 The Trust's Constitution section 35 to 37 provides details on External Audit services and their appointment. Condition 22 of the terms of authorisation outlines the Trust's responsibilities under the Audit Code.

Comment [AL(STNFT1]: Check to new constitution

4.5.3 The Audit Code for NHS Foundation Trusts ('the audit code') contains the directions of the Regulator under paragraph 24 (5) schedule 7 of the National Health Service Act 2006, with respect to the standards, procedures and techniques to be adopted by the auditor.

a The Trust shall comply with the Audit Code

b the auditor shall comply with the Audit Code

4.5.4 In the event of the external auditor issuing a public interest report the Trust shall forward a report to NHS Improvement within 30 days (or such shorter period that NHS Improvement may specify) of the report being issued. The report shall include details of the Trust's response to the issues raised within the public interest report.

4.5.5 The external audit manager will normally attend Audit Committee meetings.

5. Business planning, budgets and budgetary control

5.1 Preparation and approval of business plans and budgets

5.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

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

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

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

a be in accordance with the aims and objectives set out in the annual business plan and the commissioners' local delivery plan (LDP);

b accord with workload and workforce plans;

c be produced following discussion with appropriate budget holders;

d be prepared within the limits of available funds;

e identify potential risks; and

f be based on reasonable and realistic assumptions.

5.1.3 The Director of Finance shall monitor current financial performance, providing a forecast to the end of the financial year with a comparison against budget to date and full year as detailed in the business. Further updates are provided on cash, the capital programme and on working capital. Any significant variances should be reported by the Director of Finance as soon as they come to light and the Board shall be advised of appropriate actions required to resolve resultant issues in respect of such variances.

5.1.4 All budget holders must sign up to their allocated budgets at the commencement of each financial year and must provide information as required by the Director of Finance to enable budgets to be compiled.

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

5.2 Budgetary delegation

5.2.1 The Chief Executive will delegate the management of a budget to permit the performance of a defined range of activities. This delegation is accompanied by a clear definition of:

a the amount of the budget;

b the purpose(s) of each budget heading;

c individual and group responsibilities;

d achievement of planned levels of service; and

e the provision of regular reports.

5.2.2 The chief executive and delegated budget holders must not exceed the budgetary total set by the Board.

5.2.3 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.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without authority in writing from the Director of Finance, acting on behalf of the Chief Executive.

5.3 Budgetary control and reporting

5.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a ~~Monthly financial reports to the Board in a form approved by the Board containing:~~Financial reports to each scheduled Board meeting ~~as part of the Chief Executives update report, in a format agreed by the Director of Finance~~.

~~i Statement of Comprehensive Income to date showing trends;~~

~~ii Statement of Financial Position and cash flow update including explanation for movements with the statement, where significant;~~

~~iii capital project spend, projected outturn against plan and details of performance;~~

~~iv Forecast position on all major statements to the year end with comparison against planned budget;~~

~~v explanations of any material variances from plan/budget;~~

~~vi details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;~~

~~vii transformation programme reporting milestones and KPI's progress against the Cost Improvement Programme ; and~~

~~viii Identification of risk profiles and mediating action.~~

b The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible. ~~Challenge meetings are held with each Centre as part of the preparation of the financial report to enhance the scrutiny and review process;~~

c Investigation and reporting of variances from financial and~~,~~ workload budgets;

d Monitoring of management action to correct variances; and

e Arrangements for the authorisation of budget transfers.

f Advising the Chief Executive and the ~~Trust's~~ Board of the consequences of changes in policy, pay awards and other events and trends affecting budgets and the provision of advice on the economic and financial impact of future plans and projects

g Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Director of Finance will have access to all budget holders and budget managers on budgetary matters and shall be provided with such financial and statistical information (including information on Service Line Optimisation (SLR) and from Patient Level Information Costing Systems (PLICS) as is necessary.

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5.3.2 Each Budget Holder is responsible for ensuring that:

a any planned or known overspending or reduction of income which cannot be met by authorised virement is not incurred without the prior consent of the Board;

b officers shall not exceed the budget limit set;

c the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised; and

d no permanent employees are appointed without the approval of the Chief Executive or Director of Finance other than those provided for in the budgeted establishment as approved by the Board.

5.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual business plan and financial sustainability.

5.4 **Role of Finance and Investment Committee**

5.4.1 The role of the Committee is to maintain robust financial management by monitoring financial performance and making recommendations to the Trust Board as appropriate. The Finance Committee is a sub-committee of the Board.

5.4.2 The major duties of the Committee include:

a monitor Income and Expenditure year to date and forecast position, progress in delivering the Cost Improvement Programme, ~~Transformation Programme reports,~~ monitor Trust activity linked to income and the T~~t~~rust's financial risk profile;

b review Commissioning and Contracting, specifically key performance targets, contractual framework updates, contractual performance and make recommendations ~~t~~for action to the Board where appropriate;

c approve and monitor cash and treasury management and capital expenditure reporting; and

d receive and approve the Financial Plan for ratification by Board, receive and approve key financial policies and make recommendations to Board for individual business cases ~~with an in-year investment value greater than £1,000,000.~~with an investment value greater than £2,000,000.

5.5 **Investment expenditure**

5.5.1 The general rules applying to delegation and reporting shall also apply to expenditure on investments. (The particular applications relating to investment are contained in chapter 12).

5.6 **Monitoring returns**

5.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within the specified time-scales

6. Annual accounts and reports

6.1 Accounts

6.1.1 The Director of Finance, on behalf of the Trust, will in accordance with section 4137 of the Trust constitution:

a Prepare financial returns in accordance with the trust's accounting policies, guidance given by NHS Improvement and International Financial Reporting Standards (IFRS); and

b Prepare and submit annual financial returns to NHS Improvement each financial year certified in accordance with current guidelines and in line with the prescribed timetable.

6.1.2 In accordance with section 40 36 of the Trust's constitution, the Trust's audited annual accounts must be presented to a general meeting of the Board.

Comment [AL(STNFT2]: Check Constitution ref

6.1.3 The Trust shall:

a Lay a copy of the annual report and accounts, and any report of the auditor on them, before Parliament; and

b Once it has done so, send copies of those documents to NHS Improvement.

c Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

6.2 Annual reports

6.2.1 The Chief Executive will, on behalf of the Trust, publish an Annual Report in accordance with the Constitution and present it to a general meeting of the Board, Council of Governors and Annual General Meeting/Annual Members Meeting. The document and its submission requirements will be in compliance with the NHS Improvement's Annual Reporting Manual.

7. Banking arrangements

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS Improvement and the Trusts Treasury Management Policy.

7.1.2 The Board shall approve the banking arrangements.

7.2 Government Banking Service and other bank accounts

7.2.1 The Director of Finance is responsible for:

a Government Banking Service (GBS) accounts and other bank accounts; including forms of working capital facilities that may be available from the Department of Health.

b establishing separate bank accounts for the Trust's funds held on trust; and

c ensuring payments made from the Trust's bank accounts do not exceed the amount credited to the Trust's accounts except where arrangements have been made.

7.2.2 All accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purpose of furthering Trust activities.

7.3 **Banking procedures**

7.3.1 The Director of Finance will prepare detailed instructions on the operation of the Trust's bank accounts which must include:

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

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

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

7.3.3 Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 **Tendering and review**

7.4.1 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.

7.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board.

7.5 **Electronic transfers of funds**

7.5.1 All electronic transfers of funds must only be made under secure arrangements approved by the Director of Finance.

8. Income, fees and charges and security of cash, cheques and other negotiable instruments

8.1 **Income systems**

8.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding (both in terms of accounting and in terms of activity to maximise income) of all monies due.

8.1.2 All such systems shall incorporate, where practicable, the principles of internal check and separation of duties

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

8.2 **Fees and charges**

8.2.1 The Trust shall follow the Department of Health's advice in the NHS Costing Manual in setting prices for non-commercial contracts with NHS organisations other than those covered by the Trust Agency Purchase Contract and non-NHS organisations.

8.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards for the NHS shall be followed.

8.2.3 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.

8.3 Private healthcare

8.3.1 The Trust shall ensure that the proportion of total income of the Trust in any financial year derived from private patient charges shall not be greater than the percentage set out under the Health and Social Care Act 2012.

8.4 Debt recovery

8.4.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. This will include the use of alternative providers for the provision of debt services and external debt recovery services, where appropriate.

8.4.2 Income not received should be dealt with in accordance with losses and special payments procedures.

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

8.5 Security of cash and cheques

8.5.1 The Director of Finance is responsible for:

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

b ordering and securely controlling any such stationery;

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

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

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

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

8.5.4 Any loss or shortfall of cash, cheques or other negotiable instruments shall be reported in accordance with the procedure for losses and special payments.

8.5.6 Where there is evidence of fraud or corruption this should be dealt with in line with the Trust's Fraud and Corruption Response Plan and the guidance provided by the Counter Fraud and Security Management Service.

9. Contracting for provision of services

9.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with Standing Orders, Standing Financial Instructions, the Scheme of Delegation and be managed through the Trust's Procurement Department.

9.2 Legislation and guidance governing public procurement

The Trust shall also comply with the General Data Protection Action 2918 and ~~comply~~ with the Public Contracts Regulations 2015 (PCR 2015) and any relevant EC Directives and all requirements binding on the Trust derived from the EU Treaty relating to procurement by the Trust on the process to be applied when awarding all forms of contract. Such legislation shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

The Trust shall comply with all requirements and directives stipulated by NHS Improvement, including compliance with the requirements outlines in Section 42.

9.3 Capital investment

The Trust shall comply as far as is practicable with the requirements of the guidance published on capital investment and protection of assets – guidance for NHSFTs in respect of capital investment and estate and property transactions.

9.4 Formal competitive tendering

Formal tendering will apply to all aggregated expenditure that exceeds, or is likely to exceed, £25~~50~~,000. The only circumstances in which this can be waivered are outlined in paragraph 9.4.3.

9.4.1 General applicability

The Trust shall ensure that competitive tenders are invited for:

a the supply of goods, materials and manufactured articles;

b the rendering of services including all forms of management consultancy services.

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

d Disposals of any tangible or intangible property (including equipment, land and intellectual property).

9.4.2 Health care services (and other services as outlined in Schedule 3 of the PCR 2015)

Where the Trust has a requirement to procure healthcare services (and/or other services listed in Schedule 3 of the Public Contracts Regulations 2015, whether by way of subcontract or otherwise) the Trust shall consider its duties under the EU Treaty and whether such service requirement should be advertised. Where the

Trust considers that the circumstances require it to advertise for the supply of healthcare services, the Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure, although at all times the Trust should consider its duties under paragraph 9.2 above.

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

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

a the estimated expenditure or income does not, or is not reasonably expected to, exceed £2550,000;

b the supply can be obtained under a framework agreement that has itself been procured in compliance with the duties set out at paragraph 9.2 above and where the Trust is entitled to access such framework agreements.

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

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

d where the requirement is covered by an existing contract;

e where national or regional procurement agreements are in place and have been approved by the Board;

f where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

g where the timescale genuinely precludes competitive tendering and when supplies are deemed clinically urgent;

h where specialist expertise is required and is available from only one source;

i when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

j there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

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

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

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

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee meetings scheduled to consider the waiver of requirements to competitively tender. In the event of a waiver being approved for the supply of goods or services, the Trust should agree to carry out a tender process to support future requirements.

9.4.4 **Fair transparent and adequate competition**

Except where the exceptions set out in SFI No 9.4.3 apply and allow the use of single tender action, the Trust shall ensure that invitations to tender whether regulated by the Public Contracts Regulators 2015 or not that the tendering process adopted is fair and transparent. Where a tendering process is conducted the Trust shall, in order to assure that best value if obtained invite tenders from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than 3 firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. All tender activity must be conducted in line with Department of Health Best Practice guidance, as updated from time to time.

9.4.5 **Building and engineering construction works**

Competitive tendering cannot be waived for building and engineering construction works and maintenance without Departmental of Health approval. In the event that Interim Support is required to fund works, the P21+ Procurement Framework must be used unless otherwise agreed with NHS Improvement. Construction works relating to PFI assets on the James Cook site are procured in compliance with the variation procedure and/or the capital works procurement agreement with the concessionaire.

9.4.6 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in the authorisation documentation, usually a Single Tender Waiver .

9.5 **Contracting/tendering procedure**

9.5.1 **Invitation to tender**

a All formal tender activity must be conducted electronically via the Trust's e-procurement system. This includes submission of notices, publication of documents, interaction with potential providers and notification of outcomes. Only in exceptional circumstances, and with the prior approval of the Chief Executive, can hardcopies tenders be accepted.

b Every tender for goods, materials, services or disposals shall contain and comprise appropriate terms and conditions regulating the conduct of the tender and shall contain appropriate terms and conditions on which the contract is to be awarded and shall be substantively based to regulate the provision of the goods, materials, services to be provided or in relation to the disposal.

c Every tender for building or engineering works shall contain terms and conditions on which the contract to be awarded shall be substantively based; that shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract ; or,

when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified (in minor respects only), to cover special features of individual projects.

9.5.2 **Receipt and safe custody of tenders**

The Chief Executive or her nominated representative will be responsible for the receipt, endorsement and safe custody of the electronically held submissions until the appointed opening time.

9.5.3 **Opening tenders and Register of tenders**

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

i the name of all firms individuals invited;

ii the names of firms individuals from which tenders have been received;

iii the date the tenders were opened;

v the price shown on each tender;

vi Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 9.5.5 below).

9.5.4 **Admissibility**

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

b Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust. Evidence of this must be recorded in the authorisation documentation

9.5.5 **Late tenders**

a Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his / her nominated officer decides that there are exceptional circumstances.

b While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential.

9.5.6 **Acceptance of formal tenders**

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

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

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

i experience and qualifications of team members;

ii understanding of client's needs;

iii feasibility and credibility of proposed approach;

iv ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender (if payment is to be made by the Trust) or the highest (if payment is to be received by the Trust) clearly stated.

c 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 or through delegation to the Director of Finance.

d The use of these procedures must demonstrate that the award of the contract was:

i not in excess of the going market rate / price current at the time the contract was awarded;

ii that best value for money was achieved;

iii All tenders should be treated as confidential and should be retained for inspection in line with the Trust Retention Policy.

9.6 Quotations: competitive and non-competitive

9.6.1 General position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended aggregated expenditure or income exceeds £10,000 but is not greater than £~~5~~250~~0~~,000.

9.6.2 Competitive quotations

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

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

c The Chief Executive or 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 then the choice made and the reasons why should be recorded in a permanent record.

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9.6.3 **Non-competitive quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

a the supply of goods or manufactured articles of any kind which are required for reasons of clinical urgency and are not obtainable under existing contracts;

b where the goods or services are for emergency building and engineering maintenance by the responsible works manager. ~~must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.~~

9.6.4 **Quotations to be within financial limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

9.7 **Authorisation of tenders and competitive quotations**

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

~~Budget holders/Clinical Directors and~~ Service managers in association with Procurement up to £~~1~~50,000 Formatted: Left

~~(informal quotations)~~

~~Budget holders/ Clinical Directors/~~ Operations Directors in association with procurement~~.....~~ up to £25~~50~~,000

Director of Finance~~.....~~ up to £250,000

Chief Executive ~~.....~~ over £250,000

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

Formal authorisation must be put in writing.

9.8 **Instances where formal competitive tendering or competitive quotation is not required**

The exceptions where formal competitive tendering does not need to be applied are covered in section 9.4.3.

9.9 **Private Finance Initiatives (PFI) and Finance Leases for capital procurement**

When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

9.9.1 The Chief Executive shall demonstrate that the use of private finance represents value for money as against a public sector comparator and genuinely transfers risk to the private sector.

9.9.2 The Trust must seek all applicable approvals and the requirements of all guidance by the regulator including risk evaluation for investment decisions by NHS Foundation Trusts.

9.9.3 The proposal must be specifically agreed by the Board.

9.9.4 The selection of a contractor and or finance company must be on the basis of competitive tendering or quotations.

9.10 **Compliance requirements for all contracts**

The Board may only enter into contracts on behalf of the Trust within the statutory powers of the Trust.

9.11 **Personnel and agency or temporary staff contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

Contracts for Agency Personnel shall be approved in line with the requirements of price caps imposed by NHS Improvement.

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9.12 **Disposals**

The disposal of trust property, equipment and stores should be in line with the Trust's procedures relating to the management of medical devices and information governance policies relating to personal liability and data protection.

9.13 **In-house services**

9.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine that periodically and as specified in paragraph 9.2, that in-house services should be market tested by competitive tendering.

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

a Project group, comprising the Chief Executive or nominated officer/s and specialist support.

c Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance representative.

9.13.3 The evaluation team shall make recommendations to the Board.

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

9.14 **Applicability of SFIs on tendering and contracting to funds held in Trust**

These Instructions shall not only apply to expenditure from exchequer funds but also to works, services and goods purchased from charitable funds.

10. Terms of service and payment of directors and employees

10.1 Remuneration and terms of Service (see overlap with SO No. 6)

10.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The Committee will:

a decide the appropriate remuneration and terms of service for the Chief Executive, other executive directors and senior leadership not on agenda for change, including:

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

ii provisions for other benefits, including pensions and cars;

iii arrangements for termination of employment and other contractual terms;

b determine the terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded based on the market position for their individual contributions to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

c monitor and evaluate the performance of individual executive members (and other senior employees);

d review the Trust's policies and procedures in relation to reward, performance management, retention, recruitment and redundancy.

10.1.3 The Committee shall report in writing to the Board on an annual basis on how it has discharged its duties.

10.1.4 The Council of Governors, at a general meeting will decide the remuneration and allowances, and the other terms and conditions of office of the non-executive directors following recommendations from the Nominations Committee.

10.2 Funded establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the ~~Chief Executive~~Director of Finance and ~~HR~~ Director of Human Resources or individual nominated within the relevant section of the Scheme of Delegation.

10.3 Staff appointments

10.3.1 No executive 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;

b within the limit of their approved budget and funded establishment.

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

10.4 Processing payroll

10.4.1 The Director of Finance is responsible for ensuring that the provision of the payroll service, however that may be provided (as of 1 April 2015 this is an outsourced service) with adequate internal controls, audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies. This service has been outsourced with effect from 1 April 2015 and the Director of Finance is responsible for ensuring that processes are in place to manage the contract, key indicators are in place to manage performance and the contract is regularly reviewed in terms of cost and service.

10.4.2 The payroll provider is responsible for the provision of service and the issue of instructions including:

a making payment on agreed dates using the agreed method of payment;

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

c the final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d verification and documentation of data;

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

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

g security and confidentiality of payroll information;

h checks to be applied to completed payroll before and after payment;

i authority to release payroll data under the provisions of the data protection act;

j methods of payment available to various categories of employee and officers;

k procedures for payment by cheque, bank credit, or cash to employees and officers;

l procedures for the recall of cheques and bank credits;

m maintenance of regular and independent reconciliation of pay control accounts;

n separation of duties of preparing records and handling cash; and

o a system to ensure the recovery from leavers of sums of money and property due by them to the trust.

p provision of key performance information.

10.4.3 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 the form prescribed by the Director of Human Resources;

c submitting termination forms in the prescribed form immediately upon knowing the effective date of 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 Human Resources must be informed immediately.

10.5 **Contracts of employment**

10.5.1 The Board shall delegate responsibility to the Director of Human Resources 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 and health and safety legislation;

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

10.6 **Redundancy Payments**

10.6.1 Authorisations for the payment of redundancy / voluntary severance and comprise agreements will be authorised by both the Director of Human Resources and Director of Finance for payments totalling less than £100,000. Payments above this value must be countersigned by the Chief Executive, approved by Remuneration Committee on behalf of the Board.~~.~~

10.6.2 Payback and Value for Money for such payments should be considered.

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11. Non-pay expenditure

11.1 **Delegation of authority**

11.1.1 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.

11.1.2 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 should be updated and reviewed on an on-going basis and annually by the ~~Financial Management Department.~~Director of Finance.

b where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

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

11.2 **Choice, requisitioning, ordering, receipt and payment for goods and services**

11.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser, The Head of Procurement, on supply shall be sought.

11.2.2 **System of payment and payment verification**

The Director of Finance shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. This will be applicable subject to the availability of sufficient cash balances.

11.2.3 **The Director of Finance will:**

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

b be responsible for the timely payment of all properly authorised accounts and claims subject to the availability of cash balances;

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

i A list of directors/employees authorised to approve or incur expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system

ii Certification that:

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

- the account is in order for payment.

iii A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts cashflow permitting, subject to accounts requiring early payment and cash discounts..

iv Instructions to employees regarding the handling and payment of accounts within the Finance department.

11.2.4 Be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No 11.2.5 below.

11.2.5 **Prepayments**

Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

a Prepayments are only permitted where the financial advantages outweigh the disadvantages for cash flow purposes providing financial benefits i.e discounts.

b The Head of Procurement as part of the authorisation process must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

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

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

11.2.6 **Official orders**

Official orders must:

a include a unique identifiable number;

b be in a form approved by the Director of Finance;

c state the trust's terms and conditions of trade;

d only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.7 **Duties of managers and officers**

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

a all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a

liability are notified to the Director of Finance in advance of any commitment being made;

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

c where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and NHS Improvement regarding spend levels;

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d no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

i isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii conventional hospitality, such as lunches in the course of working visits;

e no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

f all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;

g verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "confirmation order";

h orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

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

j changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

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

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

m orders are not required to be raised for suppliers that are included on the exemptions list. Financial Management are responsible for managing and reviewing this list. Payments must be authorised in accordance with the delegated limits set for non-pay;

11.2.8 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within 'NHS Improvements protection of assets. The technical audit of these contracts shall be the responsibility of the Director of Estates Facilities and~~, Facilities and Capital Planning.~~ICT.

11.2.9 Under no circumstances should goods be ordered through the Trust for personal or private use.

11.3 **Joint finance arrangements with local authorities and voluntary bodies**

Payments to local authorities and voluntary organisations made under the powers of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12. External borrowing and investments

12.1 **External borrowing**

External borrowing includes loans to fund capital investment, working capital facilities, interim revenue support and interim capital support through the Department of Health and financing arrangements that includes the PFI agreement and finance leases. The costs of funding these arrangements are included within the Debt Service Cover ratio that forms part of the Financial Sustainability Ratings as set by NHS Improvement.

The Director of Finance will advise the Board concerning the trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, in line with agreements agreed with and approved by the Department of Health and NHS Improvement. The Director of Finance is also responsible for reporting periodically to the Board on:

i Public Dividend Capital dividend;
ii Debt service cover ratio and compliance with Financial Sustainability Ratings; and
iii updates on all working capital facilities.

Any application for a loan, ~~-~~overdraft, working capital facilities, interim revenue support or interim capital support will only be made by the Director of Finance or by an employee so delegated by him/her. The use of any such facilities will only be undertaken through NHS Improvement and the Department of Health.

The Director of Finance must prepare detailed procedural instructions concerning applications for loans, overdrafts, working capital facilities, interim revenue support and interim capital support.

All 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 in accordance with the Treasury Management Policy.

All long term borrowing must be consistent with the plans outlined in the current Annual Business Plan.

12.2 **Public Dividend Capital**

On authorisation as a Trust the Public Dividend Capital (PDC) held immediately prior to authorisation continues to be held on the same conditions.

The draw-down of additional PDC should be authorised in accordance with the mandate held by the Department of Health Provider Finance Team, and is subject to approval by the

Secretary of State. Any application for PDC will only be made by the Director of Finance or by an employee through delegation and be supported by detailed instructions.

The Trust shall be required to pay annually to the Department of Health a dividend on its PDC at a rate, currently equating to 3.5%, determined from time to time, by the Secretary of State.

12.3 **Working Capital Facility**

The Trust has a working capital facility, in accordance with guidelines and approval from NHS Improvement which can be used to help manage the Trust's ~~facilitate~~ cash position. Further support is approved on an annual basis through the Department of Health and the Director of Finance is responsible for liaising with NHS Improvement and the Department of Health where this is a requirement.

The Trust will only draw down against this facility in respect of true working capital needs to cover annual liquidity requirements in the Recovery Plan. Utilisation will be in accordance with the terms and conditions of the facilities.

12.4 **Investments**

12.4.1 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board.

12.4.2 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.

12.4.3 The Director of Finance will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Trust's Treasury Management Policy will incorporate guidance from NHS Improvement as appropriate.

12.5 **Shares**

12.5.1 The investment by the Trust in shareholdings in other companies is only permitted when authorised by the Board following FIC recommendation.~~.~~

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12.5.2 The Director of Finance is responsible for advising the Board on share purchase and sale. He/ she is responsible to~~should also~~ update the Board on the performance of such investments periodically.

13. Capital and asset management

13.1 **Investment**

13.1.1 The Chief Executive, through delegation to the Director of Finance:

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

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

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

13.1.2 For capital expenditure proposals the chief executive shall ensure:

a that a business case is produced setting out:

i the purpose for the case with full risk analysis;

ii an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

iii the involvement of appropriate trust personnel, external organisations and key commissioners;

iii appropriate project management, details of key performance management indicators and arrangements for the review of deliverables;

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

All individual business cases must proceed through the appropriate scrutiny and approval process which~~that would~~ include Finance, Centre Boards, ~~, Capital Committee, Investment Management Group,~~ Finance and Investment Committee and Board (if the annual investment is greater than £2~~1~~,000,000).

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 'NHS Improvement's Protection of Assets – Guidance for NHS Trusts".

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

13.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure. Any deferral in the capital programme to the following year would be approved at ~~Capital~~ Finance and Investment committee, up to the value of £250,000, in line with the capital approval limits set in the Scheme of Delegation (appendix 3 – section 4 : Investments). The Trust will look to minimise the deferral of capital expenditure in the programme.

13.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

a specific authority to commit expenditure;

b authority to proceed to tender;

c approval to accept a successful tender.

13.1.7 The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with 'NHS Improvement's Protection of Assets – Guidance for NHS Trusts and the Trust's Standing Orders.

13.1.8 The Director of Finance, or through appropriate delegation, shall introduce procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

These procedures will:

a be designed to ensure that each project stays within estimated budgeted costs at each key milestone;

b involve project managers and other employees involved in capital projects; and

c Incorporate simple checklists and review processes designed to ensure that important requirements are complied with on each project.

13.2 Asset registers

13.2.1 The Chief Executive is responsible for the maintenance of registers of assets, with delegated responsibility to the Director of Finance to verify the form of any register and the method of updating, and arranging for a sample physical check of assets against the asset register to be conducted once a year.

13.2.2 The Trust shall maintain an asset register recording all relevant assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by NHS Improvement.

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, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b stores, requisitions and wages records for own materials and labour including appropriate overheads; 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 (see section 9.12), 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 adjusted to current values in accordance with methods specified in the Annual Reporting Manual issued by NHS Improvement.

13.2.7 The value of each asset shall be depreciated using methods and rates as specified in the Annual Reporting Manual issued by NHS Improvement and in line with the Trust's Accounting Policies.

13.2.8 In the event that the Trust was at risk of no longer being a going concern (see Section 3), NHS Improvement would place restrictions on the Trust to prevent disposal of relevant assets without appropriate written consent.

13.2.9 As required by the Terms of Authorisation Trusts must make the Asset Register available for inspection by the general public, and may charge a reasonable fee for access to this information.

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, negotiable instruments, and donated assets) must be approved by the Director of Finance. These procedures 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 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

13.3.4 Whilst each employee has a responsibility for the security of property of the Trust, 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 directors and employees in accordance with the procedure for reporting losses.

13.3.6 Where practical, assets should be marked as trust property.

14. Stores and receipt of goods

14.1 **General position**

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

a kept to a minimum (excluding bulk purchasing stock holding);

b subjected to at least an annual stock take;

c valued at the lower of cost and net realisable value.

14.2 **Control of stores, stocktaking, condemnations and disposal general position**

14.2.1 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 by a designated estates manager.

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

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

14.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

14.2.6 The designated manager 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 Chapter 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.

14.3 Receipt of goods

14.3.1 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

14.3.2 All goods received shall be entered onto an appropriate goods received or stock record on the day of receipt. Further where the goods received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

14.3.3 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised persons shall check receipt against the delivery note to satisfy themselves that the goods have been received. Any discrepancies should be raised with the Materials Management Team within 3 days of receipt. Goods supplied by NHS Supply Chain are not electronically booked into the Trust's "Purchase to Pay" system. The Trust currently relies on the end user identifying discrepancies which require reporting to the supplier within 3 days (the invoice payment system for these goods is a manual sign off of the presented invoice)..

14.4 Issue of stocks

14.4.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Director of Finance. Regular comparisons shall be made of the quantities issued to wards and departments and an explanation recorded of significant variances.

14.4.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Director of Finance.

15. Disposals and condemnations, losses and special payments

15.1 Disposals and condemnations

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

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate. All steps should be taken to ensure that such assets are appropriately decontaminated and that all patient identifiable information is erased.

15.1.3 All unserviceable articles shall be:

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

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

15.1.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses and special payments

15.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance must also prepare a Counter Fraud Policy and a response plan that sets out the action to be taken both by the employees detecting a suspected fraud and those responsible for investigating it.

15.2.2 When any kind of loss is discovered or suspected, the matter must be reported immediately to the head of department, the Director of Finance and the Chief Executive, in accordance with the Trust's Anti-Fraud policy.

15.2.3 In cases of fraud and corruption, the Director of Finance must immediately inform the relevant LCFS and both the internal and external auditors.

15.2.4 Where a criminal offence is suspected involving theft or arson, such cases will be reported to management, and the police will be informed in accordance with the Trust's security policy.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, where the value is in excess of £10,000, the Director of Finance must immediately notify:

a the Board;

b the external auditor; and

c the Director of the Internal Audit provider.

15.2.6 The Board shall approve the writing-off of losses and special payments in accordance with the Scheme of Delegation.

15.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

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

15.2.9 The Director of Finance shall maintain a losses and special payments register in which write-off action is recorded.

15.2.10 All losses and special payments must be reported annually to the Audit Committee.

16. Information management and technology

16.1 Responsibilities and duties of the Director of Finance

16.1.1 The Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust and compliance with the ~~Data Protection Act 1998~~ General Data Protection Act 2018 and the Computer Misuse Act 1990. The Director of Finance shall:

a devise and implement any necessary procedures to ensure adequate protection of the Trust's financial data within programs, networks and computer hardware from:

i accidental or intentional disclosure to unauthorised persons;

ii deletion or modification; and

iii theft or damage.

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

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

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

16.1.2 The Director of Finance must 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.

16.1.3 The Director of ~~Quality~~ CommunicationsNursing shall 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. Information routinely published will be managed by the individual divisions and directorates.

16.2 Responsibilities and duties of other directors and officers in relation to computer systems of a general application

All proposed or upgrades to computer systems, including shared or outsourced solutions, must be in consultation with the Director of ~~Digital Technology and~~Estates, Facilities and ICT ~~Information~~ for approval in accordance with the ICT Strategy.

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

The Chief Executive 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 as per the ~~Data Protection Act 1998~~General Data Protection Act 2018 to ensure clear lines of accountability including the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Executive shall ensure that adequate controls are in operation.

16.4 Risk Assessment

The Director of Estates, Facilities and ICT~~Quality~~, as the senior information risk owner for the organisation (SIRO), shall ensure that information risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate business continuity and disaster recovery plans.

The Deputy Chief Executive, as the Caldecott Guardian, is responsible for protecting the confidentiality of patient's health and care information and appropriate action taken to mitigate or control risk

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16.5 **Requirements for Computer Systems, which have an impact on corporate financial system**

16.5.1 Where computer systems have an impact on corporate financial systems the Director of Estates, Facilities and ICT ~~Director of Digital Technology and Information~~ 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 Director of Finance staff have access to such data;

d such computer audit reviews as are considered necessary are being carried out.

e Appropriate pseudonymisation controls are applied to the secondary use of patient level data.

17. Patients property

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

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions, and

- that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and an official copy of a patients' property record is obtained as a receipt.

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

17.4 Where Department of Health or NHS Improvement instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. Funds held on trust

18.1 Introduction

18.1.1 Charitable funds are those funds which are held in the name of the Charity separately from other funds and which arise principally from gifts, donations, legacies and endowments made under the relevant charities legislation. They are administered by the Board acting as the corporate trustee.

18.1.2 Standing Orders identify the Trust's responsibilities as a corporate trustee for the management of charitable funds held and defines how those responsibilities are to be discharged. They explain that management processes may overlap with those of the organisation of the Charity.

18.1.3 The Chief Executive shall ensure that each fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements, and administered by the named fund holders.

18.2 Corporate trustee

18.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held and to the Secretary of State.

18.2.2 The schedule of matters reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

18.3 **Applicability of standing financial instructions to funds held on trust**

18.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held in the Charity.

18.3.2 The over-riding principle is that the integrity of each fund must be maintained and statutory and Charity obligations met. Materiality must be assessed separately from Trust activities and charitable funds.

18.4 **Receipts**

18.4.1 All gifts and donations accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of the specific charitable funds. As the Charity can accept gifts or donations only for the purposes relating to the NHS, employees shall in cases of doubt, consult the Chief Executive or Director of Finance before accepting such receipts. Any gifts, donations or proceeds of fund raising activities should be banked immediately upon receipt.

18.4.2 In respect of fund-raising the Chief Executive shall deal with all arrangements for fund-raising by, and on behalf of, the Charity and be empowered to liaise with other organisations or persons raising funds for the Charity and providing them with an adequate discharge.

18.4.3 In respect of investment income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and receipts from this source.

18.5 **Expenditure**

18.5.1 All expenditure from charitable funds, with the exception of legitimate expenses of administering and managing those funds ~~and expenditure for research purposes~~ must be for the benefit of patients and staff.

18.5.2 Expenditure of any charitable funds shall be conditional upon the goods and services being within the terms of the appropriate charitable fund and upon the proviso that the expenditure does not result in further payments by the Charity which have not been agreed and funded.

18.5.3 All expenditure on charitable funds in excess of £5,000 will be approved by the Additional Resources Committee.

18.6 **Investments**

18.6.1 Charitable funds shall be invested by the Director of Finance in accordance with the Treasury Management Policy and statutory requirements.

18.6.2 In managing the investments the Trust shall take due account of the written advice received from its duly appointed investment advisor.

18.7 **Records and reporting**

18.7.1 The Director of Finance shall be responsible for the maintenance of written financial instructions covering all aspects of transactions involving charitable funds.

18.7.2 The Director of Finance shall maintain such accounts and records as are necessary to record and protect all transactions and funds of the Charity as corporate trustee of the charitable funds. These accounts and records shall be maintained in accordance with the requirements of the Charity Commission and other legislative requirements, including any directions of the Secretary of State.

18.7.3 New charitable funds must only be opened where the wishes of benefactors cannot be accommodated within existing funds and in all cases must comply with the requirements of the Charity Commission.

19. Retention of documents

19.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines, the General Data Protection Act 2018 and the ~~and the~~ Freedom of Information Act 2000.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records held in accordance with ~~latest Department of Health guidance~~19.1 above shall be retained for at least the retention periods indicated in the guidance and only be destroyed at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

19.4 The methods used for the destruction of confidential records should ensure that their confidentiality is fully maintained. Normal destruction should be by incineration or shredding.

20. Risk Management and Assurance

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 current NHS Improvement assurance framework requirements, 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 engendering among all levels of staff a positive attitude towards the control of risk;

c management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d contingency plans to offset the impact of adverse events;

e audit arrangements including; Internal Audit, clinical audit, health and safety review;

f a clear indication of which risks shall be insured;

g arrangements to review the Risk Management programme.

20.1.3 The existence, integration and evaluation of the above elements will provide a basis to make an annual governance statement within the annual report and accounts as required by the NHS Trust Annual Reporting Manual.

20.1.4 The Director of Finance and Company Secretary~~, Director of Quality, Director of Estates, Facilities and Capital Planning~~ICT ~~and Director of Nursing~~ shall ensure that, where appropriate, adequate insurance arrangements exist in accordance with the risk management programme.

20.2 Insurance: risk pooling schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

20.3 Insurance arrangements with commercial insurers

20.3.1 NHS Foundation Trusts are not prohibited from purchasing commercial insurance. The Board shall ensure that when entering into commercial insurance, cover is appropriate and is incorporated into the overall risk management programme.

The Director of Finance will review existing commercial insurance cover on an annual basis to ensure that it is still appropriate. Existing commercial policies include:

a Insuring motor vehicles owned and used for Trust purposes including insuring third party liability arising from their use;

b where the Trust is involved with a consortium in a PFI contract and the other consortium members require that commercial insurance arrangements are entered into; and

c Income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority

20.4 **Arrangements to be followed by the Board in agreeing insurance cover**

20.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

20.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

20.4.3 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.

Policy Agreement / Approval

The following groups/ committees/individuals have reviewed and agreed this procedural document

Final Approved by	Date Agreed	Date for Review
Board of Directors	~~06/12/2016~~	September~~March~~ 2020~~18~~

CORPORATE GOVERNANCE POLICY

Document No: CG01
***All Sites**

STANDING ORDERS OF THE BOARD OF DIRECTORS

TITLE	Standing Orders of the Board of Directors
Version:	4
Final Approval by: Board of Directors **Date:**	
Author/lead responsible for policy:	Chairman and Chief Executive
Date issued:	
Review date:	September 2020
Target audience:	Board Members Trust Senior Staff
Amendments and Additions	Updated to reflect changes to the Trust Constitution
Replaces/supersedes:	Version 3
Associated Policies:	CG02 Standing Financial Instructions CG04 Decisions Reserved for Board of Directors and Scheme of Delegation

Issued by:

Chief Executive

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

CONTENTS

1. INTRODUCTION

The principal place of business of the Trust is The James Cook University Hospital, Marton Road, Middlesbrough.

NHS Foundation Trusts are governed by a Regulatory Framework that confers the functions of the Trust and comprises: Acts of Parliament and in particular the National Health Service Act 2006 ('the 2006 Act'); their constitutions; and the terms of their authorisation granted by the Independent Regulator of NHS Foundation Trusts ('the Independent Regulator').

The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the practice and procedure of the Board of Directors. The Board of Directors will conduct its business in as open a way as possible and will:

a) Observe the Nolan principles of Public Life of selflessness, integrity, objectivity, accountability, openness, honesty and leadership;
b) At all times seek to comply with the NHS Foundation Trust Code of Governance; and
c) At all times seek to comply with the Combined Code on Corporate Governance 2003. Everything done by the Trust should be able to stand the test of scrutiny, public judgment on propriety, and professional codes of conduct.

These Standing Orders (SOs) are for the regulation of the Board of Directors' proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders on which he/she should be advised by the Company Secretary, Chief Executive and Director of Finance.

2.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

a) **ACCOUNTABLE OFFICER** shall be the officer responsible and accountable for funds entrusted to the Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

b) **BOARD** means the Board of Directors, formally constituted in accordance with this Constitution and consisting of a Chairman, and Non-executive Directors, appointed by the Council of Governors and the Executive Directors, appointed by the Non-executive Directors and (except for his own appointment) by the Chief Executive.

c) **BUDGET** shall mean 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.

d) **CHAIRMAN** is the person appointed by the Council of Governors as a Non-Executive Chairman to lead the Board of Directors and Council of Governors to ensure it successfully discharges its overall responsibility for the Trust as a whole.

e) **CHIEF EXECUTIVE** shall mean the accountable officer of the Trust.

f) **COMMITTEE OF THE COUNCIL** means a committee formed by the Council of Governors with specific Terms of Reference, chair and membership.

g) **COMMITTEE OF THE BOARD** means a committee formed by the Board with specific Terms of Reference, Chair and Membership.

h) **COUNCIL** means the Council of Governors, formally constituted in accordance with this Constitution meeting in public and presided over by the Chairman.

i) **COUNCIL MEMBER** means a person elected or appointed to the Council of Governors.

j) **DIRECTOR** means a person appointed to the Board of Directors

k) **DEPUTY CHAIRMAN** means the Non-Executive Director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

l) **DIRECTOR OF FINANCE** shall mean the Chief Finance Officer of the Trust who will ensure compliance with Standing Financial Instructions.

m) **FUNDS HELD ON TRUST** shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 3 and 4 para 14.1c National Health Service Act 2006. Such funds may or may not be charitable.

n) **MEMBER** means a person registered as a member of one of the constituencies of the Trust as outlined in this Constitution.

o) **MONITOR or TRUST REGULATOR** is the body corporate known as Monitor, referred to in Section 61 of the 2012 Act which operates with National Health Service Trust Development Authority as NHS Improvement.

p) **MOTION"** means a formal proposition to be discussed and voted on during the course of a meeting.

q) **NOMINATED OFFICER** means an officer charged with the responsibility for discharging specific tasks within Standing Orders in line with the 2006 Act.

r) **NON-EXECUTIVE DIRECTOR** is a person appointed by the Council of Governors to be a member of the Board of Directors. Initially Non executives of the applicant NHS Trust will become Non-executives of the Foundation Trust, unless they choose not do so. This includes the chairman of the Trust.

s) **OFFICER** means an employee of the Trust

t) **SOs** means Standing Orders

u) **SFIs** means Standing Financial Instructions

v) **TRUST** means South Tees Hospitals NHS Foundation Trust.

w) **COMPANY SECRETARY** this role will act as independent advice to the Board and monitor the Trust's compliance with its terms of authorisation and constitution.

3. THE BOARD OF DIRECTORS – ITS COMPOSITION, APPOINTMENTS AND INDEMNITY ARRANGEMENTS

3.1 All business shall be conducted in the name of the Trust.

3.2 All funds received in Trust shall be in the name of the Trust as corporate trustee. In relation to funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3 All the powers of the Trust shall be exercised by the Board of Directors on its behalf.

3.4 The Board of Directors has resolved that certain powers and decisions may only be exercised or made by the Board. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders. The Board of Directors must adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

3.5 Composition of the Board of Directors

The composition of the Board of Directors will be:

- The Chairman of the Trust (Non-Executive Director as required by Schedule 7 of the NHS Act 2006)
- Within the range of 5-8 other Non-Executive Directors

- Within the range of 5-8 Executive Directors including:
- One of the executive Directors shall be the Chief Executive.
- The Chief Executive shall be the Accounting Officer.
- One of the executive Directors shall be the Finance Director.
- One of the executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).
- One of the executive Directors is to be a registered nurse or registered midwife.
- The Company Secretary to the Board of Directors will be in attendance at all Board meetings.

3.5.1 The number of Directors may be increased, (within the range of 5 – 8 as outlined above) with the approval of the Board, provided always at least half the Board, excluding the Chairman, comprises Non-executive Directors determined by the Board to be independent.

3.6 Terms of Office of the Chairman and Members of the Board

3.6.1 Guidance relating to the period of tenure of office of the Chairman and Non-executive Directors and the termination or suspension of office of the Chairman and Directors is contained in the Foundation Trust Code of Governance.

3.6.2 Non-Executive Directors including the Chairman will be appointed by the Council of Governors for a period of 3 years and subject to re-appointment thereafter at intervals of 3 years. Any term beyond six years for a Non-executive Director will be subject to rigorous review by the Council of Governors. Non-Executive Directors may serve up to~~more than~~ nine years subject to an annual re-appointment.

3.7 Appointment of the Chairman and Non-executive Directors

The Chairman and Non-executive Directors are to be appointed/removed by the Council of Governors in accordance with the constitution.

3.8 Appointment of Deputy Chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-executive Directors as a Deputy Chairman.

3.9 Any Non-executive Director so elected may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Council of Governors may thereupon appoint another Non-executive Director as Deputy Chairman in accordance with the Constitution.

3.10 Powers of Deputy Chairman

Where the Chairman of the Trust has died or has otherwise ceased to hold office or where he/she has been unable to perform his/her duties as Chairman owing to illness, absence or any other cause, references to the Chairman in the Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include the Deputy Chairman.

3.11 **Senior Independent Director** – The Chairman shall, following consultation with the Council of Governors appoint one of the Non-executive Directors as a "Senior Independent Director".

3.12 In accordance with the Constitution the Non-executive Directors shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors) and a committee consisting of the Chairman, Chief Executive and the other non-executive directors shall appoint or remove the other Executive Directors.

3.13 The Board shall nominate a Company Secretary, who, under the direction of the Chairman and Chief Executive, shall ensure good information flows within the Board and Council of Governors and their Committees, between Directors and members of the Council of Governors, and between senior management and the Board. The Company Secretary shall also advise the Board and Council of Governors on all governance matters and shall facilitate induction and professional development as required. The appointment and removal of the Company Secretary will be carried out jointly with the Chief Executive and Chairman.

3.14 A Director of the Trust, who has acted honestly and in good faith will not have to meet out his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Director save where the Director has acted recklessly. On behalf of the Directors and as part of the Trust's overall insurance arrangements the Board of Directors shall put in place appropriate insurance provision to cover such indemnity and the discretion of the Trust.

3.15 Non-executive Directors may, at the Trust's expense, seek external advice or appoint an external adviser on any material matter of concern provided the decision to do so is a collective one by the majority of Non-executive Directors. Approval of any such expenses will be done in conjunction with the allocated budget and financial procedure.

3.16 Disqualification and removal of Directors:

Over and above the legal minimum, a person may not become or continue as a Director if they:

- Are a Governor of the Trust;
- Are the subject of a disqualification order made under the Company Directors Disqualification Act 1986
- Have had their name removed by a direction under S.46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included in such a list;
- Are no longer a member of one of the public constituencies (Non-Executive Directors only)
- Have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body.
- Have had a tenure of office as a Chairman or as a member or director of a health service body terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings or for non-disclosure of a pecuniary interest;
- Have refused without reasonable cause to fulfill any training requirement established by the Board of Directors;
- Have refused to sign and deliver a statement in the prescribed format confirming acceptance of a Code of Conduct for Directors.

4. MEETINGS OF THE BOARD OF DIRECTORS

4.1 Admission of the Public and the Press

Meetings of the Board of Directors shall be open to members of the public or representatives of the press. Members of the public may be excluded from a meeting (whether for the whole or part of such meeting) for special reasons as determined by the Chairman in conjunction with the Board of Directors, which may include, but are not limited to, the following reasons:

- Publicity would be prejudicial to the public interest by reasons of the confidential nature of the business to be transacted; or
- There are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

The Chairman may exclude any member of the public from the meeting of the Board of Directors if they are interfering with, or preventing the reasonable conduct of the meeting.

4.2 Confidentiality

Directors and Officers and any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Board of Directors meeting, without the express permission of the Board of Directors. This

prohibition shall apply equally to the content of any discussion during the Board of Directors' meeting which may take place on such reports or papers.

4.3 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

4.4 The Chairman of the Trust may call a meeting of the Board of Directors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him/her at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

4.5 **Notice of Meetings** - Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his/her behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least five clear days before the meeting.

4.6 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.7 In the case of a meeting called by Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice or emergency motions allowed under these Standing Orders. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

4.8 Agendas will wherever possible be sent to Directors at least five clear days before the meeting and supporting papers, whenever possible.

4.9 The Company Secretary will ensure that a notice of a meeting of the Board of Directors is publicised to the public and papers made available on the Trust's website.

4.10 **Setting the Agenda**

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.11 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 clear days before the meeting. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

4.12 **Chairman of Meeting** - At any meeting of the Board of Directors, the Chairman of the Board of Directors, if present, shall preside. If the Chairman is absent from the meeting the Deputy-Chairman, if there is one and he/she is present, shall preside. If the Chairman and Deputy-Chairman are absent such Director (who is not also an officer of the Trust) as the Directors present shall choose shall preside.

4.13 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy-Chairman, if present, shall preside. If the Chairman and Deputy-Chairman are absent, or are disqualified from participating, such non-executive director as the Directors present shall choose shall preside. If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chairman, the Chairman shall not preside over the meeting during which the matter is under discussion.

If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Non-executive Director, the Non-Executive Directors shall not preside over the meeting during which the matter is under discussion.

4.14 The Directors (excluding the Chairman and the other non-executive Directors) shall elect one of their numbers to preside during that period and that person shall exercise all the rights and obligations of the Chairman including the right to exercise a second or casting vote where the number of votes for and against a motion is equal.

4.15 **Annual Members Meeting**

The Trust will publicise and hold an Annual Members Meeting that is open to members of the public and representatives of the press.

4.16 **Notices of Motion** - A Director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda, subject to Standing Order 4.6.

4.17 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.18 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Director who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the

Chairman to propose a motion to the same effect within 6 months; however the Chairman may do so if he/she considers it appropriate.

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

4.20 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

4.21 An amendment to the motion.
4.22 The adjournment of the discussion or the meeting.
4.23 That the meeting proceed to the next business. (*)
4.24 The appointment of an ad hoc committee to deal with a specific item of business.
4.25 That the motion be now put. (*)
4.26 A motion resolving to exclude the public (including the press).

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.21 **Chairman's Ruling** - Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final. In this interpretation he/she shall be advised by the Company Secretary on standing orders and the case of Standing Financial instructions by the Director of Finance.

4.22 **Voting** - Every question put to a vote at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

4.23 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.24 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.25 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.26 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.27 An officer who has been appointed formally by the Board of Directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

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

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

4.30 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

4.31 **Joint Directors** - Where the office of a Director is shared jointly by more than one person:

a) either or both or any of those persons may attend or take part in meetings of the Board of Directors:
b) if both/any are present at a meeting they should cast one vote if they agree:
c) in the case of disagreements no vote should be cast;
d) the presence of either/any or both/any of those persons should count as the presence of one person for the purposes of Standing Order 4.40 (Quorum).

4.32 **Suspension of Standing Orders** - Except where this would contravene any provision of the constitution or any direction made by the Independent Regulator of NHS Foundation Trusts, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

4.33 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.34 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors.

4.35 No formal business may be transacted while Standing Orders are suspended.

4.36 The Audit Committee shall review every decision to suspend Standing Orders.

4.37 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

4.37.1 a notice of motion under Standing Order 4.17 has been given; and
4.37.2 no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
4.37.3 at least two-thirds of the Directors are present; and
4.37.4 the variation proposed does not contravene a statutory provision or a direction made by the Regulator of NHS Foundation Trusts and
4.37.5 the amendment is approved by the Independent Regulator of NHS Foundation Trusts.

4.38 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

4.39 **Quorum** - No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least one non-executive director and one executive director) are present.

4.40 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

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

The above requirement for at least one executive director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration and Terms of Service Committee). The above requirement for at least one non-executive Director to form part of the quorum shall not apply where the Non-Executive Directors are excluded from a meeting.

4.41 **Adjournment of Meetings -** The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.

4.42 When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

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

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by a Director of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised jointly by the Chief Executive and the Chairman after having consulted at least two other Non-executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for ratification.

5.3 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees of Executive Directors, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board and in accordance with Schedule 7 of the Act.

The Board shall agree and regularly review the setting up of committees to assist and advise the Board in fully discharging its duties as a healthcare organisation.

5.4 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved to the Board or delegated to an executive committee may be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Executive Directors only to undertake the remaining functions for which they will still retain accountability to the Board.

5.5 The Chief Executive shall prepare a Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board, identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of

Delegation which shall be considered and approved by the Board as indicated above.

5.6 Nothing in the Schedule of Decision/Duties Delegated by the Board shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Director to provide information and advise the Board in accordance with any statutory requirements.

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

6. COMMITTEES

6.1 **Formation of Committees** – The Board may form committees of the Trust, consisting wholly or partly of members of the Board of Directors or wholly of persons who are not members of the Board of Directors.

6.2 Where the Board delegates a function or power to a committee this committee shall be formed of Directors solely and may not establish sub committees, in accordance with Schedule 7 of the Act.

6.3 Where the Board agrees to the setting up of committees consisting of other persons, this committee may not be delegated a function or any power of the Board of Directors but will advise the Board to assist in the Board effectively discharging its duties. Sub Committees of any such committees may be agreed.

6.4 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee formed by the Trust.

6.5 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither Non-executive Directors nor Directors, shall be appointed to a committee, the terms of such appointment shall be defined by the Board and the terms of reference of that committee. Those appointed would not constitute formal members of the committee and preside in an attendance capacity only.

6.7 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and directions laid down by the Board of Directors.

6.9 All committees and sub committees of the Board of Directors will be subject to an annual review to ensure best practice and fitness for purpose in conducting and governing the Trusts business.

6.10 Confidentiality

A member of the Board of Directors or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential or embargoed.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 **Declaration of Interests** If a director has a pecuniary, personal or family interest, whether the interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the director shall disclose that interest to the members of the Board of Directors as soon as he becomes aware of it.

7.2 Interests which may be declared may include but are not exclusive to:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) Shareholdings in organisations likely or possibly seeking to do business with the NHS.
d) A position of Trust in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services;
f) Any other commercial interest in the decision the committee or Board meeting may be considering

7.3 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman.

7.4 At the time Board members' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

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

7.6 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion (unless the Board decides otherwise) or decision.

7.7 The interests of Board members' spouses or cohabiting partners should be declared.

7.8 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.9 Register of Interests

In accordance with paragraph 34 of the Constitution, the Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Director and Non-executive Directors, as defined in Standing Order 7.2.

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

7.11 The Register will be available for inspection by members of the public.

8. DISABILITY OF CHAIRMANMAN AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if the Chairman or any member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter, without the Chairman of the meeting's agreement, or vote on any question with respect to it.

8.2 The Board of Directors shall exclude the Chairman or a Director from a meeting of the Board of Directors while any contract, proposed contract or

other matters in which he/she has a pecuniary interest, is under consideration.

8.3 Any remuneration, compensation or allowances payable to a member by virtue of paragraph 11 of Schedules 3 and 4 to the National Health Service Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.4 For the purpose of this Standing Order the Chairman or a Director shall be treated, subject to SO 7.1 and SO 8.5, as indirectly having a pecuniary interest in a contract, proposed contract or other matter, if:

a) he/she, or a nominee of him/her, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matters under consideration; or

b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of persons living together, the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.5 The Chairman or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only because:

a) of their membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person with which he/she is connected as mentioned in SO 8.4 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.6 Where the Chairman or a Director:

a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

b) the total nominal value of those securities does not exceed one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in

the consideration or discussion of the contract or other matter from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

8.7 Standing Order 8 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or subcommittee (whether or not they are also a member of the Board of Directors) as it applies to a member of the Board of Directors).

9. STANDARDS OF BUSINESS CONDUCT

9.1 Policy

Staff must comply with the Trust's detailed Standards of Business Conduct and Capability policy documents.

9.2 Interests of Officers in Contracts

If it comes to the knowledge of a Director of the Trust that a contract is which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein.

9.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of him/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust requires interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

9.4 Canvassing of, and recommendations by, Members in relation to Appointments

Canvassing of members of the Board of Directors or members of any committee of the Board of Directors directly or indirectly for any appointment by the Trust shall disqualify the candidate from such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

9.5 A member of the Board of Directors shall not solicit for any person any appointment by the Board of Directors or recommend any person for such appointment, but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Board of Directors.

9.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

9.7 **Relatives of Members of the Board of Directors**

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

9.8. The Chairman, and every Director of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that the Chairman, members or Director is aware. It shall be the duty of the Chief Executive or nominated Director to report to the Board of Directors any such disclosure made.

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

9.10 Where the relationship of a Director or another member of the Board or another member of the Trust is disclosed, the Standing Order headed (SO 8) shall apply (Disability of Directors in proceedings on account of pecuniary interest).

10. RESOLUTION OF DISPUTES WITH THE COUNCIL OF GOVERNORS

10.1 The Council of Governors has three main roles:

a) Advisory – Communicating to the Board the wishes of members of the Council of Governors and the wider community
b) Guardianship – Ensuring that the Trust is operating in accordance its Terms of Authorisation. In this regard it acts in a trustee role for the welfare of the organisation.
c) Strategic – Advising on a longer term direction to help the Board effectively determine its policies.

10.2 The Board of Directors has overall responsibility for running the affairs of the Trust. Its role is to:

a) Note advice from, and consider the views of the Council of Governors
b) Set the strategic direction and leadership of the Trust
c) Ensure the Terms of Authorisation are complied with
d) Set organisational and operational targets
e) Assess, manage and minimise risk
f) Assess achievement against the above objectives
g) Ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives
h) Ensure that the highest standards of Corporate Governance are applied throughout the organisation

10.3 The disputes resolution procedure recognises the different roles of the Council of Governors and the Board as described above.

10.4 The Chairman, or Deputy Chairman (if the dispute involves the Chairman) of the Board and the Council of Governors, shall first endeavour through discussion with members of the Council of Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them to resolve the matter to the reasonable satisfaction of both parties.

10.5 Failing resolution under 10.4 above then the Board and the Council of Governors, shall, at its next formal meeting, approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.6 The Chairman, or Deputy Chairman (if the dispute involves the Chairman) of the Board and the Council of Governors, shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an Agenda Item and Agenda Paper at the next formal meeting of the Board or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.7 The Chairman, or Deputy Chairman (if the dispute involves the Chairman) of the Board and the Council of Governors, shall immediately or as soon as is practicable, communicate the outcome to the other party and deliver the Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.4 above shall be repeated.

10.8 If, in the opinion of the Chairman, or Deputy Chairman (if the dispute involves the Chairman) and the Board or the Council of Governors, and following the further discussion prescribed in 10.7, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chairman or Deputy Chairman, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and the Board accordingly.

10.9 On the satisfactory completion of this disputes process the Board shall implement agreed changes.

10.10 On the unsatisfactory completion of this disputes process the view of the Board shall prevail.

10.11 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing the Independent Regulator of NHS Foundation Trusts that, in the Council of Governors' opinion, the Board has not responded constructively to concerns of the Council of Governors that the Trust is not meeting the Terms of its Authorisation.

11. NOTIFICATION TO INDEPENDENT REGULATOR OF FOUNDATION TRUSTS AND COUNCIL OF GOVERNORS

The Board shall notify the Independent Regulator of Foundation Trusts and the Council of Governors of any major changes in the circumstances of the Trust which have made or could lead to a substantial change to its financial wellbeing, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of Authorisation. The need to notify the independent regulator and Governors will also apply in situations where amendments are proposed to the Constitution or its annexes.

12. BOARD PERFORMANCE

The Chairman, with the assistance of the Company Secretary, shall lead, at least annually, a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programmes for Directors.

13. TENDERING AND CONTRACT PROCEDURE

The procedure set out in the Trusts Standing Financial Instructions should be adhered to in conjunction with the implementation of these Standing Orders for all tendering and contract procedures.

14. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

14.1 **Custody of Seal**

The Common Seal of the Trust shall be kept by the Chief Executive or nominated person in a secure place.

14.2 **Sealing of Documents**

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof or where the Board has delegated its powers.

14.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by any two as delegated by the Board – Chairman, Chief Executive, Director of Finance or Chief Operating Officer (or a nominated officer who shall not be from within the originating directorate).

14.4 The form of the attestation of documents shall be "The Common Seal of the South Tees Hospitals NHS Foundation Trust was hereto affixed in the presence of ……".

14.5 **Register of Sealing**

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who

shall have approved and authorised the document and attested the seal. A report of all sealing shall be made to the next Board of Directors meeting. (The report shall contain details of the seal number, the description of the document and date of sealing).

15. SIGNATURE OF DOCUMENTS

15.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

15.2 The Chief Executive or nominated officers shall be authorised by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

16. DISSEMINATION OF STANDING ORDERS

The Chief Executive is responsible for ensuring all existing Directors and officers, and all new appointees are notified of, an understand their responsibility within the Standing Orders.

Policy Agreement / Approval
The following groups/ committees/individuals have reviewed and agreed this procedural document

Final Approved by	Date Agreed	Date for Review
Board of Directors		September 2020

South Tees Hospitals NHS
NHS Foundation Trust

CORPORATE GOVERNANCE

Document No: CG04

DECISION RESERVED FOR THE BOARD OF DIRECTORS AND SCHEME OF DELEGATION

TITLE	Decision Reserved for the Board of Directors and Scheme of Delegation (combined)
Version:	2~~1~~
Approval by: Board of Directors **Date:**	~~06/12/2016~~
Author/lead responsible for policy:	~~Chairman and Chief Executive~~Board of Directors
Date issued:	~~December 2016~~
Review date:	March 2020~~September 2018~~
Target audience:	Board Members Trust Senior Staff
Amendments and Additions	Updated Decision Reserved for the Board of Directors and Scheme of Delegation for South Tees Hospitals NHS Foundation Trust
Replaces/supersedes:	~~Scheme of Delegation – CG05~~ ~~Decisions Reserved for the Board of Directors for South Tees Hospitals NHS Trust – CG04~~Version 1
Associated Policies:	Standing Orders Standing Financial Instructions

Issued by:

Chief Executive

South Tees Hospitals NHS
NHS Foundation Trust

DECISION RESERVED FOR THE BOARD OF DIRECTORS

AND

SCHEME OF DELEGATION

Contents

South Tees Hospitals NHS
NHS Foundation Trust

DECISION RESERVED FOR THE BOARD OF DIRECTORS AND SCHEME OF DELEGATION

1 Introduction

1.1 The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board of Directors. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.2 The Board of Directors (the Board) may make arrangements for the exercise of any of its functions by a committee, sub-committee or by a Director of the Trust.

1.3 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive or other Executive Directors. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

2 Purpose

2.1 The purpose of this document is to define the control framework set by the Board for committing trust resources. The Board reserves certain matters to itself which are set out in the Schedule of Matters Reserved to the Board. The Scheme of Delegation

identifies which powers and functions the Chief Executive shall perform personally and those which he/she has delegated to other Directors and Officers.

2.2 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. In the absence of the Chief Executive the powers of the Chief Executive are delegated to the Deputy Chief Executive.

2.3 The Scheme of Delegation shows only the top level of delegation with in the Trust. The Scheme is to be used in conjunction with the Trust's Standing Orders, Schedule of Matters Reserved to the Board, Standing Financial Instructions including the system of budgetary control and other established policies and procedures within the Trust.

2.4 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that Director or~~f~~ Officer's superior unless alternative arrangements have been approved by the Board. If the chief Executive is absent, powers delegated to him/her may be exercised by the Director who has been duly authorised to act up for him/her taking appropriate advice from the Chairman.

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3 Scope

3.1 To ensure that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures.

3.2 The Scheme of Delegation is consistent with the NHS Code of Conduct and Accountability and NHS Improvement's Code of Governance. Directors and Officers are reminded that powers are delegated to them on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern. ~~The Code of Conduct of Accountability in the NHS~~ NHS England's Managing Conflicts of Interest in the NHS (June 2017) and NHS Improvement's~~the~~ Code of Governance sets out the core standards of conduct expected of NHS managers.

3.2 Provide details of delegated limits to all officers holding responsibilities. Budget Holders agree to operate within the budget limit and within the delegated limits as outlined in this document. It is their responsibility to manage within their budget and to identify any changes to the budget assumptions surrounding activity, timing and staffing issues which may result in changes to financial risk. If a proposed transaction is beyond their authority and outside the Annual Plan, it should be referred to their manager. Failure to do so may result in disciplinary action.

3.3 The document forms part of the Trust's corporate governance framework, which is the regulatory framework for the business conduct of the Trust within which all Trust officers are expected to comply. The aim is not to create bureaucracy but to protect the

Trust's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures. The key documents in this framework include the following and should be read in conjunction with the Decisions Reserved for the Board of Directors and Scheme of Delegation:

Standing Orders
Standing Financial Instructions

4 Principles of Reserved and Delegated Powers

4.1 Principles that are followed by the Scheme of Delegation.

There is no spend beyond authorised limits except with the approval as appropriate
The business case process is mandatory.

4.2 Emergency Powers

The powers which the Board has retained to itself may in emergency be exercised by the Chief Executive and the Chair after having consulted at least 2 non-executive directors.

The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4.3 Delegation to Committees

The Board shall agree that from time to time for the delegation of executive powers to be exercised by committees, ~~or sub committees,~~ which it has formally constituted. The constitution and terms of reference of these committees~~, or sub committees~~, and their specific executive powers shall be approved by the B~~b~~oard.

4.4 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or ~~sub-committee~~committee shall be exercised on behalf of the Board by the Chief Executive.

4.5 Role of the Chief Executive

The Chief Executive shall prepare a Scheme of Decisions Reserved to the Board and Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board.

The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board, subject to any amendment agreed during the Board discussion.

5 Governors' legal responsibilities

5.1 The Trust has a body of elected individuals that make up the Council of Governors. Governors have a number of legal rights and responsibilities. These include:

a. The appointment or dismissal of the Chairman and Non-executive Directors
b. The approval of the appointment of the Chief Executive
c. At a general meeting the Council of Governors will:
    - receive the annual accounts annual report ~~and~~ Quality Report and annual audit letter from the external auditors
    - approve the remuneration and allowances and other terms and conditions of the office of the Chairman and Non-executive Directors
    - appoint or replace the Trust's auditor at a general meeting

d. Providing the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Board of Directors of the document containing information as to the Trust's forward planning in respect of each Financial Year to be given to NHS Improvement.
e. Receiving and considering the views of the Members on matters of significance to the future plans of the Trust
f. Approval of ~~the~~ amendments~~ed of~~ to the constitution
g. Hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors
h. Represent the interests of the NHS Foundation Trust members and the public served by the Trust
i. Approving significant transactions that fall within the definition
j. Appointment and removal of the External Auditors
k. Approval of the increase of non- NHS income where it is 5% or more in any one year

6 Scheme of matters reserved for the Board

6.1 General enabling provision

The Board may determine any matter (for which it has delegated or statutory authority) it wishes in full session within its statutory powers, subject to any restrictions contained in the Trust's Constitution and/ or terms of the Licence.

6.2 Constitutional Powers

a. To exercise all powers of an NHS foundation trust set out in the NHS Act 2006, subject to any restrictions in the Trust's Licence; enforcement undertakings given to regulators or as delegated in accordance with this Scheme of Delegation. (Constitution paragraph 4)
b. Determine the composition of the Board of Directors (Constitution paragraph 234)
c. Make available for inspection by members of the public the following: register of Members; register of members of the Council of Governors; register of interest of members of the Council of Governors; register of members of the Board of Directors; register of interests of members of the Board of Directors; Constitution; Licence; latest Annual Accounts and Auditor's report on them; latest Annual Report and Forward Plan; and any notice issued by the NHS Improvement under Section 52 of the NHS Act 2006.
d. Appoint the Returning Officer
e. Approve payment of expenses and remuneration to Returning Officer
f. Make available for inspection by members of the public statements of nominated candidates and nomination papers.
g. Approve and deliver to the Returning Officer a list of Members eligible to vote
h. Retain documents relating to elections to the Council of Governors and make these available for inspection by members of the public, subject to any restriction in the Election Rules.
i. Approve proposals to amend the Constitution which must be approved by the Board of Directors, Council of Governors and ratified at the next Annual Members Meeting.s.
j. Specify Partnership Organisations
k. Receive and determine disputes under the Constitution, including disputes between the Council of Governors and the Board of Directors.
l. Present Annual Accounts, any reports of the Auditor on them and the Annual Report at the Annual General Meeting/Annual Members Meeting .
m. Prepare the Annual Report
n. Prepare the Forward Plan
o. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half the member of the Council of Governors.
p. The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

q. Significant transaction is defined as:
   - The acquisition of, or on agreement to acquire, where contingent or not, assets the value of which is more than 25% of the value of the Trusts gross assets before the acquisition; or
   - The Disposal of or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trusts gross assets before the disposition; or
   - A transaction that has or is likely to have the effect of the Trust accruing rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 25% of the value of the Trusts gross assets before the transaction.

r. The views of the Council of Governors will be taken into account before the Trust enters into any proposed transactions which exceed a threshold of 10% for any criteria set out above.

~~The Trust may only apply for a merge acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.~~

~~The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.~~

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6.3 Regulation and controls

a. Approval, suspension, variation or amendment of Standing Orders, Decisions Reserved for the Board and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business
b. Approval of the Decisions Reserved for the Board and Scheme of Delegation from the Board to committees, c~~sub c~~ommittees and officers
c. Requiring and receiving the Declaration of ~~Directors'~~ Interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration
d. Requiring and receiving declaration of interest from officers which may conflict with those of the Trust.
e. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property
f. Approval of the arrangements for dealing with complaints
g. Adoption of the organisational structure, processes and procedures to facilitate the discharge of business by the Trust and to agree any modification there to
h. To establish terms of reference and reporting arrangements of all committees established by the Board of Directors
i. To receive reports from committees including those which the Trust is required to provide by the Secretary of State, ~~Monitor~~ NHS Improvement or other regulatory body or regulation to establish and to take appropriate action thereon

j. To confirm recommendations presented to the Board of Directors by the Trust's Committees
k. Ratification of any urgent decisions taken by the Chairman in accordance with Standing Orders
l. Approve the Trust's Major Incident Plan
m. Prescribe the Financial and Performance reporting arrangement required by the Board of Directors
n. Approval of arrangements relating to the discharge of the Trust's responsibility as a corporate trustee for funds received in trust and Funds Held on Trust
o. Approval of the Trust's banking arrangements (SFI 7.1.2)
p. Authorise use of the common seal of the Trust (SO13)
q. Ratify or otherwise instances of failure to comply with Standing Orders (SO6.32)
r. Discipline members of the Board of Directors or Officers who are in breach of statutory requirements or Standing Orders
s. Call meetings of the Board of Directors (SO6.4)
t. Resolve to require withdrawal of the press and public from meetings of the Board of Directors
u. Approve minutes of the proceedings of the meetings of the Board of Directors (SO6.29)
v. Resolve to adjourn any meeting of the Board of Directors
w. Notify the Independent Regulator of Foundation Trusts and the Council of Governors of any major changes in the circumstances of the Trust which have made or could lead to a substantial change to its financial sustainability, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of Authorisation.
x. Approval of the Trust's Investment Policy and authorisation of institutes with which temporary cash surpluses may be held.

6.4 Appointments/ Dismissal

a. The appointment and dismissal of Board Committees
b. The appointment of the ~~Vice~~ Deputy Chairman in consultation with the Council of Governors
c. The appointment of the Senior Independent Director in consultation with the Council of Governors
d. Through the Remuneration Committee the appointment and appraisal of Executive Directors and the disciplinary procedures of the Trust
e. The appointment of membership of the Board ~~sub~~ committees
f. The appointment of any representative body outside the organisation

6.5 Policy Determination

Operational ~~The~~ Board ~~of Directors~~ will approve policies that require specific Board approval including:

a. Management of Risk
b. Fire Safety Policy
c. Health and Safety Policy
d. Security Policy

This is not an exhaustive list.

6.6 Strategic Plans and Budgets

a. Define and approve the strategic aims and objectives of the Trust
b. Approve strategic business plans incorporating a programme of investment in respect of the application of available financial resources
c. Approve proposals for ensuring quality and safety and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State
d. Approve annually Trust budgets (SFI 5.1.2)
e. Approve Business Cases for Investment in accordance with the Trust's investment policy
f. Approve final business cases for the use of private finance for capital schemes
g. Approve proposals for action on litigation against or on behalf of the Trust
h. Review use of NHSR~~L~~A risk pooling schemes, commercial insurers and self-insurance (SFI 20.2)

6.7 General matters

a. Ratify proposals for acquisition, disposal or change of use of land and/or buildings
b. Joint ventures, partnerships etc
c. To agree actions on litigation against or on behalf of the Trust
d. Any investment regardless of size of new activity or any disinvestment
e. Purchase and maintain insurance against liability.
f. Approve opening and closing of any bank or investment account (SFI 7.1.2)
g. Approve proposals for action on litigation against or on behalf of the Trust

6.8 Financial and reporting management arrangements

a. Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust
b. Receipt and approval of the Trust's Annual Report and Annual Accounts prior to submission to the regulator and Parliament
c. Receipt and approval of the Annual Report and Accounts for funds held on trust prior to submission to the regulator and Parliament
d. Receive the annual management letter from the external auditor and agree proposed action taking account of the advice, where appropriate, of the Audit Committee

7 Delegation to Committees

7.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees~~, or sub-committees,~~ which it has formally~~,~~ constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

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~~7.2 The Board shall determine the reporting requirements in respect of committees. In accordance with Standing Orders, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.~~

7.2~~3~~ The following Committees are established in accordance with Standing Orders:

- Audit Committee;
- ~~Additional Resources Committee;~~
- Quality Assurance Committee~~ and Sub-groups;~~ ;
- Finance and Investment Committee~~,~~ ~~and Sub-groups;~~ ~~(e.g. Investment Management Group);~~
- Remuneration Committee;
- Workforce Committee;
- Risk Committee~~.~~;
- Charitable Funds Committee.

8 Operational Management Board and Sub-groups Chief Executive as Accountable Officer

8.1 The Chief Executive has a responsibility not only to the Board but also to NHS Improvement and the Secretary of State in the use made of Public Funds and Assets that they control.

8.2 The essence of the Accountable Officer role is to see that the functions of the Trust are carried out in a way which ensures the proper stewardship of public money and assets and that funds are only applied to the extent and for the purpose authorised by Parliament.

8.3 The Accountable Officer is responsible for the propriety and regularity of public finances in the NHS, for the keeping of proper accounts, for prudent and economical administration, for the avoidance of waste and extravagance and for the efficient and effective use of all resources and to ensure that the Trust's officers abide by these general requirements.
~~8.3~~

8.4 The Chief Executive should ensure that the Trust has in place effective management systems which safeguard public funds. ~~and should assist the Chair to implement the requirements of Corporate Governance as exemplified in the Codes of Conduct and Accountability.~~

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9 Chief Executive Responsibilities

9.1 The Chief Executive shall determine which functions will be performed personally and shall nominate officers to undertake the remaining functions for which they will still retain accountable~~ility~~ to the Board.

9.2 The Chief Executive shall prepare the Scheme of Delegation identifying their proposals which shall be considered and approved by the Board. The Chief Executive shall periodically review the Scheme proposing any appropriate amendments which shall be considered and approved by the Board.

9.3 Nothing in the Scheme shall release the Director of Finance or other Director from their accountability to provide information and advice in accordance with statutory requirements. Other than this the Director of Finance shall be accountable to the Chief Executive for financial operational matters.

9.4 Nothing in the Scheme shall release the Chief Executive from their responsibilities as Accountable Officer. As Accountable Officer the Chief Executive is accountable to the Independent Regulator for the funds entrusted to the Trust.

9.5 The arrangements made by the Board as set out in the Scheme shall have effect as if incorporated in Standing Orders.

10 Caution over the Use of Delegated Powers

10.1 Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

11 Directors' Ability to Delegate their own Delegated Powers

11.1 The Scheme of Delegation shows the powers delegated to directors and officers and is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

12 Absence of Directors or Officer to Whom Powers have been delegated

12.1 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to them may be exercised by the ~~Chair after taking appropriate advice from the Director of Finance.~~ Deputy Chief Executive or an alternative agreed voting Executive Director in their absence.~~.~~

12.2 The Chief Executive, in consultation with the Chair, may authorise any person to act on their behalf and exercise such delegated powers across the full range of duties carried out by the Chief Executive.

13 Delegation to Officers

13.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other Directors. The Appendix details the delegation set out by Standing Orders and Standing Financial Instructions together with associated delegated limits.

13.2 The Scheme only relates to delegation by the Board to Directors and certain other specific matters referred to in Standing Orders and Standing Financial Instructions.

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Appendix 1 - Delegation from Standing Orders

Standing Order Reference	Delegated To	Authorities/Duties Delegated
2.1	Chairman	Final authority in interpretation of Standing Orders (SOs).
5.7	Council of Governors	Appointment of Chairman and Non-executive Directors.
6.5	Chairman and one third of Board members	Call meetings.
6.12	Chairman	Chair all Board meetings and associated responsibilities.
6.22	Chairman	The Decision of the Chairman is final in matters of dispute between the Board of Directors and Council of Governors.
6.37	Board	Variation or amendment of Standing Orders.
7.3	Board	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference.
7.2	Chairman and Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-executive Directors.
7.5	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
7.7	All	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
9.1	Board	Declarations of Interests.
9.9	Chief Executive	Maintain Register(s) of Interests. (devolved to the Company secretary)
11.1	All Staff	Comply with the Trust's Standards of Business Conduct.
11.7	All	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
13.1	Chief Executive	Keep seal in safe place and maintain a register of sealing (devolved to the Company Secretary).
14.1	Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

Appendix 2 - Delegation from Standing Financial Instructions

SFI Reference	Delegated To	Authorities/Duties Delegated
1.1.2	Director of Finance	Approval of all financial procedures.
1.1.3	Director of Finance	Advice on interpretation or application of SFIs.
1.2	All members of the Board and employees	Have a duty to disclose any non-compliance with these ~~Standing Financial Instructions~~ SFIs to the Director of Finance and non-compliance with Standing Orders to the Chief Executive as soon as possible.
3.	Chief Executive	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the System of Internal Control.
3.	Chief Executive and Director of Finance	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
3.	Chief Executive	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions, Standing Orders and the Scheme of Delegation.
3.	Director of Finance	Responsible for: a Implementing the Trust's financial policies and coordinating any action necessary to further these policies; b Maintaining an effective system of financial control, including ensuring detailed financial procedures and systems are prepared and documented; c Ensuring that sufficient records are maintained to explain Trust transactions and financial position; d Providing financial advice to members of Board and staff; e Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
3.	All members of the Board and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and financial procedures.
3.	Director of Human Resources and Head of Procurement	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply with them.
4.1.1	Audit Committee	Provide independent and objective view on internal control and probity.
4.1.2	Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
4.1.3	Director of Finance	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is considered to be changed.)

SFI Reference	Delegated To	Authorities/Duties Delegated
4.2.2	Chief Executive and Director of Finance	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
4.2.4	Chief Executive and Director of Estates, Facilities and ICT~~Nursing~~	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
4.3.1	Director of Finance, Chief Executive and Director of HR	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
4.4	Director of Finance	Review, appraise and report in accordance with best practice on the system of internal control.
4.5	Audit Committee	Overseeing and ensuring value for money from External Audit.
5.1.1.	Chief Executive and Director of Finance	Compile and submit to the Board an Annual Plan which takes into account financial targets, significant assumptions and forecast of available resources.
5.1.2 & 5.1.3	Director of Finance	a Submit budgets to the Board for approval. b Monitor performance against budget; submit to the Board financial estimates and forecasts.
5.1.5	Director of Finance	Ensure adequate training is delivered on an ongoing basis to budget holders.
5.2.1	Chief Executive	Delegate budget to budget holders.
5.2.2	Chief Executive and Budget Holders	Must not exceed the budgetary total set by the Board.
5.3.1	Director of Finance	Devise and maintain systems of budgetary control.
5.3.2	Budget Holders	Each Budget Holder is responsible for ensuring that: a any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board; b officers shall not exceed the budget limit set c the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised; d no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.
5.3.3	Chief Executive	Identify and implement cost improvements and income generation activities in line with the Annual Plan.

SFI Reference	Delegated To	Authorities/Duties Delegated
5.6.1	Chief Executive	Submit monitoring returns to the requisite organisations.
6	Director of Finance	Preparation of annual accounts and reports.
7.1	Director of Finance	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
8.	Director of Finance	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
8.2.3	All employees	Duty to inform Director of Finance of money due from transactions which they initiate/deal with.
9.	Chief Executive and Director of Finance	Tendering and contract procedure.
9.4.3	~~The Chair,~~ Chief Executive and Director of Finance	Waive formal tendering procedures.
9.4.3	Chief Executive	Report waivers of tendering procedures to the Audit Committee and maintain a record of reasons where competition / formal tendering procedures waived (performed by the ~~Company secretary~~Director of Finance).
9.5.2	Chief Executive (performed by the ~~Company Secretary~~Head of Procurement)	Responsible for the receipt, endorsement and safe custody of tenders received.
9.5.3	Chief Executive (performed by the ~~Company Secretary~~Head of Procurement)	Shall maintain a register to show each set of competitive tender invitations despatched.
9.5.4	Chief Executive and Director of Finance	Where one tender is received will assess for value for money and fair price.
9.5.6	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
9.6.2	Chief Executive	The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money.
9.6.4	Chief Executive or	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Director

SFI Reference	Delegated To	Authorities/Duties Delegated
	Director of Finance	of Finance.
9.9	Chief Executive and Director of Finance	Shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
9.9	Board	All PFI proposals must be agreed by the Board.
9.11	Chief Executive	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
9.13	Chief Executive	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
9.13.4	Chief Executive	The Chief Executive shall nominate an officer to oversee and manage in-house services performance on behalf of the Trust.
10.1.1	Board	Establish Remuneration ~~and Terms of Service~~ Committee.
10.1.2	Remuneration Committee	a Decide the appropriate remuneration and terms of service for the Chief Executive and other Executive Directors to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; b Monitor and evaluate the performance of individual Executive Directors; c Review the Trust's policies and procedures in relation to reward, performance management, retention, recruitment and redundancy.
10.1.4	Nomination Committee	a. Decide the appropriate remuneration and terms of service for the Chair and other Non-Executive Directors to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; b. Monitor and evaluate the performance of individual Non-Executive Directors
10.1.3	Remuneration Committee	Report in writing to the Board its advice and its basis about remuneration and terms of service of Executive Directors.
10.2.2	Chief Executive	Approval of variation to funded establishment of any department.
10.3.1	Chief Executive	Authorise management to make arrangements within Human Resources procedures for Staff, including agency staff, appointments and re-grading.
10.4.1 and 10.4.2	Director of Finance	Payroll: a specifying timetables for submission of properly authorised time records and other notifications; b final determination of pay and allowances; c making payments on agreed dates; d agreeing method of payment; e issuing instructions (as listed in SFI 10.4.2).

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SFI Reference	Delegated To	Authorities/Duties Delegated
10.4.3	Nominated Managers	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
10.5.1	Director of Human Resources	a Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation and health and safety legislation; and b Deal with variations to, or termination of, contracts of employment.
11.1	Chief Executive	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
11.1.2	Chief Executive	Set out procedures on the seeking of professional advice regarding the supply of goods and services
11.2.1	Requisitioner	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
11.2.2	Director of Finance	Shall be responsible for the prompt payment of accounts and claims.
11.2.3 and 11.2.4	Director of Finance	a Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b Be responsible for the prompt payment of all properly authorised accounts and claims; c Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; d Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
11.2.5	Appropriate Executive Director	Make a written case to support the need for a prepayment.
11.2.5	Director of Finance	Approve proposed prepayment arrangements.
11.2.5	Budget holder	Ensure that all items due under a prepayment contract are received (and immediately inform Director of Finance if problems are encountered).
11.2.6	Chief Executive	Authorise budget managers to be issued with official orders.
11.2.7	Managers and officers	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
11.2.8	Chief Executive or Director of Finance	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within NHS Improvement Protection of Assets. The technical audit of these contracts shall be the responsibility of the relevant Director.

SFI Reference	Delegated To	Authorities/Duties Delegated
11.3	Director of Finance	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of the NHS Act.
12.1	Director of Finance	The Director of Finance will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
12.1	Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Director of Finance)
12.1	Director of Finance	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
12.4.2	Director of Finance	Will advise the Board on investments and report, periodically, on performance of same.
12.4.3	Director of Finance	Prepare detailed procedural instructions on the operation of investments held.
13.1.1 and 13.1.2	Chief Executive	Investment programme: a ensure that there is adequate appraisal and approval process for determining capital and revenue expenditure priorities and the effect that each has on plans; b responsible for the management of capital and revenue schemes and for ensuring that they are delivered on time and within cost; c ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d ensure that a business case is produced for each proposal.
13.1.2	Director of Finance	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
13.1.3	Director of Finance	Issue procedures for management of contracts involving stage payments.
13.1.4	Director of Finance	Assess the requirement for the operation of the construction industry taxation deduction scheme.
13.1.5	Director of Finance	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
13.1.6 and 13.1.7	Chief Executive	a Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. b Issue a scheme of delegation for investment management.
13.1.8	Director of Finance	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
13.2.1	Chief Executive and Director of Finance	Maintenance of asset registers (on advice from Director of Finance).

SFI Reference	Delegated To	Authorities/Duties Delegated
13.2.5	Director of Finance	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
13.2.7	Director of Finance	Calculate capital charges as specified by NHS Improvement/ Department Of Health.
13.3.1	Chief Executive	Overall responsibility for fixed assets.
13.3.2	Director of Finance	Approval of fixed asset control procedures.
13.3.4	Board, Executive Directors and all senior staff	Responsibility for security of Trust assets including notifying discrepancies to Director of Finance, and reporting losses in accordance with Trust procedure.
14.2.1	Chief Executive	Delegate overall responsibility for control of stores (subject to Director of Finance responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. ~~(Good practice to append to the scheme of delegation document.)~~
14.2.3	Director of Finance	Responsible for systems of control over stores and receipt of goods. ~~(Report to Director of Finance evidence of overstocking)~~
14.2.1	Director of Pharmacy	Responsible for controls of pharmaceutical stocks.
14.2.1	Designated Estates Officer	Responsible for control of any stocks of fuel, oil and coal.
14.3.3	Head of Procurement	Responsible for control of goods, services and clinical stock.
14.2.2	Director of Nursing	Security arrangements and custody of keys.
14.2.3	Director of Finance	Set out procedures and systems to regulate the stores.
14.2.4	Director of Finance	Agree stocktaking arrangements.
14.2.5	Director of Finance	Approve alternative arrangements where a complete system of stores control is not justified.
14.2.6	Director of Finance	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
14.2.6	Nominated officers	Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking.
14.3.3	Chief Executive	Identify persons authorised to requisition and accept goods from NHS Supplies stores.

SFI Reference	Delegated To	Authorities/Duties Delegated
15.1.1	Director of Finance	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
15.2.1	Director of Finance	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
15.2.2	All Staff	Discovery or suspicion of loss of any kind must be reported immediately to either Medical Directors/Operations Director and then inform the Chief Executive and Director of Finance.
15.2.4	Director of Finance	Where a criminal offence is suspected, Director of Finance must inform the police if theft or arson is involved. In cases of fraud and corruption Director of Finance must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.
15.2.3	Director of Finance	Notify CFSMS and External Audit of all frauds.
15.2.5	Director of Finance	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
15.2.6	Board	Approve write off of losses (within limits delegated by DH).
15.2.8	Director of Finance ~~Director Of Quality~~ Director of Estates, Facilities and ~~Capital Planning~~ICT Director of Nursing	Consider whether any insurance claim can be made.
15.2.9	Director of Finance	Maintain losses and special payments register.
16.1.1	Director of Finance	Responsible for accuracy and security of computerised financial data.
16.1.2	Director of Finance	Satisfy him/herself 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.
16.2	Relevant officers	Consult with the Director of ~~Digital Solutions and Information~~Estates, Facilitates and ICT regarding proposals for information systems and IT developments.
16.3	Director of Finance	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.

SFI Reference	Delegated To	Authorities/Duties Delegated
16.4	Director of Estates, Facilities and ICT ~~Director of Digital Solutions and Information~~	Ensure that risks to the Trust from use of IT are identified and considered and that business continuity plans are in place.
16.5.1	Director of Finance	Where computer systems have an impact on corporate financial systems satisfy him/herself that: a systems acquisition, development and maintenance are in line with corporate policies; b data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c Director of Finance and staff have access to such data; d Such computer audit reviews are being carried out as are considered necessary.
17.1	Director of Nursing	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.3	Director of Finance	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
17.6	Directorate Managers	Inform staff of their responsibilities and duties for the administration of the property of patients.
18.1	Director of Finance	Shall ensure that each fund held on trust (charitable fund) is accounted for appropriately.
18.4.1	Director of Finance	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff.
19	Chief Executive	Retention of document procedures.
20.1.1	Chief Executive	Risk management programme.
20.1.1	Board	Approve and monitor risk management programme.
20.2	Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
20.4.1 and 20.4.2	Director of Nursing	a Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Nursing 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. b Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the 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

SFI Reference	Delegated To	Authorities/Duties Delegated
		up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
20.4.3	Director of Finance	Ensure documented procedures cover management of claims and payments below the deductible.

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

Appendix 3 - Detailed Scheme of Delegation

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other senior officers as appropriate. All items concerning finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

	Delegated Matter	Authority Delegated to	Reference Documents
1	**Management of budgets** Responsibility of keeping expenditure within budgets:		SFIs Section 5
	• At individual budget level (pay and non-pay).	Budget Holders	
	• At service level.	Service Managers or Clinical Directors	
	• At Centre level.	Medical Directors or Operations Directors	
	• For all other areas:	Director of Finance or relevant Directors of service	
2	**Maintenance/operation of bank accounts**	Director of Finance	SFIs Section 7
3	**Non pay revenue and capital expenditure / requisitioning / ordering of goods and services:** **All must be within budgetary limits**		
	• Requisition / Order/Pay		
	i up to £~~510~~,000	~~Clinical Directors/~~Service Managers	
	ii £~~510~~,001 to £50,000	As above counter signed by, Operations Director	
	iii £50,001 to £100,000	As above counter signed by Medical Director or other Executive Director	

Delegated Matter	Authority Delegated to	Reference Documents
iv £100,001 - £250,000	As above counter signed by Director of Finance	
v Over £250,001	As above counter signed by Chief Executive	
• Pharmacy requisitions/orders and acceptance of Medicines	The purchase of all medicines, including new drugs, should be under the control of Pharmacy and orders for medicines should not be made by anyone other than those listed below.	
i Up to £40,000	Lead Pharmacist E and D, senior Pharmacists (band 8a and above)	
ii £40,000 to £70,000	As above but countersigned by Director of Pharmacy or Operational Chief Pharmacist	
iii £70,000 to £100,000	Director of Pharmacy or Operational Chief Pharmacist	
iv Over £100,001 to £250,000	As above counter signed by the Director of Finance	
iii Over £250,001	As above counter signed by Chief Executive	
• Placing contracts		
i Contracts for goods and services and subsequent variations to contracts for procurement suppliers	Head of Procurement, or Head of Pharmacy or Director of Finance	
ii NHS to NHS contracts	Chief Executive	
4 **Investments**		SFIs Section 13
• Produce business cases for individual revenue schemes	Project sponsor	

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Delegated Matter			Authority Delegated to	Reference Documents
in accordance with the Trust's investment policy.				
~~i Revenue scheme (providing positive contribution)~~	~~-~~	~~up to £250,000~~	~~Centre Boards~~	
~~Revenue cost pressures~~	~~-~~	~~up to £100,000~~	~~Centre Boards~~	
~~iii~~ Revenue scheme ~~(providing positive contribution)~~	-	up to £11,000,000	~~Investment Management Group~~Investment Group	
~~iv~~ii Revenue ~~cost pressures~~ scheme	-	up to £2,0500,000	Finance and Investment Committee~~Investment Management Group~~	
~~v Revenue scheme (providing positive contribution)~~	~~-~~	~~up to £5,000,000~~	~~Finance and Investment Committee prior to Trust Board ratification~~	
~~vi Revenue cost pressures~~	~~-~~	~~up to 1,000,000~~	~~Finance and Investment Committee prior to Trust Board ratification~~	
~~viiiii~~ Revenue scheme ~~(providing positive contribution)~~	-	Above £25,000,000	Board of Directors	
~~viii Revenue cost pressures~~	~~-~~	~~Above £1,000,000~~	~~Board of Directors~~	
• ~~—~~Produce business cases for individual capital schemes which require capital investment in accordance with the Trust's investment policy.			Project sponsor	
~~i Capital value~~	~~-~~	~~up to £25,000~~	~~Centre Boards~~	
~~ii Capital value~~	~~-~~	~~up to £250,000~~	~~Capital Group~~	

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Delegated Matter	Authority Delegated to	Reference Documents
i Capital value - up to £~~5~~100,000	Capital and Investment Group~~Investment Management Group~~	
ii Capital value - up to £2~~1~~,000,000	Finance and Investment Committee ~~prior to Trust Board ratification~~	
iii Capital value - Over £2~~1~~,000,000	Board of Directors	
• Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations.	Chief Executive or Director of Finance	
• Financial monitoring and reporting on all capital scheme expenditure.	Director of Finance	
• Granting and termination of leases with annual rent <£250k.	Director of Finance and Director of Estates, Facilities and ICT.	
• Granting and termination of leases of >£250k.	Chief Executive and~~or~~ Director of Finance~~, and Non-Executive Director~~	
5 **Quotation, tendering and contract procedures**		SFIs Sections 9
• Obtaining informal quotations for goods/services to demonstrate value for money and a common sense approach up to £10,000.	Budget holders ~~/ Clinical Directors~~ and Service Managers in association with Procurement	
• Obtaining 3 formal quotations for goods/services from £10,001 to £~~50~~25,000.	Budget holders /~~Clinical Directors~~Service Manager and Operations Directors in association with Procurement	
• Obtaining formal tenders for goods/services over £25,~~50,~~000	Budget Holders / ~~Clinical Directors~~Service Manager and Operations Directors in association with Procurement	
• Tenders to comply with OJEU requirements and thresholds.	Head of Procurement	
• Waiving of tenders exceeding £~~50~~25,001.	Chief Executive~~, The Chair~~ and Director of Finance and reported to Audit Committee.	

Delegated Matter	Authority Delegated to	Reference Documents
• Authorise Single Tender action		
i £2550,001 to £250,000	Chief Executive and Director of Finance	
ii Over £250,001	Chief Executive and Director of Finance and one Executive Director and Chair and reported to next Board meeting	
• Authorisation of Tenders		
i £5025,001 to £250,000	Director of Finance	
ii Over £250,001	Chief Executive	
Following approval, contracts will be let through Procurement or Pharmacy to suppliers.	Head of Procurement or Director of Pharmacy	
NHS to NHS contracts	Chief Executive or Director of Finance	
6 **Setting of fees and charges**		
• Patient, overseas visitors, income generation and other patient related services.	Director of Finance or nominated Deputy	
• Price of NHS contracts Charges for all NHS contracts, be they block, cost per case, cost and volume, spare capacity.	Director of Finance	
7 **Engagement of staff not on the establishment**		
• Non-medical consultancy staff where aggregate commitment in any one year (or total commitment) is less than £250,000.	Chief Executive or Director of Finance	
• Engagement of Trust's solicitors.	Chief Executive or Executive Director	

	Delegated Matter	Authority Delegated to	Reference Documents
	• Booking of bank, or agency Staff i Medical locums ii Nursing iii Clerical	Operations Directors, Medical Directors or Executive Director	
8	**Expenditure on charitable funds**		SFIs Section 18
	• Up to £5,000 per request.	Fund-holder - subject to confirmation by Trust Fund Manager, that funds are available.	
	• £5,001 to £25,000 per request	As above and Operations Director	
	• £25,0001 to £100,000 per request	As above and Medical Director and Director of Finance	
	• Above £100,000 per request.	As above and Chief Executive	
9	**Agreements/licences**		
	• Preparation and signature of all tenancy agreements / licences for all staff subject to Trust policy on accommodation for staff.	Director of Estates, Facilities and ~~Capital Planning~~ICT	
	• Extensions to existing leases.	Director of Finance	
	• Letting of premises to outside organisations.	Director of Estates, Facilities and ICT~~Director of Estates, Facilities and Capital Planning~~	
	• Approval of rent based on professional assessment.	Director of Estates, Facilities and ICT~~Director of Estates, Facilities and Capital Planning~~	
10	**Condemning and disposal** Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively:	Operations Director in association with Procurement and Director of Finance	SFIs Section 15
11	**Losses, write-off and compensation**	Chief Executive and Director of Finance (reported annually to	SFIs Section 15

Delegated Matter	Authority Delegated to	Reference Documents
	the Audit Committee)	
• Losses and cash due to theft, fraud, overpayment and others- up to £50,000.		
• Fruitless payments (including abandoned capital schemes) - up to £250,000.		
• Bad debts and claims abandoned, private patients, overseas visitors and other - up to £50,000.	Director of Finance	
• Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	Director of Finance	
• Culpable causes (e.g. fraud, theft, arson) or other - up to £50,000.	Director of Finance	
• Compensation payments made under legal obligation.	Director of Finance	
• Extra Contractual payments to contractors up to £50,000.	Director of Finance	
• Other up to £50,000	Director of Finance	
• All other payments and claims above set limits	Board of Directors	
• Ex gratia payments for loss of personal effects		
• Up to £10,000	~~Head of Financial Governance and Control~~Financial Controller	
• £10,000 to a maximum of £50,000	Director of Finance	
• To admit liability and settle personal injury claims up to the deductible insurance limit - (up to £10,000 employers liability and up to £3,000 public liability)	~~Head of Patient Safety, Information Governance and Legal Services~~Director of Nursing	
• Write off debtors.	Reported to Audit Committee for information	

	Delegated Matter	Authority Delegated to	Reference Documents
12	**Reporting of incidents to the police**		SFIs Section 15
	• Where a criminal offence is suspected	Director of Finance	
	• Where a fraud is involved.	Director of Finance	
13	~~**Receiving hospitality**~~**Declaration of Interests, Gifts Hospitality, Private Practice etc** ~~Applies to both individual and collective hospitality receipt items.~~	Staff 8d and above declaration of interest including gift and hospitality outside employed, shareholdings and ownership patients, donations, clinical private practice, sponsored events, sponsored posts ~~Declaration required in Trust's Hospitality Register~~	
14	**Implementation of internal and external audit recommendations.**	Executive Director responsible for the area of work concerned	SFIs Section 4
15	**Maintenance and update on Trust financial procedures.**	Director of Finance	
16	**Investment of funds**	Director of Finance	SFIs Section 12
17	**Human resources and pay**		SFIs Section 10
	• Pay and Conditions		
	i Agreement on variations to pay scales and conditions of service collectively	Director of Human Resources and Remuneration Committee	
	ii Variation to individual terms and conditions	Director of Human Resources	
	iii Approval of performance related pay schemes	Remuneration Committee	
	iv Changes to band / grading	Director of Human Resources	
	• Establishments		

Delegated Matter	Authority Delegated to	Reference Documents
i Authority to complete starter, leaver and variation forms	Line Managers	
ii Authority to authorise new starter within establishment	Line Managers	
iii Authority to approve additions to establishment	Director of Finance	
• Human Resources Policies		
i Development of new policies and variations to existing policies		
- With limited financial consequences	Director of Human Resources	
- With significant financial consequences	Director of Human Resources and Remuneration Committee	
ii Application of policies and approval of leave etc.	Line Managers	
• Medical staff study leave		
i Approval of policy and changes to policy	Senior leadership team	
ii Consultant	Medical Director	
iii Speciality doctors	Director of Post Graduate Medical Education	
iv Junior Doctors	Director of Post Graduate Medical Education	
• Employment sanctions		
i Development of policies and variations to existing policies		
- Significant changes	Senior Leadership Team	
- Updating and less significant changes	Director of Human Resources	

Delegated Matter	Authority Delegated to	Reference Documents
ii Approval of policies specifically applying to Directors	Remuneration Committee	
18 **Authorisation of sponsorship deals**	~~Medical Director, Director of Human Resources~~Director of Finance and Company Secretary	
19 **Authorisation of research projects**	~~Medical Director, Director of Human Resources and Company Secretary~~~~Director of Research and Innovation~~Director of Human Resources, Director of Research & Innovation and the Company Secretary	
20 **Authorisation of clinical trials**	Director of Research and Innovation~~Medical Director, Director of Human Resources and Company Secretary~~	
21 **Insurance policies and risk management.**		SFIs Section 20
Determine insurance in accordance with Corporate Policy	~~Director of Nursing, Director of Quality and Director of Estates Facilities and Capital Planning ICT with advice from the~~ Director of Finance and the Company Secretary, for approval by the Board	
22 **Patients & relatives complaints**		
• Overall responsibility for ensuring that all complaints are dealt with effectively.	~~Head of Patient Safety, Information Governance and Legal Services~~Director of Nursing	
• Responsibility for ensuring complaints relating to a Centre are investigated thoroughly	~~Head of Patient Safety, Information Governance and Legal Services~~Director of Nursing	
• Medico-Legal Complaints Co-ordination of their management.	~~Head of Patient Safety, Information Governance and Legal Services~~Director of Nursing	
23 **Relationships with press**		
• Non-emergency general enquiries		
i Within hours	~~Head of Communications/Engagement~~ Director of Communications	

	Delegated Matter	Authority Delegated to	Reference Documents
	ii Outside hours	~~Duty Officer or Executive Director~~Director of Communications or Executive Director	
	• Emergency		
	i Within hours	~~Head of Communications/Engagement~~Director of Communications	
	ii Outside hours	~~Duty Officer or on call Director~~Director of Communications or on call Director	
24	**Infectious diseases and notifiable outbreaks.**	Medical Director and Infection control doctor, Director of Nursing~~(s)~~	
25	**Extended role activities**		
	Approval of nurses to undertake duties/procedures which can properly be described as beyond the normal scope of nursing practice.	~~Chief Executive or~~ Director of Nursing	Nurse / Midwives / Health Visitors Act Midwives Rules / Code of Practice UKCC Code of Professional Conduct
26	**Patient services**		
	• Variation of operating and clinic sessions within existing numbers		
	i. Temporary change	Clinical Director and Operations Director	
	ii. Permanent change	Chief Executive	
	i		
	• All proposed changes in bed allocation and use		
	I. Temporary change	Patient Flow Manager	
	II. Permanent change	Chief Executive	

	Delegated Matter	Authority Delegated to	Reference Documents
	• Contract monitoring and reporting	Director of Finance	
27	**Facilities for staff not employed by the Trust to gain practical experience** Professional recognition, honorary contracts and insurance of medical staff, Work experience students.	Operations Director and Director of Human Resources	
28	**Review of all statutory compliance legislation and health and safety requirements including control of substances hazardous to health regulations.**	Medical Director, ~~&~~ Director of Nursing and Director of Estates, ICT & Health Records	
29	**Review of medicines inspectorate regulations.**	Medical Director	
30	**Review of compliance with environmental regulations, for example, those relating to clean air and waste disposal.**	~~-~~Chief Executive with advice from Director of Estates, ~~Facilities and Capital Planning~~ICT. ~~-~~ICT & Health Records	
31	**Review of Trust's compliance with the Data Protection Act.**	~~Head of Patient Safety, Information Governance and Legal Services~~Company Secretary	
32	**Monitor proposals for contractual arrangements between the Trust and outside bodies.**	Director of Finance	
33	**Review the Trust's compliance with the Access to Records Act.**	~~Head of Patient Safety, Information Governance and Legal Services and Data Protection officer~~Director of Estates, Facilities and ICT~~Nursing~~	
34	**Review of the Trust's compliance code of practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60.**	Head of Patient Safety, Information Governance and Legal Services	
35	**The keeping of a register of interest ~~Declaration of Interests Register.~~**	Chief Executive (performed by the Company Secretary)	SOs Section 9.9
36	**Attestation of sealing in accordance with Standing Orders.**	Chief Executive and Director of Finance	SOs Section 13

Delegated Matter	Authority Delegated to	Reference Documents
37 **The keeping of a register of sealing.**	Company Secretary	SOs Section 13
~~38 The keeping of the hospitality register.~~	~~Company Secretary~~	
~~39~~38 **Retention of records.**	Chief Executive	SFIs Section 19
~~40~~39 **Clinical audit.**	~~Clinical Directors and~~ Medical Directors, Clinical Directors and Director of Nursing	
~~41~~40 **Engagement of the Trust's solicitors**	All Board Directors and Company Secretary	

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Policy Agreement / Approval

The following groups/ committees/individuals have reviewed and agreed this procedural document

Final Approved by	Date Agreed	Date for Review
Board of Directors	~~06/12/2016~~	September 202~~018~~