BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on
Wednesday 12 September 2018 at 14.30 in Room 5a, Education Centre, Mile End Hospital, Bancroft Rd, Mile End, London E1 4DG
Scheduled to end by 17.00

AGENDA

Please note that this is a Trust Board meeting held in public. In accordance with the Trust’s Standing Orders, no filming or recording of the meeting is permitted. There will be an opportunity for questions and comments from members of the public at the end of the meeting.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Paper TB</th>
<th>Lead</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WELCOME</td>
<td></td>
<td>Mr I Peters</td>
<td>14.30</td>
</tr>
<tr>
<td>2</td>
<td>APOLOGIES FOR ABSENCE: Mr T Halton</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>DECLARATION OF INTERESTS</td>
<td>To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting including gifts and hospitality (accepted or refused)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MINUTES</td>
<td>To approve the Minutes of the meeting held on 4 July 2018 and review the action log appended to the Minutes</td>
<td>42/18</td>
<td>Mr I Peters</td>
</tr>
<tr>
<td>5</td>
<td>MATTERS ARISING</td>
<td>To consider any matters arising from the Minutes not covered elsewhere on the agenda</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>PATIENT STORY</td>
<td>To hear a patient story</td>
<td></td>
<td>Ms C Alexander</td>
</tr>
<tr>
<td>7</td>
<td>CHAIR’S REPORT</td>
<td>To receive the Chair’s report</td>
<td></td>
<td>Mr I Peters</td>
</tr>
</tbody>
</table>
|   | **CHIEF EXECUTIVE’S REPORT**  
To receive the Chief Executive’s report | Paper TB | Lead | Time |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Ms A Williams</td>
<td>15.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**QUALITY, SAFETY AND PERFORMANCE**

|   | **INTEGRATED PERFORMANCE REPORT – 2018/19 M4**  
To receive the report and discuss:  
- Access  
- Quality and Safety  
- People  
- Financial performance | Paper TB | Lead | Time |
|---|---|---|---|---|
| 9. | Mr S DeGaris  
Prof A Chesser  
Ms C Alexander  
Mr M Pantlin  
Ms C Alagaratnam | 15.15 |
| 10. | Ms C Alexander/Prof A Chesser | 15.50 |
| 11. | Mr A Hines | 16.00 |
| 12. | Mr M Pantlin | 16.10 |

**GOVERNANCE AND ASSURANCE**

|   | **WHIPPS CROSS REDEVELOPMENT**  
To receive an update report | Paper TB | Lead | Time |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>Mr R Coulbeck</td>
<td>16.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Mr A Hines</td>
<td>16.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Mr A Hines / Ms C Alagaratnam</td>
<td>16.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Ms C Alexander</td>
<td>16.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Mr S Collins</td>
<td>16.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ITEMS FOR INFORMATION (UNLESS OTHERWISE STATED)

<table>
<thead>
<tr>
<th></th>
<th>Paper TB</th>
<th>Lead</th>
<th>Time</th>
</tr>
</thead>
</table>
| 19. | **REPORTS FROM BOARD COMMITTEES**  
19.1 Finance and Investment Committee (oral) | 52/18 | Mr A Camp |
19.2 Nominations and Remuneration Committee | 53/18 | Mr I Peters |
19.3 Quality Assurance Committee | 54/18 | Dr T Swage |
19.4 Audit and Risk Committee | | Mr G Dalal |
| 20. | **ANNUAL AUDIT LETTER**  
To receive the letter | 55/18 | Ms C Alagaratnam |
| 21. | **ANY OTHER BUSINESS** | | |
| 22. | **QUESTIONS FROM MEMBERS OF THE PUBLIC** | | 16.55 |
| 23. | **DATE OF THE NEXT MEETING**  
The next meeting of the Trust Board in public will be held on Wednesday 7 November at 11am in the Bainbridge Room, Robin Brook Centre, St Bartholomew’s Hospital, West Smithfield, London EC1A 7BE. | | |
| 25. | **RESOLUTION**  
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960). | | |

---

Sean Collins  
Trust Secretary  
Barts Health NHS Trust  
020 3246 0637
BARTS HEALTH NHS TRUST
TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting held in public on Wednesday 4 July 2018 at 11.00am in the Board Room, Junction 6, Whipps Cross Hospital, Whipps Cross Rd, Leytonstone, London E11 1NR

Present:  
Mr G Dalal (Vice Chairman) - Chair  
Ms A Williams (Chief Executive)  
Ms C Alagaratnam (Chief Finance Officer)  
Ms C Alexander (Chief Nurse)  
Mr A Camp (Non Executive Director)  
Professor A Chesser (Chief Medical Officer)  
Mr R Coulbeck (Director of Strategy)*  
Ms M Exley (Non Executive Director)  
Mr T Halton (Director of Clinical Operations)*  
Mr A Hines (Director of Corporate Development)*  
Ms A Lachhani (NExT Director)*  
Mr M Pantlin (Director of People)*  
Dr T Swage (Non Executive Director)

In attendance:  
Mr S Collins (Trust Secretary)

Apologies:  
Mr I Peters (Chairman)  
Mr M Higson (Non Executive Director)  
Ms N Howard (Non Executive Director)  
Ms K Kinnaird (NExT Director)*  
Dr T Peachey (Deputy Chief Executive)  
Professor S Thornton (Non Executive Director)

* Non-voting member

56/18 WELCOME

The Vice Chairman welcomed everyone to the meeting.

57/18 DECLARATION OF INTERESTS

Attendees were reminded of the need to declare any interests they may have in connection with the agenda or interests acquired since the previous meeting, including gifts and hospitality (accepted or refused). There were no new declarations.
The Minutes of the meeting of the Trust Board held in public on 9 May 2018 were received and approved as an accurate record.

MATTERS ARISING

Action log

The Vice Chairman noted completed actions in relation to reporting on patient falls, sickness absence and paying patients pilot schemes. In relation to Serco and Soft FM staff terms and conditions, the Trust had been involved in discussions with union representatives and Serco with the aspiration to reach a resolution during the next two months.

STAFF STORY

The Chief Nurse introduced Karen Bryan and two members of her team who had been invited to provide details of work in the Acute Admissions Unit (AAU) to address high nursing vacancy rates and implementing a new ‘Perfect Ward’ app to support effective planning and information sharing. The Trust Board received details of steps taken to support recruitment and retention, developing a culture of listening to staff, a family-friendly approach towards rota management, career development opportunities, a flexible approach to team duties and the development of new roles to maximise support for teams. The team had recorded significant improvements in sickness absences and morale over the last year and performance data suggested a correlation between staff and patient satisfaction, with no complaints received in May or June. The team outlined the use of the new Perfect Ward app to support day-to-day management including realtime recording and monitoring of ward audits, environmental checks and discussions with medical staff. The Trust Board noted the greater responsiveness that was reported as a result of timely information being made available.

The following points were made in discussion:

- Ms Exley welcomed the steps taken to address longstanding vacancy rate issues in this specialty. She noted that pressure ulcer performance was often considered a proxy for effective nursing practices and asked whether there had been any learning from the experiences on AAU in this respect. Ms Bryan emphasised the importance of minimising temporary staffing levels to enable the essentials of good care to be consistently maintained, developing pride in delivery of high nursing standards.

- The Vice Chairman asked whether all team members used and uploaded information on the Perfect Ward app and if this information
extended to patient feedback. It was confirmed that nursing staff at grades Band 6 and upward routinely used this to record, for example, patients' responses to questions about whether they had been satisfactorily informed about wayfinding, their diagnosis and predicted discharge date.

- The Director of Corporate Development noted the focus on essentials and asked whether there were any barriers to ensuring consistent medicines management practice. Ms Bryan indicated the need for clear and repeated messages to maintain awareness and the key role of safety huddles to share headline messages.

- Mr Camp asked what the team felt to be the primary success factors in improving staff retention. Ms Bryan emphasised the importance of creating the right environment, treating staff members like family and encouraging staff to discuss issues through an open door approach. Ward leaders attended team meetings for all grades of staff to understand and problem solve.

- The Director of Corporate Development noted that AAU had historically been a challenging area due to workforce shortages and welcomed the positive steps taken to address this. He asked whether the team needed any help to support their efforts. It was confirmed that senior level liaison with partners in community settings to ease discharge and patient flow was appreciated, as was any assistance in developing career progression opportunities for teams.

The Vice Chairman thanked Ms Bryan and the team on behalf of the Trust Board for sharing details of this important work. The Chief Nurse echoed her thanks and outlined steps to roll out the Perfect Ward app to inpatient areas and embed this in existing areas to consistently realise benefits of this. It was agreed to explore this in more detail at the Quality Assurance Committee in due course.

61/18 VICE CHAIR'S REPORT

The Vice Chairman highlighted a number of important recent events held by the Trust including:

- The 486th annual View Day at St Bartholomew's Hospital, which had included an opportunity for visitors to see the Trust's surgical robot being exhibited in the atrium.

- The Volunteers Party, held each year to pay tribute to the important work carried out by the Trust's voluntary workforce.
• A Chairman's lunch, with 160 Barts Health Heroes nominees invited to attend.

The Vice Chairman noted other meetings that the Chairman had attended during this period, including those with the Barts Charity and with NHS Improvement to discuss the Trust’s financial and quality plans. The Chairman had also participated in selection of a partner to support the Trust's 'Well-Led' development plans.

62/18 CHIEF EXECUTIVE’S REPORT

The Chief Executive outlined recent developments, highlighting the following points:

• HM Government’s announcement of a five year 3.4% funding settlement for the NHS from 2019/20 and union agreement on Agenda for Change pay awards. The NHS had been tasked with the development of a ten-year plan, with priorities linked to public health improvement, closer integration of health and social care providers, mental health, digital technology and innovation.

• The appointment of Shane DeGaris as the Trust’s Deputy Chief Executive, with a start date in September. Shane’s clinical background had been in physiotherapy and he joined from Hillingdon Hospitals NHS Foundation Trust following six years’ service as Chief Executive.

• An improvement in the CQC rating for Whipps Cross surgical services, which meant that no core services were now rated as ‘inadequate’. The CQC review did, however, identify concerns regarding medicines management in the service and regular discussions were being held across the Trust to prioritise messages regarding safe and effective practices.

• The inclusion of 18 Week Referral to Treatment Time in the monthly Integrated Performance Report, following the return to national reporting.

• National recognition of Trust teams and leaders. This included the physician’s response unit, estates and cardiac imaging teams winning HSJ Value awards. National honours included an OBE for Dr Ian Basnett for services to public health and a Lieutenant of the Royal Victorian Order (LVO) award for Mr Satya Bhattacharya, consultant general surgeon at Royal London Hospital and Serjeant-Surgeon to Her Majesty the Queen and the Royal Household. Dr Bijay Sinha, a Whipps Cross consultant, and Dr Vanessa Apea, a Royal London consultant, had also won NHS Windrush 70 awards.
for their leadership and work to reduce health inequalities. A further announcement would shortly be announced in relation to Parliamentary NHS70 awards.

- Plans for NHS70 celebrations commencing on 5 July 2018, including events being held at each hospital site and a service held at Westminster Abbey. These celebrations would continue as part of the Trust’s Open Day, being held at Whipps Cross Hospital on 7 July 2018.

The Director of Corporate Development noted that staff increasingly recognised the contribution that colleagues made, with the Trust on course to exceed the record number of Barts Health Heroes nominations received last year. The Chief Executive felt it was important to recognise positive contributions and highlighted the role of the Communications teams in supporting this. The Vice Chairman noted that the staff story on recruitment and retention earlier in the meeting had provided a helpful example of the potential learning to be gained from successful interventions.

The Chief Executive and Vice Chairman, on behalf of the Board, thanked Dr Tim Peachey for his outstanding contribution to the Trust as Deputy Chief Executive. Following his decision to retire, Dr Peachey would remain in his current role until Mr DeGaris took up post in September.

63/18 INTEGRATED PERFORMANCE REPORT – MONTH 2

(i) Access standards

The Director of Clinical Operations outlined access standards performance for May 2018, which included 18 Weeks Referral to Treatment Time (RTT) performance data for April (reporting one month in arrears). He confirmed that 86% of patients had received appointments within 18 Weeks (against a national target of 92%), with 36 patients reported as waiting over 52 weeks. He outlined the significant work that had been carried out to ensure confidence in the data quality supporting this analysis. He confirmed that the overall impact of the Trust’s return to reporting on the national position for 18 Weeks RTT compliance had been minor. He recognised, however, that, due to the significant volumes involved with the Trust’s waiting lists, achievement of the 92% standard would require approximately 18 months of further work. Achieving the target of eliminating the cohort of patients waiting over 52 weeks by year end would be similarly challenging.

The Director of Clinical Operations noted that the Trust remained below the 90% emergency care standard, while it continued to see increased attendances and treat more patients when compared to previous years. He outlined improvement work being undertaken with partners to support efforts to treat
patients in the most appropriate settings, including work on pathways for frail elderly patients, and prepare for anticipated winter pressures.

Mr Camp noted that around 150 acute beds were occupied by medically optimised patients and others with delayed discharges or transfers. He asked whether communication with partners was proving productive in terms of securing closer integration of urgent care. The Director of Clinical Operations felt that there was good engagement with local authorities, with steps to improve existing models of care and develop new approaches to address the system-wide challenges faced. He indicated the importance of developing effective and timely information to help other providers to respond to peaks in demand. Dr Swage noted sustained high performance at Newham and asked if any lessons could be learned at other sites. It was confirmed that the Newham emergency department had functioned effectively for some time and had developed effective relationships with other departments when more challenging demands arose. While recognising the different mix of patients seen at the three sites (with Newham serving a younger population than Whipps Cross, and The Royal London receiving a high proportion of trauma cases), the opportunities to share learning and rotate staff across sites had been a consistent theme of discussions at the cross site Emergency Care Board.

Ms Exley asked about mixed sex accommodation breaches. The Director of Clinical Operations noted that these related to intensive care step down delays rather than mixed general ward beds. It was noted that there were different issues faced by each site and that earlier discharge of patients was a key enabler for creating additional capacity.

Mr Dalal asked about the improvements seen in consistently achieving cancer 62-day targets. The Chief Medical Officer recognised the significant work of the Cancer Board in streamlining pathways and improving communication between different organisations and the evidenced link between strong research specialties and clinical outcomes.

(ii) Quality and Safety

The Chief Medical Officer and Chief Nurse highlighted key points arising from quality and safety metrics identified in the report, including progress on pressure ulcers and reducing MSSA and MRSA incidence. Issues with data quality and transition to new processes to support capture of results had impacted on Friends and Family Test response rates, with work now under way to recover this position. The Chief Medical Officer noted an improving position on the number of reported cardiac arrests, which he felt was linked to focused work on managing acutely ill patients and input of resuscitation teams (notably at the Whipps Cross site through introducing root cause analyses).

Dr Swage asked about dementia screening rates at the St Bartholomew’s Hospital site. The Chief Medical Officer noted a deterioration while recognising
also that the small numbers involved tended to result in reported performance trends appearing relatively volatile. The Chief Nurse noted that there were a number of better performing wards, such as Syringa at Whips Cross, and learning from successful areas was being developed into a video.

Mr Camp asked about site variances on pressure ulcer incidence. It was confirmed that learning from successful practice would be further explored at the next Quality Assurance Committee meeting.

(iii) People

The Director of People outlined Trust and site-level progress on recruitment, and opportunities to develop apprenticeship models. In relation to sickness absence he noted work being led by Occupational Health teams to address the high proportion of long term absences associated with musculoskeletal issues.

Dr Swage asked about changes to restrictions on overseas doctors and nurses. It was confirmed that, prior to the recent changes, around 50 individuals had not been able to work due to visas being declined. The recent change in regulations had not extended to allied health professionals and shortages would remain an issue for retention of existing staff as well as recruitment.

Mr Dalal asked about apprenticeship opportunities. The Director of People noted work led by the Academic Health Sciences team to develop nursing pathways through this route, with local universities interested in developing qualifications. Further work would be required on non-clinical apprenticeship pathways to map these to existing gaps in skills.

(iv) Finance

The Chief Finance Officer introduced the finance section of the report and highlighted discussion at the Finance and Investment Committee meeting held earlier in the day about the financial position, including an acknowledgement that this had been the first occasion that she had been able to report that all sites and corporate directorates had met their monthly financial plan target. The Chief Executive welcomed this and noted the importance of viewing the financial improvement in the context of also securing quality improvements, as these were compatible and complementary targets.

Ms Exley asked about the central costs expenditure and it was confirmed that this related to centrally held provisions being released into the position.

OPERATIONAL PLAN

The Director of Strategy introduced TB 32/18, a report on the Operational Plan summary ‘Barts Health Cares’ 2018. He outlined the process for development and submission of the Trust’s annual plan, which accompanied the Trust’s
‘Getting to Good and Outstanding’ quality improvement plan. He noted the sections on efficiency (including targets to significantly reduce the Trust’s financial deficit in 2018/19), transformation and group model development, workforce, infrastructure and research and education. He noted the need to monitor progress against the plan during the year.

Mr Dalal asked about the development of the group model. The Director of Strategy noted proposals to further develop site governance models through the development of divisional structures and plans, while supporting clinical boards with the tools to support work on driving up standards consistently. Mr Dalal asked whether the ambitions drew on benchmarks from beyond the UK. The Chief Medical Officer recognised the need to consider longer term goals such as improving mortality rates in East London and addressing health inequalities, while also acknowledging the opportunities to develop learning from success locally and improving information from tools such as clinical audit. The Director of Strategy noted that many specialties, such as Cancer services, reviewed data against national benchmarks. The Director of Corporate Development recognised that this document had been co-produced with the Communications team as an outward-facing summary. He noted the equal importance of internal messages being clear about internal standards and granular supporting plans. In relation to relevant group model developments, he noted plans to further integrate a number of clinical support services with site management over the next year.

The Trust Board approved the summary operational plan.

65/18 BOARD ASSURANCE FRAMEWORK

The Director of Corporate Development introduced TB 33/18, the Board Assurance Framework (BAF) summarising the principal risks to the Trust’s objectives. He outlined the importance of effective development and use of this tool for tracking the effectiveness of related controls and assurances and as evidence of a well-led organisation. The Trust’s objectives remained largely unchanged (as the second year of a two-year plan) and the Board Assurance Framework reflected relatively similar risks accordingly. He noted an overall change in emphasis to reflect a move from a period of stabilisation and recovery towards sustaining transformational change, with the risks on Referral to Treatment Time linked to performance and sustaining data quality rather than a return to reporting, amendments to financial risks and identification of a new entry relating to delivery of Outpatients transformation. In line with audit recommendations, steps were being considered to enhance the Audit and Risk Committee and other board committees’ scrutiny of the BAF in future.

Mr Camp suggested that the Board Assurance Framework effectively captured the key risks to the organisation. He noted the allocation of BAF entries to a lead committee while recognising that many risks would have dimensions that were relevant to more than one of these. He confirmed that the Finance and
Investment Committee had requested assurance updates on allocated BAF entries (relating to investment in fire safety and ICT improvements in a constrained capital environment) to discuss mitigation of these.

Ms Exley noted the BAF entry in relation to patient flow and recognised the effective mitigation of some risks through enhanced winter arrangements, which had not been fully reflected in the listed controls and assurances. She also asked about educational funding risks identified in the BAF. The Chief Nurse confirmed the reduction in overall funding available to the Trust and the need to manage this in innovative and effective ways. The Board also noted emerging changes to national bursary arrangements to support nurses during their education, with a likely impact on future nursing careers. It was agreed to confirm the timing for a planned Board report on the nurse workforce model to support wider discussion of these issues.

**ACTION: Chief Nurse and Director of People**

The Vice Chairman agreed with the proposal for the Audit and Risk Committee to play an enhanced role in review of the overall BAF entries and process, given the group’s duties in relation to risk. The Trust Board approved the Board Assurance Framework.

**66/18 GETTING TO GOOD AND OUTSTANDING**

The Chief Medical Officer introduced TB 34/18, a report on Getting to Good and Outstanding and highlighted key points including preparations for forthcoming CQC inspections, progress against CQC actions plans and embedding peer review processes. He noted in particular the improved rating for Whipps Cross surgery, following the CQC’s reinspection in April 2018. However, the visit had highlighted issues with arrangements for medicines management resulting in a specific warning notice. He indicated that this had prompted a review of Trustwide controls for medicines and to raise awareness of the need for continuous challenge and improvement. The Chief Executive added that medicines management issues had been incorporated into the daily site safety huddles to support attention on this focus.

Mr Dalal asked if any themes had been highlighted in relation to medicines management or health records management to understand why these had not previously been identified as key issues. The Chief Medical Officer indicated that this had identified issues in how pharmacy services integrated with site teams effectively. Steps to roll out paperless systems should help to mitigate risks identified in relation to records being left unattended, while controls were required to prevent smartcards being left in PCs.

Mr Camp emphasised the need for robust challenge through peer reviews ahead of forthcoming CQC inspections. Ms Exley agreed, highlighting the importance of staff being clear on key messages and likely areas of challenge during CQC inspections. The Chief Nurse endorsed the involvement of senior
staff as CQC inspectors and peer reviewers to support these core activities. The Director of Corporate Development noted that external reviews had also been commissioned to challenge and assure the Trust’s self-assessment against the Well Led domain.

**67/18 PEOPLE STRATEGY**

*Equalities and inclusion*

The Director of People introduced TB 35/18 a report on equalities and inclusion. He highlighted key points, including the development of a diversity charter for Board approval, the Workforce Race Equality Standards annual assessment and the role of the Inclusion Board.

Mr Dalal asked about gender pay gap information. The Director of People recognised that the Trust was not an outlier. The greatest gender differentials related to what had been categorised as ‘bonuses’ (which was limited to national arrangements for consultant grade medical staff Clinical Excellence Awards). The Chief Medical Officer felt that this gap largely reflected historic awards and confirmed that more recent awards had been more balanced in terms of gender, reflecting the increasing proportion of female consultants in the workforce.

Ms Exley highlighted the diversity seen in the Barts Health Heroes processes and positive recognition of staff from all backgrounds. She felt that there could be opportunities for training on ‘unconscious bias’ to support more inclusive recruitment and retention of staff.

Dr Swage endorsed the Diversity Charter and noted plans to report back in the next equalities and inclusion report on deliverables and progress against the specific elements set out.

**68/18 MEDICAL REVALIDATION**

The Chief Medical Officer introduced an annual report on the Trust’s arrangements for revalidation. He outlined key details of the leadership, monitoring and training provided by the Office of the Chief Medical Officer, Revalidation Team and Responsible Officers to support medical appraisal and related five yearly revalidation requirements for senior medical staff. He noted the strong performance of the Trust's team in securing consistently high appraisal rates, while recognising opportunities to focus on the quality of these.

Mr Dalal asked about the reasons why deferral of appraisals may be accepted. It was confirmed that there could be a range of acceptable reasons for deferring appraisals or for the responsible officer to seek additional detail
before sign off. The Chief Medical Officer noted that failure to engage with appraisal requirements was a more serious concern and had proved rare.

Dr Swage asked about nursing revalidation. It was confirmed that processes were in place to support and assure on nursing appraisal and revalidation with further details available on compliance with this.

The Trust Board noted the report and approved the statement of compliance.

69/18 COMPLAINTS ANNUAL REPORT

The Chief Nurse introduced the Trust's complaints annual report and noted headline messages on performance during the year, including an overall reduction in the volume of complaints, increased local resolution and Patient Advisory and Liaison Service input. She noted the ongoing challenge of responding to complaints in a timely way, key themes of complaints received and Internal Audit assurance on complaints processes. The Quality Assurance Committee had reviewed this report and continued to monitor progress on

The Trust Board noted and approved the report.

70/18 USE OF THE SEAL

The Trust Board approved the use of the Seal as indicated in the report.

71/18 REPORTS FROM BOARD COMMITTEES

(i) Quality Assurance Committee

The Trust Board reviewed key items discussed by the Committee and noted the exception report.

(ii) Audit and Risk Committee

The Trust Board reviewed key items discussed by the Committee and noted the exception report detailing the annual accounts review and audit.

(iii) Nomination and Remuneration Committee

The Trust Board reviewed key items discussed by the Committee and noted the exception report.

(iv) Finance and Investment Committee

Mr Camp outlined key agenda items covered at the meeting held earlier in the day, relating to Month 2 performance, the Trust's 2018/19 financial plans, a
theatres efficiency workstream and Whipps Cross cost improvement plan schemes.

72/18

ANY OTHER BUSINESS

There was no other business.

73/18

QUESTIONS FROM MEMBERS OF THE PUBLIC

The Waltham Forest Save our NHS campaign group representative noted the progress made on staff equalities and inclusion but queried whether this had been similar for equality of access to care for patients and whether a proposed performance dashboard for patient equalities metrics had been delivered as previously indicated.

The Chief Medical Officer felt that this was a fair challenge and suggested some progress had been made with clinical boards having a specific role on equality of access to services. The Chief Executive confirmed that this work was being supported by the Public Health team to focus attention on key lines of enquiry for core services. Dashboards were being developed but these had not yet been finalised and implemented so far. Evidence collated to date suggested that some work was required to address inequalities in emergency care waiting times for older patients. A further area to explore related to the higher proportion of BAME patients recorded as 'did not attend' for appointments.

The Waltham Forest Save our NHS campaign group representative asked whether the Whipps Cross redevelopment SOC had been approved.

The Director of Strategy confirmed that formal approval had not been received as yet although active dialogue continued on this.

The Waltham Forest Save our NHS campaign group representative asked whether the Trust monitored response rates to Freedom of Information enquiries.

The Director of Corporate Development confirmed that the standard response time for FoI enquiries was 20 days, with approximately 86% compliance with this target since April 2018. He noted that compliance had been more challenging for the 2017/18 period, due in large part to disruption associated with the cyber attack.

A query relating to the staff story was raised, relating specifically to the use of healthcare assistants to substitute for registered nursing staff.

The Chief Nurse noted that skill mix decisions were supported by a risk assessment framework to ensure appropriate assignment of professional duties and roles.

A query was received in relation to steps pursued to discharge patients earlier and implications for readmissions.
The Chief Nurse noted that the Trust monitored readmission rates and indicated that there was little evidence to suggest that work to reduce the cohort of long stay patients resulted in higher readmission rates, with many hospital stays in excess of 21 days relating to factors such as availability of social care accommodation.

**74/18 DATE OF THE NEXT MEETING**

The next meeting of the Trust Board (Part 1) in public would be held on 12 September 2018 at 14.30 in Rooms 5a and b, Education Centre, Mile End Hospital, Bancroft Rd, Mile End, London E1 4DG.

**75/18 RESOLUTION**

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960).

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0637
### Action log

#### Trust Board Part 1: 4 July 2018

<table>
<thead>
<tr>
<th>Page No.</th>
<th>Action</th>
<th>Lead</th>
<th>By</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Nursing establishment: confirm timescale for reporting on the future nursing workforce model</td>
<td>Chief Nurse and Director of People</td>
<td>12 October 2018</td>
</tr>
</tbody>
</table>

#### Trust Board Part 1: 9 May 2018

| IPR (quality): provide Quality Assurance Committee with update following investigation on patient fall case resulting in harm. | Chief Nurse | Completed – 18 July 2018 |
### Executive summary

The Integrated Performance Report provides detail in relation to performance drivers and recovery actions at Trust and Hospital Site level in relation to the NHSI single oversight framework indicators as well as the Trust’s own improvement plan, Safe and Compassionate. The report also identifies exceptions, including positive exceptions, where performance has outperformed usual tolerances, or where a target has been failed. The report will be presented by the respective lead directors for access, quality and safety, finance and people sections.

### Related Trust objectives

All trust objectives

### Risk and Assurance

This report provides assurance in relation to all trust objectives - including 1, 2, 4 and 9.

### Related Assurance Framework entries

All BAF entries

### Legal implications/ regulatory requirements

N/A

### Action required by the Board

The Trust Board is asked to note the Trust’s position against all standards detailed, including those indicators where sustained improvement has been made due to the actions taken, exceptions to target achievement, reasons for variation and remedial actions to address the position.
<table>
<thead>
<tr>
<th>Report</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Activity</td>
<td>8</td>
</tr>
<tr>
<td>Quality &amp; Performance Report</td>
<td>10</td>
</tr>
<tr>
<td>Finance Report</td>
<td>29</td>
</tr>
<tr>
<td>People Report</td>
<td>38</td>
</tr>
<tr>
<td>Glossary</td>
<td>49</td>
</tr>
<tr>
<td>Appendix</td>
<td>54</td>
</tr>
</tbody>
</table>
Executive Summary
Quality & Performance

Performance Against National Constitutional Standards (Responsive)

The NHSI Single Oversight Framework includes five constitutional standards:

Referral to Treatment (18 Weeks)

• Barts Health resumed national RTT Reporting from Apr-18, the first submission of national data since Sep-14 and a significant milestone on the Trust’s improvement journey. The Trust has since submitted its performance data for May-18 and Jun-18 with the Jun-18 data now published. Barts Health recorded an incomplete pathway performance of 85.1% (an improvement of 0.4% on the May-18 position), with a total of 91,892 patients waiting for treatment, an increase of 109 against May-18. At the end of Jun-18, 63 patients had waited longer than 52 weeks for treatment, above trajectory.

A&E

• For Jul-18, the Trust’s performance was 84.98%, a reduction of 3.37% against Jul-17. The Trust did not record any 12 hour trolley waits during Jul-18. During the month, demand continued to increase with 3.61% more patients attending the Trust’s A&E services compared to the same month last year and 3.67% more patients compared to Jun-18.

Cancer Waiting Time Standards (62 Day GP/62 Day Screening)

• The Trust met all national cancer waiting time standards in Jun-18, the most recent reporting month. For Cancer 62 Days from GP Referral, the Trust’s performance was 86.1% against the 85% standard. For Cancer 62 Days from Screening Service Referral, the Trust’s performance was 100% against the 90% standard.

Diagnostic 6 Week Waits

• The Trust maintained its performance against the national standard, with a performance of 99.5% in Jul-18 against the 99% standard.
Quality & Performance (Continued)

Caring

- Friends and Family Test (FFT) response rates remain low due to the technical issues with the text messaging service via the new provider. Work continues on identification of issues and implementation of improvements to processes. An improvement plan is in place and is monitored weekly, with a weekly dashboard to track progress in place, and the picture is improving. Also, all sites are now ensuring that patients are offered alternative ways to respond via paper, website link or iPad. The results are being loaded and will show an improving position over the next few months.
- The number of complaints received continues to reduce, with performance of overdue complaints also improving.
- There has been under-performance on duty of candour in Jun-18 on a number of sites and the leadership teams are addressing this locally.

Safe and Effective

- Good performance continues in reducing Hospital Acquired Pressure Ulcers with targeted work continuing in hot spot areas.
- Good performance on MRSA and C.difficile continues. E.coli bacteraemias are above target; Whipps Cross is showing higher numbers. All cases are being reviewed across the Trust but have not identified any themes. Plans are in place across each of the sites. The Trust is participating in a national collaborative to support improvements in catheter management.
- Serious incident closure rates are improving; however, there is still significant work to do to eliminate these delays. Enhanced monitoring and improvement plans are in place.
- 2 never events were reported in Jul-18. The cases have been reviewed by the Chief Medical Officer/Chief Nursing Officer with site leadership teams and clinical teams to determine any common themes/trends. Individual immediate actions have been taken in each case.
Executive Summary

Finance

- At the end of Jul-18 (month 4), the Trust is reporting a Pre-Provider Sustainability Fund (PSF) surplus of £14.0m which is £4.5m favourable compared to plan. This is primarily due to non-recurrent benefits, including the excess of profit on disposal from the Whitechapel sale in Jul-18 (month 4) which is estimated at £2.3m subject to the finalisation of the accounting treatment.

- The year to date PSF (£11.9m) is not included in the Trust’s position as this is pending formal agreement of the 2018/19 control total, which is expected to be confirmed by the end of 2018/19 quarter 2.

- Income excluding PSF is £8.8m favourable against plan for the year to date. Patient treatment income is £7.2m favourable against plan for the year to date; the key driver of over performance is non-elective activity across the sites. Other income is £1.6m favourable against plan for year to date; the key driver is overseas income over-performance.

- Operating expenditure is £6.5m adverse against plan. Site and Directorate pay expenditure is £3.5m adverse against plan for the year to date; overspending relates to temporary staffing costs. Other operating expenditure is £3.0m adverse against plan; this includes receivables impairments in relation to overseas income over-performance.

- The Trust is planning a capital programme for 2018/19 of £101.9m (including £9m of capital expenditure planned to be funded by charitable sources). It is intended to fund this programme from: retained net depreciation of £18.3m, £0.3m Specific Public Dividend Capital (PDC) award, £2.8m prior year Capital Resource Limit (CRL) brought forward, £54.2m of NHS Improvement (NHSI) Financing and £17.3m from asset sales. At this stage only £32.7m of this funding has been confirmed. At the end of Jul-18 (month 4), the Trust has spent £8.1m on capital (excluding donated capital) and has contractually committed £24.1m with £36.1m of schemes committed to progress to delivery.

- The cash balance of £43.6m at the end of Jul-18 (month 4) was £12.9m higher than planned. The Trust received the 2017/18 Sustainability and Transformation Fund of £36.2m in month as well as the £75.1m proceeds from the Whitechapel sale.
Executive Summary

People

- The Trust’s substantive staff fill rate in Jul-18 was 90.9% with 14,820 Whole Time Equivalents (WTE) in post.

- Temporary staffing usage increased by 119.4 WTE in Jul-18, with a 91.4 WTE increase in Bank and 28 WTE increase in agency. The temporary usage proportion has increased to 13.8% (against 13.1% in Jun-18) against a new target for this financial year of 10.2%.

- The Trust was 43 WTE (0.2%) above the collated site workforce plans for Jul-18, with variation in performance across sites. A refresh of site, CSS and Corporate workforce plans is currently in progress, in order to capture current Cost Improvement Programme (CIP) assumptions. Revised plans are due to be in use for Aug-18 reporting.

- In Jul-18, pay expenditure exceeded budget by £0.7m in month. This is largely driven by CIPs that remain in development and unplanned opening of additional capacity.

- Sickness absence was above target at 3.43% in Jun-18. Highlights of a review into long term sickness absence are provided in the spotlight section of this report, along with a number of recommendations which are being taken forward.
Activity
ACTIVITY

Chargeable Activity

Actual Activity Against Plan

<table>
<thead>
<tr>
<th>Group</th>
<th>Indicator</th>
<th>Targets</th>
<th>Performance</th>
<th>YTD</th>
<th>Jul-18 (Site)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Target</td>
<td>Jun-18</td>
<td>Jul-18</td>
<td>RLH</td>
</tr>
<tr>
<td>OP</td>
<td>Actual Activity</td>
<td>==Plan</td>
<td>104,188</td>
<td>104,695</td>
<td>411,594</td>
</tr>
<tr>
<td></td>
<td>Planned Activity</td>
<td>-</td>
<td>103,689</td>
<td>110,485</td>
<td>416,702</td>
</tr>
<tr>
<td>Day Case</td>
<td>Actual Activity</td>
<td>==Plan</td>
<td>6,349</td>
<td>6,770</td>
<td>25,988</td>
</tr>
<tr>
<td></td>
<td>Planned Activity</td>
<td>-</td>
<td>7,092</td>
<td>7,454</td>
<td>28,245</td>
</tr>
<tr>
<td>Elective</td>
<td>Actual Activity</td>
<td>==Plan</td>
<td>2,104</td>
<td>1,883</td>
<td>7,854</td>
</tr>
<tr>
<td></td>
<td>Planned Activity</td>
<td>-</td>
<td>2,025</td>
<td>2,141</td>
<td>8,018</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>Actual Activity</td>
<td>==Plan</td>
<td>11,766</td>
<td>12,087</td>
<td>46,983</td>
</tr>
<tr>
<td></td>
<td>Planned Activity</td>
<td>-</td>
<td>11,399</td>
<td>11,673</td>
<td>45,271</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Actual Activity</td>
<td>==Plan</td>
<td>4,371</td>
<td>4,252</td>
<td>17,375</td>
</tr>
<tr>
<td></td>
<td>Planned Activity</td>
<td>-</td>
<td>4,433</td>
<td>4,578</td>
<td>18,022</td>
</tr>
</tbody>
</table>

- With the exception of non-elective activity, the overall activity is below plan this month.
- Outpatient activity is below plan for WXH, SBH and CSS this month.
- Day case activity continues to be below plan across all sites.
- Elective activity has fallen this month for most sites, with SBH over-performing against plan.
- The over-performance in non-elective activity continues for RLH and WXH, but the activity is below plan for the other sites.

N.B. Activity reported above relates to activity reported on the main data warehouse and excludes chargeable activity collated through manual monitoring and other means. This is an early view of activity and will alter retrospectively as clinical coding is completed.

<table>
<thead>
<tr>
<th>Targets for Actual Against Plan (% Variance)</th>
<th>&gt;=0%</th>
<th>Between 0% and -5%</th>
<th>&lt;=-5%</th>
</tr>
</thead>
</table>

Trust Performance Report
Quality & Performance Report
**Domain Scorecard**

### Exception Triggers

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Month</th>
<th>Step Change</th>
<th>Contl. Limit</th>
<th>This Period</th>
<th>This Period Target</th>
<th>YTD</th>
<th>Site Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>A&amp;E 4 Hours Waiting Time</td>
<td></td>
<td></td>
<td></td>
<td>Jul-18 (m)</td>
<td>&gt;= 90.7%</td>
<td>86.6%</td>
<td></td>
</tr>
<tr>
<td>R7</td>
<td>Cancer 62 Days From Urgent GP Referral</td>
<td></td>
<td></td>
<td></td>
<td>Jun-18 (m)</td>
<td>&gt;= 85%</td>
<td>87.2%</td>
<td></td>
</tr>
<tr>
<td>R13</td>
<td>Cancer 62 Days From Screening Programme</td>
<td></td>
<td></td>
<td></td>
<td>Jun-18 (m)</td>
<td>&gt;= 90%</td>
<td>94.4%</td>
<td></td>
</tr>
<tr>
<td>R6</td>
<td>Diagnostic Waits Over 6 Weeks</td>
<td></td>
<td></td>
<td></td>
<td>Jul-18 (m)</td>
<td>&gt;= 99%</td>
<td>99.6%</td>
<td></td>
</tr>
<tr>
<td>R4</td>
<td>18 Week RTT Compliance (Incomplete)</td>
<td></td>
<td></td>
<td></td>
<td>Jun-18 (m)</td>
<td>&gt;= 84.4%</td>
<td>84.7%</td>
<td></td>
</tr>
</tbody>
</table>

### Performance

- **Last Period**
- **This Period**
- **YTD**

### Site Comparison

<table>
<thead>
<tr>
<th>Royal London</th>
<th>Whips Cross</th>
<th>Newham</th>
<th>St Bart’s</th>
<th>CSS</th>
<th>Other</th>
<th>Excep.</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.5%</td>
<td>87.2%</td>
<td>88.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>•</td>
</tr>
<tr>
<td>84.6%</td>
<td>86.3%</td>
<td>91.7%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>•</td>
</tr>
<tr>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>98.8%</td>
<td>99.8%</td>
<td>97.0%</td>
<td>99.8%</td>
<td>99.5%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>83.7%</td>
<td>83.7%</td>
<td>84.8%</td>
<td>92.2%</td>
<td>94.8%</td>
<td>-</td>
<td>•</td>
</tr>
</tbody>
</table>

*Targets for A&E 4 Hours Waiting Time and 18 Weeks RTT Compliance (Incomplete) are PSF trajectory targets*
A&E 4 Hours Waiting Time

- Barts Health: A&E 4 Hour Wait Trajectory
- Royal London: A&E 4 Hour Wait Trajectory
- Whipps Cross: A&E 4 Hour Wait Trajectory
- Newham: A&E 4 Hour Wait Trajectory

Overall A&E Performance - Jul-18

All Type Attendances by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Jul-17</th>
<th>Jul-18</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barts Health</td>
<td>41,342</td>
<td>42,834</td>
<td>3.6%</td>
</tr>
<tr>
<td>Royal London</td>
<td>14,805</td>
<td>15,849</td>
<td>7.1%</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>14,038</td>
<td>13,555</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Newham</td>
<td>12,499</td>
<td>13,430</td>
<td>7.4%</td>
</tr>
</tbody>
</table>
For Jul-18, the Trust’s performance was 84.98%, a reduction of 3.37% against Jul-17. Performance reduced by 2.60% at Royal London compared to Jul-17, by 2.20% at Whipps Cross and by 5.38% at Newham.

Demand pressures increased on all sites, with 1,517 more patients attending the Trust’s A&E services in Jul-18 against Jun-18, an increase of 3.67%. A&E attendances were consistently higher across all sites, with the Royal London recording a 5.84% increase, Whipps Cross a 3.61% increase and Newham a 1.28% increase.

Apart from demand pressures, A&E performance was also significantly influenced during Jul-18 by an increase in the number of patients occupying beds with a length of stay greater than 21 days, across all sites. Across Barts Health, long stay patients peaked to 225, a count that was experienced in Mar-18 after the extreme winter weather. Analysis has been undertaken identifying specialty and diagnostic group drivers behind this increase.

Jul-18 performance was adversely affected by workforce shortfalls. Although it is not usual for medical cover to become difficult in July preceding the national medical examinations, this year Bank Partners also noted that locums were choosing not to work during the very hot weather. As a result, minimal staffing levels in ED limited progress against improvement plans and impacted on patient flow.

After the junior doctor rotation in Aug-18, workforce cover for medics across all areas has improved and better progress is being made against plans to reduce journey times for all patients admitted to hospital via ED.

- The Trust continues to work with the Emergency Care Improvement Programme (ECIP) across the three Type 1 A&E provider sites. The work has been crystallised into a series of Trust level actions designed to support performance improvement at hospital site level:
  - Extend and improve the A&E front-door model.
  - Reduce avoidable delays to ambulatory care and the Acute Assessment Units.
  - Continue to reduce the count of stranded (7 day length of stay) patients.
  - Develop frailty pathways.
  - Embed and standardise Rapid Assessment & Treatment models of care.
  - Trial of therapist functional streaming following ambulance handovers.
  - Alternative care pathways for ambulance conveyed patients.

- To ensure that learning and continuous improvement is achieved throughout the summer months, localised 6 and 8 week plans were signed off for each site at the end of Jul-18. These summer plans will support the build up to whole system winter plans for implementation at the beginning of Sep-18.
### Breakdown by Internal/External Pathways - Jun-18

<table>
<thead>
<tr>
<th>Internal / External</th>
<th>Start Site</th>
<th>End Site</th>
<th>Seen</th>
<th>Breaches</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>Royal London</td>
<td>Royal London</td>
<td>17</td>
<td>1</td>
<td>94.1%</td>
</tr>
<tr>
<td></td>
<td>St Bart's</td>
<td>5</td>
<td>2</td>
<td>60.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Whipps Cross</td>
<td>Whipps Cross</td>
<td>32</td>
<td>2</td>
<td>93.8%</td>
</tr>
<tr>
<td></td>
<td>St Bart's</td>
<td>14</td>
<td>6</td>
<td>57.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newham</td>
<td>Royal London</td>
<td>3</td>
<td>1</td>
<td>66.7%</td>
</tr>
<tr>
<td></td>
<td>Newham</td>
<td>13</td>
<td>0</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>St Bart's</td>
<td>6</td>
<td>2</td>
<td>66.7%</td>
<td></td>
</tr>
<tr>
<td>Internal Total</td>
<td>117</td>
<td>15</td>
<td></td>
<td></td>
<td>87.2%</td>
</tr>
<tr>
<td>Transfer In</td>
<td>Basildon</td>
<td>St Bart's</td>
<td>0.5</td>
<td>0.5</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Colchester</td>
<td>St Bart's</td>
<td>0.5</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Homerton</td>
<td>Royal London</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td></td>
<td>Whipps Cross</td>
<td>0.5</td>
<td>0</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>St Bart's</td>
<td>3.5</td>
<td>0.5</td>
<td>85.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>King George</td>
<td>St Bart's</td>
<td>1</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Queen's</td>
<td>Royal London</td>
<td>1.5</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Transfer In Total</td>
<td>9.5</td>
<td>2</td>
<td></td>
<td></td>
<td>78.9%</td>
</tr>
<tr>
<td>Transfer Out</td>
<td>Royal London</td>
<td>Broomfield</td>
<td>0.5</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Royal Free</td>
<td>0.5</td>
<td>0.5</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UCLH</td>
<td>0.5</td>
<td>0</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Whipps Cross</td>
<td>UCLH</td>
<td>0.5</td>
<td>0.5</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Newham</td>
<td>Royal Free</td>
<td>0.5</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>St Bart's</td>
<td>North Middlesex</td>
<td>0.5</td>
<td>0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Transfer Out Total</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td>66.7%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>129.5</td>
<td>18</td>
<td></td>
<td></td>
<td>86.1%</td>
</tr>
</tbody>
</table>

### Commentary

- The trust was compliant with all of the cancer standards in Jun-18. Performance for the Cancer 62 Days from GP Referral standard was 86.1%.
- Challenges within Urology remain, due to diagnostic capacity and reporting. The trust has an action plan to track and monitor improvements.
- Lower Gastrointestinal was also not compliant because of colonoscopy capacity due to leave; a number of weekend sessions have been scheduled to increase capacity.
Summary of RTT Incomplete Pathways - Jun-18

<table>
<thead>
<tr>
<th>Category</th>
<th>Barts Health</th>
<th>Royal London</th>
<th>Whipps Cross</th>
<th>Newham</th>
<th>St Bart’s</th>
<th>CSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>78,199</td>
<td>33,602</td>
<td>19,532</td>
<td>13,590</td>
<td>9,904</td>
<td>1,571</td>
</tr>
<tr>
<td>18-40</td>
<td>12,777</td>
<td>5,915</td>
<td>3,609</td>
<td>2,344</td>
<td>823</td>
<td>86</td>
</tr>
<tr>
<td>40-52</td>
<td>853</td>
<td>596</td>
<td>167</td>
<td>77</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>&gt;52</td>
<td>63</td>
<td>38</td>
<td>16</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total Pathways</td>
<td>91,892</td>
<td>40,151</td>
<td>23,324</td>
<td>16,017</td>
<td>10,743</td>
<td>1,657</td>
</tr>
<tr>
<td>Trajectory (Total Pathways)</td>
<td>88,690</td>
<td>37,838</td>
<td>21,970</td>
<td>16,956</td>
<td>10,307</td>
<td>1,619</td>
</tr>
<tr>
<td>Trajectory (&gt;52)</td>
<td>34</td>
<td>27</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% Performance</td>
<td>85.1%</td>
<td>83.7%</td>
<td>83.7%</td>
<td>84.8%</td>
<td>92.2%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Trajectory (% Performance)</td>
<td>84.4%</td>
<td>82.5%</td>
<td>84.0%</td>
<td>83.6%</td>
<td>92.3%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Breaches</td>
<td>13,693</td>
<td>6,549</td>
<td>3,792</td>
<td>2,427</td>
<td>839</td>
<td>86</td>
</tr>
<tr>
<td>Breaches Above Target</td>
<td>-109</td>
<td>-71</td>
<td>286</td>
<td>-351</td>
<td>43</td>
<td>-16</td>
</tr>
<tr>
<td>Unknown Waits</td>
<td>3,096</td>
<td>1,355</td>
<td>675</td>
<td>418</td>
<td>620</td>
<td>25</td>
</tr>
</tbody>
</table>

Note: all figures exclude pathways with an unknown waiting time (these are shown in the "Unknown" category) and those for Non-English CCGs

Commentary

Barts Health resumed national RTT Reporting from Apr-18, the first submission of national data since Sep-14 and a significant milestone on the Trust’s improvement journey.

The Trust has since submitted its performance data for May-18 and Jun-18, with the Jun-18 data now published. Barts Health recorded an incomplete pathway performance of 85.1% (an improvement of 0.4% on the May-18 position), with a total of 91,892 patients waiting for treatment, an increase of 109 against May-18. At the end of Jun-18, 63 patients had waited longer than 52 weeks for treatment against 37 reported in May-18. Incomplete pathway performance was better than the Trust’s internal trajectory; however, the trust was off trajectory in relation to a growing number of patients on the waiting list and 52 week breaches.

The increase in 52 week breaches between May-18 and Jun-18 has been analysed, with the key driver identified as "tip overs". These are pathways that migrated from under 52 weeks in May-18 to over 52 weeks in Jun-18. Operational services are being supported in identifying and actioning long-waiting pathways by the provision of daily reports identifying the individual patients and highlighting those waiting for outpatient appointments or an admission for treatment.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Month Target</th>
<th>Step</th>
<th>Change</th>
<th>Contl. Limit</th>
<th>This Period</th>
<th>This Period</th>
<th>YTD</th>
<th>Site Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Royal London</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Whipps Cross</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newham</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>St Bart’s</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CSS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Excep.</td>
</tr>
<tr>
<td>C12</td>
<td>MSA Breaches</td>
<td>Jun-18 (m)</td>
<td>&lt;= 0</td>
<td></td>
<td></td>
<td>16</td>
<td>19</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>C10</td>
<td>Written Complaints Rate Per 1,000 Staff</td>
<td>2017/18 Q4 (q)</td>
<td>SPC Breach</td>
<td></td>
<td></td>
<td>29.4</td>
<td>30.2</td>
<td>30.2</td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td>FFT Recommended % - Inpatients</td>
<td>Jun-18 (m)</td>
<td>&gt;= 95%</td>
<td></td>
<td></td>
<td>85.9%</td>
<td>86.8%</td>
<td>86.7%</td>
<td></td>
</tr>
<tr>
<td>C2</td>
<td>FFT Recommended % - A&amp;E</td>
<td>Jun-18 (m)</td>
<td>&gt;= 95%</td>
<td></td>
<td></td>
<td>73.2%</td>
<td>75.3%</td>
<td>74.0%</td>
<td></td>
</tr>
<tr>
<td>C3</td>
<td>FFT Recommended % - Maternity</td>
<td>Jun-18 (m)</td>
<td>&gt;= 95%</td>
<td></td>
<td></td>
<td>86.7%</td>
<td>77.5%</td>
<td>85.2%</td>
<td></td>
</tr>
<tr>
<td>C20</td>
<td>FFT Response Rate - Inpatients</td>
<td>Jun-18 (m)</td>
<td>&gt;= 19.6%</td>
<td></td>
<td></td>
<td>4.1%</td>
<td>4.5%</td>
<td>3.4%</td>
<td></td>
</tr>
<tr>
<td>C21</td>
<td>FFT Response Rate - A&amp;E</td>
<td>Jun-18 (m)</td>
<td>&gt;= 10.5%</td>
<td></td>
<td></td>
<td>6.1%</td>
<td>6.9%</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>C22</td>
<td>FFT Response Rate - Maternity</td>
<td>Jun-18 (m)</td>
<td>&gt;= 16.6%</td>
<td></td>
<td></td>
<td>2.5%</td>
<td>3.1%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>OH4</td>
<td>CQC Inpatient Survey</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>R78</td>
<td>Complaints Replied to in Agreed Time</td>
<td>Jul-18 (m)</td>
<td>&gt;= 100%</td>
<td></td>
<td></td>
<td>41.4%</td>
<td>45.3%</td>
<td>42.1%</td>
<td></td>
</tr>
<tr>
<td>R30</td>
<td>Duty of Candour</td>
<td>Jun-18 (m)</td>
<td>&gt;= 100%</td>
<td></td>
<td></td>
<td>96.6%</td>
<td>80.6%</td>
<td>89.4%</td>
<td></td>
</tr>
</tbody>
</table>

Trust Performance Report

Domain Scorecard

Sep-18

Service User Support

Patient Experience

Patient Feedback
Performance Overview

- Performance continues to fluctuate and reflects pressures on flow across the sites.

Responsible Director Update

- Current performance has been reviewed at all site performance reviews. Focus on improvement on flow at all sites should support better performance. Shared learning from an outstanding Trust is being applied.
Progress Summary

- A concerted effort by all sites to reduce/eliminate overdue complaints is in place.
- Site and Trust-wide action plans are in place and a task and finish group has been established to support site leads with overall complaint management.
- The central complaints team have undertaken diagnostic work on each site to improve processes and undertake any training needs.
- Managing directors are overseeing performance.
- Weekly tracking is in place for all sites and a new metric on complaint response time has been added to the site Integrated Performance Reports and the Board Report.
- Long overdue cases are being reviewed by senior teams to ensure the pace of response for these in particular.

Noteworthy Improvements

- Additional support at Newham is having an impact on performance.

Risks & Issues

- Site governance teams are carrying vacancies.

Next Steps

- Complete diagnostic interventions and move to implementing improvements to processes.
- Recruitment to teams continues.
• There has been a decrease in performance in Jun-18 compared to May-18, though the number of incidents is relatively small. Whipps Cross has maintained its performance at 100%.

• Newham has developed a weekly report to support performance.
• Stronger oversight is being put in place; Chief Medical Office/Chief Nursing Officer reviewing.
• Exception reporting to be put in place to better understand process or circumstantial issues causing breaches.

Implications of non-compliance: each non-compliant incident needs to be reported to the CQC, published on the trust’s website and may be subject to a fine of the whole cost of the episode or £10k if the cost is not known (the “Possible Fine” column above has been based on £10k per non-compliant incident).
## Domain Scorecard

### Exception Triggers

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Month Target</th>
<th>Step Target</th>
<th>Contl. Target</th>
<th>This Period</th>
<th>Last Period</th>
<th>YTD Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>510</td>
<td>Clostridium difficile - Infection Rate</td>
<td>Jul-18 (m)</td>
<td>&lt;= 13</td>
<td></td>
<td>7.9</td>
<td>9.4</td>
<td>11.0</td>
</tr>
<tr>
<td>511</td>
<td>Clostridium difficile - Incidence</td>
<td>Jul-18 (m)</td>
<td>&lt;= 7</td>
<td></td>
<td>4</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>52</td>
<td>Assigned MRSA Bacteraemia Cases</td>
<td>Jul-18 (m)</td>
<td>&lt;= 2</td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>577</td>
<td>MSSA Bacteraemias</td>
<td>Jul-18 (m)</td>
<td>SPC Breach</td>
<td></td>
<td>1</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>576</td>
<td>E.coli Bacteraemia Bloodstream Infections</td>
<td>Jul-18 (m)</td>
<td>&lt;= 12</td>
<td></td>
<td>13</td>
<td>13</td>
<td>44</td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Royal London</th>
<th>Whipps Cross</th>
<th>Newham</th>
<th>St Bart’s</th>
<th>CSS</th>
<th>Other</th>
<th>Excep.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.3</td>
<td>11.8</td>
<td>11.1</td>
<td>0.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>-</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>0</td>
<td>-</td>
</tr>
</tbody>
</table>

### Site Comparison

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Month Target</th>
<th>Step Target</th>
<th>Contl. Target</th>
<th>This Period</th>
<th>Last Period</th>
<th>YTD Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Never Events</td>
<td>Jul-18 (m)</td>
<td>&lt;= 2</td>
<td></td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>545</td>
<td>Falls Per 1,000 Bed Days</td>
<td>Jul-18 (m)</td>
<td>&lt;= 4.8</td>
<td></td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>525</td>
<td>Medication Errors - Percentage Causing Harm</td>
<td>Jul-18 (m)</td>
<td>&lt;= 4%</td>
<td></td>
<td>2.1%</td>
<td>4.1%</td>
<td>2.8%</td>
</tr>
<tr>
<td>548</td>
<td>Medication Errors - Rate Per 1,000 Bed Days</td>
<td>Jul-18 (m)</td>
<td>&lt;= 10</td>
<td></td>
<td>9.4</td>
<td>9.8</td>
<td>9.6</td>
</tr>
<tr>
<td>549</td>
<td>Patient Safety Incidents Per 1,000 Bed Days</td>
<td>Jul-18 (m)</td>
<td>SPC Breach</td>
<td></td>
<td>60.7</td>
<td>65.1</td>
<td>61.9</td>
</tr>
<tr>
<td>553</td>
<td>Serious Incidents Closed in Time</td>
<td>Jun-18 (m)</td>
<td>&gt;= 100%</td>
<td></td>
<td>7.7%</td>
<td>20.8%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

Trust Performance Report
## SAFE Domain Scorecard

### Exception Triggers

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Month Target</th>
<th>Step Change</th>
<th>Contl. Limit</th>
<th>This Period</th>
<th>This Period Target</th>
<th>Last Period</th>
<th>This Period</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>514</td>
<td>Pressure Ulcers Per 1,000 Bed Days (Grades 2, 3 and 4)</td>
<td>Jul-18 (m) &lt;= 1.1</td>
<td>0.7</td>
<td>0.8</td>
<td>0.5</td>
<td>1.1</td>
<td>0.4</td>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td>517</td>
<td>Emergency C-Section Rate</td>
<td>Jul-18 (m) &lt;= 18%</td>
<td>17.0%</td>
<td>16.3%</td>
<td>17.9%</td>
<td>16.0%</td>
<td>16.3%</td>
<td>17.9%</td>
<td>16.0%</td>
</tr>
<tr>
<td>527</td>
<td>Patient Safety Alerts Overdue</td>
<td>Jul-18 (m) &lt;= 0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>536</td>
<td>VTE Risk Assessment</td>
<td>Jul-18 (m) &gt;= 95%</td>
<td>97.6%</td>
<td>96.1%</td>
<td>97.2%</td>
<td>95.7%</td>
<td>96.1%</td>
<td>97.2%</td>
<td>95.7%</td>
</tr>
<tr>
<td>55</td>
<td>Dementia - Screening</td>
<td>Jun-18 (m) &gt;= 90%</td>
<td>91.1%</td>
<td>86.7%</td>
<td>87.3%</td>
<td>95.6%</td>
<td>85.3%</td>
<td>85.3%</td>
<td>65.5%</td>
</tr>
<tr>
<td>56</td>
<td>Dementia - Risk Assessment</td>
<td>Jun-18 (m) &gt;= 90%</td>
<td>79.9%</td>
<td>63.8%</td>
<td>75.4%</td>
<td>65.1%</td>
<td>57.6%</td>
<td>85.0%</td>
<td>55.6%</td>
</tr>
<tr>
<td>57</td>
<td>Dementia - Referrals</td>
<td>Jun-18 (m) &gt;= 90%</td>
<td>93.4%</td>
<td>89.5%</td>
<td>93.1%</td>
<td>92.9%</td>
<td>82.8%</td>
<td>93.8%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Site Comparison

<table>
<thead>
<tr>
<th>Royal London</th>
<th>Whipps Cross</th>
<th>Newham</th>
<th>St Bart's</th>
<th>CSS</th>
<th>Other</th>
<th>Excep.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>0.4</td>
<td>1.6</td>
<td>0.4</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>13.7%</td>
<td>16.6%</td>
<td>18.4%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>95.7%</td>
<td>97.8%</td>
<td>91.9%</td>
<td>98.7%</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>95.6%</td>
<td>85.3%</td>
<td>85.3%</td>
<td>65.5%</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>65.1%</td>
<td>57.6%</td>
<td>85.0%</td>
<td>55.6%</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>92.9%</td>
<td>82.8%</td>
<td>93.8%</td>
<td>100.0%</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
Never Events

Responsible Director Update

• **Royal London Paediatric Dentistry**: a child required the extraction of several milk teeth under general anaesthetic. Pre-procedure checks were carried out but despite this, one of the teeth was misidentified during the surgery.

• **St Bart’s Theatres**: a small swab was retained and resulted in delayed healing of a post-operative wound. Swab counts had taken place according to standard procedures but a miscount had occurred.

• In both cases, full explanations were provided to the patient/guardian. Staff were commended for reporting the errors promptly and with full transparency.

<table>
<thead>
<tr>
<th>Never Event Type</th>
<th>Site</th>
<th>Number of Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong site surgery</td>
<td>Royal London</td>
<td>2</td>
</tr>
<tr>
<td>Unintentional connection of a patient</td>
<td>Whipps Cross</td>
<td>1</td>
</tr>
<tr>
<td>requiring oxygen to an air flowmeter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained foreign object post-operation</td>
<td>St Bart’s</td>
<td>1</td>
</tr>
<tr>
<td>Wrong implant/prosthesis</td>
<td>Royal London</td>
<td>1</td>
</tr>
<tr>
<td>Wrong route administration of medication</td>
<td>Royal London</td>
<td>1</td>
</tr>
<tr>
<td>Wrong implant/prosthesis</td>
<td>Whipps Cross</td>
<td>1</td>
</tr>
<tr>
<td>Retained foreign object post-operation</td>
<td>Newham</td>
<td>1</td>
</tr>
</tbody>
</table>

Never Events - Jul-18

<table>
<thead>
<tr>
<th>Site</th>
<th>Specialty</th>
<th>Location</th>
<th>Never Event Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal London</td>
<td>Paediatric Dentistry</td>
<td>Theatres</td>
<td>Wrong site surgery</td>
</tr>
<tr>
<td>St Bart’s</td>
<td>Cardiology</td>
<td>Theatres</td>
<td>Retained foreign object post-operation</td>
</tr>
</tbody>
</table>

Never Events - Last 12 Months

Performance Overview

- **Royal London Paediatric Dentistry**: a child required the extraction of several milk teeth under general anaesthetic. Pre-procedure checks were carried out but despite this, one of the teeth was misidentified during the surgery.

- **St Bart’s Theatres**: a small swab was retained and resulted in delayed healing of a post-operative wound. Swab counts had taken place according to standard procedures but a miscount had occurred.

- In both cases, full explanations were provided to the patient/guardian. Staff were commended for reporting the errors promptly and with full transparency.

Responsible Director Update

- An additional level of scrutiny has been applied to each of the recent cases and they have also been reviewed collectively to determine any common themes/trends.

- Individual immediate actions have been taken in each case, as well as Trust-wide safety alerts.

- Chief Medical Officer/Chief Nursing Officer review with site leadership teams and clinical teams is being undertaken for each case.
Progress Summary

• A concerted effort by all sites to reduce/eliminate overdue serious incidents is in place.
• Site and Trust-wide action plans are in place and a task and finish group has been established to support site leads with overall serious incident management. It is looking at ways to improve performance of serious incident closure, including development of investigation templates, process changes and funding for training for investigators. A bid to pilot a new model of dedicated investigators is being explored.
• Weekly tracking is in place for all sites and a new metric on closure time for serious incidents has been added to the site Integrated Performance Reports and the Board Report.
• Managing directors are overseeing performance.
• Funding for training has been identified.
• Each outstanding case is being reviewed to ensure that early learning has been implemented.

Noteworthy Improvements

• Additional support at Newham is in place.
• Some sites have developed a round table approach to improve the process which is reducing delays.

Risks & Issues

• Training for investigators to be developed.
• Vacancies within governance teams.

Next Steps

• Bid submitted to test dedicated resource approach to undertaking investigations.
• Awaiting outcome of national consultation on new serious incident process.

Overdue SIs - Summary as at 09/08/2018

<table>
<thead>
<tr>
<th>Site</th>
<th>No of Overdue SIs</th>
<th>Average Days Overdue</th>
<th>Min Days Overdue</th>
<th>Max Days Overdue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>36</td>
<td>71</td>
<td>1</td>
<td>380</td>
</tr>
<tr>
<td>Royal London</td>
<td>14</td>
<td>62</td>
<td>2</td>
<td>224</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>6</td>
<td>23</td>
<td>1</td>
<td>64</td>
</tr>
<tr>
<td>Newham</td>
<td>13</td>
<td>73</td>
<td>2</td>
<td>247</td>
</tr>
<tr>
<td>St Bart’s</td>
<td>2</td>
<td>111</td>
<td>2</td>
<td>219</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>380</td>
<td>380</td>
<td>380</td>
</tr>
</tbody>
</table>

Open Incidents as at 21/08/2018

<table>
<thead>
<tr>
<th>Site</th>
<th>No of Open Incidents</th>
<th>Average Days Open</th>
<th>Max Days Open</th>
<th>No Open More than 1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>4,125</td>
<td>40</td>
<td>1,996</td>
<td>70</td>
</tr>
<tr>
<td>Royal London</td>
<td>1,532</td>
<td>45</td>
<td>1,349</td>
<td>36</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>1,127</td>
<td>28</td>
<td>365</td>
<td>0</td>
</tr>
<tr>
<td>Newham</td>
<td>844</td>
<td>39</td>
<td>719</td>
<td>17</td>
</tr>
<tr>
<td>St Bart’s</td>
<td>566</td>
<td>25</td>
<td>228</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>333</td>
<td>1,996</td>
<td>17</td>
</tr>
</tbody>
</table>
**Performance Overview**

- The Trust was below the 90% national target for all three metrics in Jun-18, with the performance lowest in risk assessment and highest in referrals where it was at 89.5%, just below the national target.

**Responsible Director Update**

- A new process which automatically prompts doctors to perform screening on eligible patients has been introduced in Aug-18. It is expected this will improve screening recording and adherence.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Exception Triggers</th>
<th>Performance</th>
<th>Site Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This Period</td>
<td>This Period</td>
<td>Royal London</td>
</tr>
<tr>
<td></td>
<td>Mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1</td>
<td>Summary Hospital Level Mortality Indicator</td>
<td>●</td>
<td>2017/18 Q3 (q)</td>
<td>&lt;= 100</td>
</tr>
<tr>
<td>E3</td>
<td>Risk Adjusted Mortality Index</td>
<td>●</td>
<td>Jun-18 (m)</td>
<td>&lt;= 100</td>
</tr>
<tr>
<td>E25</td>
<td>Number of Avoidable Deaths</td>
<td>●</td>
<td>2017/18 Q4 (q)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S51</td>
<td>Proportion of Cardiac Arrest 222 Calls</td>
<td>●</td>
<td>Jul-18 (m)</td>
<td>&lt;= 18%</td>
</tr>
<tr>
<td>S42</td>
<td>Sepsis 6 Antibiotic Administration (60 Mins)</td>
<td>●</td>
<td>Jul-18 (m)</td>
<td>&gt;= 90%</td>
</tr>
</tbody>
</table>
Performance Overview

- The Trust’s performance did not meet its target in Jul-18; this metric does see considerable fluctuation. Performance was lowest at Newham, with 6 cardiac arrest calls out of 12 overall 2222 calls.

Responsible Director Update

- Work is continuing at Newham to develop the critical care outreach team to enable it better to respond to deteriorating patients on the wards. This will be a focus of quality improvement work on the site in coming months.
Performance Overview

- The Trust’s performance did not meet its target in Jul-18, at 63.2% against a target of 90%. However, this was an improvement against the Jun-18 performance and there has been a gradual general trend towards improvement, particularly in that screening is being carried out more consistently.

Responsible Director Update

- An electronic recording form has been developed to allow audits to take place on the time to antibiotic administration for potentially septic patients. Over time this will facilitate the collection of data on this measure.

---

**Table: Sepsis 6 Screening Carried Out - Jul-18**

<table>
<thead>
<tr>
<th>Site</th>
<th>Needed Screening</th>
<th>Screened</th>
<th>Percentage Screened</th>
<th>Minimum Number Needing Screening (CQUIN Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal London</td>
<td>44</td>
<td>20</td>
<td>45.5%</td>
<td>50</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>30</td>
<td>24</td>
<td>80.0%</td>
<td>50</td>
</tr>
<tr>
<td>Newham</td>
<td>33</td>
<td>33</td>
<td>100.0%</td>
<td>50</td>
</tr>
<tr>
<td>St Bart’s</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>50</td>
</tr>
</tbody>
</table>

---

**Graphs:**

- Sepsis 6 Antibiotic Administration (60 Mins)
- Sepsis 6 Screening Carried Out
In the reporting period, two responses to Her Majesty’s Coroner were sent following the issue of Regulation 28 (Prevention of Future Deaths) notices. One concerns a death in 2010, and the other in early 2017.

**Patient 1**

- A newborn baby boy died in Mar-17 from sepsis, having previously been seen in the emergency department with concerns about passing urine. An abnormal kidney function test was detected, and it is possible that if it had been acted on more urgently the death of the baby might have been avoidable.

- The coroner noted that a number of improvements have already been made by the Trust to prevent recurrence. These include: the introduction by the children’s health team at Whipps Cross of greatly improved processes for checking abnormal blood results; clearer sign-posting to reference ranges for doctors has been provided for results from blood gas testing; and improvements have been made in the wording in the discharge booklet, which is given to all parents of newborns, to provide greater clarity in regards to healthy urine stream.

**Patient 2**

- In 2007, a patient was found to have an incidental aortic aneurysm when having a CT scan for another condition. This was not noted at the time, and the patient subsequently died in 2010 following emergency surgery. It is acknowledged that vast improvements have been made in the 11 years since this incident occurred, including the introduction of a “significant findings” policy which ensures that radiology reports with significant but unexpected findings are now routinely flagged to the referring clinician. A Trust-wide introduction of a specific referral pathway for incidentally detected abdominal aortic aneurysms is also now being introduced as a further failsafe.
## Finance Key Metrics

### Pre-PSF Control Total

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>9.4</td>
</tr>
<tr>
<td>Actual</td>
<td>14.0</td>
</tr>
<tr>
<td>Variance</td>
<td>4.5</td>
</tr>
</tbody>
</table>

At the end of month 4, the Trust is reporting a Pre-Provider Sustainability Fund (PSF) surplus of £14.0m which is £4.5m favourable compared to plan. This is primarily due to non-recurrent benefits, including £2.3m excess of profit on disposal from the Whitechapel sale in month 4.

### Trust Surplus / (Deficit)

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>21.3</td>
</tr>
<tr>
<td>Actual</td>
<td>14.0</td>
</tr>
<tr>
<td>Variance</td>
<td>(7.4)</td>
</tr>
</tbody>
</table>

The post-PSF year to date surplus is £14.0m, which is £7.4m adverse against plan. The year to date PSF (£11.9m) is not included in the Trust's position as this is pending formal agreement of the 2018/19 control total, which is expected to be confirmed by the end of quarter two.

### Total Income

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>493.3</td>
</tr>
<tr>
<td>Actual</td>
<td>490.2</td>
</tr>
<tr>
<td>Variance</td>
<td>(3.1)</td>
</tr>
</tbody>
</table>

Patient treatment income is £7.2m favourable against plan for the year to date. The key driver is non-elective activity across the sites. The reported position is based on April and May freeze, submitted June flex data and July estimate which is informed by review of weekly un-coded activity data and feedback from sites. The year to date PSF (£11.9m) is not included in the Trust's position. Other income is £1.6m favourable against plan for the year to date, which is primarily due to over performance on overseas patient income.

### Operating Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>(492.0)</td>
</tr>
<tr>
<td>Actual</td>
<td>(498.5)</td>
</tr>
<tr>
<td>Variance</td>
<td>(6.5)</td>
</tr>
</tbody>
</table>

Year to date expenditure overspent by £7.1m in Sites and Directorates primarily due to non-elective activity pressures. Key overspends included temporary staffing costs and increased receivables impairment provisions in respect of overseas income and patient transport services activity which is offset by income.

### Cost Improvement Plan

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>10.8</td>
</tr>
<tr>
<td>Actual</td>
<td>10.9</td>
</tr>
<tr>
<td>Variance</td>
<td>0.1</td>
</tr>
</tbody>
</table>

As at month 4 there is a reported surplus of £0.1m against the year to date plan of £10.8m, this contains slippage on CIP schemes within the Sites and Clinical Support Services, which is being offset by Corporate overperformance. The forecast outturn at month 4 is £54.7m against annual plan of £55.5m.

### Capital Spend

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>16.4</td>
</tr>
<tr>
<td>Actual</td>
<td>8.4</td>
</tr>
<tr>
<td>Variance</td>
<td>8.0</td>
</tr>
</tbody>
</table>

The Trust is planning a capital programme for 2018/19 of £101.9m (including £9m of capital expenditure planned to be funded by charitable sources). It is intended to fund this programme from: retained net depreciation of £18.3m (£0.3m Specific PDC award, £2.8m prior year Capital Resource Limit (CRL) brought forward, £54.2m of NHSI Financing and £17.3m from asset sales. At this stage only the £32.7m funding has been confirmed. At the end of month 4, the Trust has spent £8.1m on capital (excluding donated capital), has contractually committed £24.1m with £36.1m of schemes committed to progress to delivery.

### Working Capital

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Assets</td>
<td>263.7</td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>(349.4)</td>
</tr>
<tr>
<td>Total</td>
<td>(85.7)</td>
</tr>
</tbody>
</table>

The Trust's current liabilities exceed its current assets by £85.7m which is predominantly because of higher trade payables than initially planned.

### Key Issues

At the end of month 4, the Trust is reporting a Pre-Provider Sustainability Fund (PSF) surplus of £14.0m which is £4.5m favourable compared to plan. The year to date PSF (£11.9m) is not included in the Trust's position as this is pending formal agreement of the 2018/19 control total, which is expected to be confirmed by the end of quarter two.

### Risks & Opportunities

- Year to date PSF income is not included in the Trust's position.
- Delivery of CIP savings and the planned asset sales will be key to achieving the control total for 2018/19.
### Income & Expenditure - Trustwide

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Year to Date</th>
<th>2018/19 Year to Date</th>
<th>Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Patient Treatment Income</td>
<td>114.9</td>
<td>116.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Other Patient Care Activity Income</td>
<td>2.0</td>
<td>2.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>9.4</td>
<td>9.1</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Total Income</td>
<td>126.2</td>
<td>128.1</td>
<td>1.9</td>
</tr>
<tr>
<td>Operating Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>(280.5)</td>
<td>(285.3)</td>
<td>(4.8)</td>
</tr>
<tr>
<td>Drugs</td>
<td>(53.6)</td>
<td>(56.6)</td>
<td>(3.0)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>(41.9)</td>
<td>(44.6)</td>
<td>(2.7)</td>
</tr>
<tr>
<td>Other Non Pay</td>
<td>(83.3)</td>
<td>(87.3)</td>
<td>(4.1)</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>(459.3)</td>
<td>(473.9)</td>
<td>(14.6)</td>
</tr>
<tr>
<td>Site &amp; Directorate Budgets Total</td>
<td>8.7</td>
<td>(24.2)</td>
<td>(32.9)</td>
</tr>
<tr>
<td>Central NHS PT Income</td>
<td>(7.4)</td>
<td>(5.0)</td>
<td>2.4</td>
</tr>
<tr>
<td>Central Other Income</td>
<td>0.3</td>
<td>0.3</td>
<td>-</td>
</tr>
<tr>
<td>Central Expenditure</td>
<td>(3.5)</td>
<td>0.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Reserves</td>
<td>(4.3)</td>
<td>(0.3)</td>
<td>4.1</td>
</tr>
<tr>
<td>Total EBITDA</td>
<td>(6.5)</td>
<td>(28.9)</td>
<td>(22.4)</td>
</tr>
<tr>
<td>Depreciation and Amortisation</td>
<td>(16.1)</td>
<td>(14.7)</td>
<td>1.4</td>
</tr>
<tr>
<td>Profit On Fixed Asset Disposal</td>
<td>60.0</td>
<td>62.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Interest</td>
<td>(23.7)</td>
<td>(23.5)</td>
<td>0.1</td>
</tr>
<tr>
<td>PDC Dividends</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Pre-PSF Control Total Surplus / (Deficit)</td>
<td>50.6</td>
<td>53.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Surplus / (Deficit)</td>
<td>54.3</td>
<td>53.1</td>
<td>(1.2)</td>
</tr>
</tbody>
</table>

**EBITDA**

- **2017/18**: 0.8
- **2018/19**: 1.0
- **Annual**: 0.8

- **Budget**: 1.0
- **Actual**: 1.0
- **Variance**: 0.2
- **%**: 20%

**PSF Income**

- **2017/18**: 3.7
- **2018/19**: -
- **Annual**: 3.7

- **Budget**: 3.7
- **Actual**: -
- **Variance**: (3.7)
- **%**: (100%)

**Surplus / (Deficit)**

- **2017/18**: 54.3
- **2018/19**: 53.1
- **Annual**: 54.3

- **Budget**: 53.1
- **Actual**: 53.1
- **Variance**: (0.0)
- **%**: 0%
### Net Contribution by Site

#### Sites

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Year to Date</th>
<th>2018/19 Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget (millions)</td>
<td>Actual (millions)</td>
</tr>
<tr>
<td>St Bartholomew’s Hospital</td>
<td>8.0</td>
<td>8.4</td>
</tr>
<tr>
<td>The Royal London Hospital</td>
<td>11.5</td>
<td>11.0</td>
</tr>
<tr>
<td>Whipps Cross University Hospital</td>
<td>3.2</td>
<td>3.4</td>
</tr>
<tr>
<td>Newham University Hospital</td>
<td>4.2</td>
<td>4.2</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>(6.0)</td>
<td>(6.4)</td>
</tr>
<tr>
<td><strong>Total Clinical Ops Net Contribution</strong></td>
<td>20.9</td>
<td>20.6</td>
</tr>
</tbody>
</table>

#### Corporate Areas

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Year to Date</th>
<th>2018/19 Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget (millions)</td>
<td>Actual (millions)</td>
</tr>
<tr>
<td>Clinical Operations</td>
<td>(0.2)</td>
<td>(0.2)</td>
</tr>
<tr>
<td>Deputy CEO</td>
<td>(6.7)</td>
<td>(6.8)</td>
</tr>
<tr>
<td>Chief Medical Officer</td>
<td>4.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Chief Nursing</td>
<td>(0.8)</td>
<td>(0.7)</td>
</tr>
<tr>
<td>People Development</td>
<td>(0.7)</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Finance</td>
<td>(1.5)</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td>(11.5)</td>
<td>(11.0)</td>
</tr>
<tr>
<td>Strategy</td>
<td>(0.2)</td>
<td>(0.1)</td>
</tr>
<tr>
<td><strong>Total Corporate Net Contribution</strong></td>
<td>(17.4)</td>
<td>(17.1)</td>
</tr>
</tbody>
</table>

#### Site & Directorate Budgets Total

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Year to Date</th>
<th>2018/19 Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget (millions)</td>
<td>Actual (millions)</td>
</tr>
<tr>
<td>Central NHS PT Income</td>
<td>(2.2)</td>
<td>(1.7)</td>
</tr>
<tr>
<td>PSF Income</td>
<td>3.7</td>
<td>(3.7)</td>
</tr>
<tr>
<td>Central Other Income</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Central Expenditure</td>
<td>(0.9)</td>
<td>(1.7)</td>
</tr>
<tr>
<td>Reserves</td>
<td>(0.6)</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Financing &amp; Depreciation</td>
<td>49.8</td>
<td>52.1</td>
</tr>
<tr>
<td><strong>Total Central Net Contribution</strong></td>
<td>50.7</td>
<td>49.6</td>
</tr>
<tr>
<td><strong>Total Trust Net Contribution</strong></td>
<td>54.3</td>
<td>53.1</td>
</tr>
</tbody>
</table>

### Key Messages

At the end of month 4, all sites reported favourable year to date contribution as a percentage of planned income: St Bartholomew’s Hospital 0.9%, The Royal London Hospital 0.5%, Whipps Cross Hospital 0.3% and Newham University Hospital 1.4%.
### Cost Improvement Programme (CIP)

#### Year to Date

<table>
<thead>
<tr>
<th>Year to Date</th>
<th>Budget £millions</th>
<th>Actual £millions</th>
<th>Variance £millions</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>1.7</td>
<td>1.0</td>
<td>(0.7)</td>
<td>(39)%</td>
</tr>
<tr>
<td></td>
<td>3.4</td>
<td>2.6</td>
<td>(0.9)</td>
<td>(25)%</td>
</tr>
<tr>
<td></td>
<td>0.9</td>
<td>0.5</td>
<td>(0.4)</td>
<td>(48)%</td>
</tr>
<tr>
<td></td>
<td>1.7</td>
<td>1.3</td>
<td>(0.5)</td>
<td>(27)%</td>
</tr>
</tbody>
</table>

#### Total Site CIP

|                      | 2.4 | 1.3 | (1.1) | (45)% |

#### Non Site Specific

<table>
<thead>
<tr>
<th>Year to Date</th>
<th>Budget £millions</th>
<th>Actual £millions</th>
<th>Variance £millions</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>1.7</td>
<td>0.2</td>
<td>(1.4)</td>
<td>(86)%</td>
</tr>
</tbody>
</table>

#### Corporate Areas

<table>
<thead>
<tr>
<th>Corporate Areas</th>
<th>Year to Date</th>
<th>Budget £millions</th>
<th>Actual £millions</th>
<th>Variance £millions</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>0.4</td>
<td>0.3</td>
<td>(0.0)</td>
<td>(9)%</td>
<td></td>
</tr>
</tbody>
</table>

#### Total Corporate CIP

|                      | 5.7 | 6.2 | 0.5 | 9% |

#### Total Cost Improvement Programme

|                      | 3.5 | 3.1 | (0.4) | (11)% |

### Key Messages

As at month 4 there is a reported surplus of £0.1m against the year to date plan of £10.8m, this contains slippage on CIP schemes within the Sites and Clinical Support Services, which is being offset by Corporate overperformance. The forecast outturn at month 4 is £54.7m against annual plan of £55.5m.
Capital Expenditure Summary - Trustwide

Key Messages

The Trust is planning a capital programme for 2018/19 of £101.9m (including £9m of capital expenditure to be funded by charitable sources). It is intended to fund this programme from: retained net depreciation of £18.3m, £3.0m Specific PDC award, £2.8m prior year Capital Resource Limit (CRL) brought forward (fully secured), £4.2m of NHSI Financing \(^{\text{NOTE-1}}\) (£5m secured to date) and £17.3m from asset sales \(^{\text{NOTE-2}}\) (£6.3m secured).

At the end of July, the Trust only has £32.7m of secured funds and has already contractually committed £24.1m with £36.1m of schemes committed to progress to delivery. The Trust continues to actively review and reprioritise to accommodate emerging risks and to look to manage within available resources.

As at the end of July, the Trust has spent £8.1m on capital (excluding donated capital). The rate of expenditure will rise over the coming months as funding sources are confirmed, business cases are approved and projects delivered. The Trust is currently forecasting to deliver to plan but will need to continue assessing the deliverability of the programme in light of likely timing of capital loan receipts and project delivery timescales.

Note 1 - The Trust is applying for capital financing over three applications, application 1 (£5m) and application 2 (£24.3m), bringing the programme up to the level of retained depreciation. Application 3 (£25m) looks to extend the basic programme recognising that the Trust has a growing issue with estates-related backlog maintenance, equipment replacement and underinvestment in ICT. To date the Trust has received £5m from application 1 and submitted application 2 to NHSI.

Note 2 - The Whitechapel site sale completed in July generated CRL of £12.7m, the Trust is intending to use £9.4m of this CRL generated from the sale to support the costs of achieving vacant possession of the site. These costs will be incurred in 2018/19 (£3.0m) and in future years (£6.4m) and the Trust is working with colleagues from NHSI (Taunton) to carry the unused balance of £6.4m from 2018/19 over to cover the costs in future years.
### Cashflow & Balance Sheet

#### Cashflow

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Actual</th>
<th>2018/19 Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash at bank</td>
<td>£millions</td>
<td>£millions</td>
</tr>
<tr>
<td>Sep-18</td>
<td>3.1</td>
<td>3.1</td>
</tr>
</tbody>
</table>

#### Cash inflows

- Healthcare contracts: £1,344.3m
- Other income: £430.7m
- Financing - Interim Working Capital Loan: £56.0m
- Financing - Capital Loans / PDC: £54.5m

#### Cash outflows

- Salaries and wages: £535.0m
- Tax, NI and pensions: £391.0m
- Non pay expenditures: £788.6m
- Capital expenditure: £1,885.6m
- Dividend and Interest payable: £12.0m
- Financing - Loan repayments: £57.1m

#### Net cash inflows / (outflows)

- £208.4m

#### Closing cash at bank

- Actual: £47.4m
- Forecast: £25.6m

#### Key Messages

The cash balance of £43.6m at the end of month 4 was £12.9m higher than planned. The Trust received the 2017/18 Sustainability and Transformation Fund (STF) of £36.2m in month as well as the £75.1m proceeds from the Whitechapel sale.
# Rolling Cashflow

## 2018/19

<table>
<thead>
<tr>
<th>Emillions</th>
<th>Aug 18</th>
<th>Sep 18</th>
<th>Oct 18</th>
<th>Nov 18</th>
<th>Dec 18</th>
<th>Jan 19</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash at bank</td>
<td>43.6</td>
<td>52.1</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>3.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>Cash inflows</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare contracts</td>
<td>126.0</td>
<td>104.4</td>
<td>104.6</td>
<td>99.2</td>
<td>114.9</td>
<td>105.3</td>
<td>104.8</td>
<td>162.6</td>
<td>104.7</td>
<td>104.2</td>
<td>116.8</td>
<td>103.2</td>
</tr>
<tr>
<td>Other income</td>
<td>21.9</td>
<td>13.0</td>
<td>31.8</td>
<td>18.6</td>
<td>24.2</td>
<td>30.2</td>
<td>19.7</td>
<td>68.3</td>
<td>35.5</td>
<td>10.1</td>
<td>11.2</td>
<td>28.8</td>
</tr>
<tr>
<td>Financing - Interim Working Capital Loan</td>
<td>-</td>
<td>14.7</td>
<td>-</td>
<td>10.0</td>
<td>-</td>
<td>4.3</td>
<td>-</td>
<td>-</td>
<td>14.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Financing - Capital Loans / PDC</td>
<td>-</td>
<td>0.3</td>
<td>4.9</td>
<td>4.9</td>
<td>13.2</td>
<td>13.1</td>
<td>13.2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total cash inflows</strong></td>
<td>147.9</td>
<td>132.4</td>
<td>141.3</td>
<td>122.7</td>
<td>154.0</td>
<td>148.7</td>
<td>137.6</td>
<td>248.4</td>
<td>140.2</td>
<td>114.3</td>
<td>142.2</td>
<td>132.0</td>
</tr>
<tr>
<td><strong>Cash outflows</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>(49.5)</td>
<td>(44.0)</td>
<td>(44.0)</td>
<td>(46.1)</td>
<td>(44.0)</td>
<td>(44.6)</td>
<td>(44.0)</td>
<td>(46.5)</td>
<td>(44.0)</td>
<td>(46.1)</td>
<td>(44.0)</td>
<td>(44.0)</td>
</tr>
<tr>
<td>Tax, NI and pensions</td>
<td>(33.0)</td>
<td>(35.1)</td>
<td>(32.5)</td>
<td>(32.5)</td>
<td>(32.5)</td>
<td>(32.5)</td>
<td>(32.5)</td>
<td>(31.8)</td>
<td>(32.5)</td>
<td>(32.5)</td>
<td>(32.5)</td>
<td>(32.5)</td>
</tr>
<tr>
<td>Non pay expenditures</td>
<td>(52.4)</td>
<td>(73.8)</td>
<td>(57.5)</td>
<td>(30.9)</td>
<td>(65.9)</td>
<td>(50.6)</td>
<td>(44.7)</td>
<td>(167.8)</td>
<td>(38.1)</td>
<td>(31.2)</td>
<td>(63.5)</td>
<td>(54.2)</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>(3.5)</td>
<td>(3.1)</td>
<td>(7.0)</td>
<td>(12.5)</td>
<td>(11.1)</td>
<td>(20.7)</td>
<td>(15.4)</td>
<td>(19.4)</td>
<td>(3.0)</td>
<td>(4.0)</td>
<td>(1.4)</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Dividend and Interest payable</td>
<td>(1.0)</td>
<td>(2.0)</td>
<td>(0.3)</td>
<td>(0.7)</td>
<td>(0.5)</td>
<td>(0.3)</td>
<td>(1.0)</td>
<td>(3.4)</td>
<td>(0.6)</td>
<td>(0.5)</td>
<td>(0.8)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Financing - Loan repayments</td>
<td>-</td>
<td>(1.5)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total cash outflows</strong></td>
<td>(139.4)</td>
<td>(159.5)</td>
<td>(141.3)</td>
<td>(122.7)</td>
<td>(154.0)</td>
<td>(148.7)</td>
<td>(137.6)</td>
<td>(270.4)</td>
<td>(118.2)</td>
<td>(114.3)</td>
<td>(142.2)</td>
<td>(132.0)</td>
</tr>
<tr>
<td><strong>Net cash inflows / (outflows)</strong></td>
<td>8.5</td>
<td>(27.1)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(22.0)</td>
<td>22.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Closing cash at bank - actual / forecast</strong></td>
<td>52.1</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>3.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td><strong>Closing cash at bank - plan</strong></td>
<td>30.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>3.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
</tbody>
</table>

The March 2019 cashflow assumes that other NHS organisations will make additional cash payments to reduce their debtor balances as part of the year end process which the Trust will then use to make additional payments to reduce its creditor balances for year end.
## Statement of Financial Position

### 2017/18 Balance as 31 Mar 2018

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>1,316.1</td>
<td>1,313.6</td>
<td>1,310.2</td>
<td>1,297.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,351.8</td>
<td>(21.3)</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>5.1</td>
<td>5.3</td>
<td>5.6</td>
<td>5.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>1,321.4</td>
<td>1,319.1</td>
<td>1,316.0</td>
<td>1,303.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,359.4</td>
<td>(20.6)</td>
</tr>
</tbody>
</table>

| Current assets: |       |       |       |       |       |       |       |       |       |       |       |       |              |
| Inventories | 28.8    | 27.3    | 27.2    | 27.0    |       |       |       |       |       |       |       | 27.4    | (0.4)         |
| Trade and other receivables | 201.6  | 211.4  | 200.9  | 193.1  |       |       |       |       |       |       |       | 187.8  | (21.0)        |
| Cash and cash equivalents | 47.4    | 25.6    | 23.6    | 43.6    |       |       |       |       |       |       |       | 3.0    | 40.6           |
| **Total current assets** | 277.8  | 264.3  | 251.7  | 263.7  |       |       |       |       |       |       |       | 218.2  | 19.2           |

| Total assets | 1,568.9 | 1,583.4 | 1,567.7 | 1,567.5 |       |       |       |       |       |       |       | 1,577.6 | (1.4)         |

### Current liabilities

| (176.7) | Trade and other payables | (210.3) | (193.9) | (199.2) | (202.9) |       |       |       |       |       | (157.4) | (26.2)       |
| (2.9)   | Provisions               | (2.9)   | (2.9)   | (2.5)   | (2.0)   |       |       |       |       |       | (1.5)   | 0.9           |
| (26.2)  | Liabilities arising from PFIs / Finance Leases | (26.2) | (26.2) | (26.2) | (26.4) |       |       |       |       |       | (24.7)  | (0.2)         |
| (115.0) | DH Revenue Support Loan (Including RWCSF) | (115.0) | (115.0) | (115.0) | (115.0) |       |       |       |       |       | (27.8)  | 0.0           |
| (3.1)   | DH Capital Investment Loan | (3.1)   | (3.1)   | (3.1)   | (3.1)   |       |       |       |       |       | (3.3)   | 0.0           |
| **Total current liabilities** | 357.5  | 341.1  | 346.0  | 349.4  |       |       |       |       |       |       | (214.5) | (25.5)       |

### Net current (liabilities) / assets

| (79.4)  | Net current (liabilities) / assets | (79.7)  | (76.8)  | (94.3)  | (85.7)  |       |       |       |       |       | 3.7     | (6.3)         |

| **Total assets less current liabilities** | 1,241.7 | 1,242.3 | 1,221.7 | 1,218.1 |       |       |       |       |       |       | 1,363.1 | (26.9)       |

### Non-current liabilities

| (14.7)  | Provisions               | (14.4)  | (14.9)  | (14.8)  | (14.7)  |       |       |       |       |       | (15.1)  | 0.0           |
| (1,013.7)| Liabilities arising from PFIs / Finance Leases | (1,011.2) | (1,011.2) | (1,007.8) | (1,005.6) |       |       |       |       |       | (992.6) | 11.7          |
| (290.5) | DH Revenue Support Loan (Including RWCSF) | (307.5)  | (317.5)  | (317.5)  | (263.4)  |       |       |       |       |       | (379.6) | 27.1          |
| (20.4)  | DH Capital Investment Loan | (20.4)  | (20.4)  | (20.4)  | (20.4)  |       |       |       |       |       | (71.6)  | 0.0           |
| (1,342.9)| Total non-current liabilities | 1,333.3  | 1,364.0  | 1,360.5  | 1,304.1  |       |       |       |       |       | (1,458.9) | 38.8           |

| (97.9)  | Total Assets Employed | (111.8) | (121.8) | (138.8) | (86.0)  |       |       |       |       |       | (95.8)  | 11.9          |

### Financed by:

| Taxpayers' equity | 327.1  | 327.1  | 327.1  | 327.1  |       |       |       |       |       |       | 327.4  | 0.0           |
| Retained earnings | (706.3) | (715.8) | (732.8) | (677.0) |       |       |       |       |       |       | (690.6) | 15.4          |

| Revaluation reserve | 267.4  | 267.0  | 266.9  | 263.9  |       |       |       |       |       |       | 267.4  | 0.0           |

| **Total Taxpayers' Equity** | (111.8) | (121.8) | (138.8) | (86.0)  |       |       |       |       |       |       | (95.8)  | 11.9          |

---

*Note 1 Forecast Outturn - The table above includes the closing balances from the Trust's audited accounts. As such, the forecast closing balances have been revised from the original plan as appropriate.*
People Report
# Workforce Summary

<table>
<thead>
<tr>
<th>Group</th>
<th>Indicator</th>
<th>Targets</th>
<th>Performance</th>
<th>YTD (Latest Month)</th>
<th>Jul-18 (Site)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Utilisation (Total Fill Rate)</td>
<td>&lt;=100%</td>
<td>101.5%</td>
<td>101.4%</td>
<td>101.4%</td>
</tr>
<tr>
<td></td>
<td>Staff in Post - Actual</td>
<td>&gt;=Plan</td>
<td>14,833</td>
<td>14,819</td>
<td>14,819</td>
</tr>
<tr>
<td></td>
<td>Staff in Post - Actual</td>
<td>-</td>
<td>15,039</td>
<td>15,120</td>
<td>15,120</td>
</tr>
<tr>
<td></td>
<td>Bank WTE - Plan</td>
<td>&lt;=Plan</td>
<td>1,900</td>
<td>2,004</td>
<td>2,004</td>
</tr>
<tr>
<td></td>
<td>Bank WTE - Plan</td>
<td>-</td>
<td>1,725</td>
<td>1,673</td>
<td>1,673</td>
</tr>
<tr>
<td></td>
<td>Agency WTE - Plan</td>
<td>&lt;=Plan</td>
<td>355</td>
<td>387</td>
<td>387</td>
</tr>
<tr>
<td></td>
<td>Agency WTE - Plan</td>
<td>-</td>
<td>375</td>
<td>368</td>
<td>368</td>
</tr>
<tr>
<td></td>
<td>Total Staffing - Plan</td>
<td>&lt;=Plan</td>
<td>17,088</td>
<td>17,210</td>
<td>17,210</td>
</tr>
<tr>
<td></td>
<td>Total Staffing - Plan</td>
<td>-</td>
<td>17,139</td>
<td>17,161</td>
<td>17,161</td>
</tr>
<tr>
<td>Recruit. Plans</td>
<td>Unconditional Offers - Actual</td>
<td>&gt;=Plan</td>
<td>294</td>
<td>332</td>
<td>332</td>
</tr>
<tr>
<td></td>
<td>Unconditional Offers - Plan</td>
<td>-</td>
<td>373</td>
<td>349</td>
<td>349</td>
</tr>
<tr>
<td>Rosters</td>
<td>Roster Compliance - % Approved on Time</td>
<td>&gt;=100%</td>
<td>57.9%</td>
<td>60.6%</td>
<td>60.6%</td>
</tr>
<tr>
<td></td>
<td>(&gt;20 WTEs)</td>
<td></td>
<td>3.3%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td>Roster Compliance - % Unused Hours</td>
<td>&lt;=0.49%</td>
<td>42,541</td>
<td>44,050</td>
<td>44,050</td>
</tr>
</tbody>
</table>

## Targets for Bank, Agency and Total Staffing Actual Against Plan (% Variance)

<table>
<thead>
<tr>
<th>Variance</th>
<th>RLH</th>
<th>WKH</th>
<th>NUH</th>
<th>SBH</th>
<th>CSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=-5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 0% and -5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;=0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Target for Roster Compliance - % Unused Hours

<table>
<thead>
<tr>
<th>Variance</th>
<th>RLH</th>
<th>WKH</th>
<th>NUH</th>
<th>SBH</th>
<th>CSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;=-0.49%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 0.5% and 0.99%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;=1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: YTD figures for workforce metrics are the latest historic period (in most cases the latest historic week)*
Workforce Summary - Commentary

Overall Commentary

• The Trust’s substantive staff fill rate in Jul-18 was 90.9% with 14,820 Whole Time Equivalents (WTE). The increase in % fill rate has been driven by an in-month reduction of 34.3 Budgeted WTE, but this is subject to review in the refresh of the workforce plans.

• Fill rates varied across sites as follows: SBH (89.8%), RLH (92.2%), CSS (94%), NUH (90.1%), WXH (86.1%).

• The total utilisation rate (WTE used against budgeted WTE, including temporary staffing) was 101.4% in Jul-18 (against 101.5% in Jun-18). Key reasons for a higher usage against plan are due to:
  • Enhanced care and additional activity at WXH.
  • Increases in activity at SBH, with additional lists for CT and MRI work.

• There is a review of all workforce plans, following the finalisation of Cost Improvement Programmes (CIPs). These will be concluded in time for Aug-18 reporting.

Commentary on Recruitment

• Recruitment commissioning levels were significantly above plan in Jul-18 (206% against plan), and unconditional offers were just short of the monthly target (93.5% against plan).

• High commissioning levels have generated an improved candidate pipeline that will support the delivery of higher volumes of unconditional offers in 2018/19 Q3.

• Over and above existing activity in the UK and overseas, new candidate pipelines are being explored through partnerships with the Ministry of Defence, attracting ex-armed forces and armed forces reservist candidates, and also with Newham Workplace, part of Newham Council, who work with local residents to identify suitable employment opportunities.

• The Trust welcomed 684 new doctors onto rotations on 01/08/2018.
## Domain Scorecard

### Exception Triggers

<table>
<thead>
<tr>
<th>Ref</th>
<th>Indicator</th>
<th>Month Target</th>
<th>Step</th>
<th>Change</th>
<th>Contl. Limit</th>
<th>This Period</th>
<th>This Period Target</th>
<th>Last Period</th>
<th>This Period</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W19 Turnover Rate</td>
<td>Jun-18 (m)</td>
<td></td>
<td></td>
<td>&lt;= 13%</td>
<td>12.9%</td>
<td>12.8%</td>
<td>12.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OH7 Proportion of Temporary Staff</td>
<td>Jun-18 (m)</td>
<td></td>
<td></td>
<td>&lt;= 10.2%</td>
<td>13.2%</td>
<td>13.2%</td>
<td>13.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>W20 Sickness Absence Rate</td>
<td>Jun-18 (m)</td>
<td></td>
<td></td>
<td>&lt;= 3%</td>
<td>3.41%</td>
<td>3.43%</td>
<td>3.43%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C6 Staff FFT Percentage Recommended - Care</td>
<td>2018/19 Q2 (q)</td>
<td>&gt;68%</td>
<td></td>
<td>&gt;68%</td>
<td>77.4%</td>
<td>80.7%</td>
<td>80.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OH6 NHS Staff Survey</td>
<td>2017/18 (y)</td>
<td>&gt;3.78</td>
<td></td>
<td>&gt;3.78</td>
<td>3.78</td>
<td>3.76</td>
<td>3.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>W50 Mandatory and Statutory Training - All</td>
<td>Jul-18 (m)</td>
<td></td>
<td></td>
<td>&gt;= 85%</td>
<td>91.0%</td>
<td>91.8%</td>
<td>90.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>W11 Mandatory and Statutory Training - National</td>
<td>Jul-18 (m)</td>
<td></td>
<td></td>
<td>&gt;= 85%</td>
<td>90.4%</td>
<td>91.1%</td>
<td>90.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Royal London</th>
<th>Whipps Cross</th>
<th>Newham</th>
<th>St Bart's</th>
<th>CSS</th>
<th>Other</th>
<th>Excp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.5%</td>
<td>12.2%</td>
<td>10.5%</td>
<td>13.3%</td>
<td>13.9%</td>
<td>14.0%</td>
<td></td>
</tr>
<tr>
<td>12.7%</td>
<td>20.6%</td>
<td>15.6%</td>
<td>14.3%</td>
<td>10.3%</td>
<td>5.1%</td>
<td></td>
</tr>
<tr>
<td>3.07%</td>
<td>3.92%</td>
<td>4.10%</td>
<td>2.97%</td>
<td>3.60%</td>
<td>3.48%</td>
<td></td>
</tr>
<tr>
<td>88.0%</td>
<td>81.7%</td>
<td>84.4%</td>
<td>83.1%</td>
<td>72.2%</td>
<td>75.3%</td>
<td></td>
</tr>
<tr>
<td>3.80</td>
<td>3.72</td>
<td>3.82</td>
<td>3.83</td>
<td>3.69</td>
<td>3.71</td>
<td></td>
</tr>
<tr>
<td>91.4%</td>
<td>92.5%</td>
<td>90.2%</td>
<td>91.9%</td>
<td>95.4%</td>
<td>88.4%</td>
<td></td>
</tr>
<tr>
<td>90.4%</td>
<td>91.7%</td>
<td>88.9%</td>
<td>91.3%</td>
<td>94.6%</td>
<td>88.8%</td>
<td></td>
</tr>
</tbody>
</table>

### Site Comparison

<table>
<thead>
<tr>
<th>Royal London</th>
<th>Whipps Cross</th>
<th>Newham</th>
<th>St Bart's</th>
<th>CSS</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.5%</td>
<td>12.2%</td>
<td>10.5%</td>
<td>13.3%</td>
<td>13.9%</td>
<td>14.0%</td>
</tr>
<tr>
<td>12.7%</td>
<td>20.6%</td>
<td>15.6%</td>
<td>14.3%</td>
<td>10.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>3.07%</td>
<td>3.92%</td>
<td>4.10%</td>
<td>2.97%</td>
<td>3.60%</td>
<td>3.48%</td>
</tr>
<tr>
<td>88.0%</td>
<td>81.7%</td>
<td>84.4%</td>
<td>83.1%</td>
<td>72.2%</td>
<td>75.3%</td>
</tr>
<tr>
<td>3.80</td>
<td>3.72</td>
<td>3.82</td>
<td>3.83</td>
<td>3.69</td>
<td>3.71</td>
</tr>
<tr>
<td>91.4%</td>
<td>92.5%</td>
<td>90.2%</td>
<td>91.9%</td>
<td>95.4%</td>
<td>88.4%</td>
</tr>
<tr>
<td>90.4%</td>
<td>91.7%</td>
<td>88.9%</td>
<td>91.3%</td>
<td>94.6%</td>
<td>88.8%</td>
</tr>
</tbody>
</table>
WELL LED

Proportion of Temporary Staff

Proportion of Temporary Staff - Top by Site (by Bank & Agency WTE in Latest Month) - Target 10.2%

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Bank &amp; Agency WTE</th>
<th>All Used WTE</th>
<th>%</th>
<th>Bank &amp; Agency WTE</th>
<th>All Used WTE</th>
<th>%</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal London</td>
<td>All Staff Groups</td>
<td>667</td>
<td>5,361</td>
<td>12.4%</td>
<td>679</td>
<td>5,352</td>
<td>12.7%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>All Staff Groups</td>
<td>522</td>
<td>2,644</td>
<td>19.7%</td>
<td>549</td>
<td>2,669</td>
<td>20.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>St Bart’s</td>
<td>All Staff Groups</td>
<td>304</td>
<td>2,289</td>
<td>13.3%</td>
<td>331</td>
<td>2,317</td>
<td>14.3%</td>
<td>1.0%</td>
</tr>
<tr>
<td>CSS</td>
<td>All Staff Groups</td>
<td>316</td>
<td>2,999</td>
<td>10.5%</td>
<td>307</td>
<td>2,976</td>
<td>10.3%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Newham</td>
<td>All Staff Groups</td>
<td>321</td>
<td>1,895</td>
<td>17.0%</td>
<td>292</td>
<td>1,870</td>
<td>15.6%</td>
<td>-1.3%</td>
</tr>
</tbody>
</table>

Performance Overview

- Temporary staffing usage increased by 119.4 WTE in Jul-18, with a 91.4 WTE increase in Bank and 28 WTE increase in agency.
- NHS improvement agency cap breaches for Jul-18 decreased by 2% from 752 to 736 shifts.
- Overall, bank and agency usage shows 84% bank (>=80% target) and 16% agency (=<20% target).
- The bank fill rate for doctors has remained at 80%; however, 5,514 shifts were filled which is the highest number of bank shifts filled to date. The agency fill has reduced by 3% from the previous month to 9%.

Responsible Director Update

- Work is ongoing to reduce the volume and value of bookings, including recruiting to substantive posts.
- Following concerns for shortages of Bank Healthcare Assistant (HCA) staff, shortlisting is complete for the HCA recruitment drive at Whips Cross and better fill rates should be seen over the next few months.
- The Pan London Bank pay rates for doctors went live on 03/09/2018. The Trust will be reporting on the Pan London breaches internally to track progress.
Sickness Absence Rate

Performance Overview

- Annualised sickness absence has increased a little to 3.43% in Jun-18, up from 3.41% in May-18 and against a Trust and NHS target of 3%.
- Within this, the rates vary with 4.10% at Newham, 3.92% at Whipps Cross, 3.60% at CSS, 3.07% at Royal London and 2.97% at St Bart’s.

Responsible Director Update

- Nationally, the Trust’s sickness absence is below that seen in comparable organisations, where the average exceeds 4%.
- A full review on long term absence is summarised in the spotlight section of this report, with a number of areas identified to help improve the current position.
Staff FFT Positive Response Rates - 2018/19 Q1

- How likely are you to recommend your organisation to friends and family if they needed care or treatment? 81%
- How likely are you to recommend your organisation to friends and family as a place to work? 78%
- Care of patients/service users is the trust's top priority. 75%
- I am able to make suggestions to improve the work of my team / department. 73%
- There are frequent opportunities for me to show initiative in my role. 69%
- I am able to make improvements happen in my area of work. 62%
- I look forward to going to work. 58%
- I am enthusiastic about my job. 71%
- Time passes quickly when I am working. 78%
- I have had feedback from my manager from the national staff survey. 48%
- I believe that action arising from the staff survey have had a positive impact on my workplace. 48%
Staff FFT

Progress Summary

- The Staff Friends and Family Test (Staff FFT) 2018/19 Q1 survey was carried out between 18/06/2018 and 30/06/2018. 8,000 colleagues were randomly selected to participate in the survey; 1,617 responded, with a response rate of 20%. This quarter an increased sample size of 8,000 (approximately 3,000 additional colleagues) was selected to participate in the survey and 9 additional questions were also asked, related to staff engagement and colleagues’ experience of the 2017 staff survey.

Noteworthy Improvements

- For the first time since 2016, the Trust has been able to achieve a 20% response rate (the Trust’s typical response rate is between 15-17%).
- Staff perception of Barts Health as a place of work and receive care is on an improving trend with a significant improvement of 4% in “recommend for care” which reached an all time high score of 81%.
- There is also a 2% improvement in the “recommend for work” results which reached a second all time high score of 64%.
- Benchmarking the Trust’s score with the national average 2017/18 Q4 data, Barts Health is 1% higher than the national average (80%) on “recommend for care”. Similarly for “recommend for work”, Barts Health is 1% higher than the national average (63%) for this area.

Next Steps

- Staff FFT results continue to form part of the site Performance Review (PR) process to track progress made at each site.
- Results to also be made available at divisional, service line and ward/team levels for local engagement in improvements.
Staffing performance is being tracked against the Workforce Plan, where the Whole Time Equivalents (WTEs) are aligned to the financial plan.

Plans are based on site workforce plan submissions for 2018/19. A refresh of site, CSS and Corporate workforce plans is currently in progress, with the revised plans due to be in use by Sep-18 reporting.

The final reported position for Jul-18 (Month 4) shows the Trust was 42 WTE (0.2%) above plan according to current available data:

- Whipps Cross was 20 WTE (0.8%) above plan
- St Bart’s was 33 WTE (1.4%) above plan
- Royal London was 20 WTE (0.4%) above plan
- Corporate was 10 WTE (0.6%) above plan
- CSS was 22 WTE (0.7%) below plan
- Newham was 10 WTE (0.5%) below plan
- Substantive staffing was 220 WTE below plan
- Bank staffing was 254 WTE above plan
- Agency Staffing was 8 WTE above plan

Establishment WTEs are -344 WTE below the workforce plan set earlier in the year. This is partly because previously unallocated Cost Improvement Programmes (CIPs) have been allocated to pay on a proportional basis. Sites are now refreshing workforce plans to correctly correspond with identified CIP assumptions.

This work will be completed in Sep-18.
Summary

• A deep dive of long term sick absence at Barts Health has been undertaken.

Findings

• The NHS as a whole has an absence rate of 4.13%, against which Barts Health performs well at 3.4%. Against 22 other London Trusts, Barts Health is ranked 10th.
• On average, 260 Whole Time Equivalents (WTEs) are lost to long term sickness absence each month, with Back & Musculoskeletal Problems being the main reported reason (21% of episodes). Anxiety and Stress is second (15% of episodes). These issues are reflected in our National Staff Survey results.
• Recording of ill health categories could be improved. "Unknown" is used, for example, where a shift leader changes and the reason is not understood or where the reason remains confidential.
• 90% of long term absences are from one episode. This indicates a significant opportunity to intervene earlier with support staff in order to shorten absence periods.
• Only 60% of long term absences were referred to the Employee Wellbeing Service (EWS).
• A review of formal case management indicated opportunities to improve the confidence of managers and their awareness of services and best practice.

Recommendations Now Being Taken Forward

1. EWS service development for early intervention. This is to develop the ability of the EWS to contact managers early, rather than to wait until after 28 days, and help enable a return to work earlier.
2. Develop the training given to managers around managing sickness absence, policy deployment and managing complex issues.
3. Review the potential to remove “Unknown” as an option from Healthroster, to focus on improving the data quality of absence reporting with more suitable options.
4. Update the absence policy to set clearer expectations for reporting ill health to the manager.
5. Absence data reports to be pulled direct from Healthroster to enable live data to be used for more timely intervention.
Safe Staffing

- Jul-18 had an average overall fill rate of over 90% for day and night shifts across Barts Health NHS Trust for Registered Nurses/Midwives (RN/RM) and Health Care Assistants (HCAs).

- One red flag safe staffing incident was reported at Royal London due to unfilled RN shifts; patient safety was maintained. The ward has a vacancy rate of 16.5% with recruitment underway. The RN fill rate for the month was above 95%.

- Senior midwifery and nursing staff use clinical judgement in their respective areas to assess the safety and effectiveness of staffing deviations. These are escalated through the site daily safety huddles to agree mitigation. Appendix 1 shows the staffing fill rates by ward and site.

- At St Bart’s, patient safety in critical care continued to be maintained by flexing capacity to staffing availability. On two wards, HCA fill rates were impacted by sickness or unfilled shifts. On ward 5D, safety was maintained with the ward manager working clinically.

- At Whipps Cross, shortfalls in maternity were mitigated at the time by support from senior staff and the matron; safety was maintained. Critical care was mitigated by support from senior staff and adjusting capacity. In the wards, fill rates less than 90% were due to sickness and some unfilled shifts; staff were moved within the site to maintain safety. Victory ward also had a staggered bed reduction for planned maintenance work. In the Neonatal Unit (NNU), issues were due to sickness, with RNs covering the workload. Additional capacity on Acorn ward, Acacia ward and B3 ward continues.

- At Royal London, the NNU and paediatric critical care continue to use their capacity based on available staffing; recruitment plans are ongoing. On ward 9E HDU, when capacity allows HCAs are redeployed to accommodate shortfalls elsewhere as agreed at the site safety huddle. On wards 13E and 13F, the RNs were flexed across day and night duty to meet patients’ needs. In paediatrics, there is an increase in the RN vacancies; staff were deployed across the Children’s hospital, when it was appropriate, to maintain patient safety. In maternity, staff are redeployed based on activity, with on call staff utilised as part of the escalation process.

- At Newham, Maple ward is unchanged. The NNU flexed staff to meet the acuity and dependency of the patients; safe staffing was maintained.
Glossary
<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub Domain</th>
<th>Metric Ref</th>
<th>Metric Name</th>
<th>Description</th>
<th>Frequency</th>
<th>Target Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Responsive</td>
<td>Waiting Times</td>
<td>R1</td>
<td>A&amp;E 4 Hours Waiting Time</td>
<td>The number of Accident &amp; Emergency (A&amp;E) attendances for which the patient was discharged, admitted or transferred within four hours of arrival, divided by the total number of A&amp;E attendances. This includes all types of A&amp;E attendances including Minor Injury Units and Walk-in Centres.</td>
<td>Monthly</td>
<td>PSF</td>
</tr>
<tr>
<td>1. Responsive</td>
<td>Waiting Times</td>
<td>R7</td>
<td>Cancer 62 Days From Urgent GP Referral</td>
<td>Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>1. Responsive</td>
<td>Waiting Times</td>
<td>R13</td>
<td>Cancer 62 Days From Screening Programme</td>
<td>Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of referral from a NHS Cancer Screening Service.</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>1. Responsive</td>
<td>Waiting Times</td>
<td>R6</td>
<td>Diagnostic Waits Over 6 Weeks</td>
<td>The number of patients still waiting for diagnostic tests who had waited more than 6 weeks from the referral date to the end of the calendar month, divided by the total number of patients still waiting for diagnostic tests at the end of the calendar month. Only the 15 key tests included in the Diagnostics Monthly (DM01) national return are included.</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>1. Responsive</td>
<td>Waiting Times</td>
<td>R4</td>
<td>18 Week RTT Compliance (Incomplete)</td>
<td>The number of patients on incomplete 18 week referral to treatment (RTT) pathways who had waited 18 weeks or less from the referral date (or clock start date) to the end of the calendar month, divided by the total number of incomplete 18 week RTT pathways at the end of the calendar month.</td>
<td>Monthly</td>
<td>PSF</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>People</td>
<td>W19</td>
<td>Turnover Rate</td>
<td>The number of leavers (whole time equivalents) who left the trust voluntarily in the last 12 months divided by the average total number of staff in post (whole time equivalents) in the last 12 months.</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>People</td>
<td>OH7</td>
<td>Proportion of Temporary Staff</td>
<td>The number of bank and agency whole time equivalents divided by the number of bank and agency whole time equivalents plus permanent staff in post (whole time equivalents).</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>People</td>
<td>W20</td>
<td>Sickness Absence Rate</td>
<td>The number of whole time equivalent days lost to sickness absence (including non-working days) in the last 12 months divided by the total number of whole time equivalent days available (including non-working days) in the last 12 months, i.e. the annualised percentage of working days lost due to sickness absence.</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>Staff Feedback</td>
<td>C6</td>
<td>Staff FFT Percentage Recommended - Care</td>
<td>The number of staff who responded that they were extremely likely or likely to recommend the trust to friends and family if they needed care or treatment, divided by the total number of staff who responded to the Staff Friends and Family Test (Staff FFT).</td>
<td>Quarterly</td>
<td>Local</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>Staff Feedback</td>
<td>OH6</td>
<td>NHS Staff Survey</td>
<td>The overall staff engagement score from the results of the NHS Staff Survey.</td>
<td>Yearly</td>
<td>National</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>Compliance</td>
<td>W50</td>
<td>Mandatory and Statutory Training All</td>
<td>For all statutory and mandatory training topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant).</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub Domain</td>
<td>Metric Ref</td>
<td>Metric Name</td>
<td>Description</td>
<td>Frequency</td>
<td>Target Source</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------</td>
<td>------------</td>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>2. Well Led</td>
<td>Compliance</td>
<td>W11</td>
<td>Mandatory and Statutory Training</td>
<td>For the 10 Core Skills Training Framework topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>National</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Experience</td>
<td>C12</td>
<td>MSA Breaches</td>
<td>The number of patients admitted to mixed sex sleeping accommodation (defined as an area patients are admitted into), except where it was in the overall best interest of the patient or reflected their personal choice</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C10</td>
<td>Written Complaints Rate Per 1,000 Staff</td>
<td>The number of initial reportable complaints received by the trust per 1,000 whole time equivalent staff (WTEs), i.e. the number of initial reportable complaints divided by the number of WTEs which has been multiplied by 1,000</td>
<td>Quarterly</td>
<td>SPC breach</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C1</td>
<td>FFT Recommended % - Inpatients</td>
<td>The number of patients who responded that they were extremely likely or likely to recommend the inpatient service they received to friends and family, divided by the total number of patients who responded to the inpatient Friends and Family Test (FFT)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C2</td>
<td>FFT Recommended % - A&amp;E</td>
<td>The number of patients who responded that they were extremely likely or likely to recommend the A&amp;E service they received to friends and family, divided by the total number of patients who responded to the A&amp;E Friends and Family Test (FFT)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C3</td>
<td>FFT Recommended % - Maternity</td>
<td>The number of patients who responded that they were extremely likely or likely to recommend the maternity (birth) service they received to friends and family, divided by the total number of patients who responded to the maternity (birth) Friends and Family Test (FFT)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C20</td>
<td>FFT Response Rate - Inpatients</td>
<td>The total number of patients who responded to the inpatient Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the inpatient FFT (i.e. all inpatient discharges in the reporting period)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C21</td>
<td>FFT Response Rate - A&amp;E</td>
<td>The total number of patients who responded to the A&amp;E Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the A&amp;E FFT (i.e. all A&amp;E attendances in the reporting period)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>C22</td>
<td>FFT Response Rate - Maternity</td>
<td>The total number of patients who responded to the maternity (birth) Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the maternity (birth) FFT (i.e. all delivery episodes in the reporting period)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Patient Feedback</td>
<td>OH4</td>
<td>CQC Inpatient Survey</td>
<td>The indicator is a composite, calculated as the average of five survey questions. Each question describes a different element of the overarching theme “responsiveness to patients’ personal needs”</td>
<td>Yearly</td>
<td>TBC</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Service User Support</td>
<td>R78</td>
<td>Complaints Replied to in Agreed Time</td>
<td>The number of initial reportable complaints replied to within the agreed number of working days (as agreed with the complainant). The time agreed for the reply might be 25 working days or might be another time such as 40 working days. The time to reply is counted from the date consent was obtained (if consent was required and the date is available) or the date first received</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub Domain</td>
<td>Metric Ref</td>
<td>Metric Name</td>
<td>Description</td>
<td>Frequency</td>
<td>Target Source</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>3. Caring</td>
<td>Service User Support</td>
<td>R30</td>
<td>Duty of Candour</td>
<td>The percentage of patient incidents (where harm was moderate, severe or death) where an apology was offered to the patient within 2 weeks (14 calendar days) of the date the incident was reported</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Infection Control</td>
<td>S10</td>
<td>Clostridium difficile - Infection Rate</td>
<td>The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust per 100,000 bed days (inpatient bed days with day cases counted as 1 day each)</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Infection Control</td>
<td>S11</td>
<td>Clostridium difficile - Incidence</td>
<td>The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Infection Control</td>
<td>S2</td>
<td>Assigned MRSA Bacteraemia Cases</td>
<td>The number of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias which can be directly associated to the trust</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Infection Control</td>
<td>S77</td>
<td>MSSA Bacteraemias</td>
<td>The number of Methicillin-susceptible Staphylococcus aureus (MSSA) bacteraemias which can be directly associated to the trust</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Infection Control</td>
<td>S76</td>
<td>E.coli Bacteraemia Bloodstream Infections</td>
<td>The number of Escherichia coli (E.coli) bacteraemia bloodstream infections at the trust (i.e. for which the specimen was taken by the trust)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Incidents</td>
<td>S3</td>
<td>Never Events</td>
<td>The number of never events reported via the Strategic Executive Information System (STEIS)</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Incidents</td>
<td>S45</td>
<td>Falls Per 1,000 Bed Days</td>
<td>The total number of patient falls occurring at the trust per 1,000 inpatient bed days, i.e. the total number of patient falls occurring at the trust divided by the number of inpatient bed days which has been multiplied by 1,000</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Incidents</td>
<td>S25</td>
<td>Medication Errors - Percentage Causing Harm</td>
<td>The number of medication error incidents occurring at the trust which caused harm divided by the total number of medication error incidents occurring at the trust</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Incidents</td>
<td>S48</td>
<td>Medication Errors - Rate Per 1,000 Bed Days</td>
<td>The number of medication error incidents occurring at the trust per 1,000 inpatient bed days, i.e. the total number of medication error incidents occurring at the trust divided by the number of inpatient bed days which has been multiplied by 1,000</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Incidents</td>
<td>S49</td>
<td>Patient Safety Incidents Per 1,000 Bed Days</td>
<td>The number of reported patient safety incidents per 1,000 bed days. This is the NHS Single Oversight Framework metric &quot;Potential Under-Reporting of Patient Safety Incidents&quot;</td>
<td>Monthly</td>
<td>SPC breach</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Incidents</td>
<td>S53</td>
<td>Serious Incidents Closed in Time</td>
<td>Percentage of serious incidents investigated and closed on the Strategic Executive Information System (STEIS) within 60 working days</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Harm Free Care</td>
<td>S14</td>
<td>Pressure Ulcers Per 1,000 Bed Days (Grades 2, 3 and 4)</td>
<td>The number of new grade 2, 3 or 4 pressure ulcers acquired at the trust (including those which occurred at the trust and those which deteriorated to grade 2, 3 or 4 at the trust) per 1,000 inpatient bed days, i.e. the number of new grade 2, 3 or 4 pressure ulcers acquired at the trust divided by the number of inpatient bed days which has been multiplied by 1,000</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Harm Free Care</td>
<td>S17</td>
<td>Emergency C-Section Rate</td>
<td>The number of deliveries which were emergency caesarean sections divided by the total number of deliveries</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub Domain</td>
<td>Metric Ref</td>
<td>Metric Name</td>
<td>Description</td>
<td>Frequency</td>
<td>Target Source</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>------------</td>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Harm Free Care</td>
<td>S27</td>
<td>Patient Safety Alerts Overdue</td>
<td>The number of NHS England or NHS Improvement patient safety alerts overdue (past their completion deadline date) at the time of the snapshot. These are a subset of all Central Alerting System (CAS) alerts</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Assess &amp; Prevent</td>
<td>S36</td>
<td>VTE Risk Assessment</td>
<td>The number of adult hospital admissions (aged 18 and over) who were risk assessed for Venous Thromboembolism (VTE) divided by the number of adult hospital admissions</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Assess &amp; Prevent</td>
<td>S5</td>
<td>Dementia - Screening</td>
<td>Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay &gt; 72 hours, who were asked the dementia case finding question within 72 hours of admission, or who had a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia, excluding those for whom the case finding question could not be completed for clinical reasons</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Assess &amp; Prevent</td>
<td>S6</td>
<td>Dementia - Risk Assessment</td>
<td>Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay &gt; 72 hours, who scored positively on the case finding question, or who had a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>4. Safe</td>
<td>Assess &amp; Prevent</td>
<td>S7</td>
<td>Dementia - Referrals</td>
<td>Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay &gt; 72 hours, who have had a diagnostic assessment (with an outcome of “positive” or “inconclusive”) and who have been referred for further diagnostic advice in line with local pathways</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>5. Effective</td>
<td>Mortality</td>
<td>E1</td>
<td>Summary Hospital-Level Mortality Indicator</td>
<td>The ratio between the actual number of patients who died following hospitalisation at the trust and the number who would be expected to die on the basis of average England figures (given the characteristics of the patients treated at the trust), multiplied by 100</td>
<td>Quarterly</td>
<td>National</td>
</tr>
<tr>
<td>5. Effective</td>
<td>Mortality</td>
<td>E3</td>
<td>Risk Adjusted Mortality Index</td>
<td>The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100, at trust level. This metric considers mortality on weekdays and weekends</td>
<td>Monthly</td>
<td>National</td>
</tr>
<tr>
<td>5. Effective</td>
<td>Mortality</td>
<td>E25</td>
<td>Number of Avoidable Deaths</td>
<td>The number of adult inpatient deaths which occurred at the trust or site which were considered avoidable</td>
<td>Quarterly</td>
<td>National</td>
</tr>
<tr>
<td>5. Effective</td>
<td>Outcomes</td>
<td>S51</td>
<td>Proportion of Cardiac Arrest 2222 Calls</td>
<td>The number of 2222 emergency calls which were for cardiac arrests on wards (including medical emergencies leading to cardiac arrests) divided by the total number of 2222 emergency calls on wards</td>
<td>Monthly</td>
<td>Local</td>
</tr>
<tr>
<td>5. Effective</td>
<td>Outcomes</td>
<td>S42</td>
<td>Sepsis &amp; Antibiotic Administration (60 Mins)</td>
<td>The number of audited inpatients who deteriorated, were screened for sepsis and found to have sepsis who received antibiotics 60 minutes or less after the time of deterioration divided by the total number of audited inpatients who deteriorated, were screened for sepsis and found to have sepsis</td>
<td>Monthly</td>
<td>Local</td>
</tr>
</tbody>
</table>
## Interpretation of Scorecards

### How to Interpret an SPC Chart

Statistical process control (SPC) is a method of quality control which uses statistical methods. When you are interpreting these SPC charts there are 3 rules that help you identify what the performance is doing. If one of the rules has been broken, this means that "special cause" variation is present in the system.

**Rule 1:** Any point outside one of the control limits (upper or lower control limits)

**Rule 2:** A run of five points all above or all below the centre line

**Rule 3:** Any unusual pattern or trends within the control

**Indication of Good or Bad performance:** to help users identify whether performance is changing in a positive or negative way, the upper and lower control limits are coloured to indicate whether a high value is good (green) or bad (red). In the example to the left, a higher value would be seen as a deterioration in performance (the upper control limit is red).

### How Exceptions Are Identified For Inclusion

The general principle is to ensure that as many exceptions as possible can be included as detailed exceptions in the report without overwhelming the meeting and that hot topics or particularly important, large or otherwise noteworthy exceptions are definitely included.

- Some exceptions are not given exception pages if it is felt that the commentary and discussion would be the same as the previous month or if it is a minor or consistent exception at a time where there are many other exceptions which need to be covered, in order to focus discussions on the most important topics that month.
- When making these decisions, factors such as the number of sites with an exception for that metric, the magnitude of the exception, the context of the exception within the organisation as a whole and the number of other exceptions that month are all taken into account.
Site

Ward name

Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London
Royal London

10E RLH
10F RLH
11C RLH
11E & 11F AAU
12C RLH
12D RLH
12E RLH
12F RLH
13C RLH
13D RLH
13E RLH
13F RLH
14E RLH
14F RLH
3D RLH
3E RLH
3F RLH
4E RLH
6C RLH
6E & 6F RLH
7C RLH
7D RLH
7E NORTH RLH
7E RLH
7F RLH
8C RLH
8D RLH
8F RLH
9E HDU RLH
9E RLH
9F RLH
BARKANTINE RLH

Safe Staffing Fill Rates by Ward and Site
Registered
Care Staff
midwives/nurses
Total
Total
Total
Total
monthly
monthly
monthly
monthly
actual
actual
planned
planned
staff
staff
staff hours
staff hours
hours
hours
1,940.3 2,203.5
713.0
864.5
1,060.0 1,010.5
744.0
740.5
1,780.0 1,833.3
713.0
780.0
3,920.0 3,778.5
1,827.5 1,991.2
1,923.5 2,130.0
1,063.5 1,042.5
1,393.0 1,478.0
379.5
742.8
2,748.5 2,741.2
1,414.5 1,413.6
1,782.5 1,700.0
1,805.5 1,852.0
1,679.0 1,980.3
1,058.0 1,046.5
2,135.0 2,123.5
711.0
753.5
2,139.0 1,946.0
735.0
929.2
1,774.5 1,693.5
988.0
954.5
1,679.0 1,735.5
1,092.5 1,263.0
1,788.0 1,853.8
1,078.0 1,092.5
4,731.5 5,009.3
2,691.0 2,784.9
2,486.5 2,313.0
1,414.5 1,456.5
1,426.0 1,464.2
1,069.5 1,074.0
13,888.0 14,006.7
720.5
683.5
3,102.5 1,974.8
264.5
0.0
5,413.0 5,171.3
1,350.8 1,306.3
1,426.0 1,396.8
368.0
333.5
1,426.0 1,391.5
356.5
356.5
1,437.5 1,251.0
356.5
541.2
1,426.0 1,403.0
713.0
423.0
1,446.8 1,376.3
667.0
758.0
1,671.3 1,591.8
721.5
856.3
9,495.5 8,362.5
1,003.0 1,161.0
1,836.0 1,733.3
1,129.5 1,058.0
1,322.5 1,391.5
356.5
264.0
1,788.0 1,764.4
707.5
806.5
1,783.0 1,743.5
713.0
922.5
2,230.0 1,637.8
583.5
428.5

Registered
Care Staff
Day
midwives/nurses
Total
Total
Total
Average fill
Total
monthly monthly
monthly
rate monthly
planned actual
actual
registered
planned
staff
staff
staff
nurses /
staff hours
hours
hours
hours midwives (%)
1,435.3 1,845.3
713.0
945.0
113.6%
682.0
715.0
682.0
660.0
95.3%
1,426.0 1,483.5
713.0
851.9
103.0%
3,565.0 3,715.5 1,414.5 1,628.0
96.4%
1,943.5 2,102.5 1,069.5 1,081.0
110.7%
1,437.5 2,146.4
356.5
768.9
106.1%
2,495.5 2,492.8 1,426.0 1,439.9
99.7%
1,781.0 1,794.5 1,805.5 1,920.5
95.4%
1,426.0 1,414.5
724.5
787.0
117.9%
1,782.5 1,770.0
713.0
807.0
99.5%
1,759.5 1,437.5
655.5
805.0
91.0%
1,771.0 1,494.0
724.5
736.0
95.4%
1,081.0 1,159.8 1,069.5 1,319.3
103.4%
1,069.5 1,235.0 1,068.5 1,092.5
103.7%
3,220.0 3,923.5 1,886.0 2,210.6
105.9%
2,495.5 2,449.5
724.5
782.0
93.0%
1,069.5 1,152.0
713.0
736.0
102.7%
13,902.5 13,954.5
345.0
342.1
100.9%
2,139.0 1,840.0
264.5
0.0
63.7%
5,359.0 5,317.5 1,058.0 1,046.5
95.5%
1,069.5 1,108.5
379.5
479.8
97.9%
1,069.5 1,069.5
356.5
356.5
97.6%
1,069.5 1,060.0
356.5
470.5
87.0%
966.0
1,058.8
713.0
747.5
98.4%
1,449.0 1,368.5
678.5
677.5
95.1%
1,437.5 1,458.0
713.0
935.0
95.2%
9,016.0 7,754.8
563.5
241.5
88.1%
1,127.0 1,092.5 1,081.0 1,066.8
94.4%
1,426.0 1,403.0
0.0
11.5
105.2%
1,426.0 1,483.5
356.5
678.0
98.7%
1,426.0 1,426.0
356.5
621.0
97.8%
460.0
407.5
356.5
357.5
73.4%

Night
Average
fill rate care staff
(%)
121.2%
99.5%
109.4%
109.0%
98.0%
195.7%
99.9%
102.6%
98.9%
106.0%
126.4%
96.6%
115.6%
101.3%
103.5%
103.0%
100.4%
94.9%
0.0%
96.7%
90.6%
100.0%
151.8%
59.3%
113.6%
118.7%
115.8%
93.7%
74.1%
114.0%
129.4%
73.4%

Average fill
rate registered
nurses /
midwives (%)
128.6%
104.8%
104.0%
104.2%
108.2%
149.3%
99.9%
100.8%
99.2%
99.3%
81.7%
84.4%
107.3%
115.5%
121.8%
98.2%
107.7%
100.4%
86.0%
99.2%
103.6%
100.0%
99.1%
109.6%
94.4%
101.4%
86.0%
96.9%
98.4%
104.0%
100.0%
88.6%

Sep-18
Care Hours Per Patient Day (CHPPD)

Average
Patients Registered
fill rate at
midwives /
care staff
Midnight
nurses
(%)
132.5%
96.8%
119.5%
115.1%
101.1%
215.7%
101.0%
106.4%
108.6%
113.2%
122.8%
101.6%
123.4%
102.2%
117.2%
107.9%
103.2%
99.2%
0.0%
98.9%
126.4%
100.0%
132.0%
104.8%
99.9%
131.1%
42.9%
98.7%
190.2%
174.2%
100.3%

784.0
323.0
766.0
1,338.0
814.0
461.0
727.0
769.0
746.0
793.0
740.0
624.0
776.0
788.0
1,221.0
673.0
511.0
1,287.0
150.0
793.0
314.0
342.0
324.0
285.0
355.0
548.0
1,111.0
1,286.0
256.0
712.0
683.0
51.0

5.2
5.3
4.3
5.6
5.2
7.9
7.2
4.5
4.6
4.9
4.6
5.1
3.7
3.9
7.3
7.1
5.1
21.7
25.4
13.2
8.0
7.2
7.1
8.6
7.7
5.6
14.5
2.2
10.9
4.6
4.6
40.1

Care
Staff

Overall

2.3
4.3
2.1
2.7
2.6
3.3
3.9
4.9
2.5
2.0
2.3
2.7
3.3
2.8
4.1
3.3
3.5
0.8
0.0
3.0
2.6
2.1
3.1
4.1
4.0
3.3
1.3
1.7
1.1
2.1
2.3
15.4

7.5
9.7
6.5
8.3
7.8
11.1
11.1
9.4
7.0
6.9
6.9
7.8
7.1
6.7
11.4
10.4
8.7
22.5
25.4
16.2
10.6
9.3
10.3
12.7
11.8
8.8
15.8
3.8
12.0
6.6
6.9
55.5

56

Trust Performance Report

Page 74 of 190

TB 43-18 Integrated
Performance Report

APPENDIX


## Safe Staffing Fill Rates by Ward and Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward name</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Average fill rate - registered midwives/registered midwives (%)</th>
<th>Average fill rate - registered midwives/registered midwives (%)</th>
<th>Patients at Midnight</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whips Cross</td>
<td>AAU WXH</td>
<td>4,634.5</td>
<td>4,414.7</td>
<td>2,495.5</td>
<td>2,495.5</td>
<td>96.8%</td>
<td>100.0%</td>
<td>98.9%</td>
<td>100.5%</td>
<td>1,742.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>ACACIA</td>
<td>966.0</td>
<td>1,305.0</td>
<td>460.0</td>
<td>790.4</td>
<td>135.1%</td>
<td>171.8%</td>
<td>150.7%</td>
<td>149.3%</td>
<td>517.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>ACORN</td>
<td>3,819.3</td>
<td>3,652.7</td>
<td>784.8</td>
<td>706.3</td>
<td>95.6%</td>
<td>90.0%</td>
<td>113.9%</td>
<td>12.9%</td>
<td>526.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>B3</td>
<td>1,234.5</td>
<td>1,300.5</td>
<td>707.0</td>
<td>1,099.5</td>
<td>105.3%</td>
<td>155.5%</td>
<td>95.7%</td>
<td>293.4%</td>
<td>579.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>BIRCH</td>
<td>1,069.5</td>
<td>1,072.2</td>
<td>1,069.5</td>
<td>1,087.0</td>
<td>100.3%</td>
<td>101.6%</td>
<td>98.8%</td>
<td>111.3%</td>
<td>549.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>BLACKTHORN</td>
<td>1,411.0</td>
<td>1,352.5</td>
<td>1,273.5</td>
<td>1,244.2</td>
<td>95.9%</td>
<td>97.6%</td>
<td>98.9%</td>
<td>101.3%</td>
<td>608.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>CEDAR</td>
<td>1,483.5</td>
<td>1,497.0</td>
<td>1,088.0</td>
<td>1,416.0</td>
<td>100.9%</td>
<td>130.1%</td>
<td>98.2%</td>
<td>148.1%</td>
<td>654.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>CHESTNUT</td>
<td>1,299.0</td>
<td>1,111.5</td>
<td>1,064.5</td>
<td>1,194.0</td>
<td>85.9%</td>
<td>112.2%</td>
<td>100.0%</td>
<td>132.2%</td>
<td>581.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>CONFER</td>
<td>1,423.0</td>
<td>1,486.5</td>
<td>1,069.5</td>
<td>1,416.0</td>
<td>104.5%</td>
<td>132.4%</td>
<td>110.1%</td>
<td>151.6%</td>
<td>664.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>CURIE</td>
<td>1,423.5</td>
<td>1,439.5</td>
<td>1,069.5</td>
<td>1,349.5</td>
<td>101.5%</td>
<td>126.5%</td>
<td>106.6%</td>
<td>147.8%</td>
<td>722.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>DELIVERY SUITE WXH</td>
<td>5,155.8</td>
<td>4,154.0</td>
<td>878.0</td>
<td>560.0</td>
<td>80.6%</td>
<td>63.8%</td>
<td>97.1%</td>
<td>100.0%</td>
<td>536.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>ELIZABETH</td>
<td>1,679.0</td>
<td>1,623.0</td>
<td>356.5</td>
<td>402.5</td>
<td>96.7%</td>
<td>112.9%</td>
<td>79.7%</td>
<td>104.5%</td>
<td>544.0</td>
<td>5.1</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>FARADAY</td>
<td>1,064.0</td>
<td>1,057.5</td>
<td>711.7</td>
<td>843.2</td>
<td>99.4%</td>
<td>118.5%</td>
<td>99.9%</td>
<td>167.6%</td>
<td>482.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>Frail Elderly WXH</td>
<td>701.5</td>
<td>698.5</td>
<td>356.5</td>
<td>469.8</td>
<td>99.6%</td>
<td>131.8%</td>
<td>98.3%</td>
<td>154.8%</td>
<td>233.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>ICU WXH</td>
<td>5,196.5</td>
<td>4,462.3</td>
<td>1,800.0</td>
<td>1,311.0</td>
<td>85.9%</td>
<td>70.5%</td>
<td>86.4%</td>
<td>70.1%</td>
<td>195.0</td>
<td>43.8</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>MARGARET</td>
<td>946.5</td>
<td>925.5</td>
<td>521.5</td>
<td>520.5</td>
<td>97.8%</td>
<td>99.8%</td>
<td>101.6%</td>
<td>103.2%</td>
<td>270.0</td>
<td>6.1</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>MIDWIFERY WXH</td>
<td>792.5</td>
<td>753.0</td>
<td>360.0</td>
<td>241.0</td>
<td>95.0%</td>
<td>66.9%</td>
<td>98.9%</td>
<td>92.4%</td>
<td>165.0</td>
<td>8.8</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>MULBERRY</td>
<td>2,219.0</td>
<td>1,848.1</td>
<td>1,574.0</td>
<td>718.0</td>
<td>83.3%</td>
<td>45.6%</td>
<td>97.5%</td>
<td>91.7%</td>
<td>1,314.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>NEONATAL WXH</td>
<td>2,321.5</td>
<td>2,413.8</td>
<td>1,138.5</td>
<td>755.5</td>
<td>104.0%</td>
<td>66.4%</td>
<td>110.1%</td>
<td>57.7%</td>
<td>496.0</td>
<td>9.6</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>NIGHTINGALE</td>
<td>1,069.0</td>
<td>1,080.0</td>
<td>356.5</td>
<td>356.5</td>
<td>101.0%</td>
<td>100.0%</td>
<td>98.8%</td>
<td>99.8%</td>
<td>480.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>PEACE</td>
<td>1,679.0</td>
<td>1,541.0</td>
<td>816.5</td>
<td>1,000.0</td>
<td>91.8%</td>
<td>122.6%</td>
<td>99.0%</td>
<td>130.6%</td>
<td>570.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>POPULAR</td>
<td>1,271.5</td>
<td>1,931.8</td>
<td>1,128.0</td>
<td>1,749.3</td>
<td>153.5%</td>
<td>155.1%</td>
<td>153.6%</td>
<td>288.9%</td>
<td>740.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>PRIMROSE</td>
<td>1,782.5</td>
<td>1,702.0</td>
<td>1,069.5</td>
<td>1,238.0</td>
<td>95.5%</td>
<td>120.4%</td>
<td>104.0%</td>
<td>113.9%</td>
<td>760.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>ROWAN</td>
<td>1,782.5</td>
<td>1,733.7</td>
<td>1,069.5</td>
<td>1,238.0</td>
<td>97.3%</td>
<td>115.8%</td>
<td>100.8%</td>
<td>119.2%</td>
<td>778.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>SAGE</td>
<td>965.0</td>
<td>780.5</td>
<td>351.5</td>
<td>299.0</td>
<td>80.9%</td>
<td>85.1%</td>
<td>98.4%</td>
<td>67.7%</td>
<td>196.0</td>
<td>7.6</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>SYCAMORE</td>
<td>1,701.0</td>
<td>1,572.4</td>
<td>1,466.0</td>
<td>1,437.5</td>
<td>92.4%</td>
<td>104.9%</td>
<td>100.0%</td>
<td>117.4%</td>
<td>740.0</td>
<td>4.1</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>SYRINGA</td>
<td>1,596.5</td>
<td>1,491.5</td>
<td>1,725.0</td>
<td>1,702.0</td>
<td>93.4%</td>
<td>98.7%</td>
<td>98.9%</td>
<td>101.1%</td>
<td>787.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Whips Cross</td>
<td>VICTORY</td>
<td>1,069.5</td>
<td>954.5</td>
<td>1,351.8</td>
<td>1,143.0</td>
<td>89.2%</td>
<td>84.6%</td>
<td>98.5%</td>
<td>100.0%</td>
<td>484.0</td>
<td>3.4</td>
</tr>
</tbody>
</table>

### Sep-18

**APPENDIX**

**Trust Performance Report**

Page 75 of 190
## Safe Staffing Fill Rates by Ward and Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward name</th>
<th>Total monthly planned staff hours</th>
<th>Total monthly actual staff hours</th>
<th>Average fill rate - registered nurses/ midwives (%)</th>
<th>Average fill rate - care staff (%)</th>
<th>Overall</th>
<th>Patients at Midnight</th>
<th>Registered midwives/nurses</th>
<th>Registered Care Staff</th>
<th>Care Staff Per Patient Day (CHPPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham</td>
<td>BECKTON</td>
<td>945.0</td>
<td>870.6</td>
<td>92.1%</td>
<td>100.0%</td>
<td>87.6%</td>
<td>3.3</td>
<td>5.4</td>
<td>1.4</td>
<td>8.0</td>
</tr>
<tr>
<td></td>
<td>CCU NUH</td>
<td>2,512.5</td>
<td>2,535.5</td>
<td>97.9%</td>
<td>119.8%</td>
<td>101.9%</td>
<td>3.0</td>
<td>16.2</td>
<td>3.0</td>
<td>19.2</td>
</tr>
<tr>
<td></td>
<td>EAST HAM</td>
<td>1,426.0</td>
<td>1,359.0</td>
<td>93.5%</td>
<td>101.1%</td>
<td>98.4%</td>
<td>2.3</td>
<td>2.7</td>
<td>2.4</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>HEATHER</td>
<td>1,069.5</td>
<td>1,159.0</td>
<td>108.4%</td>
<td>114.0%</td>
<td>222.6%</td>
<td>4.4</td>
<td>4.4</td>
<td>4.4</td>
<td>9.7</td>
</tr>
<tr>
<td></td>
<td>ICU NUH</td>
<td>2,507.0</td>
<td>2,288.5</td>
<td>91.3%</td>
<td>93.5%</td>
<td>92.0%</td>
<td>4.0</td>
<td>26.3</td>
<td>4.4</td>
<td>30.3</td>
</tr>
<tr>
<td></td>
<td>LARCH</td>
<td>3,813.5</td>
<td>3,877.6</td>
<td>101.7%</td>
<td>100.8%</td>
<td>100.7%</td>
<td>1.2</td>
<td>2.2</td>
<td>1.3</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>MAPLE</td>
<td>1,426.0</td>
<td>1,173.0</td>
<td>82.3%</td>
<td>95.2%</td>
<td>80.2%</td>
<td>6.3</td>
<td>10.2</td>
<td>6.3</td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>MAU NUH</td>
<td>1,732.5</td>
<td>1,711.3</td>
<td>102.3%</td>
<td>106.6%</td>
<td>106.2%</td>
<td>2.1</td>
<td>9.2</td>
<td>2.1</td>
<td>8.0</td>
</tr>
<tr>
<td></td>
<td>NEONATAL NUH</td>
<td>3,254.0</td>
<td>2,882.0</td>
<td>88.6%</td>
<td>93.9%</td>
<td>89.0%</td>
<td>4.0</td>
<td>9.1</td>
<td>2.2</td>
<td>11.3</td>
</tr>
<tr>
<td></td>
<td>NUN MIDWIFE</td>
<td>1,429.5</td>
<td>1,447.5</td>
<td>101.3%</td>
<td>96.7%</td>
<td>100.1%</td>
<td>6.9</td>
<td>1.7</td>
<td>8.5</td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>PLASHT</td>
<td>534.5</td>
<td>429.4</td>
<td>92.7%</td>
<td>120.1%</td>
<td>163.5%</td>
<td>3.8</td>
<td>3.1</td>
<td>6.9</td>
<td>9.8</td>
</tr>
<tr>
<td></td>
<td>RAINBOW</td>
<td>2,700.5</td>
<td>2,533.3</td>
<td>79.4%</td>
<td>126.9%</td>
<td>74.1%</td>
<td>2.5</td>
<td>25.1</td>
<td>2.5</td>
<td>29.7</td>
</tr>
<tr>
<td></td>
<td>SILVERTOWN</td>
<td>1,065.0</td>
<td>1,310.0</td>
<td>123.1%</td>
<td>106.6%</td>
<td>103.2%</td>
<td>4.1</td>
<td>8.6</td>
<td>4.1</td>
<td>12.7</td>
</tr>
<tr>
<td></td>
<td>STRATFORD</td>
<td>1,061.5</td>
<td>1,275.0</td>
<td>120.1%</td>
<td>95.9%</td>
<td>129.0%</td>
<td>5.1</td>
<td>3.4</td>
<td>8.5</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td>TAYBERRY</td>
<td>1,424.3</td>
<td>1,643.0</td>
<td>113.5%</td>
<td>105.6%</td>
<td>134.3%</td>
<td>4.0</td>
<td>3.8</td>
<td>7.8</td>
<td>10.8</td>
</tr>
<tr>
<td></td>
<td>THISTLE</td>
<td>1,069.5</td>
<td>1,058.0</td>
<td>98.9%</td>
<td>115.8%</td>
<td>93.2%</td>
<td>4.8</td>
<td>6.0</td>
<td>10.8</td>
<td>12.8</td>
</tr>
<tr>
<td></td>
<td>WEST HAM</td>
<td>494.5</td>
<td>621.0</td>
<td>125.6%</td>
<td>128.6%</td>
<td>154.7%</td>
<td>5.5</td>
<td>2.7</td>
<td>8.2</td>
<td>10.8</td>
</tr>
<tr>
<td>St Bart's</td>
<td>1C</td>
<td>6,076.3</td>
<td>4,823.5</td>
<td>79.4%</td>
<td>126.9%</td>
<td>74.1%</td>
<td>2.5</td>
<td>27.2</td>
<td>2.5</td>
<td>29.7</td>
</tr>
<tr>
<td></td>
<td>1D</td>
<td>2,748.5</td>
<td>2,390.3</td>
<td>87.0%</td>
<td>79.9%</td>
<td>90.0%</td>
<td>14.4</td>
<td>2.8</td>
<td>17.2</td>
<td>26.3</td>
</tr>
<tr>
<td></td>
<td>1E</td>
<td>6,169.5</td>
<td>4,511.8</td>
<td>73.1%</td>
<td>112.9%</td>
<td>82.8%</td>
<td>2.6</td>
<td>2.6</td>
<td>3.2</td>
<td>32.4</td>
</tr>
<tr>
<td></td>
<td>3A SBH</td>
<td>4,957.0</td>
<td>4,474.3</td>
<td>104.3%</td>
<td>96.8%</td>
<td>103.8%</td>
<td>6.4</td>
<td>4.0</td>
<td>10.4</td>
<td>13.9</td>
</tr>
<tr>
<td></td>
<td>3D SBH</td>
<td>1,604.0</td>
<td>1,673.5</td>
<td>96.8%</td>
<td>88.2%</td>
<td>98.9%</td>
<td>7.6</td>
<td>5.2</td>
<td>12.8</td>
<td>18.7</td>
</tr>
<tr>
<td></td>
<td>4A SBH</td>
<td>1,782.5</td>
<td>1,782.5</td>
<td>97.0%</td>
<td>93.2%</td>
<td>99.2%</td>
<td>5.0</td>
<td>2.2</td>
<td>7.2</td>
<td>12.9</td>
</tr>
<tr>
<td></td>
<td>4B SBH</td>
<td>1,426.0</td>
<td>1,380.0</td>
<td>96.8%</td>
<td>88.2%</td>
<td>98.9%</td>
<td>3.2</td>
<td>3.2</td>
<td>13.9</td>
<td>18.9</td>
</tr>
<tr>
<td></td>
<td>4C SBH</td>
<td>1,782.5</td>
<td>2,012.5</td>
<td>112.9%</td>
<td>117.9%</td>
<td>145.1%</td>
<td>5.6</td>
<td>3.3</td>
<td>8.9</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td>4D &amp; 4E SBH</td>
<td>1,686.0</td>
<td>1,669.5</td>
<td>89.6%</td>
<td>95.2%</td>
<td>108.1%</td>
<td>5.6</td>
<td>2.2</td>
<td>7.8</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>5A SBH</td>
<td>2,337.8</td>
<td>2,296.7</td>
<td>102.6%</td>
<td>91.4%</td>
<td>100.2%</td>
<td>6.2</td>
<td>2.0</td>
<td>8.3</td>
<td>13.9</td>
</tr>
<tr>
<td></td>
<td>5B SBH</td>
<td>1,426.0</td>
<td>1,399.0</td>
<td>98.1%</td>
<td>93.9%</td>
<td>98.4%</td>
<td>5.5</td>
<td>2.5</td>
<td>8.0</td>
<td>13.8</td>
</tr>
<tr>
<td></td>
<td>5C SBH</td>
<td>2,139.0</td>
<td>2,066.0</td>
<td>96.6%</td>
<td>93.3%</td>
<td>99.4%</td>
<td>6.7</td>
<td>1.8</td>
<td>8.5</td>
<td>14.8</td>
</tr>
<tr>
<td></td>
<td>5D SBH</td>
<td>2,195.5</td>
<td>1,966.5</td>
<td>89.6%</td>
<td>95.2%</td>
<td>108.1%</td>
<td>5.6</td>
<td>2.2</td>
<td>7.8</td>
<td>13.6</td>
</tr>
<tr>
<td></td>
<td>6A SBH</td>
<td>6,191.5</td>
<td>6,335.0</td>
<td>102.3%</td>
<td>93.5%</td>
<td>93.5%</td>
<td>33.9</td>
<td>1.8</td>
<td>35.7</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>6D SBH</td>
<td>1,782.5</td>
<td>1,759.5</td>
<td>98.7%</td>
<td>85.8%</td>
<td>100.0%</td>
<td>5.1</td>
<td>2.9</td>
<td>8.0</td>
<td>13.6</td>
</tr>
</tbody>
</table>
**Report to the Trust Board: 12 September 2018**

<table>
<thead>
<tr>
<th>Title</th>
<th>Getting to Good and Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Director</td>
<td>Chief Medical Officer and Chief Nurse</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Director of Quality Governance</td>
</tr>
<tr>
<td>Purpose</td>
<td>To update the Board on current and future CQC activity</td>
</tr>
<tr>
<td>Previously considered by</td>
<td>Trust Executive Committee</td>
</tr>
</tbody>
</table>

**Executive summary**
This paper updates the Trust Board on current and future CQC activity and progress with implementation of the ‘Getting to Good and Outstanding’ improvement plan.

**Related Trust objectives**

| SO1: Safe and Compassionate Care |

**Risk and Assurance**
The report provides assurance on the approach taken to address the CQC findings and to provide consistently safe, compassionate, effective and high quality care.

**Related Assurance Framework entries**
BAF entry 2. Failure to deliver 'Getting to Good and Outstanding' quality improvement plans impairs quality of care and objectives to exit quality special measures and achieve improved CQC rating.

**Legal implications/ regulatory requirements**
No direct legal implications identified.

**Action required by the Board**
The Trust Board is asked to:
- Note the plans for CQC inspections over summer 2018.
- Note progress on implementation of “Getting to Good and Outstanding”.
GETTING TO GOOD AND OUTSTANDING

OBJECTIVE

1. The objective of this paper is to summarise progress on the Trust’s improvement plans and current and future CQC activity.

CQC INSPECTION SCHEDULE

2. Work continues in preparation for scheduled CQC inspections, including the Well-Led assessment which will take place w/c 8 October 2018.

3. The CQC has confirmed that it will be undertaking inspections of 21 core services across Whipps Cross, Newham and Royal London hospitals prior to the well-led review. Due to the number of services being inspected the CQC has provided the dates for the inspection, Tuesday 11 to Thursday 13 September. Some services will be inspected in the first week of October due to inspector availability.

4. The external review of the PIR submissions has been completed and feedback shared with the hospitals and corporate teams. These have been included as part of the readiness reviews which have been held with each hospital between the Trust executive and the site senior leadership team.

5. Following the CQC Regulatory Planning meeting held on 3 August, the CQC has confirmed that a Well-Led assessment will be undertaken between Tuesday 9 and Thursday 11 October. The CQC have confirmed who they wish to interview.

6. The sites have focused on a number of areas, including spot checks of compliance with all ‘must do’ and ‘should do’ actions to ensure that they are consistently implemented – through routine peer reviews/clinical Fridays, environmental walkrounds and medicine management audits.

7. In addition, 40 focused quality review and a number of spot checks have been organised and led by the corporate team these include ED, out patients and OPS.

UPDATE ON ‘MUST DO’ AND ‘SHOULD DO’ ACTIONS

8. Progress on CQC must do’ and should do actions continue with only 1 red action remaining. This relates to the recruitment of a consultant specialising in End of Life
care at Whipps Cross. This position has now been appointed to and so will move from this position as soon as the Consultant is in post.

<table>
<thead>
<tr>
<th></th>
<th>Whipps Cross</th>
<th>Newham</th>
<th>St Bartholomew’s Hospital</th>
<th>Royal London Hospital</th>
<th>Clinical Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Must do</td>
<td>Should do</td>
<td>Must do</td>
<td>Should do</td>
<td>Must do</td>
</tr>
<tr>
<td>Blue – action closed</td>
<td>18</td>
<td>18</td>
<td>12</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Green – project on time</td>
<td>24</td>
<td>23</td>
<td>7</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>Amber – project delayed</td>
<td>12</td>
<td>14</td>
<td>3</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Red – project behind plan</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**QUALITY IMPROVEMENT**

9. The Quality Hub has integrated the Quality Objectives into the planning for the 2018/19 breakthrough series. The breakthrough series represents a quality improvement methodology that has been adopted by the Trust to review key objectives through workshops and related interventions.

10. Existing quality collaboratives and core groups have continued from 2017/18 in order to sustain positive momentum and engagement in performance outcomes.

11. Three waves of the breakthrough series have been commissioned by each site.

*Procurement of QI external partner*

12. Procurement of an external partner for the Trust’s Quality Improvement programme has progressed, with a contract agreed with the Institute of Healthcare Improvement. This partnership is due to commence on 17 September 2018. A mobilisation schedule has been established with planning of activity over the three year contract period, commencing with a 3 month ‘diagnostic’ phase.

**QUALITY ASSURANCE**

13. Peer review framework – the framework is fully operational and being utilised as part of CQC preparedness.
14. Perfect ward - Wards are continuing to participate and actively engage in the Perfect Ward activity. Where there is variation this is being targeted through specific intervention. Update has been integrated into the Integrated Performance Reporting schedule. Barts Health has been shortlisted in the National Nursing Times awards for this innovation that has linked the Well Run Ward tool into the Perfect Ward App.

15. Quality & Safety Dashboard - The upgrade has been completed and launch events on each site have been facilitated during August and early September.

16. Ward accreditation scheme - The ward accreditation programme has commenced with a review of national schemes and local initiatives. The accreditation will be co-designed with the Nursing, Midwifery and Allied Healthcare Professionals senior leadership team, multi-professional leadership and patient representation.

PATIENT EXPERIENCE AND ENGAGEMENT STRATEGY

17. The patient experience and engagement strategy continues to be developed and tested with internal and external partners. In addition an NHS improvement self assessment framework has been undertaken to contribute to the strategy. The strategy is due to be reviewed at the Trust Board seminar on 3 October 2018, following the Board’s initial review in April 2018.

LEADERSHIP AND GOVERNANCE

Group Operating Model

18. There has been continued progress implementing our Group model programme plan, which aims to ensure that we maximise the benefits of our scale while ensuring effective management and oversight of services at hospital site level. Areas of progress in the last quarter include:

Transforming outpatient services

19. In August, responsibility for the day to day management of outpatient services was devolved to the hospital site leadership teams. This will ensure integrated management of the outpatient and inpatient pathway as locally as possible. Work has commenced to standardise our outpatient administrative processes across the Trust such as the booking of appointments, in order to ensure that we are more responsive to the needs of patients. Plans are being implemented to switch to solely electronic GP referrals in line with national policy.

Strengthening clinical leadership

20. Clinical leadership at divisional and hospital site level is being strengthened. The divisional structure has been reviewed and divisional clinical directors are being
appointed to lead the clinical divisional teams and to join the hospital site leadership teams. Leadership development support is being provided to the divisional leadership teams.

Ensuring accountability

21. We have continued to develop and formalise our accountability framework to ensure ward to board accountability for delivering high quality services. Accountability frameworks are now in place for the hospital sites and the clinical boards, and work is underway for corporate services.

Maximising learning from incidents and investigations

22. Work continues on improving learning from incidents and investigations across the Trust. A paper was presented at the Quality Board in August 2018 outlining current and future ways of sharing learning with a focus on ensuring refresher training and education. A pilot for cataloguing serious incident summaries has been successfully run and full implementation of this will now commence. A Trust wide newsletter is to be relaunched at the end of September which will have case studies and learning in relation to all aspects of safety.

CULTURE CHANGE

Leadership Development

23. Supporting effective development of the Group Model, we continuing to pursue the enabling actions set out in the People Strategy that was approved by the Board in November 2017. Our Leadership Team Development Programme “Super T” has been expanded. The 8 senior leadership teams who commenced in August 2017, TEC, 4 Site HMBs and 2 Clinical Boards (over 90 participants) conclude the programme of executive team coaching and master classes in November. Cohort 2, covering the remaining clinical boards, site divisional teams and corporate taskforce team (25 teams with over 150 participants) commenced the launch event in July 2018 and are progressing through team development centre, ahead of commencing 12 months of team coaching.

24. Our partnership with the London Leadership Academy to co-design an inclusive manager development programme series is now well underway, with the inaugural Strategic Inclusive Leaders Workshop due to take place in October, with further work planned with our staff diversity networks and Trust Board.

25. Mindful of the need to review our broader prospectus of leadership and management learning and development, we are preparing to undertake a training needs analysis, led by the Education Academy and will inform the work programme of our Faculty for Leadership, Improvement and Management. New programmes of induction, bespoke for managers and, for consultants have been launched in the last 6 months. With further work in train to enhance the leadership development
available for medical staff, through the appointment of dedicated Consultant Leadership Development Directors.

26. In addition to the key activities in relation to leadership development and quality improvement outline above, our other key enablers of culture change set out in the People Strategy are progressing to implementation. As part of our WECARE values embedding plan, we have made progress with values-based recruitment material and are now focusing on designing our inclusive recruitment activities, informed by our recently published commitments in the Diversity Charter. Current activity includes piloting use of Inclusion Ambassadors on selection panels and revising our Recruitment and Selection training to be mandated for anyone sitting on a appointing panel. The launch of our WECARE appraisal documentation and training, previously shared with the Board, provides further evidence of this embedding work.

27. In the near future, we will be seeing the outputs of joint working with the Staff Partnership Forum to support WECARE values aligned policies.

28. Building on learning from NHS Improvement, Kings Fund and the Centre for Creative Leadership, we have begun the process of testing the national Leadership and Culture Toolkit on our Newham Hospital site, with support from Prof Michael West, an external member/advisor to our Faculty of Leadership, Improvement and Management. The work of our Staff Diversity Network subgroups is making a material contribution to our goal of creating a healthy and inclusive workplace, with key developments achieved this year in embedding BartsAbility Passport within our new appraisal documents, supporting effective consideration of work place adjustment. Working to secure a dedicated budget for workplace adjustment support within Occupational Health will also be of benefit. All subgroups have made material contribution to the design of our inclusive recruitment literature and the emerging design of our Inclusive Leaders Programme. Our LGBTQ+ subgroup is working closely with Stonewall to positively impact of our activities to improve experience of LGBTQ+ staff and patients. Recently established, our Women’s subgroup is going to be a key reference group for our developing work on tackling gender pay gap issues flagged in our recently published data.

29. Feedback from staff, through the annual national NHS Staff Survey and quarterly Staff Friends and Family Test surveys, continues to aid tracking of the impact of interventions we are pursuing.

30. The Trust Board is asked to:

• Note the forthcoming CQC inspections.

• Note progress on implementation of the “Getting to Good and Outstanding” improvement plan.
Executive summary
The Risk Management Strategy sets out the future vision for risk management in the context of ‘Getting to Good and Outstanding’, assesses the current status of the organisation, and sets out three year strategic goals and the actions being taken in 2018/19 to achieve the vision.

Related Trust objectives
All Trust objectives

Risk and Assurance
Assurance on all Trust objectives

Related Assurance Framework entries
All items on the Board Assurance Framework

Legal implications/ regulatory requirements
A Board-approved risk management strategy contributes to the Trust’s compliance with the joint CQC / NHS Improvement Well-Led Framework.

Action required
The Trust Board is asked to approve the Risk Management Strategy.
INTRODUCTION TO STRATEGY

1.1 The Trust Risk Management Strategy defines the strategic direction for risk management and provides clear direction on which to base all risk management activity. The strategy is organised in three parts: Part 1 sets out the vision and objectives for risk management; Part 2 provides an overview of the Trust’s current position; and Part 3 details the journey to achieving the vision and measures of success.

1.2 The strategy supports the Trust’s journey in continuous improvement and to achieve ‘good’ and ‘outstanding’ CQC ratings through the ongoing development of a strong risk culture where all risks are identified, assessed, understood and proactively managed as part of everyday business. All risks (corporate, site and CSS) should be managed within appropriate resources, with the aim of reducing risks to strategic objectives. The Trust accepts its responsibility for the management of safety, environmental and financial risks, ensuring the health, safety and welfare of staff, patients, visitors, volunteer workers and all other people who attend our premises and who may be affected by our activities. The Trust’s Health and Safety policies also advise on risk management and these should be read and adhered to in conjunction with the risk management policy.

1.3 The purpose is to set out a clear strategy to achieving the Trust’s vision in relation to the management of risk, detailing the systems and processes in place and identifying roles and responsibilities for actions. The strategy recognises the need for robust systems and processes to support the risk management cycle at corporate and local levels.

1.4 Healthcare is a high-risk activity and the Trust needs to understand and manage the risks to achieving our objectives. The Board recognises that complete risk avoidance and control is impossible, however, risks can be minimised when identified and managed appropriately.

1.5 The Trust’s aim is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will encourage a way of working that ensures that risk management is embedded in the culture of the organisation and becomes an integral part of the Trust’s objectives, plans, practices and management systems as part of everyday business.

1.6 The strategy has been developed with an emphasis on understanding the current status of risk management within Barts Health and the vision of risk management in the future. All sites and corporate departments have been invited to comment and contribute, and the strategy has been reviewed by the Risk Management Committee, Trust Executive Committee and Audit and Risk Committee.
1.7 Barts Health NHS Trust is the biggest NHS teaching trust in the country. It is a complex organisation with five hospitals and is distinctive in having a **group operating model**. This results in a requirement to ensure clarity of responsibility regarding ownership of risks between sites and corporate functions, and the role of clinical boards and networks in the management of risk. The group model also presents opportunities to ensure consistency across the group through standardised operations and processes.

**THE VISION**

The vision for Barts Health NHS Trust is to be:

*A high performing group of NHS hospitals, renowned for excellence and innovation and providing safe and compassionate care to our patients in east London and beyond.*

The Trust recognises that **effective risk management** is key to delivering this vision and this recognition is reflected in the Trust’s vision for risk management where:

*Risk management is embedded in everyday business and is integral to everything that we do.*

**WHAT GOOD RISK MANAGEMENT LOOKS LIKE**

3.1 To structure the improvement journey ahead, the Trust has developed the following:

- **Risk Strategy Statement**;
- **Risk Management Objectives**;
- **Risk Management Goals and Assurances for 2018 – 2021** (Appendix 1);

3.2 The approach outlined in this strategy is informed by the following:

- The Manchester Patient Safety Framework\(^1\) which is a maturity tool used by the Trust’s Risk Management Committee to self assess its current position (discussed in section 6.).

- The **Cultural Aspects Model** developed by the Institute of Risk Management which identifies eight aspects of risk culture grouped into four themes supported with key indicators of the health of a risk culture. The basis of which forms the Trust’s risk management objectives (An overview of the model is provided in *Figure 3.1*).

- The NHS Improvement’s **Well Led Framework (Key Line of Enquiry 5)**\(^2\) which informs the expected assurances for the Trust’s risk management goals and assurances in appendix 1.

---

\(^1\) Endorsed by the National Patient Safety Agency.
**Figure 3.1 IRM Risk Culture Aspects Model**

<table>
<thead>
<tr>
<th>TONE AT THE TOP</th>
<th>DECISION MAKING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1) RISK LEADERSHIP</strong></td>
<td><strong>(3) INFORMED RISK DECISIONS</strong></td>
</tr>
<tr>
<td>▪ Senior management set clear and consistent expectations for managing risks.</td>
<td>▪ Leaders seek out risk information in supporting decisions.</td>
</tr>
<tr>
<td>▪ Leaders role model risk management thinking and actively discuss tolerance to risk issues.</td>
<td>▪ The Trust’s willingness to take on risks is understood and communicated.</td>
</tr>
<tr>
<td><strong>(2) DEALING WITH BAD NEWS</strong></td>
<td><strong>(4) REWARD</strong></td>
</tr>
<tr>
<td>▪ Senior management actively seek out information about risk events.</td>
<td>▪ Performance management linked to risk taking. Leaders are supportive of those actively seeking to understand and manage.</td>
</tr>
<tr>
<td>▪ Those that are open and honest about risks are recognised.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOVERNANCE</th>
<th>COMPETENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(5) ACCOUNTABILITY</strong></td>
<td><strong>(7) RISK RESOURCES</strong></td>
</tr>
<tr>
<td>▪ Management are clear about their accountability for managing Trust risks.</td>
<td>▪ The risk function has a defined remit and has the support of leaders</td>
</tr>
<tr>
<td>▪ Role descriptions and targets include risk accountabilities.</td>
<td>▪ The risk function is able to challenge how risks are managed</td>
</tr>
<tr>
<td><strong>(6) TRANSPARENCY</strong></td>
<td><strong>(8) RISK SKILLS</strong></td>
</tr>
<tr>
<td>▪ Timely communication of risk information across the Trust.</td>
<td>▪ A structure of risk champions support those managing risks</td>
</tr>
<tr>
<td>▪ Risk events are seen as an opportunity to learn.</td>
<td>▪ Training programmes are in place for all staff</td>
</tr>
</tbody>
</table>

---

2 KLOE 5 asks: Are there clear and effective processes for managing risks, issues and performance?
RISK STRATEGY STATEMENT

4.1 The Trust Board is committed to leading the organisation in delivering a high quality, effective, sustainable, value for money service. Robust and practicable systems and processes are required in order to achieve this and enable staff to understand risk and integrate risk management into their daily activities. This embedding of risk management in Trust culture will support better decision making.

4.2 The Trust is committed to a risk management culture that underpins and supports the business of the Trust and enhances the safety of our patients, visitors and staff. Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and exploited in order to take opportunities for development. Foreseeable risks are identified with an active risk reduction plan.

4.3 Considered risk taking and innovation is encouraged within authorised and defined limits of the Trust’s risk appetite. The priority is to reduce risks that impact upon safety and quality and to minimise our financial, operational and reputational risks.

4.4 Senior management will lead change by being a role model for behaviours and culture: ensuring risks are identified, assessed and managed at all levels. Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance. Line managers will encourage staff to identify risks as part of our open, honest and fair culture.

4.5 The strategy will be delivered by linking the Trust’s strategic objectives to local objectives and by delivering a focused training programme as reflected in the Trust Training Needs Analysis.

4.6 Risk management is the responsibility of all staff who should have an awareness and understanding of the risks that affect patients, visitors and staff.

SCOPE

5. The strategy applies to all Trust staff, contractors, volunteers and other third parties, including honorary contract holders working in all areas of the Trust.
PART 2: THE CURRENT POSITION

OVERVIEW

6.1 The Manchester Patient Safety Framework is a maturity tool to help organisations and healthcare teams to self-assess their progress in developing a safety culture. Organisations assessed under the framework are categorised on a maturity scale ranging from A (low maturity) to E (risk mature- defined as risk management being an integral part of everything we do). A summary of the maturity scale is shown in Figure 1.

**Figure 6.1: Manchester Patient Safety Assessment Framework (MPSAF)**

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>Defined as:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Pathological (LOW)</td>
<td>Why waste our time on safety?</td>
<td>This is where people don’t really care about safety and are only driven by regulatory compliance and not getting caught. At this level you can hear people say things like “of course we have accidents, it’s a dangerous business”. Team working across the organisation (i.e. bridging) is ignored and so is bad news.</td>
</tr>
<tr>
<td>B Reactive</td>
<td>Do something when we have an incident.</td>
<td>This is where safety is taken seriously, but it only gets sufficient attention after things have already gone wrong.</td>
</tr>
<tr>
<td>C Bureaucratic</td>
<td>We have systems in place to manage all identified risks.</td>
<td>This is where an organisation is comfortable with systems and numbers. A risk management system has been implemented successfully and there is a major concentration upon the statistics and ticking the boxes to demonstrate that the organisation is safe.</td>
</tr>
<tr>
<td>D Proactive</td>
<td>We are always on the alert for risks that might emerge.</td>
<td>Proactive organisations consider what might go wrong in the future and take steps before being forced to. Proactive organisations are those where the workforce start to be involved in practice, not just in theory.</td>
</tr>
<tr>
<td>E Generative (MATURE)</td>
<td>Risk management is an integral part of everything that we do.</td>
<td>Very high standards area set for safety and it is ingrained in the hearts and minds of all staff throughout the organisation. They are honest about failure, but use it to improve, not to blame. Management knows what is really going on, because the workforce is willing to tell them and trusts them not to over-react on hearing unwelcome news. People live in a state of ‘chronic unease’ and are mindful of what could go wrong, trying to be as informed as possible, because it prepares them for whatever will be thrown at them next. At this level bad news is actively looked for, because it provides the best opportunity to learn, so messengers are trained and welcomed.</td>
</tr>
</tbody>
</table>

6.2 The Trust Risk Management Committee self assessed itself prudently against the Manchester Patient Safety Framework in October 2017 and rated the Trust at level B/C (defined as we do something when we have an incident, and we have systems in place to manage all identified risks.) Figure 2 positions the Trust’s current rating on the framework scale. A SWOT analysis was also undertaken which is shown in Figure 3.
In February 2018 the Trust’s self assessment against the well-led framework rated the risk management KLOE as ‘good’.

6.3 In February 2018 the Trust’s self assessment against the well-led framework rated the risk management KLOE as ‘good’.

6.3 In February 2018 the Trust’s self assessment against the well-led framework rated the risk management KLOE as ‘good’.
**PART 3: ACHIEVING THE VISION**

7.1 The Trust aims to mature from its current position on the Manchester Patient Safety Framework over a three year period through the implementation of the 2018/19 risk management action plan and future annual action plans developed from the Trust’s *Risk Management Goals for 2018-2021*. The 2018/19 action plan is supported by ongoing Trust wide initiatives to strengthen staff engagement and culture.

- **to step C** (*We have systems in place to manage all identified risks*) in 2018/19;
- **to step D** (*We are always on the alert for risks that might emerge*) in 2019/20;
- **to step E** (*Risk Management is an integral part of everything that we do*) in 2020/21.

![Figure 7.1: Trust Maturity from B/C to E](image)

**RISK MANAGEMENT OBJECTIVES**

8.1 All decision making is based on an integrated review of risk appetite, risk performance and assurance.

8.2 Senior management actively seek out information about risk events.

8.3 There are clear lines of accountability for the management of risks.

8.4 Risk information is communicated in a timely and professional manner across the Trust and with stakeholders.

8.5 Systematic processes are used to learn and share lessons from our successes, best practice, errors and failures with staff, patients and the public.

8.6 There is an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/ de-escalation and challenge.

8.7 All staff are competent and supported in the reporting and management of risks, and not blamed or seen as unduly negative for identifying these.
**RISK MANAGEMENT GOALS FOR 2018 - 2021**

<table>
<thead>
<tr>
<th>RISK MANAGEMENT OBJECTIVE</th>
<th>GOALS</th>
<th>ASSURANCES (<em>denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</em></th>
</tr>
</thead>
</table>
| 1. All decision making is based on an integrated review of risk appetite, risk performance and assurance. | • The Trust has a clearly articulated and communicated risk appetite statement supported with clear policy. | • A Trust Board approved risk appetite statement, policy and strategy have been communicated to all internal and external stakeholders.  
• Risk assessments are available for all bids, programmes and projects.  
• Minutes and agendas are available for Trust Board, Hospital Management Board and Trust Committees to demonstrate risk appetite has clearly been discussed, articulated and communicated.  
• Evidence of Trust wide staff communication is available. |
| 2. Senior management actively seek out information about risk events. | • Leaders role model risk management thinking and actively discuss tolerance to risk issues. | • Leaders across the Trust are able to describe the current and future quality, operational and financial risks that relate to their areas of work, and the plans to mitigate them through their risk registers.  
• Risk is discussed as a prominent agenda item at Trust Board, Trust Executive Committee and Hospital Management Board levels.  
• Site Assurance Frameworks (SAF) are in place for all sites and CSS. There is alignment between SAFs and the Trust Board Assurance Framework (BAF).  
Minutes and agendas are available for Trust Board, Trust Committee and Hospital Management Board to demonstrate risk management thinking and tolerance to risk. |
<table>
<thead>
<tr>
<th>RISK MANAGEMENT OBJECTIVE</th>
<th>GOALS</th>
<th>ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. There are clear lines of accountability for the management of risks.</td>
<td>The Trust clearly articulates and communicates the accountability structure for risk.</td>
<td>Accountability for risk management is clearly articulated in the Risk Management Policy, related policies and risk management training material. Hospital Management Board and Trust Executive Committee Terms of Reference clearly articulate risk management accountabilities. Job descriptions include risk accountabilities.</td>
</tr>
<tr>
<td>4. Risk information is communicated in a timely and professional manner across the Trust and with stakeholders.</td>
<td>Risk information/ risk management contributes to achieving strategic objectives and outcomes.</td>
<td>Site Assurance Frameworks (SAF) are in place for all sites and Clinical Support Services. There is synergy between SAFs, the Trust Board Assurance Framework (BAF) and operational risks. Minutes, agendas and highlight reports are available for Trust Board, Hospital Management Board and Trust Executive Committee to demonstrate the timely reporting of risk. Minutes are available of relevant risk information being shared and discussed within directorate/ team meetings to contribute towards achieving objectives. Quarterly reporting of high level risks to the Trust Executive Committee. Monthly reporting of risks to the Trust Risk Management Committee. Evidence to demonstrate the top-down cascade of risk information from Trust Directors to their directorates.</td>
</tr>
<tr>
<td>RISK MANAGEMENT OBJECTIVE</td>
<td>GOALS</td>
<td>ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Risk assessments are available to demonstrate potential risks are taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ There is a systematic programme of clinical and internal audit (Annual Audit Plan) to monitor quality, operational, and financial processes, and systems to identify where action should be taken.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Results from annual audit of compliance with Risk Management Policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Results from annual audit of risk maturity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Results from annual internal audit of risk management system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Results from internal audit review of risk management.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Senior leaders can evidence that there is a clear, co-ordinated, continuous programme of clinical audit, peer review and internal audit, overseen and challenged by the board, which:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o aligns with priorities identified from risk intelligence and/or gaps in other assurance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o competent individuals or teams (as appropriate) carry out to meet the needs identified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o is oriented to action, to address gaps from the audits in a timely manner and monitor them to ensure they are driving improvement</td>
</tr>
</tbody>
</table>

4. Risk information is communicated in a timely and professional manner across the Trust and with stakeholders.
### RISK MANAGEMENT

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework*)

- ensures learning from the audits is shared across the organisation to facilitate wider improvement.
- * When considering developments to services or efficiency changes, the impact on quality and sustainability are assessed and monitored. Quality and Business Impact Assessments are available.
- * Senior leaders can evidence that service development or efficiency initiatives:
  - are developed with relevant stakeholders (especially service users, their carers, clinical and operational staff), with due regard to the public sector equality duty.
  - make use of relevant published research, evidence, benchmarking data and operational experience
  - identify measures and early warning indicators to be monitored during and after implementation, with an associated risk management plan
  - are assessed consistently according to their impact on quality and sustainability, including the cumulative and aggregate impact of smaller schemes on patient pathways or professional groups
  - are monitored during implementation and afterwards, with mitigating actions taken if necessary.

4. Risk information is communicated in a timely and professional manner across the Trust and with stakeholders.

- Risk information/risk management contributes to achieving strategic objectives and outcomes.
### RISK MANAGEMENT

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Risk management processes facilitate effective risk management.</td>
<td>▪ Senior leaders can evidence that the organisation has effective, timely, horizon-scanning, scenario-planning and reporting processes so that it is sufficiently aware of changes in the internal and external environment (including risks from the wider local health and care economy) that may affect delivery of strategy and/or affect quality and financial sustainability. Minutes are available to demonstrate effective risk management processes at Trust Board, Hospital Management Board and Trust Committee level.</td>
</tr>
<tr>
<td>▪ Senior leaders can evidence that a board assurance framework and dynamic risk registers are in place and assessed by the board at least quarterly and demonstrate:</td>
<td>▪ Senior leaders can evidence that a board assurance framework and dynamic risk registers are in place and assessed by the board at least quarterly and demonstrate:</td>
</tr>
<tr>
<td>o attention to both internal and external risks, and their impact on planning</td>
<td>o attention to both internal and external risks, and their impact on planning</td>
</tr>
<tr>
<td>o a robust process for collating, evaluating, quantifying and reporting key risks</td>
<td>o a robust process for collating, evaluating, quantifying and reporting key risks</td>
</tr>
<tr>
<td>o a clear understanding of the board’s risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff</td>
<td>o a clear understanding of the board’s risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff</td>
</tr>
<tr>
<td>o a commitment to learning lessons from inquiries, internal and external reviews of their own organisation, and of other organisations, and sharing this learning with staff, patients and the public.</td>
<td>o a commitment to learning lessons from inquiries, internal and external reviews of their own organisation, and of other organisations, and sharing this learning with staff, patients and the public.</td>
</tr>
</tbody>
</table>

5. Systematic processes are used to learn and share lessons from our successes, best practice, errors and failures with staff, patients and the public.
<table>
<thead>
<tr>
<th>RISK MANAGEMENT OBJECTIVE</th>
<th>GOALS</th>
<th>ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</th>
</tr>
</thead>
</table>
| 6. There is an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/de-escalation and challenge. | ▪ The risk function is able to challenge how risks are managed. | ▪ *Senior leaders can evidence that there is a clear risk management process understood by staff members, including the board, its subcommittees and subgroups, so that they identify, assess, understand, assign responsibility for and act on risks relevant to their area of responsibility. This includes internal escalation and external escalation if the risks affect other organisations.  
▪ Minutes and Terms of References are available to demonstrate effective risk management processes at Trust Board, Hospital Management Board Trust Committee and site levels.  
▪ Site Assurance Frameworks (SAF) are in place for all sites and CSS. There is synergy between SAFs, the Trust Board Assurance Framework (BAF) and operational risks.  
▪ *Senior leaders can evidence that emergency preparedness/crisis management planning has been carried out and there is a robust business continuity plan. Emergency Preparedness, Resilience and Response (EPRR) plans and business continuity plans are tested, up to date and in place. |
<table>
<thead>
<tr>
<th>RISK MANAGEMENT OBJECTIVE</th>
<th>GOALS</th>
<th>ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</th>
</tr>
</thead>
</table>
| 6. There is an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/de-escalation and challenge. | ▪ The risk function is able to challenge how risks are managed. | ▪ Senior leaders can evidence that there is a performance management system for quality, operations and finance across all departments, which comprises:  
  o appropriate performance measures relating to relevant goals and targets  
  o reporting lines within which these will be managed, including how this will happen across teams (for example finance and operations)  
  o policies for managing/responding to deteriorating performance across all activities, at individual, team, service-line and organisational levels, with clear processes for re-forecasting performance trajectories  
  o a programme or portfolio management approach that allows the co-ordination of initiatives across the organisation, and with external partners as required  
  o a clear process for identifying lessons from performance issues and sharing these across the organisation on a regular, timely basis  
 ▪ Minutes and Terms of References are available to demonstrate an effective performance system across the Trust. |
### RISK MANAGEMENT

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>GOALS</th>
<th>ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. There is an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/de-escalation and challenge</td>
<td>The risk function is able to challenge how risks are managed.</td>
<td>o clear processes for reviewing and updating policies regularly to take account of organisational learning, and changes in the operating environment and national policy.</td>
</tr>
</tbody>
</table>

- *Senior leaders can evidence that there are clear processes for:
  - escalating quality, operational and financial performance issues through the organisation to the relevant committees as part of and outside the regular meeting cycle as required, linked to the organisation’s risk matrix and consistent with the organisation’s risk appetite.
  - creating robust action plans, with clear ownership, timeframes and dependencies, all of which are monitored and followed up at subsequent meetings until they are resolved.

- *Senior leaders can further evidence that:
  - these processes are effective
  - the appropriate individuals/management levels are aware of the issues and are managing them through to resolution
  - themes arising from the most frequent risks and issues are analysed to identify barriers that need to be removed to drive improvement.

- Evidence of continuous improvement to the Datix Risk Module.
### RISK MANAGEMENT

#### OBJECTIVE

6. There is an integrated and effective approach to managing risk across the Trust with defined structures, clear routes for escalation/de-escalation and challenge.

#### GOALS

<table>
<thead>
<tr>
<th>ASSURANCES (*denotes assurances required by NHS Improvement in relation to KLOE 5 of the Well Led Framework)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Matrix for management of complex multi site, multi directorate, risks in place clearly showing Risk Owner, Risk Control Owners, Risk Action Owners in place and monitored.</td>
</tr>
<tr>
<td>▪ The Trust Risk Register differentiates between site, CSS, multisite, SAF and BAF risks.</td>
</tr>
<tr>
<td>▪ * There are comprehensive assurance systems and performance issues are escalated appropriately through clear structures and processes. These are regularly reviewed and improved.</td>
</tr>
<tr>
<td>▪ * There are processes to manage current and future performance which are regularly reviewed and improved.</td>
</tr>
<tr>
<td>▪ * There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions? There is alignment between the recorded risks and what staff say is 'on their worry list'.</td>
</tr>
<tr>
<td>▪ * Risks with partners are managed consistently.</td>
</tr>
</tbody>
</table>
7. All staff are competent and supported in the reporting and management of risks, and not blamed or seen as unduly negative for identifying these.

- All staff are equipped and supported to identify and manage risks well.
- Training programmes are in place for all staff.
- An approved Training Needs Analysis for risk management is in place.
- Gaps in training provision are identified and tracked through to development via the Trust Risk Management Committee.
- Training uptake metrics are periodically monitored by the Trust Risk Management Committee.
- A structure of risk champions is in place to support those managing risks.
- A Trust Risk Manager is in post.

8.1. REFERENCES
5. Do You Want to Find Out More About Risk Culture (Institute of Risk Management, January 2013)
<table>
<thead>
<tr>
<th>THEME</th>
<th>TASK</th>
<th>OWNER</th>
<th>TARGET DATE(S)</th>
<th>STATUS</th>
<th>ACTUAL DATE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>OBJECTIVE 1:</strong> All decision making is based on an integrated review of risk appetite, risk performance and assurance.</td>
<td>Review Risk Management Policy for consultation and Trust Board approval</td>
<td>Trust Risk Manager</td>
<td>Feb 2018</td>
<td>Complete</td>
</tr>
<tr>
<td>2.</td>
<td>Develop Trust Risk Management Strategy for Trust Board approval</td>
<td>Director Corporate Development</td>
<td>Jul 2018</td>
<td>Behind Plan</td>
<td>Sept 2018</td>
</tr>
<tr>
<td>3.</td>
<td>Trust Board to refresh risk appetite and communicates to internal and external stakeholders</td>
<td>Director Corporate Development /Trust Secretary</td>
<td>Mar 2019</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td><strong>OBJECTIVE 1:</strong> All decision making is based on an integrated</td>
<td>Conduct audit of compliance with Risk Management Policy</td>
<td>Trust Risk Manager</td>
<td>Sep 2018 Dec 2018 Mar 2019</td>
<td>On Track</td>
</tr>
</tbody>
</table>

3 The 2018/19 Action Plan and its deliverables will be monitored by the Risk Management Committee quarterly.
<table>
<thead>
<tr>
<th>THEME</th>
<th>TASK</th>
<th>OWNER</th>
<th>TARGET DATE(S)</th>
<th>STATUS</th>
<th>ACTUAL DATE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Assess risk management resourcing / infrastructure</td>
<td>Director Corporate Development</td>
<td>Dec 2018</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>7. OBJECTIVE 2. Senior management actively seek out information about risk events.</td>
<td>Bespoke education/ training on risk management as part of Board development</td>
<td>Director Corporate Development/ Board Secretary and Trust Risk Manager</td>
<td>Mar 2019</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Review high level risks to assess quality of risk profiles and scoring</td>
<td>Trust Risk Manager</td>
<td>Continuous programme of review</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>THEME</td>
<td>TASK</td>
<td>OWNER</td>
<td>TARGET DATE(S)</td>
<td>STATUS</td>
<td>ACTUAL DATE(S)</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-------</td>
<td>----------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>9.</td>
<td>Develop and implement a Site Assurance Framework (SAF) template which aligns with the Trust Board Assurance Framework (BAF)</td>
<td>Trust Risk Manager</td>
<td>Oct 2018</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>OBJECTIVE 3. There are clear lines of accountability for the management of risks.</td>
<td>Review roles and responsibilities in Risk Management Policy and related policies</td>
<td>Trust Risk Manager</td>
<td>Dec 2018</td>
<td>On Track</td>
</tr>
<tr>
<td>11.</td>
<td>Review Trust Committee terms of references to ensure risk management accountabilities are reflected</td>
<td>Board Secretary</td>
<td>Oct 2018</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>THEME</td>
<td>TASK</td>
<td>OWNER</td>
<td>TARGET DATE(S)</td>
<td>STATUS</td>
<td>ACTUAL DATE(S)</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-------</td>
<td>----------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
<tr>
<td>12.</td>
<td>Reflect clear lines of accountability in all risk management training</td>
<td>Trust Risk Manager</td>
<td>Sept 2018</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>OBJECTIVE 4. Risk information is communicated in a timely and professional manner across the Trust and with stakeholders.</td>
<td>Review visibility of risk as an agenda item on committee and working group agendas</td>
<td>Board Secretary</td>
<td>Nov 2018</td>
<td>On Track</td>
</tr>
<tr>
<td>14.</td>
<td>Review risk reporting flows</td>
<td>Trust Risk Manager</td>
<td>Aug 2018 Behind Plan</td>
<td>Sept 2018</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>THEME</td>
<td>TASK</td>
<td>OWNER</td>
<td>TARGET DATE(S)</td>
<td>STATUS</td>
</tr>
<tr>
<td>-----</td>
<td>-------</td>
<td>------</td>
<td>-------</td>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>15.</td>
<td>OBJECTIVE 5. Systematic processes are used to learn and share lessons from our successes, best practice, errors and failures with staff, patients and the public.</td>
<td>Review approaches to shared learning within the Trust with consideration to case studies</td>
<td>Trust Risk Manager</td>
<td>Sept 2018</td>
<td>On Track</td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td>Review and report on Business Continuity Planning testing</td>
<td>Director Clinical Operations</td>
<td>Continuous programme of review and testing</td>
<td>On Track</td>
</tr>
<tr>
<td>17.</td>
<td>OBJECTIVE 6. There is an integrated and effective approach to managing risk across the Trust with defined</td>
<td>Test risk management in a group model: Develop a matrix for management of complex and cross site/directorate risks enabling clear ownership for mitigation actions/monitoring.</td>
<td>Trust Risk Manager</td>
<td>Jun 2018</td>
<td>Complete</td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td>Improvements to Datix risk register module</td>
<td>Trust Risk Manager Risk Systems Manager</td>
<td>Continuous programme of review</td>
<td>On Track</td>
</tr>
<tr>
<td>THEME</td>
<td>TASK</td>
<td>OWNER</td>
<td>TARGET DATE(S)</td>
<td>STATUS</td>
<td>ACTUAL DATE(S)</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-------</td>
<td>----------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>19.</td>
<td>structures, clear routes for escalation/de-escalation and challenge.</td>
<td>Regular BAF/Datix risk register mapping</td>
<td>Trust Secretary</td>
<td>Monthly</td>
<td>On Track</td>
</tr>
<tr>
<td>21.</td>
<td>2018/19 Risk maturity assessment – present to RMC</td>
<td>Trust Risk Manager</td>
<td>Apr 2019</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Internal Audit review of risk management</td>
<td>Internal Audit</td>
<td>By Mar 2019</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Agree standards for assessing risks with partners</td>
<td>Deputy Chief Executive Officer</td>
<td>Mar 2019</td>
<td>On Track</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td><strong>OBJECTIVE 7</strong>: All staff are competent and supported in the reporting and management of risks, and not blamed or</td>
<td>Develop e-learning and face to face training to sit independently of the current Trust Training Needs Analysis (TNA) but with a view to making it part of the Essential training category from April 2019 onwards.</td>
<td>Trust Risk Manager</td>
<td>Sept 2018</td>
<td>On Track</td>
</tr>
<tr>
<td></td>
<td>Head of Health &amp; Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THEME</td>
<td>TASK</td>
<td>OWNER</td>
<td>TARGET DATE(S)</td>
<td>STATUS</td>
<td>ACTUAL DATE(S)</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-------</td>
<td>----------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>25.</td>
<td>seen as unduly negative for identifying these.</td>
<td>Formal plan to address gaps in training provision</td>
<td>Trust Risk Manager</td>
<td>Sept 2018</td>
<td>On Track</td>
</tr>
<tr>
<td>26.</td>
<td></td>
<td>Set up of risk champions support network</td>
<td>Trust Risk Manager</td>
<td>Aug 2018</td>
<td>Complete Aug 2018&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>27.</td>
<td></td>
<td>Formal launch and delivery of education/training programme – including updated risk management policy/ processes</td>
<td>Trust Risk Manager</td>
<td>Sep 2018</td>
<td>On Track</td>
</tr>
<tr>
<td>28.</td>
<td>OBJECTIVE 7: All staff are competent and supported in the reporting and management of risks, and not blamed or seen as unduly negative for identifying these.</td>
<td>System for the collation and monitoring of training metrics by the Risk Management Committee confirmed</td>
<td>Trust Risk Manager</td>
<td>Sept 2018</td>
<td>On Track</td>
</tr>
<tr>
<td>29.</td>
<td></td>
<td>Development work with Education Academy to ensure risk training becomes part of the Essential training category from April 2019 onwards.</td>
<td>Trust Risk Manager</td>
<td>Mar 2019</td>
<td>On Track</td>
</tr>
</tbody>
</table>

<sup>4</sup> Scope of current Trust Datix User Group broadened.
<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Staff Health and Wellbeing – Mainstreaming the Your Health Matters (YHM) Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable Directors</strong></td>
<td>Director of People and Chief Medical Officer</td>
</tr>
</tbody>
</table>
| **Author(s)** | Michael Pantlin, Director of People  
Ian Basnett, Director of Public Health  
Andrew Attfield, Associate Director of Public Health  
Liam Slattery, Director of People Services  
Sue Kennard, Health of Employee Wellbeing |
| **Purpose** | To seek approval for the Trust’s application for Excellence in the Healthy Workplace Charter and to set out steps to strengthen and sustain the programme |
| **Previously considered by** | Health and Wellbeing Committee |

**Executive summary**
The Board received a report in January 2018 which set out the ambition for a healthy and inclusive workplace. Your Health Matters is the programme developed from an evidence review, NICE guidance, workforce metrics and staff views. It covers three areas of: Physical Health (Get Active); Mental Wellbeing; and General health linked to healthy weight and diet (Healthy Lifestyles). The Board asked for six monthly reports and to approve the application for excellence in the Healthy Workplace Charter. This report seeks to meet these requirements and show what else needs to be done to meet the ambitions of the charter and sustain and strengthen the programme.

**Related Trust objectives**
D) Developing our People

**Risk and Assurance**
This report provides assurance in relation to Objective D

**Related Assurance Framework entries**
10. Risk of not delivering workforce and patient equality and inclusion goals impacts on delivery of key objectives

**Legal implications/regulatory requirements**
None

**Action required by the Board**
The Trust Board is asked to note the report and agree the application for the Trust to secure ‘excellence’ level in the Healthy Workplace Charter during 2018/19.
INTRODUCTION

1.1 The Your Health Matters programme was established in 2016 in response to needs identified by staff through the staff HWB survey, an analysis of workforce data and good practice. The programme was supported by funding related to the staff Health and Wellbeing CQUIN and was based on the “Being caring and compassionate with each other” business case to the Health and Wellbeing Committee. This set out the wider benefits of improved health and wellbeing of staff in improving clinical outcomes and patient experience, as well as the financial benefits or reducing sickness, turnover and improving staff engagement.

1.2 The aim of the CQUIN funding is to provide seed funding for programmes focused on delivering specific targets, migrating those services and activities which deliver the greatest value into business as usual where possible and to establish the evidence base for additional funding where this is not immediately possible.

1.3 Following the report in January 2018 the Board asked to be updated every 6 months on this programme and to sign off the Trust’s application for ‘excellence’ status in the Healthy Workplace Charter.

1.4 The Trust Board is also asked to reaffirm the Trust’s commitment to the Time for Change mental health pledge as an indication of its support for this agenda. It is proposed to affirm this commitment on International Mental Health Day (11 October 2019)

YOUR HEALTH MATTERS (YHM)

2.1 The programme has been successful in expanding occupational health provision, helping staff become more active and supporting their mental health and wellbeing. This progress has made it possible for the Trust to seek to apply for ‘Excellence’ status in the Healthy Workplace Charter.

2.2 Most of the programme has been supported by budgets made available through the Staff Health and Wellbeing CQUIN which (in line with the CQUIN budgets as whole) has been reduced in 2018/19 prior to concluding March 2019. An assessment of options for long term funding is in progress.
2.3 The Health and Wellbeing Committee has adopted a programme and objectives to address this, but there are resource and commitment requirements at corporate and site level.

2.4 Your Health Matters (YHM) was developed up by the Public Health team working with Occupational Health using
- Data from a staff health and wellbeing survey that attracted 1500 responses in 2016 and 2000 in 2017 (being repeated for 2018).
- Review of NICE guidance and best practice elsewhere in the NHS.
- Review of sickness and occupational health data and existing programmes in this area.
- The requirements of the NHS England Health and Wellbeing CQUIN.

2.5 Staff in the survey were asked to rank the below areas by order of priority in the Health and Wellbeing Programme. A ranking average was calculated for each answer choice, which assigns a weight to each ranked position and takes into account the number of people choosing each ranking. The answer choice with the largest ranking average is the most preferred choice which in this case is health checks:

1. Health checks – 6.61
2. Healthy weight management – 6.32
4. Physiotherapy – 5.77
5. Physical Activity – 5.72
6. Smoking cessation – 4.64
7. Active Travel – 3.8
8. Alcohol/drug abuse support – 3.79
9. Other – 2.60

Based on the above, a health and well-being plan was developed which combined preventative actions with an improved occupational health offer. The results from the 2018 Staff Health and Wellbeing survey are still being analysed.

2.6 The Your Health Matters plan has three core aims:
- Improved physical health and wellbeing
- Improved mental health and wellbeing
- Improved general health linked to a healthy weight and diet

2.7 The Health and Wellbeing Committee also set the following objectives:

1. Ensuring that staff are aware of the YHM initiative and that it is understood to be a corporate priority.
2. To incorporate the objectives set in the YHM’s plan across the trust with a particular focus on sites and service identified less engaged as the trust average.
3. Ensure each Objective has an aspirational improvement goal for 18/19 and to agree key metrics demonstrating this improvement.
4. Consider the capacity of the trust to maintain existing programme and agree priorities for 2018/19. An identity for the programme was developed by the communications team was developed based on an idea by staff members and is shown below:

Healthy Workplace Charter

3.1 The Charter is accredited by the Greater London Authority and is at three levels – Commitment, Achievement and Excellence. Having been successful with the first two levels the Trust is ready to submit its application for Excellence and this report asks the Board to approve the submission. It should be noted that the Charter has been adopted by a large number of businesses and organisations, including trusts such as Homerton University Hospital NHS FT, which attained excellence status.

3.2 The charter has eight domains and has been used as an improvement framework in developing the health and wellbeing programme. It covers:

- Corporate Leadership
- Attendance Management
- Health and Safety
- Mental Health and Wellbeing
- Tobacco
- Physical Activity Healthy Eating
- Alcohol and Substance Misuse
- Healthy Eating
- Alcohol and Substance Misuse

3.3 A shortened version of the charter has been circulated to the site management teams for them to consider and complete with the aim of generate site Health and Wellbeing Plans that reflect the needs and environment of each site. This plan will promote the existing work that has been conducted and set out the basis for incorporating staff health and wellbeing in site operations.
In preparation for application for the Excellence level, the Trust has worked with the Greater London Authority (GLA) to self-assess its progress.

### Key

<table>
<thead>
<tr>
<th></th>
<th>Meeting standard</th>
<th>Almost meeting standard</th>
<th>Need support</th>
</tr>
</thead>
</table>

### Healthy Workplace Charter – Excellence Standards

#### 1 Corporate support for wellbeing

1.1 Line managers demonstrate regular joint working and shared decision making with employees and empower employees to work in an independent way.

1.2 Line managers have training in how to have difficult conversations, developing people skills and resolving disputes.

1.3 Employees are offered learning and development opportunities to maximize their potential.

1.4 Organisational development and change are managed appropriately.

1.5 The organisation has a health, work and wellbeing strategy in place with a detailed action plan.

1.6 Specific consideration is given to the health and wellbeing of lower paid employees.

#### 2 Attendance management

2.1 Absence trends are monitored across the organisation and specific programmes are designed and implemented to address the issues identified to prevent further absence.

2.2 The organisation’s return to work policies are designed to support sustainable rehabilitation and early return to work with adjustments made to accommodate this when necessary.

2.3 The organisation has a proactive system in place to support staff on long term sickness absence to return to work and will support staff with long term conditions.

#### 3 Health and safety requirements

3.1 There are identified trained health and safety representatives (trade union and/or company representatives).

3.2 Staff representatives have been involved in the development and/or evaluation of health and safety policies.

3.3 There is a clear emphasis on prevention of ill health across all health and safety policies.

3.4 All managers have received health and safety management training.
3.5 | Regular health and safety meetings are held and recorded

4 | Mental health and wellbeing

4.1 | A mental health and wellbeing strategy/stress prevention strategy is in place and followed. This should highlight the promotion of mental wellbeing to the organisation and address investment in the mental wellbeing of the workforce

4.2 | Mental health awareness training is available for all employees and it has been delivered to the majority of employees

4.3 | Staff consultations/surveys take place that seek information on the mental wellbeing of staff and also cover working conditions, communication, work life balance, staff support and work related or other causes of stress, with action plans drawn up to address major issues

4.4 | The organisation provides a confidential support service, in-house or externally, to individuals who come forward with a problem

4.5 | Organisational and individual change is accompanied by support, information or targeted intervention programmes e.g. retirement or redundancy planning

4.6 | Social support groups, volunteering and out-of-work activities are actively encouraged and supported by the organisation.

5 | Tobacco

5.1 | All open areas (outdoor) are clearly signposted as smoke-free and steps are taken to prevent smoking in these areas

5.2 | There is active promotion of ‘stop-smoking’ services and staff are given time to attend

6 | Physical activity

6.1 | Opportunities for physical activity linked to the workplace have been investigated and implemented. These activities are sustainable and embedded in the organisational culture.

6.2 | The organisation has a travel plan that promotes physically active ways of getting to and from work and travelling between meetings.

7 | Healthy eating

7.1 | A corporate healthy eating food plan, guidelines or similar has been produced in consultation with staff that covers: Corporate hospitality; Catering provision; Local sourcing of food using local providers where appropriate; Vending/in-house catering pricing strategy to promote healthy options.

7.2 | Internal or external support is on offer for those who wish to lose weight
The draft outline of the submission reflects the progress made in the past three years and is shown in the table. Where applicants cannot demonstrate attainment of all the criteria, they are asked to show detailed plans aimed at achieving these.

The submission has gone through the first stage of the verification process and received the green light to proceed to full verification.

**Health and Wellbeing CQUIN**

**4.1** The Your Health Matters programme was established in response to the need to address the Health and Wellbeing CQUIN, which was set for NHS acute trusts for 2016-19. This aims to incentivise NHS Trusts to improve staff health and wellbeing.

**4.2** The specific CQUIN targets support the wider aim of the Trust in working toward improving its profile as an employer that cares about the health and wellbeing of its staff (in line with the WE CARE values). The highlights of this report are outlined below:

**Get Active**
- Provision of access to physiotherapy across sites. This was a new service to address MSK issues, the single biggest reason given for sickness absence at the trust. This provides a rapid access clinic for staff suffering from MSK conditions that have either resulted in sickness absence or risks causing sickness absence episodes. This is available on each site and is specifically targeting work related issues. From September 2018 there will be the
provision of REHAB Pilates to strengthen the programme and once sustainable will look to develop service to make first day contact to reduce length of absence and recurrence.

- Partial subsidy for workplace exercise classes. These include cardio-vascular classes as well as yoga and Pilates and the programme has resulted in a 70% increase in activity with 386 staff per quarter participating in regular sports and physical activity (SPA) classes and 1025 staff participating in one off SPA or wellbeing events (average of 256 per quarter).

**Chart A – Accumulative attendance of all Workplace Sports and Physical activity**

<table>
<thead>
<tr>
<th>Year</th>
<th>Staff attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>1100</td>
</tr>
<tr>
<td>2015/16</td>
<td>1743</td>
</tr>
<tr>
<td>2016/17</td>
<td>2090</td>
</tr>
<tr>
<td>2017/18</td>
<td>2569</td>
</tr>
</tbody>
</table>

- Step Jockey fitness challenges at the Royal London and Prescot Street sites which along with other walking challenges has been popular with staff teams. 600 staff have participated in step challenges in addition to regular users. The challenges measured over 3.5 million steps taken up staff teams who participate in these.

**Mental Health and Wellbeing**

- Mindfulness programmes – these have been piloted with excellent feedback from colleagues and have been supported by the Education Academy. Ten eight-week mindfulness courses have been delivered over the past 18 months with 180 staff reached. This has allowed Barts Health owned training materials and the establishment of a ‘mindful’ community. The course demonstrates marked success for all attendees with an average improvement in stress perception (reduced by 30%) and increase of in overall life satisfaction.

- Cognitive Behavioural Therapist (CBT) - Employed 2 days per week in Employee Wellbeing Service offering support for staff following the
Management referral consultation. The service is also supporting clinical supervision for the Employee Wellbeing Service and pilot for two groups of staff to help support and hold group discussions. Workshops are available on each site supporting with stress management, sleep hygiene and identifying signs and symptoms of pressure

- Mental Health First Aid – this is a social movement led by staff and has led to a group of 40 MH first aiders across the trust. MHFA is an intervention that has the support of NHSE and PHE and consists of a two day course allowing participants the knowledge to identify mental health issues and refer staff onto further support. It is a workstream in the BartsAbility programme, and is a key part of this initiative in supporting staff with mental health issues. This work was preceded by the Trust’s pledge to the Time for Change pledge against mental health discrimination. This was five years ago, and given the programme of work it has undertaken since then, the Mental Health First Aid network has asked the Trust to re-affirm its support on International Mental Health Day.

- Psychologically Safe Training and Development - bespoke programmes aimed at services identified as having high pressures and/or low staff engagement scores. To date it has run programmes in the Royal London Emergency Department, Women’s and Children Division, People Services and Procurement services and the impact of this is still being evaluated.

Healthy Lifestyles
- Health MOTs- These are offered at WX, NUH, RLH and available as a mobile unit to cover other sites.
- The sessions include height, weight, BMI, Diabetes Cholesterol heart age and lifestyle support (The Director of People has personally lost 51lb since his consultation).
- Weight Management Weight watchers programme has been available at WX and RLH running for a 12 week course. The plan is to include into the programme offered by Employee wellbeing service and to look at sustainable changes not just block diets.

Sustaining the programme

5.1 The following interventions have established plans for transferring the activity into business as usual supported by funding through the following measures:
• The Physiotherapy Service is now coded so that income can be recovered via the commissioning route.

• The CBT Service will be developed to increase capacity so it can be an enhanced offering to the commercial contracts delivered by EWS. The initial programmes in 2018/19 will be funding from CQUIN with an expectation that sites will fund specific programmes of activity from their own budgets in 2019/20.

• Physical Activity (exercise classes) are being funding by collecting contributions from staff (c. £5 per month). In addition specific targeted activity aligned to site staff survey results will also be explored with the expectation that sites will contribute towards funding. These measures are intended to make the programme self-funding part-way through 2019/20.

• Mental health first aid programme. There is a waiting list of 40 staff who wish to be trained and the request is to support courses to cater for this demand while considering steps to integrate the training into the wider learning and development offer of the trust and develop the network more widely. The intention is to build a MHFA network with clinical governance, clear role descriptions for the First Aiders and a business plan showing targeted areas, outcomes and support mechanisms in place.

• Mindfulness. The aim is to expand the offer to reach 400 more staff in 2018/19 and address the current waiting list of 300 staff who have expressed an interest. Demand for these courses outstrips supply and a funding application has been submitted to additional funding has been requested from Health Education England (HEE).

• Development costs. To extend the programme further and sustain other activities not included in the above, a business case proposal is being prepared for the Investment Steering Committee.

RECOMMENDATIONS

6.1 The Trust Board is asked to:

• Endorse the Your Health Matters programme and progress made with delivering this.

• Approve the application for Excellence Status in the Healthy Workplace Charter

• Re-affirm the Trust’s support for the Time for Change pledge on International Mental Health Day (11 October 2018).

• Note the development of a business case to support the programme in 2018/19 and in subsequent years.
## Appendix A – Your Health Matters 2018/19 programme

<table>
<thead>
<tr>
<th>HWB Objective – Key theme &amp; description</th>
<th>Key outcomes we are aiming for in 18/19</th>
<th>Specific actions for 18/19</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1a) To improve the physical HWB of staff</strong></td>
<td><strong>Metrics:</strong> Increase percentage of staff using active travel methods of getting to work (TfL Travel Survey) Reduce 2017 percentage of staff reporting as ill through MSK problems Increase the numbers of staff participating in workplace exercise classes (baseline 600) (pending continuance of funding is second half of 2018/19) Increase numbers of staff participating in SPA events such as sports days and healthy living week (baseline 200) (pending continuance of funding is second half of 2018/19) Maintain numbers of staff participating in walking or step challenges such as Step Jockey</td>
<td>Provide access to Crystal Palace Physiotherapy service across all main sites Provide subsidised exercise classes across sites and staff enrolled in IWL card scheme Promote Healthy Living Week Maintain access to Step Jockey step challenges Promote cycling and walking to work events Improve facilities for cyclists (safe storage; changing facilities) as part of site Green Travel Plans</td>
<td>5 a side football tournament – July 2018 Progress report on Improving Working Lives programme Communication plan for healthy living week (26-30 September 2018) Report on step jockey uptake Review of staff using active travel methods / facilities for cycling Ill health through MSK problems and uptake of physio service report</td>
</tr>
<tr>
<td><strong>GOALS –</strong> 2018 NHS Staff Survey increase in staff reported as meeting PHE guidelines on physical activity Reducing proportion of staff reporting sick through MSK problems</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **1b) To improve the mental HWB of staff** | **Proposed metrics:** Reduce 2017 percentage of staff reporting as ill through stress problems To increase the numbers of staff who are Mental Health First Aiders (MHFA) (target group of 50 MHFA staff trained) (pending funding) To provide targeted intervention aimed at services demonstrating high sickness/low engagement rates (*‘hot spots’*) (pending | MHFA programme for 2016/17 completed and initial MHFA network established Mindfulness programme completed Psychologically Safe management programme completed for selected hotspots Staff benefits programme maintained CIC programme available and on line | Report on mental health and wellbeing Communication plan for Your Health Matters Uptake of mindfulness programme / psychologically safe management / CIC programme monitored One off wellbeing events (e.g. Mental Health week) Progress report on Improving Working Lives programme (including staff benefits) |

<p>| <strong>5 a side football tournament – July 2018</strong> | | | |
| <strong>Progress report on Improving Working Lives programme</strong> | | | |
| <strong>Communication plan for healthy living week (26-30 September 2018)</strong> | | | |
| <strong>Report on step jockey uptake</strong> | | | |
| <strong>Review of staff using active travel methods / facilities for cycling</strong> | | | |
| <strong>Ill health through MSK problems and uptake of physio service report</strong> | | | |</p>
<table>
<thead>
<tr>
<th>1c) Improving general health of staff linked to a healthy weight and diet</th>
<th>Proposed Metrics</th>
<th>2000 staff reply to HWB survey</th>
<th>Communication plan for staff survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase number of staff over 40 attending MOTs</td>
<td>2000 staff reply to HWB survey</td>
<td>Healthy Workplace Charter Excellence Status report</td>
</tr>
<tr>
<td></td>
<td>Number of staff who smoke and have attended an MOT referred to stop smoking support (and subsequently quitting)</td>
<td>Intranet pages reviewed</td>
<td>Report on Sports Day and progress on Improving Working Lives programme</td>
</tr>
<tr>
<td></td>
<td>Number of staff who smoke and have attended an MOT referred to weight management support (and attending)</td>
<td>Two rounds of recruitment events on site to sign staff up to exercise classes</td>
<td>Excellence in Healthy Workplace Charter achieved (September 2018)</td>
</tr>
<tr>
<td></td>
<td>Number of staff who smoke and have attended an MOT referred to SPA (and attending)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of staff using Weightwatchers or similar To improve access to healthy food in restaurants and vending outlets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GOALS</strong></td>
<td>To reduce the number of smokers among staff (SS) To reduce number of staff who are overweight or obese (SS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) To ensure that staff are aware of the YHM initiative</td>
<td>Proposed Metrics</td>
<td>2000 staff reply to HWB survey</td>
<td>Communication plan for staff survey</td>
</tr>
<tr>
<td></td>
<td>Run staff HWB survey again in June/July 2018 To ensure widespread coverage of YHM on the intranet and though site events To improve the proportion of staff in Staff Survey 2017</td>
<td>Intranet pages reviewed</td>
<td>Healthy Workplace Charter Excellence Status report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two rounds of recruitment events on site to sign staff up to exercise classes</td>
<td>Report on Sports Day and progress on Improving Working Lives programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthy Living Week</td>
<td>Excellence in Healthy Workplace Charter achieved (September 2018)</td>
</tr>
<tr>
<td></td>
<td>GOALS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>reporting that the trust is supportive of their HWB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attain Excellence status in Healthy Workplace Charter in 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>GOALS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To become seen as leader in staff HWB in the NHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To improve Staff Survey results year on year in terms of staff reporting that the trust is supportive of their HWB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td>Successfully move to structure with site and service dimensions and reporting effectively to Trust Board</td>
<td>To agree a new reporting structure that includes sites based representatives (e.g. chairs of appropriate wellbeing committees)</td>
<td>Reports from site based representatives</td>
</tr>
<tr>
<td></td>
<td><strong>GOALS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To establish clear reporting lines to Trust Board and to Hospital Management Boards</td>
<td>To establish cross attendance with Health and Safety Committee</td>
<td>Site plans, including site communications and engagement activity</td>
</tr>
<tr>
<td></td>
<td>To establish and sustain staff input into the HWB programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4)</td>
<td>Ensure each Objective has agree key metrics demonstrating this improvement</td>
<td><strong>GOAL</strong></td>
<td>Plan agreed</td>
</tr>
<tr>
<td></td>
<td><strong>GOAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To demonstrate improving participations rates and measure outcomes where possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td>Consider the capacity of the trust to maintain existing programme and agree priorities for 2019/20</td>
<td><strong>GOAL</strong></td>
<td>Sustainability plan required</td>
</tr>
<tr>
<td></td>
<td><strong>GOAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To sustain YHM programme where funding allows and where outcomes and participation rates merit continued support</td>
<td>Business case to be developed</td>
<td></td>
</tr>
</tbody>
</table>
### Executive summary
This paper sets out progress to date with the Strategic Outline Case (SOC) for the redevelopment of Whipps Cross hospital following its submission to NHS Improvement (NHSI) in April 2017 and planned next steps.

### Related Trust objectives
- SO3 Service Transformation
- SO5 Improving our Infrastructure

### Risk and Assurance
| Assurance in relation to Objectives 3 and 5 |

### Related Assurance Framework entries
- 7. Failure to define in detail and implement the clinical and organisational strategy impacts on sustainability and development.

### Legal implications/ regulatory requirements
None

### Action required by the Board
The Trust Board is asked to note the current position on the SOC approval and next steps, including the work under way for preparing for the next phase of the redevelopment programme.

---

<table>
<thead>
<tr>
<th>Title</th>
<th>Whipps Cross Redevelopment Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Director</td>
<td>Ralph Coulbeck, Director of Strategy</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Alastair Finney, Redevelopment Director, Whipps Cross</td>
</tr>
<tr>
<td>Purpose</td>
<td>To provide an update on the status of the Whipps Cross redevelopment programme</td>
</tr>
<tr>
<td>Previously considered by</td>
<td>-</td>
</tr>
</tbody>
</table>
INTRODUCTION

1. The Strategic Outline Case (SOC) for the redevelopment of Whipps Cross Hospital was considered by Finance and Investment Committee (FIC) and the Trust Board on 1 February 2017. Following endorsement by local partner organisations, the SOC was formally submitted to NHS Improvement (NHSI) in April 2017.

2. This paper outlines the current position on NHSI’s review of the SOC and the next steps following a letter from NHSI last month.

NATIONAL CAPITAL BIDDING PROCESS

3. Due to the restrictions on capital funding, the Department of Health and Social Care (DHSC) has introduced a national bidding process for capital funding. This scheme is administered by NHSI and NHS England (NHSE) on behalf of DHSC and bids have been submitted via the Sustainability and Transformation Partnership (STP). Schemes are identified as either a large scheme or small-medium schemes, depending on whether the capital value is over or under £100m. Whipps Cross was the only large scheme supported by the East London Health and Care Partnership (ELH&CP) and a bid was submitted on 16 July reinforcing the strategic importance of redeveloping the hospital.

4. The bids are currently being reviewed by NHSI and NHSE with large schemes being assessed separately to small-medium schemes. NHSI and NHSE acknowledge that large schemes will be subject to a longer timeframe for decision making. As yet, there is no clear timetable for when a decision will be reached about whether Whipps Cross will be included in the list of large schemes that DHSC will support.

NHS IMPROVEMENT POSITION

5. The most recent development is receipt of a letter of 3 August from NHSI, outlining their current position in relation to the SOC. It acknowledges NHSI’s understanding and support of the strategic imperative to redevelop the estate at Whipps Cross Hospital site and that we should continue the development of the business case for future consideration and approval. Specifically, as part of the next phase of work, we need to do everything possible to deliver our vision while ensuring the cost is affordable to the taxpayer, which means looking carefully at overall costs and how we can ensure value for money.
6. In essence, NHSI’s primary intention is to allow the Trust to move to the next phase of the programme, which would be to develop a set of more detailed proposals and to do that through the wider engagement of stakeholders including local partner organisations, patients, the public and their representatives; but to undertake this work in advance of securing the SOC’s approval. It should be noted as well that the work NHSI sets out as expecting to be undertaken would, in any case, be required as part of the development of the OBC, even had the SOC been formally approved at this stage.

7. To this extent, NHSI’s position should be seen as a positive development in enabling the plans for the redevelopment of Whipps Cross to progress further, particularly as the outcome of the national bidding process outlined above (paras. 3-4) is likely to influence the timeline for the decision-making process for the SOC and subsequent business cases. We acknowledge that the SOC still needs to be formally approved in advance of the OBC being approved, but ongoing conversations with NHSI colleagues suggest that we should focus on the detailed work required for an OBC as well as strengthening the SOC itself.

NEXT STEPS

8. As noted, the next step in the programme is to strengthen the SOC so it can be approved but, at the same time, move the work forward as if beginning to develop an OBC for the future of the entire site, including a detailed specification for the hospital’s redevelopment and high-level masterplan for the remainder of the site. This will need to strike the right balance between the strategic, economic and commercial opportunities that only a redevelopment of the whole site can deliver in full. Following submission and approval of the OBC, the Trust will need to develop a Full Business Case to secure funding, procure relevant development partners and negotiate contracts before construction of the new hospital begins.

9. In light of NHSI setting out their position, work is under way to mobilise the next phase of the programme. As outlined below a number of workstreams are now being progressed at pace:

Preliminary Masterplanning

10. Working jointly with Waltham Forest Council colleagues, in July an architectural firm was appointed to undertake preliminary masterplanning for the future of the site, in line with vision in the SOC. A series of workshops has already been held involving key staff and partner organisations looking at a range of topics including the infrastructure and the fabric of buildings, planning and economic regeneration, clinical and other services, and transport and access.

11. We expect this work to be completed around the end of November 2018. This will set out the opportunities, challenges and constraints for the site’s redevelopment, which will then be explored in more detail as part of the development of a final master plan in the OBC phase.
Establishing a Community Involvement Group

12. The Redevelopment Programme Board previously approved a proposal to create a community involvement group to ensure local people are able to shape elements of the programme and OBC. The proposal has been informed by feedback from the local community, following a number of discussions with different groups and a workshop held in February 2018.

13. Having previously confirmed to stakeholders that the group would be established in time for the beginning of the next phase of work, the next steps including finalising the terms of reference and design of the group, running and completing a recruitment process and agreeing an established rhythm of meetings and set of immediate tasks for the group. The aim is to have the work completed well before the end of the calendar year in order for the group to hit the ground running in 2019.

Programme Team

14. The programme budget for 2018/19 has been agreed and work is well under way to procure short-term support and advisors to help design and establish the Programme Management Office (PMO) with a detailed programme plan agreed. It is anticipated the programme plan will be agreed and the PMO in place and fully mobilised by the end of November, with core members of the programme team recruited to work alongside the existing Redevelopment Director within the same timescale. A broader recruitment and procurement plan will be developed by December 2018 for the recruitment of advisers including cost consultants and legal advisors.

RECOMMENDATION

15. The Trust Board is asked to note the current position on the SOC’s approval and the next steps, including the work under way for preparing for the next phase of the redevelopment programme.
The Audit and Risk Committee, Nomination and Remuneration Committee, Quality Assurance Committee and Finance and Investment Committee have completed their scheduled reviews of their terms of reference (in line with the frequency of reviews set out in respective terms of reference). The revised terms of reference recommended by the committees are attached for Trust Board approval, with amendments identified in ‘tracked changes’. There are no significant / material changes to the terms of reference (or updates to the Committee membership agreed in January 2018) to highlight following this review process. The Trust Board’s terms of reference will be updated in due course, following completion of ongoing board development work.

**Related Trust objectives**

| n/a |

**Risk and Assurance**

| n/a |

**Related Assurance Framework entries**

| n/a |

**Legal implications/ regulatory requirements**

| No direct legal implications identified. |

**Action required by the Board**

The Trust Board is asked to approve the revised terms of reference for the Audit and Risk Committee, Nomination and Remuneration Committee, Quality Assurance Committee and Finance and Investment Committee.
1. Authority

1.1 The Audit and Risk Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. Purpose

2.1 The Audit and Risk Committee will assist the Trust Board with its oversight responsibilities and will independently and objectively monitor, review and report to the Trust Board on the processes of governance, internal control and risk management in place in the Trust and, where appropriate, facilitate and support through its independence the attainment of effective processes.

2.2 In fulfilling its responsibilities, the Audit and Risk Committee will work with the Quality Assurance Committee, which has a specific focus on the quality of services provided by the Trust and the governance, risk management and internal control systems to ensure that the Trust’s services deliver safe, high quality, patient-centred care.
3. **Membership**

3.1 The Committee shall be appointed by the Trust Board and shall be composed of three Non Executive Directors, one of whom will be appointed as the Chair of the Audit and Risk Committee by the Trust Board. At least one member of the Audit and Risk Committee should have significant, recent and relevant financial experience.

3.2 A quorum shall be two members. The Chairman of the Trust shall not be a member of the Committee.

3.3 One of the Non Executive Director members of the Trust’s Quality Assurance Committee should also be a member of the Audit and Risk Committee.

3.4 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend two meetings in a calendar year. If a member fails to attend more than two meetings in a calendar year the Chair of the Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4. **Attendance**

4.1 The Chief Financial Officer, Deputy Chief Executive, Director of Corporate Development and appropriate representatives of Internal and External Audit shall generally attend routine meetings at the invitation of the Committee. The Chief Executive will be invited and attend at least annually.

4.2 Other executive directors or any other individual deemed appropriate by the Committee may be invited to attend for specific items for which they have responsibility.

4.3 A representative of the local counter fraud service (part of the Internal Audit function) may be invited to attend meetings of the Committee.

4.4 A pre-meet (ahead of each meeting of the Committee) will normally be held with the Internal and/or External Auditors and without executive directors present.

4.5 The Director of Corporate Development will ensure that the Trust Office provides a Secretary to the Committee and appropriate administrative support and advice to the Chair and committee members. This shall include agreement of the agenda with the Chair and attendees, collation of papers, taking the minutes and keeping a record of matters arising
and issues to be carried forward and advising the Committee as appropriate.

5. Access

5.1 Internal and external auditors have a right of direct access to the Committee Chair.

6. Frequency of meetings

6.1 Meetings shall be held at least four times a year (to coincide with key dates in the Trust’s financial reporting cycle), with additional meetings where necessary. The External Auditor or Director of Internal Audit may request a meeting if they consider that one is necessary.

7. Reporting

7.1 The approved minutes of the Audit and Risk Committee’s meetings will be circulated to all Trust Board members for information and the Chair of the Audit and Risk Committee will provide an exception report to the next Trust Board after each Committee meeting.

7.2 The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or require executive action. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters.

7.3 The Committee will report annually to the Trust Board in respect of the fulfilment of its functions in connection with these terms of reference.

7.4 Such a report should specifically include:

- A summary of the role of the Audit and Risk Committee.
- The names and qualifications of all members of the Audit and Risk Committee during the period.
- The number of Audit and Risk Committee meetings and attendance by each member.
- The way the Audit and Risk Committee has discharged its responsibilities.
- The Committee’s work in support of the Annual Governance Statement, specifically commenting on:
  - the fitness for purpose of the Board Assurance Framework;
  - the completeness and maturity of risk management in the Trust;
  - the integration of governance arrangements;
○ the appropriateness of compliance with CQC regulatory standards. In doing so, it will in particular draw on the work undertaken and the assurances gained by the Quality Assurance Committee on quality and safety; and
○ the robustness of the process supporting development of the quality accounts.

7.5 The Quality Assurance Committee will provide an annual report to the Audit and Risk Committee on the effectiveness of its work and its findings, including its review of the Board Assurance Framework and the high level risk register and audit reports covering areas within its terms of reference.

7.6 In addition, there will be a standing item on the agenda at each meeting for the Chair of the Quality Assurance Committee to report back on the work of that Committee (Minutes of the Quality Assurance Committee will also be shared with the Audit and Risk Committee and Board members). The Audit and Risk Committee will also receive a regular exception report covering issues escalated from the Risk Management Committee. This will assist the Audit and Risk Committee in discharging its responsibility for providing assurance to the Trust Board in relation to all aspects of governance, risk management and internal control within the Trust.

8. Review

8.1 The Terms of Reference should be reviewed by the Committee and approved by the Trust Board at least every two years.

9. Duties

**Governance, internal control and risk management**

9.1 The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust’s activities that support the achievement of the organisation’s objectives. The Audit and Risk Committee will be assisted in this duty by the Quality Assurance Committee, which will have responsibility for providing assurance in relation to clinical, research and development, and education and training governance and risk management.

9.2 In particular, the Committee will review – either directly or through the work of the Quality Assurance Committee – the adequacy of:

- The Trust’s general risk management structures, processes and responsibilities. This will include an annual review of the Trust’s Risk Management Strategy and Policy ahead of Trust Board approval.
• All risk and control-related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Essential Standards of Quality and Safety), together with any accompanying Head of Internal Audit Opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Trust Board.

• The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

• Policies for ensuring compliance with relevant regulatory, legal and conduct requirements and any related reporting and self-certifications.

• Policies and procedures for all work related to fraud and security (including addressing NHS Counter Fraud Authority standards).

9.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions such as Risk Management and Clinical Audit, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, and in particular the Quality Assurance Committee, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

9.4 This will be evidenced through the Committee’s use of an effective Board Assurance Framework (BAF) to guide its work and that of the audit and assurance functions that report to it. The Audit and Risk Committee will receive and review at each meeting the BAF entries to be overseen by the Audit and Risk Committee. (Agreement on the allocation of primary oversight of BAF risks between the Quality Assurance Committee, Finance and Investment Committee and the Audit and Risk Committee will be made by the chairs of these committees.) The Quality Assurance Committee will similarly undertake a review of the BAF entries allocated to it. The full BAF will be received by the Trust Board at least three times a year and the Audit and Risk Committee will receive and review the BAF ahead of this.

9.5 A thematic report on the Trust’s high level risk register (risks scoring 15 and above) will be reviewed by the Audit and Risk Committee twice a year. This will take account of the review of clinical, research and development, and education and training risks undertaken by the Quality Assurance Committee.
9.6 The Committee shall ensure that there is an effective internal audit function put in place by management that meets mandatory NHS Internal Audit standards (including Public Sector Internal Audit Standards, 2013) and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the Internal Audit strategy, operational plan and detailed work programme, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework and the recommendations of the Quality Assurance Committee.

- Consideration of the major findings of Internal Audit work and the management response and ensuring coordination between Internal Audit, Clinical Audit and External Auditors (including joint work) to optimise audit resources. While the Quality Assurance Committee will lead on the review of audit reports covering patient safety, quality and experience, education and research, the Audit and Risk Committee will receive assurance that they have been carefully reviewed by the Quality Assurance Committee. If there is any perceived ambiguity regarding the relative roles of the Audit and Risk Committee and the Quality Assurance Committee in this respect, the committee chairs will liaise to agree a satisfactory approach.

- Reviewing and monitoring management’s responsiveness to auditor’s findings and recommendations, assuring itself that the management of the Trust is implementing the agreed recommendations of Internal Audit reports in a timely and effective way.

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

- An annual review of the effectiveness of Internal Audit, based on the HFMA Audit Committee Handbook self-assessment checklists and the results of independent quality reviews.

**External Audit**

9.7 From 2017/18, following changes to the centralised arrangements overseen by the former Audit Commission, NHS trusts appoint their own External Audit providers. The Audit and Risk Committee will act as the Board appointed Auditor Panel in line with the Local Audit and Accountability Act 2014 in order
to (i) review and make recommendations to the Board on the appointment and removal of External Auditors and (ii) retain oversight of the following:

- Ensuring contract arrangements (i.e. procurement and the selection of external auditors) are appropriate;
- Ensuring the relationship and communications with the external auditors are professional; and
- Ensuring conflicts of interest are effectively dealt with.

9.8 The Committee shall review and monitor the external auditors’ independence and objectivity and the effectiveness of the audit process. In particular the Committee will review the work and findings of the External Auditors and consider the implications and management responses to their work. This will be achieved by:

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy.

- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- Agreeing the policy and approach for the conduct of any non-audit work conducted by External Audit partners.

- Review of External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses. While the Quality Assurance Committee will lead on the review of external audit reports covering patient safety and quality risk and controls, the Audit and Risk Committee will seek assurance that they have been carefully reviewed by the Quality Assurance Committee.

- Assuring itself that the management of the Trust have implemented the agreed recommendations of External Audit reports in a timely and effective way.

**Other assurance functions**

9.9 The Audit and Risk Committee shall review as appropriate the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These may include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission) and professional bodies with
responsibility for the performance of staff or functions (for example, Royal Colleges).

9.10 In doing this, the Committee may review the work of other committees within the Trust whose work can provide relevant assurance to the Audit and Risk Committee’s own scope of work. In particular, the Audit and Risk Committee will look to the assurance provided by the Quality Assurance Committee, which will report annually to the Audit and Risk Committee on its work. In reviewing clinical governance arrangements the Audit and Risk Committee will wish to satisfy itself on the assurance that can be gained from the work of the Quality Assurance Committee.

**Counter Fraud and Security Management**

9.11 The Committee shall satisfy itself that the Trust has adequate arrangements in place for counter fraud and security management that meet NHS Counter Fraud Authority standards and shall review the outcomes of work in these areas.

**Management**

9.12 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements

**Whistleblowing / Raising Concerns**

9.13 The Committee should review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently following Trust whistleblowing policies and procedures (or similar agreed reporting mechanisms).

**Financial Reporting (including Annual report and accounts review)**

9.14 The Audit and Risk Committee shall review the statutory annual report (finance and governance sections) and accounts before these are presented to the Trust Board. This review will cover but not be limited to:

- Completeness, objectivity, integrity and accuracy of the figures shown in financial statements and related notes.
- Completeness, integrity and accuracy of the Annual Governance Statement.
• Significant judgements exercised in preparation of the financial statements, including changes in, and compliance with, accounting policies and practices.
• Explanation of estimates or provisions having material effect.
• Any unadjusted misstatements.
• Explanations for significant variances from plan.
• Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved.
• Letters of representation.

9.15 The Committee shall also ensure that the systems for financial reporting to the Finance and Investment Committee and the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board.

**Standing Orders, Standing Financial Instructions and Standards of Business Conduct**

9.16 The Audit and Risk Committee will review on behalf of the Trust Board the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Scheme of Delegation and Standards of Business Conduct, including the maintenance of registers of interests.

9.17 The Committee will examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

9.18 Specifically, the Committee will receive regular reports on Waivers of Standing Orders, Losses and Special Payments, and Directors’ expenses.

Reviewed by the Audit and Risk Committee: 23 May 2018 Last Approved by Trust Board: 01 June 2016
BARTS HEALTH NHS TRUST

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1 The Nominations and Remuneration Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to obtain outside legal, remuneration or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. Purpose

2.1 The Nominations and Remuneration Committee shall have delegated authority from the Trust Board to (i) appoint and remove the Chief Executive and, together with the Chief Executive, to appoint and remove the other Executive Directors; and (ii) to set the remuneration, allowances and other terms and conditions of office for the Trust’s Executive Directors and to recommend and monitor the structure of remuneration, including setting pay ranges and receiving at least annual reports, for senior managers as defined by the roles in Tiers 1A and 1B of the Trust’s pay structure.

3. Membership

3.1 The Committee shall be appointed by the Trust Board and comprise the Chair of the Trust and all Non Executive Directors of the Trust. One member will be appointed as the Chair of the Nominations and Remuneration Committee and another will be appointed as the Vice Chair by the Trust Board.

3.2 A quorum shall be three members.

3.3 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend two or more meetings in a calendar year. If a member fails to attend more than two meetings in a calendar year the Chair of the
Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4. Attendance

4.1 The Chief Executive and the Director of People shall normally be in attendance except when issues regarding their own positions are discussed.

4.2 Other directors or any other individual deemed appropriate by the Committee may be invited to attend by the Chair of the Committee for specific items.

4.3 The Trust Secretary shall act as Secretary to the Committee and provide appropriate administrative support to the Chair and committee members. This will include agreement of the agenda with the Chair and attendees, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee as appropriate.

5. Frequency of meetings

5.1 Meetings of the Nominations and Remuneration Committee shall be held as deemed necessary by the Chair but not less than twice a year.

5.2 Where it is necessary for decisions to be taken between meetings of the Committee, these decisions shall be taken by the Chair of the Committee and ratified and minuted at the next meeting of the Committee to ensure an effective audit trail.

6. Reporting

6.1 The approved minutes of the Nominations and Remuneration Committee’s meetings will be circulated to the Trust Chair, all Non Executive Directors, the Chief Executive and the Director of People. The minutes will not be shared with Executive Directors unless agreed on a case-by-case basis by the Chair of the Committee.

6.2 The Chair of the Committee will provide an exception report to the next Trust Board meeting after each Committee meeting, having due regard for the sensitive nature of some of the Committee’s discussions. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require Board approval or ratification.

6.3 The Trust’s Annual Report, which is approved by the Trust Board, shall include a statement of the Trust’s broad remuneration policy.

7. Review
7.1 The Terms of Reference shall be reviewed by the Committee and approved by the Trust Board at least every two years.

8. Duties

**Nominations**

8.1 To regularly review the structure, size and composition (including the skills, knowledge and experience) of the Trust Board and make recommendations to the Board with regard to any changes.

8.2 To give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the Board in future.

8.3 Before an individual appointment is made, to evaluate the balance of skills, knowledge and experience on the Board and, in the light of this evaluation, prepare a description of the role and the capabilities required for the particular appointment. The Committee shall ensure that candidates are considered on merit against objective criteria.

8.4 To lead the process for identifying and appointing the Chief Executive and to be involved in the process for Executive Directors (with the Chief Executive) as and when vacancies arise. Identify the most appropriate Non Executive Directors to support the appointment of the Chief Executive and Executive Directors including:

- Ensuring appropriate advertising of posts.
- Appointing interview panels.
- Reviewing applications and drawing up short lists against agreed selection criteria.
- Ensuring appropriate selection methods are used.
- Interviewing short listed candidates.
- Recommending candidates for appointment to the Nominations and Remuneration Committee.

8.5 To consider any matter relating to the continuation in office of the Chief Executive or an Executive Director, including the suspension or termination of service as an employee of the Trust.

**Remuneration**

8.6 To agree and keep under review the overall remuneration policy of the Trust.
8.7 To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust’s Executive Directors, subject to approval by NHS Improvement/Department of Health and Social Care/HM Treasury in accordance with prevailing guidance.

8.8 To recommend and monitor the structure of remuneration, including setting pay ranges and receiving at least annual reports, for senior managers as defined by the roles in Tiers 1A and 1B of the Trust’s pay structure.

8.9 To monitor and evaluate the performance of the Trust’s Chief Executive and Executive Directors against objectives for the previous year and note forward objectives. Performance of other senior managers will be monitored and evaluated by their line managers.

8.10 To ratify decisions taken between meetings by the Chair of the Committee.

8.11 In determining remuneration policy and packages, to have due regard to the policies and recommendations of the Department of Health and Social Care and the NHS, and to adhere to all relevant laws, codes and regulations.

8.12 To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.

8.13 To agree those Compromise Agreements, Settlements and Redundancy Payments which require final approval by NHS Improvement/HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.

8.14 To receive regular reports on other Compromise Agreements, Settlements and Redundancies approved in accordance with Trust policies.

8.15 To receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round.

8.16 To undertake any other duties as directed by the Trust Board.

Review:
Nominations and Remuneration Committee: 6 June 2018
Last approved by Trust Board: 2 December 2015
1. Authority

1.1 The Quality Assurance Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. Purpose

2.1 The Quality Assurance Committee will monitor, review and report on the quality of clinical services provided by the Trust. This will include review of:

- Governance, performance and internal control systems supporting the delivery of safe, high quality, patient-centred care.
- Quality indicators flagged as of concern through escalation reporting or as requested by the Trust Board.
- Progress in implementing action plans to address shortcomings in the quality of services, should they be identified.

2.2 Through the steps outlined in paragraph 2.1, the Quality Assurance Committee will provide assurance to the Trust Board via the Audit and Risk Committee that effective systems are in place and the associated assurance processes are optimal. The Trust Board may request that the Quality Assurance Committee reviews specific issues where it requires additional assurance about the effectiveness of the systems in place to deliver items listed at 2.1 and any quality and safety matters arising from the Trust’s recent operational and quality and safety performance).
2.3 The Quality Assurance Committee will also be responsible for reviewing, on behalf of the Trust Board, the proposed quality improvement priorities set in the annual plan and Quality Account. It will provide assurance to the Trust Board that improvement targets are based on achievable action plans to deliver them and support the development of the Trust’s quality strategy.

2.4 The Trust’s Audit and Risk Committee will retain overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. Section 6 of these terms of reference sets out the reporting arrangements which will support the Audit and Risk Committee in discharging this responsibility.

3. Membership

3.1 The Committee shall be appointed by the Trust Board and be composed of:

- Three Non Executive Directors
- Chief Executive and/or Deputy Chief Executive
- Chief Medical Officer
- Chief Nursing Officer
- Director of Clinical Operations
- NHSI Improvement Director

3.2 One Non Executive Director will be appointed as the Chair of the Quality Assurance Committee and another will be appointed as the Vice Chair by the Trust Board. At least one member of the Quality Assurance Committee should preferably have relevant clinical experience or qualifications. One of the Non Executive Director members of the Quality Assurance Committee should also be a member of the Trust’s Audit and Risk Committee.

3.3 A quorum shall be three members, at least two of whom should be Non Executive members of the Trust Board.

3.4 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend four meetings in a calendar year. If a member fails to attend more than four meetings in a calendar year the Chair of the Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.
4. **Attendance**

4.1 Site Managing Directors and Clinical Board Chairs will be regularly invited to attend to support a rolling programme of exception reports. Other Non Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.

4.2 The Committee may invite other Trust staff to attend its meetings as appropriate. In particular, where appropriate, the Committee will invite clinical teams to attend its meetings to provide assurance on key governance and risk issues.

4.3 The Director of Corporate Development will ensure that the Trust Office provides a Secretary to the Committee and appropriate administrative support to the Chair and committee members. This shall include agreement of the agenda with the Chair and attendees, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee as appropriate.

5. **Frequency of meetings**

5.1 Meetings will generally be held on a bi-monthly basis, with a minimum of six meetings a year.

6. **Reporting**

6.1 The Quality Assurance Committee will receive regular exception reports covering quality and safety issues escalated from the Quality Board and Risk Management Committee as part of an executive highlights report. The Committee will also receive regular exception reports from any sub-committee it establishes.

6.2 The approved minutes of the Quality Assurance Committee’s meetings will be circulated to all Trust Board members for information and an exception report presented to the next Trust Board meeting following each Committee meeting to draw to the attention of the Trust Board any issues that require disclosure to the full Board.

6.3 The Quality Assurance Committee will provide an annual report to the Audit and Risk Committee on the effectiveness of its work and its findings, including its review of relevant Board Assurance Framework entries and audit reports covering areas within its terms of reference. This will assist the Audit and Risk Committee in discharging its responsibility for providing assurance to the Trust Board in relation to all aspects of governance, risk management and internal control. In addition, a Quality Assurance Committee exception report will be included as a standing item on the Audit and Risk Committee agenda for information enabling the Chair of the Quality Assurance Committee to report back on the work of the Quality Assurance Committee. If there is any
perceived ambiguity regarding the relative roles of the Audit and Risk Committee and the Quality Assurance Committee in this respect, the committee chairs will liaise to agree a satisfactory approach.

7. Review

7.1 The Terms of Reference should be reviewed by the Committee and approved by the Trust Board at least every two years.

8. Duties

**Governance, internal control, performance and risk**

8.1 To review the establishment and maintenance of an effective system of governance, performance and internal control in relation to clinical services, research and development, and education and training in order to ensure the delivery of safe, high quality, patient-centred care.

8.2 To receive and review at each meeting those entries on the Trust’s Board Assurance Framework (BAF) which are to be overseen by the Quality Assurance Committee. (Agreement on the allocation of oversight of BAF risks between the Quality Assurance Committee and the Audit and Risk Committee will involve the chairs of the two committees and will be endorsed by the Trust Board.) The full BAF will be received by the Trust Board at least three times a year.

8.3 To advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion on the Trust Integrated Performance Framework and supporting data quality for these metrics. To support the development and ongoing monitoring of ward quality and safety dashboards.

8.4 At the request of the Trust Board (and in line with paragraph 2.1), the Quality Assurance Committee will include within its work plan regular reviews of operational performance where there is ongoing non-compliance with constitutional standards e.g. suspension of reporting against the 18 Weeks Referral to Treatment Time standard, 4-hour emergency care waiting time standards. This will include a review of performance against recovery trajectories and supporting governance arrangements.

**Quality and safety reporting**

8.5 The Trust’s Improvement Plan (Safe and Compassionate – Getting to Good and Outstanding) has been developed with key stakeholders in response to:

- The Care Quality Commission’s inspection visits in November 2014 (to Whipps Cross University Hospital), January 2015 (to The Royal London Hospital and Newham University Hospital) and February 2015 (to the
Margaret Centre at Whipps Cross) and the resulting inspection findings, Warning Notices and compliance actions.

- NHS Improvement’s decision in March 2015, as a consequence of the Whipps Cross CQC report combined with Trust-wide challenges to place Barts Health NHS Trust in Special Measures.

8.6 The Quality Assurance Committee will take a lead role in reviewing progress against this plan, through reporting from each site on its action plans (see paragraph 8.6) and through site quality assurance reports and Clinical Board Assurance reports. The Committee will, specifically:

- Through Improvement PMO reporting, track the implementation and delivery of the Barts Health Quality Improvement Plan against key milestones and outcomes, in relation to cross-cutting clinical board and site-specific aspects.
- Receive deep dive workstream PMO reports on a regular basis (aligning with the Quality Board’s work plan).
- Consider key issues and risks and seek assurance that appropriate mitigations are in place, escalating to the Trust Board as necessary.
- Agree any additional resources required to secure the delivery of the Quality Improvement Plan.
- Review progress against the supporting communications and engagement plan.

8.7 The Committee will receive exception reports from each site on a rolling basis to update on progress in delivering its site Quality Improvement Plans; and other key actions taken to enhance clinical quality and safety, including in response to the findings of internal and external reviews, audits and inspections and trends in adverse events, complaints, claims and litigation. Managing Directors and senior members of the site leadership team will be invited to attend for these items.

8.8 The Committee will receive exception reports from Clinical Boards on a rolling basis to update on steps to improve clinical standards on a Trust-wide basis. This will focus on monitoring KPIs and seek to include reviews of benchmarking, clinical audit and external assurances.

8.9 The Committee will receive Key Lines of Enquiry reports based on key quality and safety themes (identified and agreed by the Chair and lead executives as part of its work plan). These will include, but not be limited to, reports on infection control, safeguarding, mortality, maternity safety, complaints, etc.

8.10 To receive, at least annually, assurance reports in relation to:

- Research and development and education and training governance issues.
• Work of the Health and Safety Committee.

• Work of the Infection Control Committee

• Clinical Audit (see paragraph below).

• Aggregated analyses of adverse events (including serious incidents), complaints, claims and litigation to identify common themes and trends and gain assurance that appropriate actions are being taken to address these.

• Patient experience (see paragraph below).

• Safeguarding children and adults.

• Progress against annual quality objectives.

8.11 To receive other related reporting on compliance with the Care Quality Commission’s Fundamental Standards, including any areas of current concern or focus. This will include involve work with executive groups established to support related improvement work (e.g. Quality Board).

8.12 To receive and review the Quality Account and any other key non-financial governance submissions to national bodies and to make recommendations for sign off by the Trust Board.

Audit and assurance

8.13 To review the annual Clinical Audit programme and receive assurances from Internal Audit (including an in-depth review on a three-yearly basis) regarding the effectiveness of the Trust’s clinical audit function.

8.14 To receive details of all national clinical audits where the Trust is identified as an outlier or a potential outlier. This should include but not be limited to mortality outlier alerts.

8.15 To review the Internal Audit operational plan and more detailed work programme and to make recommendations, subject to Audit and Risk Committee approval, on the clinical, research and development, and education and training aspects of the Internal Audit annual work plan.

8.16 To receive and review the findings of Internal and External Audit reports covering patient safety, quality and experience, research and development, and education and training, and to assure itself that the management of the Trust is implementing the agreed recommendations in a timely and effective way.
**External Assurance**

8.17 To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.

8.18 To ensure that the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the safety and quality of care.

8.19 To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address these (including, specifically, any external quality reviews commissioned by the Trust Board or conducted by third parties and due for publication, with potential stakeholder or media interest).

8.20 To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

8.21 To ensure the work of the Committee is informed by and feeds into the work of the Trust’s Quality Board (and any associated executive patient experience groups), including reviewing key messages from survey findings and ensuring a specific focus on sharing best practice, promotion of and learning from patient experience.

*Reviewed by the Quality Assurance Committee: 18 July 2018
Last Approved by Trust Board: 1 June 2016, and amended by Chair’s Action on 2 August 2016*
BARTS HEALTH NHS TRUST

FINANCE AND INVESTMENT COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1 The Finance and Investment Committee is constituted as a standing committee of the Trust Board and has no executive powers. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. Purpose

2.1 The Finance and Investment Committee shall undertake on behalf of the Trust Board objective scrutiny of the Trust’s financial plans, investment policy and major investment decisions. The Committee will review the Trust’s monthly financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board. Additionally, the Trust Board may request that the Committee reviews specific aspects of financial performance where the Board requires additional scrutiny and assurance.

3. Membership

3.1 The Committee shall be appointed by the Trust Board and be composed of:

- Non Executive Director lead for Finance
- Three additional Non Executive members of the Board
- Chief Executive and/or Deputy Chief Executive
- Chief Finance Officer
- Director of People
- Director of Financial Improvement

3.2 One Non Executive member of the Board will be appointed as the Chair of the Committee.
Committee and another will be appointed as the Vice Chair by the Trust Board.

3.3 A quorum shall be three members, at least two of whom should be Non Executive members of the Trust Board.

3.4 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend two formal meetings in a calendar year. If a member fails to attend more than two formal meetings in a calendar year the Chair of the Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4. Attendance

4.1 All members of the Trust Board will receive papers to be considered by the Committee.

4.2 Other executive directors or any other individual deemed appropriate by the Committee should be invited to attend for specific agenda items for which they have responsibility.

4.3 The Trust Secretary will ensure that the Trust Office provides a Secretary to the Committee and appropriate administrative support to the Chair and committee members. This shall include agreement of the agenda with the Chair and attendees, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee as appropriate.

5. Frequency of meetings

5.1 Meetings will normally be held monthly, with additional meetings where necessary.

6. Reporting

6.1 The approved minutes of the Finance and Investment Committee’s meetings will be circulated to all Trust Board members for information and the Chair of the Finance and Investment Committee will provide an exception report to the next Trust Board after each Committee meeting.

6.2 The Chair of the Committee will draw to the attention of the Trust Board key issues arising from the Committee’s monthly review of financial performance which require Board discussion and/or decision. The Chair of the Committee will draw to the attention of the Board any other issues that require disclosure to the full Board, including those that affect the financial standing of the Trust or require executive action.
7. Review

7.1 The terms of reference should be reviewed by the Committee and approved by the Trust Board at least every two years.

8. Duties

8.1 Scrutinise the development of the Trust’s annual financial plan and long-term financial strategy and plan (both revenue and capital plans), including the underlying assumptions and methodology used, ahead of review and approval by the Trust Board.

8.2 Review the Trust’s monthly financial performance (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust Board, recognising that the primary ownership and accountability for the Trust’s financial performance rests with the full Trust Board.

8.3 Review at the request of the Trust Board specific aspects of financial performance including cash position where the Board requires additional scrutiny and assurance.

8.4 Conduct an annual review of service line reporting and discuss the implications for potential investment or disinvestment in services.

8.5 Approve and keep under review, on behalf of the Trust Board, the Trust’s investment and borrowing strategy and policies. Receive reports on any non-compliance with treasury policies and procedures.

8.6 Evaluate, scrutinise and approve individual investment decisions, including through the review of Strategic, Outline and Full Business Cases. Business cases will usually be referred to the Committee following initial review by the executive Investment Steering Committee and/or Trust Executive Committee, with input from Procurement as appropriate. The following investment decisions shall be subject to review by the Committee:

- All capital schemes (including leased assets and property) with an investment value in excess of £1 million.
- All revenue investment proposals with a cost implication in excess of £3 million over three years.
- All proposed asset disposals where the value of the asset exceeds £1 million.

8.7 Receive reports from the Investment Steering Committee on the monitoring of major capital schemes and/or post project evaluation reports where related business cases have required prior Finance and Investment Committee approval (or on an exception basis following ISC/other executive committee review).
8.8 Receive a report each year regarding the key principles and assumptions for the Trust’s business planning and budget setting process.

8.9 To receive and review at each meeting those entries on the Trust’s Board Assurance Framework (BAF) which are to be overseen by the Committee. Agreement on the allocation of oversight of BAF risks to lead committees will involve the relevant chairs and will be endorsed by the Trust Board. The full BAF will be received by the Trust Board at least three times a year.

8.10 Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.

8.11 Examine any matter referred to the Committee by the Trust Board.

Reviewed by the Finance and Investment Committee: 12 September 2018
Approved by Trust Board: 1 June 2016
<table>
<thead>
<tr>
<th>Title</th>
<th>Update of Standing Orders, reservation and delegation of powers and Standing Financial Instructions</th>
</tr>
</thead>
</table>
| Sponsoring Director | Chief Finance Officer  
Director of Corporate Development |
| Author | Associate Director of Finance  
Trust Secretary  
Director of Procurement |
| Purpose | Review of standing orders, reservation and delegation of powers and standing financial instructions and update where appropriate |
| Previously considered by | Audit and Risk Committee: 18 July 2018 |

**Executive summary**

The Trust’s Standing Orders, reservation and delegation of powers and Standing Financial Instructions (SOs and SFIs) have been reviewed (in line with Board agreement to review on a two-yearly basis). The proposed amendments have been reviewed and endorsed by the Audit and Risk Committee. The full SOs and SFIs have been circulated separately due to their length.

**Standing Orders**

- Organisational titles and roles updated throughout SOs and SFIs- including replacing references to the Appointments Commission to reflect those now carried out by NHS Improvement; the Department of Health becoming Department of Health and Social Care, and NHS Protect amended to NHS Counter Fraud Authority (NHS CFA).
- Executive titles and roles updated throughout SOs and SFIs. Replacing references to the Chief Operating Officer to reflect responsibilities carried out by other officers; references to Director of Corporate Affairs and Trust Secretary to reflect a split of roles and responsibilities carried out by either the Trust Secretary or the Director of Corporate Development.
- Removing a requirement for Trust Board approval of the Risk Management Strategy and Policy (as now split, with the Audit and Risk Committee reviewing the Risk Management Policy).
- Inclusion of the Board’s role on appointment of external auditors, utilising the recommendations of the Audit and Risk Committee acting as an auditor panel;
- National guidance reference updates– included specific reference to a model conflicts of interest policy. [with Fit and Proper Persons regulations covered via reference to the Health and Social Care Act 2008].
Reservation and Delegation of Powers: Scheme of Delegation New Hospitals Programme

- This has been removed, as this related to the construction phase of the new hospitals. Any further expenditure would follow the normal Trust process.

Standing Financial Instructions: Section 16: Tendering and Contracting Procedure

- Removal of reference to requiring a unique code for each tender – as now electronic system generated automatically.
- Removal of reference to a separate ‘Non Tender Breaches register’ as all waivers and retrospective waivers are currently recorded on the same system.
- Removal of references to manual tender processes. All tenders and quotations are now required to be electronic submissions.
- Removal of reference to the Director of Corporate Affairs and Trust Secretary role in opening tenders – following eTendering introduction, electronic tendering process ensures tenders are time/date stamped automatically and fully auditable via log-in IDs.
- Insertion of a clause stipulating that contracts for standard clinical consumables and associated services can be signed by the Director of Procurement above Trust Board thresholds.

Related Trust objectives

All

Related Assurance Framework entries

All

Legal implications/regulatory requirements

The SOs and SFIs incorporate key legal and statutory requirements in relation to corporate and financial governance.

Action required:
The Trust Board is asked to approve the above changes to the Trust standing orders, reservation and delegation of powers and standing financial instructions.
Executive summary
This report provides an executive summary of the annual report relating to work undertaken across adult safeguarding in 2017/18, including the key achievements and challenges and outlines the priorities areas of focus for 2018/19. The Trust Board are asked to note assurance on the policy and processes in place for safeguarding, MCA and DoLS. However there is more work to do to improve assurance about staff training and compliance which will be monitored by the Integrated Safeguarding Adults Committee and the report sets out key safeguarding adult priorities for 2018/19. This report also provides an executive summary of the safeguarding children’s annual report 2017/18 outlining statutory responsibilities and key risks and achievements. This includes challenges with regard to level 3 training compliance and review of systems to strengthen this for 2018/19.

Related Trust objectives
1. We will maintain a focus on delivering high quality, safe and compassionate care for our patients
2. We will meet all national minimum standards and regulatory requirements, delivering consistent and standardised clinical practice.

Risk and Assurance
This report provides assurance that work is being undertaken to ensure the Trust is meeting statutory requirements to protect adults at risk of abuse and neglect.
<table>
<thead>
<tr>
<th>Related Assurance Framework entries</th>
<th>-</th>
</tr>
</thead>
</table>

**Action required by the Board**
The Trust Board is asked to note the work undertaken over the reporting period.
PART 1 – SAFEGUARDING ADULTS EXECUTIVE SUMMARY

INTRODUCTION

1. This report outlines activity and progress in improving and strengthening the safeguarding arrangements for adults across Barts Health NHS Trust for the period April 2017 to March 2018.

2. Since the introduction of the Care Act (2014), which placed Safeguarding Adults on a statutory footing, the Trust continues to respond effectively to concerns about abuse or neglect of vulnerable adults. The trust supports the respect of people’s rights to live the way they want to live, free from abuse and neglect wherever possible but with regard to their wishes and freedom to choose. This may include living with a level of risk that causes concern to families as well as staff.

SAFEGUARDING ADULT TEAM

3. The Head of Adult Safeguarding retired in March 2018 and her replacement started in July 2018. The safeguarding coordinator with a lead for MHA, MCA/DoLS and PREVENT also retired in August 2017, this post has now been successfully recruited to and the appointee will commence during September 2018. A new member of the team started in June 2018 as safeguarding coordinator with a lead on domestic abuse and modern day slavery.

SAFEGUARDING ADULT RISKS

4. The key risks relating to adult safeguarding are capacity within the team during the year related to team vacancies; and staff awareness and understanding of the Mental Capacity Act, Deprivation of Liberty and Prevent strategy. All the risks are part of the workplan for 2018/19 and have mitigations in place to manage the risks.

TRAINING

5. Safeguarding adult training is currently provided through the statutory and mandatory training programme at level 1 and level 2. In addition, face to face sessions have been provided to the nursing preceptorship programme, overseas nurses training and the health care assistant care certificate. Supplementary bespoke
training is provided for clinical areas such as stroke wards and others on request.

6. Staff are also able to access a number of workshops and training events provided by external partners. The provision of face to face training has been limited owing to resource constraints in the last 6 months of 2017/2018.

7. All sites consistently achieve 90% compliance with level 1 Safeguarding Adults Training. Safeguarding adults level 2 statutory training is provided across the Trust, however Whipps Cross Hospital is the only site to achieve compliance of 90%. There has however been a steady increase in compliance across all hospitals.

SAFEGUARDING ADULT REFERRALS

8. A total number of 809 safeguarding alerts have been raised during this period. Of these 614 were raised by our staff about incidents or standards of care provided to our patients by external agencies. 195 concerns were raised about Barts Health services, by our own staff and by external partners, members of the public, friends or relatives. This is a reduction on the previous 12 months when 896 concerns were raised of which 293 were about Barts Health.

DOLS APPLICATIONS

9. In 2017/18, 1334 DoLS applications were made, less than 5% (65) of these were assessed by Local Authorities (LA). Almost all of the others patients were either discharged or died before the local authority had undertaken or completed an assessment.

10. LAs continue to prioritise applications for those patients where the hospital stay may be prolonged. Of applications that were assessed, 69% were approved, indicating that the majority of DOLS applications made by Barts Health continue to be appropriate. Almost all refusals were made on the basis that the patient was deemed to have capacity at the point when the assessment was undertaken.

MISSING PATIENTS

11. Over the last year we have seen a rise in the number of incidents relating to patients who are vulnerable because they either, lack of mental capacity or are experiencing mental ill health who leave the hospital against medical advice. Twenty six safeguarding alerts were raised about people missing from our care in the reporting period. The Trust has a duty to ensure these patients are safe and managing incidents of this nature is a significant issue for safeguarding teams.
**ACHIEVEMENTS**

12. Simulation training using safeguarding scenarios has been piloted and received positive feedback from participants and peer evaluation from the faculty. Elements of safeguarding scenarios have been incorporated into simulations aimed at clinical staff and a series of ‘talking head’ videos have been produced to highlight themes from patients’ experience. We delivered a second simulation programme to staff from surgical wards at Whipps Cross Hospital. Five scenarios were run over the course of each day enacting a range of safeguarding issues such as: a person decides to discharge themself against medical advice and without the on-going care they need; making a clinical assessment of a person with a learning disability; identifying physical abuse of a frail elderly person and responding to allegations of assault made against staff. Thirty three staff members attended the course and evaluated the course as being well presented, will meet their learning objectives and will be useful in their practice, positively influence their performance and increase their confidence in responding to safeguarding concerns.

13. It is anticipated that this innovative course will support staff to develop level 3 competencies for safeguarding adults.

**MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)**

14. Barts Health contributed to a national consultation by the Law Commission which resulted in a white paper in March 2017 suggesting changes to this legislation. On 15 March 2018 the government responded by accepting most of the recommendations made.

**AUDIT AND ASSURANCE**

15. An audit was undertaken as part of the Trust’s Internal Audit Plan. The results of this audit found that there is significant assurance for a formally approved and up to date Trust policy that fully reflects the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), there was also evidence of a comprehensive procedure setting out the specific processes to be followed by staff to ensure that the MCA and DoLS requirements are complied with. There was reasonable assurance that all relevant Trust staff receive adequate training, including refresher training where appropriate on MCA and DoLS, and general patient safeguarding and there being compliance with this. MCA and DoLS is subject to on-going scrutiny by a designated Board sub-committee with responsibility for ensuring that where performance is found to be deficient in any way, timely corrective measures are put in place. The recommendations were agreed and progress is monitored through the Integrated Safeguarding Committee.
SAFEGUARDING ADULT PRIORITIES AND RECOMMENDATIONS

16. The Trust Board is asked to note the following improvement priorities for Safeguarding Adults in 2018/19 (outlined in the ISAC work plan):

1. To strengthen the application of mental capacity assessments, patient advocacy and best interest decision making.
2. To reduce the risks of people with complex needs being discharged from hospital coming to harm.
3. To reduce the risk of people without the mental capacity to consent to care and treatment going missing from hospital.
PART 2 - SAFEGUARDING CHILDREN’S ANNUAL REPORT (EXECUTIVE SUMMARY)

17. Barts Health has a statutory responsibility to make arrangements to safeguard and promote the welfare of children. The purpose of this annual report is to update the Board against a number of specific elements of the Safeguarding Children’s agenda affecting the Trust’s performance on Safeguarding and on progress and challenges since the last report was presented.

18. This report is an executive summary of the annual report. This report has been shared internally within the team and once approved be shared with key stakeholders external to the organisation. Within Barts Health there are regular meetings at both site and corporate level for safeguarding governance with the Integrated safeguarding assurance committee (ISAC) which has membership from our external stakeholders chaired by the Chief Nurse.

19. During the reporting period BH has contributed to 10 Serious Case Reviews (SCRs) which have involved a number of different Local Safeguarding Children Boards (LSCBs). Only 3 of these SCRs have been completed and published the others are still on-going. During the process of completing the SCRs all immediate learning for the organisation has been shared and actioned appropriately. Once the SCRs have been completed lessons learnt are shared through the site safeguarding groups, training and supervision.

KEY ISSUES

20. The following areas are the key issues identified within the year. These issues are reviewed at both team and corporate level regularly to make improvements to systems and processes and form part of the work plan for 2018/19.

- Level 3 safeguarding children training remains below the compliance target. Non-compliant staff are targeted regularly and their managers are also informed. Training is monitored at monthly site safeguarding groups.
- Supervision whilst compliance is still below the target value of 85% there has been considerable improvement within the previous 6 months especially on The Royal London site. Main hotspots are with medical staff training compliance at the Newham, Royal London and St Bartholomew’s hospital sites.
- Trust involved in a large number of serious case reviews (SCRs) in the last reporting period, 3 have been completed and published and the action plans are being progressed, those actions where there have been delays in completing have been escalated to the site Director of Nursing.

21. A review of investigations that have been undertaken show the following to be some of the key themes from Serious Case Reviews and Serious Incidents:
Evidence of over-reliance on statutory Children’s Social Care Services.
Escalation process not embedded.
Documentation and the number of different electronic record systems in use.
Supervision of vulnerable 16-17 year olds.
Evidence of a lack of communication between services.

22. Recommendations from investigations are tracked within the team and monitored via the safeguarding operational group.

ACHIEVEMENTS

23. The following are felt to be key achievements of the team this year:

- Nursing team is fully established.
- Development of rotation programme for safeguarding children advisors.
- Funding has been secured for 3 Named Midwife posts - recruitment in progress
- Increased number of PAs for the Named Doctor at Royal London site and post has been filled.
- Went live with CP-IS information system, which is fully integrated with CERNER.
- Significant progress on supervision compliance whilst this is still a risk the increase in compliance should be recognised as an achievement particularly on The Royal London site.
- Delivered safeguarding training to Trust Board.

RISKS

24. The following risks have been identified and are part of the improvement work for the team for 2018/19:

- Safeguarding children supervision compliance - this is monitored monthly at the site safeguarding meetings with exception reports to the Trust operational meetings and development plans in place.
- Completion of audits, due to the lack of capacity within the team due to vacancies in the reporting period audits were unable to be carried out. For the following reporting period this has been resolved due to the team being fully established.
- Safeguarding children training compliance - as with supervision compliance training is also monitored at site safeguarding meetings.
- Named Doctor within community services - this role has been vacant since the previous post holder left but has now been recruited into and it is expected the new post holder will be in place by the end of quarter 1. To mitigate against future risks with this role there is a succession plan in place to train a junior consultant to ensure there will be adequate on-going cover.
PLANS FOR 2018-2019

25. The following areas inform the workplan for the safeguarding team for 2018/19:

- To review the assurance dashboards for internal and external reporting.
- Develop and adopt single referral form for children social care to be used by Barts Health Staff.
- Participate in partnership working with the changes from LSCBs to Safeguarding Boards including implementation of changes to processes with child deaths.
- Review policies in response to new Working Together and Intercollegiate documents.
- Continue to increase compliance with supervision and training.
- Review the provision for safeguarding children at the St Bartholomew’s Hospital site.

26. The Trust Board is asked to note the report.
Report to the Trust Board: 12 September 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Use of the Trust Seal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsoring Director</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Author(s)</td>
<td>As above</td>
</tr>
<tr>
<td>Purpose</td>
<td>To seek Trust Board ratification of use of the Seal, pursuant to Standing Order 21.2.</td>
</tr>
<tr>
<td>Previously considered by</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Executive summary

This paper documents the use of the Trust Seal on the following occasions:

2 July 2018

- A Contract for the Sale of Freehold Land subject to leases at The Royal London Hospital, Whitechapel Road, London E1 1BB and 1-17 Mount Terrace and 80-82 and 84 New Road, London E1 2BB between Barts Health NHS Trust and The Secretary of State for Health.
- A Transfer of Title for Part of The Royal London Hospital, Whitechapel Road, London E1 1BB between Barts Health NHS Trust and The Secretary of State for Health.
- An Overage Deed between Barts Health NHS Trust and The Secretary of State for Health in relation to property at Whitechapel.
- A Services Agreement in relation to property at Whitechapel between The Secretary for State for Health and Barts Health NHS Trust.
- A Lease of Part of The Royal London Hospital (Plot A), Whitechapel Road, London E1 1BB between The Secretary of State for Health and Barts Health NHS Trust.
- A Lease of Part of The Royal London Hospital (Land at Ambrose King, Plot B), Whitechapel Road, London E1 1BB between The Secretary of State for Health and Barts Health NHS Trust.
- A Lease of Part of The Royal London Hospital (Building at Ambrose King, Plot B), Whitechapel Road, London E1 1BB between The Secretary of State for Health and Barts Health NHS Trust.
- A Lease of Part of The Royal London Hospital (Land at Outpatients, Plot B), Whitechapel Road, London E1 1BB between The Secretary of State for Health and Barts Health NHS Trust.
- A Lease of Part of The Royal London Hospital (Building at Outpatients, Plot B), Whitechapel Road, London E1 1BB between The Secretary of State for Health and Barts Health NHS Trust.
- A Lease of Part of The Royal London Hospital (Plot D), Whitechapel Road, London E1 1BB between The Secretary of State for Health and Barts Health NHS Trust.
### 12 July 2018
- A Lease of Parts of Henry VIII Gate House, St Bartholomew’s Hospital, West Smithfield, London EC1A 7BE between Barts Health NHS Trust and Nuffield Health.

### 31 July 2018
- A Sixth Deed of Amendment relating to the Project Agreement dated 27 April 2006 for the redevelopment of The Royal London Hospital and St Bartholomew’s Hospital between Barts Health NHS Trust and Capital Hospitals Limited.
- A Supplemental to the Lease Agreement dated 3 May 2017 in respect of the Private Patient Unit at The Pathology Building and RSQ Building, Giltspur Street, Smithfield, London.

### 13 August 2018
- A Deed of Variation relating to the Lease of The Robin Brook Centre, St Bartholomew’s Hospital, West Smithfield, EC1A 7BE between Barts Health NHS Trust and Queen Mary University of London.

### 3 September 2018
- A Deed of Surrender relating to Steel’s Lane Health Centre, 384-398 Commercial Road, London E1 0LR between Barts Health NHS Trust and Compass Wellbeing CIC.
- A Licence for undertenants alterations relating to a retail unit, Whipps Cross University Hospital, Whipp Cross Rd, Leytonstone E11 between Barts Health NHS Trust, Elior UK Holdings Ltd and Elior UK PLC.

<table>
<thead>
<tr>
<th>Related Trust objectives</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and Assurance</td>
<td>n/a</td>
</tr>
<tr>
<td>Related Assurance Framework entries</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<p>| Legal implications/ regulatory requirements | The Trust’s lawyers were involved in drawing up the documents requiring sealing. |
| Action required by the Board | The Trust Board is asked to ratify the use of the Seal on the occasions listed above. |</p>
<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Nominations and Remuneration Committee Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chair</strong></td>
<td>Ian Peters, Chairman</td>
</tr>
</tbody>
</table>
| **Author(s) / Secretary** | Chair of Committee  
                      Trust Secretary |
| **Purpose** | To advise the Trust Board on work of Trust Board Committees  
(detailed minutes are provided to Board members separately) |

**Date of meeting**  
The Nominations and Remuneration Committee met on 5 September 2018

**Key areas of discussion arising from items appearing on the agenda**  
The Nominations and Remuneration Committee held a meeting on 5 September 2018. At this meeting the Committee discussed a talent management and succession planning paper, remuneration changes for two very senior manager (VSM) posts and considered an update on executive team portfolios. The Committee also discussed the annual performance appraisals of the executive team, Chief Executive and Chairman.

**Any key actions agreed / decisions taken to be notified to the Board**  
See above.

**Any issues for escalation to the Board**  
None.

**Legal implications/ regulatory requirements**  
n/a

**Action required by the Board**  
The Trust Board is asked to note this exception report from the Nominations and Remuneration Committee.
Executive summary
The Quality Assurance Committee met on 18 July 2018 to discuss items on its agenda (drawn from its annual work plan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items
- Emergency Care & Trauma Clinical Board Assurance Report
- Patient Experience Report
- Chief Medical Officer & Chief Nurse Highlight Report
- Newham University Hospital Quality Governance Exception report
- Safeguarding Annual Reports
- Mortality Report
- Quality Account External Auditors’ Assurance Review
- Annual Report Quality Assurance Committee & Terms of Reference
- NED Walk-round Feedback & Standards of Operating Procedures

Key areas of discussion arising from items appearing on the agenda

Clinical Board Assurance Report (Emergency Care & Trauma Board) – the Committee received a presentation on the progress and development of the Emergency Care & Trauma Clinical Board. The Committee was informed of the models of service across the networks, recruitment and retention initiatives and the development of co-ordinated emergency care across the Trust. The Committee noted efforts to reduce breaches of the 4 hour standard and the development of a fragility score used to assess the emergency care needs of the elderly. The committee also noted the measures taken to look after the psychological needs of clinicians and others working in the services.

Patient Experience Report
The Committee received a report on Patient Experience activity across the Trust noting activity in: PALS, Complaints, Friends and Family Test (FFT), patient surveys and NHS Choices. The Committee noted performance against local and national standards set for reportable complaint responses and acknowledgements as well as feedback from FFT activity across each hospital site. The Committee received the draft patient experience strategy which described the Trust’s plan to improve patient experience from good to outstanding within the next 2-3 years by improving the quality of care, culture and leadership and governance.
Chief Medical Officer/CNO Highlight report – The Committee received the report considering areas identified for discussion. The Committee noted a progress update of CQC inspection preparedness, Never Events and serious incidents, MHRA action plans, Quality Improvement work, infection control and the Trust’s Mental Health Act arrangements.

Newham University Hospital Quality Governance Exception Report – The Committee received a report which included a plan to improve the culture of care in Older People’s and Stroke Services following an increase in hospital-acquired pressure ulcers and the launch of a Culture and Leadership programme in April 2018 to sustain quality improvement and improve leadership and talent management.

Safeguarding Annual Reports
The Committee received and noted Annual reports for Adult Safeguarding in 2017/18 and Children Safeguarding in 2017/18. The reports provided details on the work of the Safeguarding Teams including the key achievements and challenges and outlined the priorities areas of focus for 2018/19.

Mortality Report
The Committee received a report which provided details on the activity of the Mortality Review Group for the last financial year together with analysis of mortality data provided. The committee was noted the appointment of medical examiners at every site whose key responsibility was to ensure the timely, clinical review of all inpatient deaths.

Quality Account External Audit Assurance Review – The Committee received and noted the report which focused on key outputs from External Audit’s review of the data quality used to support the Quality Accounts. The Committee noted that the review was positive in terms of outcomes and found that the Quality Account was consistent with the annual governance statement and other returns. The Committee acknowledged the challenging timescales for the production and publication of the Quality Account.

Annual Report Quality Assurance Committee & TORs – The Committee reviewed annual report for the period 2017/18 which highlighted the activities undertaken by the Committee for the period April 2017 to March 2018. The Committee reviewed the Annual Report agreeing that the Committee fulfilled its obligations under the terms of reference. This would be subsequently submitted for approval by the Audit and Risk Committee.

NED Walk-round Feed Back – The Committee received the report noting that actions arising out of NED visits would be reported through Site exception reporting for assurance. The Committee received and noted the final form of Standard Operating Procedures for NED Walk rounds.

Any key actions agreed / decisions taken to be notified to the Board
None

Any issues for escalation to the Board
None.
<table>
<thead>
<tr>
<th>Legal implications/ regulatory requirements</th>
<th>The above report provides assurance in relation to CQC Regulations and Outcomes and BAF entries as detailed above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action required</td>
<td>The Board is asked to note the report</td>
</tr>
</tbody>
</table>
Report to the Trust Board: 12 September 2018

TB 53/18

<table>
<thead>
<tr>
<th>Title</th>
<th>Audit and Risk Committee Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>Mr Gautam Dalal, Non Executive Director (Chair)</td>
</tr>
<tr>
<td>Author(s) / Secretary</td>
<td>Trust Secretary</td>
</tr>
<tr>
<td>Purpose</td>
<td>To advise the Trust Board on work of Trust Board Committees</td>
</tr>
</tbody>
</table>

Executive summary
The Audit and Risk Committee met on 18 July 2018 to discuss items on its agenda (drawn from its annual workplan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items

<table>
<thead>
<tr>
<th>Item</th>
<th>BAF entries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual audit letter</td>
<td>5</td>
</tr>
<tr>
<td>External Audit progress report including audit findings report</td>
<td>5</td>
</tr>
<tr>
<td>Internal Audit progress report</td>
<td>All</td>
</tr>
<tr>
<td>Quality Assurance Committee exception report</td>
<td>1-4</td>
</tr>
<tr>
<td>Standing items on waivers, losses and counter fraud</td>
<td>5</td>
</tr>
<tr>
<td>ARC annual report and Terms of Reference</td>
<td>9</td>
</tr>
</tbody>
</table>

Key areas of discussion arising from items appearing on the agenda

Internal Audit reports
The Committee reviewed a limited assurance review of chemotherapy stock controls. This had indicated significant issues with accurate recording of stock for chemotherapy, compliance with a related SOP and identified system weaknesses which contributed to stock recording errors. Interim arrangements had been put in place to support stocktakes and the Trust Executive Committee had subsequently approved investment in a replacement stock control system. The Committee also noted a concern regarding the time involved in finalising the report.

External Audit
The Committee received the 2017/18 audit letter (appearing elsewhere on the Board’s agenda). This reflected an effective audit process and unqualified opinion, while highlighting an adverse value for money conclusion (related to the deficit and CQC inspection ratings that applied during the year). The Committee also received the assurance review of the Quality Account.

BAF
The Committee reviewed the BAF and agreed proposals to strengthen the role of the Committee (and other lead committees) in relation to review of the BAF.

Other items
The Committee reviewed recent counter-fraud activity (and the Counter Fraud annual report), waivers, losses and special payments and the committee’s annual report. The Committee approved the submission of Reference Costs for 2017/18. The Committee endorsed the draft Risk Management Strategy and agreed proposed updates to the Trust’s Standing Orders and SFIs and minor amendments to the Committee’s Terms of Reference (all items appearing elsewhere in Board papers for approval).
### Any key actions agreed / decisions taken to be notified to the Board

The Committee approved the submission of Reference Costs for 2017/18. The Committee, acting as an auditor panel, recommended the exercising of an option to extend for a further 12 months the appointment of Grant Thornton UK LLP as the Trust’s External Audit provider.

### Any issues for escalation to the Board

The Trust Board is asked to:

- Approve the recommendation referenced above to extend the contract of Grant Thornton UK LLP as External Audit partner for a further 12 months.
- Approve the appended Committee annual report.

<table>
<thead>
<tr>
<th>Legal implications/ regulatory requirements</th>
<th>The above report provides assurance in relation to CQC Regulations and Outcomes.</th>
</tr>
</thead>
</table>

### Action required by the Board

The Trust Board is asked to note the Audit and Risk Committee exception report and approve the Committee annual report appended.
INTRODUCTION AND SCOPE OF THE ANNUAL REPORT

1. In line with established best practice, the Audit and Risk Committee (ARC) submits an annual report to the Board setting out the approach taken to meet its terms of reference during the year, as well as confirming the framework within which ARC should operate. This year’s report covers the 12 month period to 23 May 2018 (extended beyond the financial year to provide coverage of the Committee’s key role in relation to review of statutory year end reporting).

2. The upwards reporting provided in this annual report is in addition to regular reporting to the Trust Board via the circulation of ARC minutes to all Board members and the provision of written exception reports to each Trust Board meeting following an ARC meeting. This annual report seeks to focus on (i) performance against ToR requirements and (ii) escalation of issues.

3. The purpose of the Audit and Risk Committee is to assist the Trust Board by acting independently and objectively to monitor, review and report to the Trust Board on the processes of governance in place in the Trust. In fulfilling its responsibilities, the ARC works in conjunction with the Quality Assurance Committee - which has a specific focus on the quality of services provided by the Trust and the governance, risk management and internal control systems required to ensure that the Trust’s services deliver safe, high quality, patient-centred care.

SUMMARY OF COMPLIANCE WITH TERMS OF REFERENCE

4. The Audit and Risk Committee (ARC) retained oversight of the key risks to delivery of the Trust’s objectives during 2017/18 (as detailed in the Board Assurance Framework) through the assurances outlined in the Committee’s terms of reference (see table 1 below for headline details).

Table 1

<table>
<thead>
<tr>
<th>TERMS OF REFERENCE HEADINGS</th>
<th>REQUIREMENT</th>
<th>EVIDENCE/DETAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority/Purpose</td>
<td>Role ✓</td>
<td>Met purpose - ARC self assessment checklist completed [25/05/16].</td>
</tr>
<tr>
<td>Membership / frequency</td>
<td>Meetings quorate ✓</td>
<td>Details of frequency/attendance published in Trust Annual Report.</td>
</tr>
<tr>
<td></td>
<td>Attendance (of members/attendees) satisfactory ✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No of meetings per year (4) ✓</td>
<td></td>
</tr>
<tr>
<td>Reporting / escalation</td>
<td>Escalation of issues in-year ✓</td>
<td>Every Board meeting / Each ARC meeting</td>
</tr>
<tr>
<td></td>
<td>ARC Annual report ✓</td>
<td>26/07/17</td>
</tr>
<tr>
<td></td>
<td>QAC Annual report ✓</td>
<td>25/10/17</td>
</tr>
</tbody>
</table>
Annual work plan ✓

On agenda (28/02/2018) Last reviewed by ARC on 23/05/18 (to be submitted for Board approval)

Terms of Reference

Review every two years ✓

TOR key duties

(i) Highlight any potential ultra vires, unlawful or improper transactions (None reported). ✓

i) Review risk management structure, policy and processes ✓

iii) Review of adequacy of annual disclosures ahead of Board approval ✓

iv) Ensure effective internal audit service and appropriate assurances received, including:
   - Review of audit findings / management responsiveness to findings.
   - Adequately resourced and effective function. ✓

v) Ensure effective External Audit function and consider implications of External Audit work, including Annual Accounts audit. ✓

vi) Operation of Standing Orders and Standing Financial Instructions ✓

vii) Whistleblowing / raising concerns

Compliance with key duties

Appendix 1 detail papers received (and date).

Sources of assurance:

Counter Fraud service reporting (every meeting), Return on compliance with laws and regulations (28/02/18 and 23/05/18).

Review of high risk register (28/02/18) Annual Governance Statement (23/05/18) and BAF (each meeting). RM policy reviewed 28/02/17. RM draft strategy scheduled for 18/07/18 meeting.

Annual Accounts / Annual Report, Annual Governance Statement, HoIA Opinion (23/05/18) and Annual Audit Letter (26/07/17, due 18/07/18). [Also Informal meeting held on 2 May 2018]

Internal Audit progress reports, including progress against plan and audit recommendations (each meeting), IA and LCFS annual reports against KPIs (26/07/17), Audit plan agreed (26/07/17; 23/05/18). Private pre-meetings held with auditors to provide opportunity for raising concerns.

External audit progress reports (each meeting), review of accounts audit (May 2017). Private pre-meetings with auditors provide opportunity for raising concerns. Contract review meeting due 18/07/18.

Review of SFIs every two years (last completed 27/07/16 due 18/07/18), review of waivers, losses and special payments (every meeting), review of directors’ expenses (quarterly).

Progress reports received 28/02/18, 23/05/18.

Key exceptions /

External Audit ‘adverse’ conclusion Use of the Audit Committee self-
Possible gaps in compliance with key duties

| Possible gaps in compliance with key duties | on use of resources reflects financial deficit and special measures status. Audit review of financial risks reflect challenges but improved outcomes in 2017/18. High number of limited assurance audit reviews indicate control improvements required. | assessment checklist provides assurance that key duties are completed each year. |

5. A number of important issues have been brought to the attention of the Committee since its last annual report. The above does not seek to provide a comprehensive list of assurances received as the Committee reviewed a number of relevant reports (for example in relation to cyber security briefings, compliance with provider licence conditions, GDPR proposals etc). All Internal Audit limited assurance reviews are routinely reflected in the Head of Internal Audit Opinion each year.

ESCALATION TO THE BOARD

6. Any issues for escalation are reported to the Trust Board following each meeting. Key issues escalated by the Audit and Risk Committee in assessing the effectiveness of systems of internal control included:

   o Limited assurance reviews received in July 2017 in relation to Soft FM tendering, capital programme management and Cerner disaster recovery arrangements (with the latter included as a significant control weakness in the AGS).

   o Limited assurance review of payroll / salary overpayments in October 2017 (subsequent follow-up indicated improvements in selected controls).

   o Limited assurance review of staff expenses in February 2018.

   o Audit and Risk Committee review of annual accounts and annual report sections on 23 May 2018 reflected the External Audit adverse value for money opinion and S.30 letter to the Secretary of State regarding the three year breakeven duty. The Committee recognised the need to revisit timings of ARC and Board meetings in future to provide additional scope for amendments prior to final sign off.

7. The Audit and Risk Committee and Quality Assurance Committee act as the primary assurance committees of the Trust Board and the respective terms of reference and planning meetings are designed to ensure effective joint working. These Committees in turn draw on the work of the executive Risk Management Committee (which also formally reports in to the Trust Executive Committee). Arrangements are in place with chairs of the respective Board committees to avoid risks of duplication of roles and responsibilities.

CONCLUSION

8. As a result of its work during 2017/18, the Audit Committee has fulfilled the duties required by the Board as outlined in its terms of reference and the Audit Committee Handbook. The Audit and Risk Committee is asked to note the Audit and Risk Committee annual report 2017/18. This report will subsequently be submitted to the Trust Board for formal approval.
Executive summary

The Annual Audit Letter 2017/18 summarises the key issues arising from the work that External Audit undertook during their audit of the annual accounts, quality account and annual accountability report. The Annual Audit Letter was subject to review by the Barts Health Audit and Risk Committee at its meeting on 18 July 2018, with any issues raised in the Letter due to be monitored by the Audit and Risk Committee.

Related Trust objectives
S02 Efficient and Effective Care

Risk and Assurance

The Annual Audit Letter provides assurance in relation to a range of financial and governance issues reviewed by the External Auditors during the year.

Related Assurance Framework entries
6. Performance against the financial plan for 2016/17 and cash position is impaired by (i) QCIPs delivery and (ii) income under performance

Legal implications/ regulatory requirements

The Trust is required to publish its Annual Audit Letter.

Action required by the Board

The Trust Board is asked to note and approve:
- In line with usual practice, publication of the Annual Audit Letter.
Annual Audit Letter
Year ending 31 March 2018

Barts Health NHS Trust
June 2018
Contents

Section                                      Page
1. Executive Summary                         3
2. Audit of the Accounts                    5
3. Value for Money conclusion               11
4. Quality Accounts                         15

Appendices
A  Reports issued and fees                  17

key Grant Thornton team members are:

Paul Grady
Engagement lead
T: 020 7728 2301
E: paul.d.grady@uk.gt.com

Paul Jacklin
Senior Manager
T: 020 7728 3263
E: paul.j.Jacklin@uk.gt.com

Parris Williams
Manager
T: 020 7728 2542
E: parris.Williams@uk.gt.com

Chloe Edwards
In Charge
T: 07983 633262
E: chloe.edwards@uk.gt.com
Executive Summary

Purpose
Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Barts Health NHS Trust (the Trust) for the year ended 31 March 2018.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 15 May 2018.

Respective responsibilities
We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

Our work

| Materiality | We determined materiality for the audit of the Trust's accounts to be £29,196k, which is 1.8% of the Trust's Gross Revenue Expenditure. |
| Financial Statements opinion | We gave an unqualified opinion on the Trust's financial statements on 24 May 2018. We included a going concern material uncertainty paragraph in our report on the Trust's financial statements to draw attention to the note which explains the basis on which the Trust has determined that it is still a going concern. This does not affect our opinion that the statements give a true and fair view of the Trust's financial position and its income and expenditure for the year. |
| NHS Group consolidation template (WGA) | We also reported on the consistency of the accounts consolidation template provided to NHS England with the audited financial statements. We concluded that these were consistent. |
| Use of statutory powers | We referred a matter to the Secretary of State, as required by section 30 of the Act, on 24 May 2018 because the Trust has not achieved a break-even position over the three year period ended 31 March 2018 |
Executive Summary

Value for Money arrangements

We were not satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources because of the Trust’s continued financial deficit position, the scale of the challenge in delivering the 2018/19 Cost Improvement Plan, and the risks present in the achievement of next year’s financial plans.

We therefore issued an adverse value for money conclusion in our audit report to the Trust on 24 May 2018.

Quality Accounts

We completed a review of the Trust’s Quality Account and issued our report on 29 June 2018. We concluded that the Quality Account and the indicators we reviewed were prepared in line with the Regulations and guidance.

Certificate

We certify that we have completed the audit of the accounts of Barts Health NHS Trust in accordance with the requirements of the Code of Audit Practice.

Working with the Trust

During the year we have delivered a number of successful outcomes with the Trust:

• An efficient audit – we delivered an efficient audit in May, delivering the accounts fieldwork in time to meet the 23 May 2018 audit and risk committee deadline, releasing the finance team for other work.

• Improved financial processes – we worked with the Trust to streamline processes including the fixed asset register and stock takes.

• Understanding the Trust’s operational health – through the value for money conclusion we provided the Trust with assurance on the operational effectiveness and highlighted the key areas for Board attention in 2018/19.

• Sharing our insight – we provided regular audit committee updates covering best practice. We also shared our thought leadership reports.

• Providing training – we provided finance teams with training on financial accounts and annual reporting.

• Providing assurance over data quality – we provided assurance over two indicators within the Trust’s Quality Accounts.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust’s management staff, and for the constructive relationships we have enjoyed.

Grant Thornton UK LLP
June 2018
Audit of the Accounts

Our audit approach

Materiality
In our audit of the Trust’s financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust’s financial statements to be £29,196,000, which is 1.8% of the Trust’s Gross Revenue Expenditure. We used this benchmark as, in our view, users of the Trust’s financial statements are most interested in where the Trust has spent its revenue in the year.

We set a lower threshold of £1,460,000, above which we reported errors to the Audit and Risk Committee in our Audit Findings Report.

The scope of our audit
Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:
- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the accounts included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust’s business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.
# Audit of the Accounts

## Significant Audit Risks

These are the significant risks which had the greatest impact on our overall strategy and where we focused more of our work.

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fraud in revenue recognition</strong></td>
<td>We have undertaken the following work:</td>
<td>The Trust were in dispute with NHS England (London) Specialised Commissioning regarding work undertaken on patients. The balance under dispute that is being decided by expert determination, and that the Trust have not provided for, is £7,237k. The outcome of the expert determination will not be known until later in the year, which is after the deadline for submitting the final audited accounts. As there was no certainty that this income would be paid, we considered the income in the accounts to be overstated by an uncertainty of £7,237k as at the year end. The Trust’s judgement after obtaining their own expert advice is that Trust are due this income and so have reflected this within the financial statements.</td>
</tr>
<tr>
<td>Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. Approximately 85% of the Trust income is from patient care activities and contracts with NHS commissioners and NHS England. These contracts include the rates for and level of patient care activity to be undertaken. The Trust recognise patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the accounts for these additional services that is not subsequently agreed to by the commissioners. We have identified the occurrence and accuracy of income from contract variations as a risk requiring special audit consideration.</td>
<td>• evaluated the Trust’s accounting policy for recognition income from patient care activities for appropriateness;  • gained an understanding of the Trust’s system for accounting for income from patient care activities and evaluated the design of the associated controls;  • compared the expected income to actual income received from commissioning bodies. Where variances are significant we tested a sample of credit notes and additional invoices to verify that the balances;  • reviewed the NHS agreement of balances tool to verify that the healthcare year end balances agree with commissioning bodies returns;  • tested a sample of healthcare revenues from private commissioners; and  • reviewed any year end provision against amounts billed to NHS institutions.</td>
<td></td>
</tr>
<tr>
<td><strong>Management override of controls</strong></td>
<td>We have undertaken the following work:</td>
<td>Our audit did not identify any material instances of management override of controls.</td>
</tr>
<tr>
<td>Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Trust face pressure to meet the deficit control total, and this could potentially place management under undue pressure in terms of how they report performance. We identified management override of controls as a risk requiring special audit consideration.</td>
<td>• review of accounting estimates, judgements and decisions made by management;  • testing of journal entries;  • review of accounting estimates, judgements and decisions made by management;  • review of unusual significant transactions; and  • review of significant related party transactions outside the normal course of business.</td>
<td></td>
</tr>
</tbody>
</table>
## Audit of the Accounts

### Significant Audit Risks – continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud in expenditure transactions.</td>
<td>We have undertaken the following work:</td>
<td>Our audit work did not identify any material issues in relation to expenditure recognition.</td>
</tr>
<tr>
<td>The expenditure cycle includes fraudulent transactions. Creditor balances are understated. Practice Note 10 suggests that the risk of material misstatement due to fraudulent financial reporting that may arise from the manipulation of expenditure recognition needs to be considered, especially where the Trust are required to meet targets.</td>
<td>• performed a walkthrough test of the payables system to gain assurance that the in-year controls were operating in accordance with our documented understanding; • verified that the operating expenses included within the financial statements are complete via review of the reconciliations between the Accounts Payable system and the General Ledger; • tested operating expenditure to verify cut-off has been correctly applied; • undertaken substantive testing procedures on all in year expenditure; and • tested year end creditor and accrual balances.</td>
<td></td>
</tr>
<tr>
<td>Going concern material uncertainty disclosures</td>
<td>Auditor commentary</td>
<td>The Trust has considered the materiality uncertainties in respect of going concern. Uncertainties in relation to the delivery of financial plans and anticipated cash flows were disclosed in note 1.1 to the financial statements.</td>
</tr>
<tr>
<td>As auditors, we are required to obtain sufficient appropriate audit evidence about the appropriateness of management’s use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity’s ability to continue as a going concern.</td>
<td>We have undertaken the following work:</td>
<td></td>
</tr>
<tr>
<td>The Trust made a £108 million financial deficit in delivering services in 2017/18 and are receiving financial revenue support via working capital loans. Management anticipates that it may take a few years before the Trust’s income equals or exceeds its expenditure. The Trust will therefore require further cash support via revenue loans to pay its expenses in 2018/19. The source and value of the loans has yet to be confirmed. We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust’s ability to continue as a going concern in the financial statements as a significant risk requiring special audit consideration.</td>
<td>• discussed the Trust’s financial standing with senior officers; • reviewed management’s assessment of the going concern assumptions and supporting information, e.g. 2018/19 and 2019/20 budgets and cash flow forecasts; • examined the terms of available cash support facilities; and • reviewed the completeness and accuracy of disclosures on material uncertainties with regard to going concern in the financial statements.</td>
<td></td>
</tr>
</tbody>
</table>

© 2018 Grant Thornton UK LLP | Annual Audit Letter | June 2018
## Significant Audit Risks – continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
</table>
| **Non-healthcare revenues**      | We have undertaken the following work:  
- performed a walkthrough test to gain assurance that the in-year controls were operating in accordance with our documented understanding;  
- selected a sample of non healthcare revenues across the financial year for detailed substantive testing;  
- verified that the non-healthcare revenue included within the financial statements are completed via review of the reconciliations between Accounts Receivable system and the General Ledger; and  
- tested non-healthcare revenues to verify cut-off has been correctly applied. | Our audit work did not any material issues in relation to non-healthcare revenues. |

Revenues fraudulently recognised.  
Recorded revenues and debtors not valid.

| Healthcare revenues | We have undertaken the following work:  
- performed a walkthrough test to gain assurance that the in-year controls were operating in accordance with our documented understanding;  
- compared the expected income to the actual income received from commissioning bodies. Where these variances are significant we will test a sample of credit notes and additional invoices to verify the figures in the accounts are accurate;  
- reviewed the NHS agreement of balances tool to verify that the healthcare year end balances agree with commissioning bodies’ returns;  
- tested a sample of healthcare revenues from private commissioners; and  
- reviewed the year end provision against amounts billed to NHS institutions | The Trust were in dispute with NHS England (London) Specialised Commissioning regarding work undertaken on patients. The balance under dispute that is being decided by expert determination, and that the Trust have not provided for, is £7,237k. The outcome of the expert determination will not be known until later in the year, which is after the deadline for submitting the final audited accounts. As there was no certainty that this income would be paid, we considered the income in the accounts to be overstated by an uncertainty of £7,237k as at the year end. The Trust’s judgement after obtaining their own expert advice is that Trust are due this income and so have reflected this within the financial statements. |

Accounting for contract arrangements with commissioning bodies not consistent with terms.
Audit of the Accounts

Significant Audit Risks – continued

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private Finance Initiative (PFI)</strong></td>
<td><strong>Auditor commentary</strong></td>
<td><strong>Our audit work did not any material issues in relation to the Private Finance Initiatives.</strong></td>
</tr>
<tr>
<td>The trust have embarked on the largest hospital redevelopment programme in Britain at the Barts and Royal London sites which are financed through PFI. In addition, the Trust has a PFI at Newham University Hospital. As these PFI transactions are significant, complex and involve a degree of subjectivity in the measurement of financial information we have categorised them as a significant risk</td>
<td>We have undertaken the following work:</td>
<td></td>
</tr>
<tr>
<td>• reviewed the PFI models and assumptions contained therein</td>
<td>• compared the PFI models to the previous year to identify any changes</td>
<td></td>
</tr>
<tr>
<td>• reviewed and tested the output produced by the PFI models to generate the financial balances within the financial statements</td>
<td>• reviewed the PFI disclosures to ensure they are consistent with the Manual For Accounts and the International Accountancy Standard IFRIC12</td>
<td></td>
</tr>
<tr>
<td>• checked the additional disclosures that are included within the financial statements to the PFI models.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Valuation of property, plant and equipment</strong></td>
<td><strong>We have undertaken the following work:</strong></td>
<td><strong>Our audit work did not any material issues in relation to Property Plant and Equipment</strong></td>
</tr>
<tr>
<td>The Trust revalues land and buildings on an annual basis to ensure that carrying value is not materially different from fair value. This represents a significant estimate by management in the accounts.</td>
<td>• review of management's processes and assumptions for the calculation of the estimate;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• review of the competence, expertise and objectivity of any management experts used;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• review of the instructions issued to valuation experts and the scope of their work;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• discussed with the Trust's valuer the basis on which the valuation was carried out, challenging the key assumptions;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• review and challenge of the information used by the valuer to ensure it was robust and consistent with our understanding;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• testing of revaluations made during the year to ensure they were input correctly into the asset register; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• evaluation of the assumptions made by management for those assets not revalued during the year and how management satisfied themselves that these were not materially different to current value.</td>
<td></td>
</tr>
</tbody>
</table>
Audit of the Accounts

Audit opinion
We gave an unqualified opinion on the Trust's financial statements on 24 May 2018, in advance of the national deadline.

Preparation of the accounts
The Trust presented us with draft accounts in accordance with the national deadline, and provided a good set of working papers to support them. The finance team were responsive, helpful and fully engaged with the audit process, and provided the majority of responses in line with agreed turnaround times.

Issues arising from the audit of the accounts
We reported the key issues from our audit to the Trust’s Audit and Risk Committee on 23 May 2018.
There were no amendments to the Trust’s financial statements that impacted on the Trust’s financial position. Amendments made to the financial statements were textual or presentational in nature.

Annual Report, including the Annual Governance Statement
We are also required to review the Trust’s Annual Report, including the Annual Governance Statement. The Trust provided these on a timely basis with the draft accounts with supporting evidence.

Whole of Government Accounts (WGA)
We issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any significant issues for the group auditor to consider.

Other statutory powers
We are also required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. On 24 May 2018 we reported to the Secretary of State that the Trust had not achieved a break even position over the three year period ended 31 March 2018.

Certificate of closure of the audit
We are also required to certify that we have completed the audit of the accounts of Barts Health NHS Trust in accordance with the requirements of the Code of Audit Practice.
Value for Money conclusion

**Background**
We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2017 which specified the criterion for auditors to evaluate:

*In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.*

**Key findings**
Our first step in carrying out our work was to perform a risk assessment and identify the key risks where we concentrated our work.

The key risks we identified and the work we performed are set out overleaf.

As part of our Audit Findings report agreed with the Trust in May 2018, we agreed recommendations to address our findings.

**Overall Value for Money conclusion**
Because of the significance of the matters we identified in our work, we were not satisfied that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018.
## Value for Money conclusion

### Key Value for Money Risks

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial outturn</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Trust’s 2017/18 control total was a planned deficit of £85m pre Sustainability and Transformational Funding (STF) and £46m post STF. At month 7 reporting an in-year deficit of £96.3m. A recovery plan has been implemented but this contains a net risk of £20m with uncertainty over the timing and value of Whitechapel property sales. Achieving the control total remains a challenge for the Trust as the full impact of Winter Pressures has yet to be substantiated and the Trust continue to back-end some of the CIP schemes.</td>
<td>We reviewed the Trust’s arrangements for putting together and agreeing budget savings and recovery plans including monitoring of delivery.</td>
<td>The Trust remains in Financial Special Measures and continues to work closely with NHS Improvement on a recovery plan, with the aim of reducing the deficit further while continuing to provide safe and compassionate services for patients. The Trust continues to make progress, but is yet to exit from clinical and financial special measures. The Trust is anticipating being released from these regimes during 2018/19. The Trust delivered a deficit of £108.3m. This is inclusive of £36.6m Sustainability and Transformation Funding (STF) and other non-recurrent measures, totalling £12.5m, which include movements due to balance sheet adjustments such as changes in partially completed spells estimates and year-end agreements with local commissioners. The shortfall of £2.8m against the revised control total deficit of £106m is due to the loss of STF income associated with the Trust not achieving the national A&amp;E performance target, and is in part offset by £6.4m of incentive STF (general distribution) and £1.5m of incentive STF (bonus) as notified by NHSI. The position before additional technical and Sustainability and Transformational Funding adjustments was a deficit of £144.9m which is in line with the £145m Pre STF control total.</td>
</tr>
<tr>
<td><strong>Cost improvement Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Trust have a cost improvement plan of £65m for 2017/18 with a significant proportion of schemes not being fully work up and risk rated and signed off by the start of the year. The Trust have consistently underachieved on targets in prior years.</td>
<td>We reviewed the Trust’s arrangements for identifying, setting, monitoring and reporting savings plans.</td>
<td>The Trust set a 2017-18 CIP target of a £65m (and had stretch CIP targets of £74.8) and delivered £60.7m. The total shortfall against the £65m target of £4.3m was mainly due to CIP shortfalls with Sites and Clinical Support services. The performance included some unexpected savings which were not included in the original plan such as reduced temporary staff premium of £2.8m, VAT recovery of £815k and a PFI credit for £800k. The delivery of £60.7m CIPs is inclusive of £16.8m (28%) non-recurrent savings, meaning that equivalent savings will need to be generated in 2018/19 to meet financial plans.</td>
</tr>
</tbody>
</table>
Value for Money conclusion

Key Value for Money Risks

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
</table>
| Financial sustainability          |                             | The Trust managed to achieve a year end deficit of £144.9m prior to STF (£108.3m including STF). In order to reduce the deficit from the underlying position of £139.8m (i.e. adding back £49m non recurrent in 17/18 and taking off year end savings impacting on next year £18.1m), the Trust is planning a £55.4m Cost Improvement Programme in 2018/19 and profit on disposal of assets of £60m that are expected early in the 2018/9 financial year. If successfully achieved the Trust would produce a deficit prior to STF of £56.8m in 2018/19, and the overall underlying deficit run rate would reduce to £134m. At the end of May 2018 the planned deficit for 2018/19 is £56.8m prior to STF. The key assumptions in achieving this position are:  
• Ensuring recurrent delivery of the 2017/18 recovery plan exit run rate – ensuring all budget holders deliver their agreed budgets  
• Achievement of a profit of £60m profit on disposal of fixed assets in 2018/19.  
• Receipt of Sustainability and Transformation Fund income of £54.9m.  
• Full achievement of the £55m Cost Improvement Plan, which represents 4% of turnover. |
| Care Quality Commission (CQC)     | We reviewed the CQC reports and the processes and arrangements that the Trust implement to respond to any findings. | The CQC reported that they were particularly encouraged by the improvements that have been made by the Trust since their inspections of 2016. As a result the Trust has achieved a significant milestone on their improvement journey by being uprated to ‘requires improvement’ as an organisation, two years after the regulators put the Trust into quality special measures. The Trust’s next step is to demonstrate it can sustain this progress, and exit special measures. In March the Trust published its medium-term plan to become ‘good’ and ultimately ‘outstanding’ across the board.  
The CQC reported that there were particular improvements in:  
• The number of domains within the core services that were inspected  
• Improvements in the governance framework of the Trust.  
• Embedding of the site based Leadership Operating Model.  
The Board fully understands that there is more work to be completed. Each hospital has its own improvement plan identifying what is needed to deliver high quality care. These reflect the Trust’s strategic direction of travel while also resolving all the specific ‘must dos’ and ‘should dos’ required and recommended by the CQC. There is a Trust-wide programme for each quality objective, led by clinicians within a governance framework to assure delivery. At corporate level, the quality board (which reports to the Quality Assurance Committee of the Trust Board) oversees the quality of services and identifies themes, trends and opportunities for sharing learning across the organisation. |
## Value for Money conclusion

### Key Value for Money Risks

<table>
<thead>
<tr>
<th>Risks identified in our audit plan</th>
<th>How we responded to the risk</th>
<th>Findings and conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ransomware</strong></td>
<td>We reviewed the results of the Trust’s investigation and the arrangements put in place to prevent any further attacks</td>
<td>The Trust computer systems were impacted by the Ransomware cyber attack on 12 May 2017. The attack impacted more than 200,000 organisations across 150 countries. A Major Incident was declared by the Trust in the afternoon on 12 May 2017 and NHS England (London team) was informed. The pre-planned Major Incident alert was cascaded to the Trust using pager and mobile phone alerts and 4 Silver Site based control rooms and a single overarching Trust Gold Command Room were set up. The Major Incident, Gold Command worked closely with NHS England (London) and neighbouring NHS Providers and Major Trauma Centres to put in place and review clinical diverts. Whilst this was taking place the Silver Commands under the oversight of Gold were ensuring that patient safety was not compromised and IT work arounds were effective. From 15th May with additional site presence staff were rolled out to sweep and patch PCs whilst ICT staff continued to cleanse IT network architecture and support patching of diagnostic modalities. Sites were progressively turned back on from 16 May to 19 May starting with Whipps Cross, followed by St Bartholomew’s, Royal London, Newham and Prescott Street and the major incident stood down on 24 May 2018. There was an urgent need to significantly remediate the defects in the Trust’s current ICT infrastructure. The Trust has undertaken a number of immediate remediation actions to secure the network as well as possible within the constraints caused by the age of the infrastructure, including further tightening of network control (to the limit of that which is possible), extensive patching of PC and other operating systems, and upgrading of anti-virus software. Restrictions on the use of the internet and heightened monitoring of the network is also in place. The Trust is implementing the lessons learnt from the internal and external review of the causes and response to the attack.</td>
</tr>
</tbody>
</table>

© 2018 Grant Thornton UK LLP | Annual Audit Letter | June 2018

Page 187 of 190
Quality Accounts

The Quality Account
The Quality Account is an annual report to the public from an NHS Trust about the quality of services it delivers. It allows Trust Boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work
We carry out an independent assurance engagement on the Trust's Quality Account, following Department of Health (DH) guidance. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Account is not prepared in line with set DH criteria;
- the Quality Account is not consistent with other documents, as specified in the DH guidance; and
- the two indicators in the Quality Account where we have carried out testing are not compiled in line with DH regulations and do not meet expected dimensions of data quality.

Quality Account Indicator testing
We tested the following indicators:

- Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period.
- Rate of Clostridium difficile infections ("CDIs") per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period.

For each indicator tested, we considered the processes used by the Trust to collect data for the indicator. We checked that the indicator presented in the Quality Account reconciled to underlying Trust data. We then tested a sample of cases included in the indicator to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation of the indicator was in accordance with the defined indicator definition.

Key messages
- with the requirements of the Regulations. We identified 3 requirements which had been omitted in the draft Quality Account. The Trust included these in the final version.
- We confirm that the Quality Account is not materially inconsistent with the sources specified in the Guidance.
- We found that the commentary on indicators in the Quality Account was not inconsistent with the reported outcomes.
- Our testing of two indicators included in the Quality Account found identified the following issues.
  - The percentage of patient safety incidents resulting in severe harm or death included in the draft quality report related to previous years. This information has since been updated for the 2017/18 figures and we have agreed these figures to the National Reporting Learning System (NRLS data).
  - The data supporting the rate of clostridium difficile infections required updating as the calculation included March 2017 which related to the previous year and the calculation did not agree to data submitted. The indicator has been amended.
- Based on the results of our procedures, nothing came to our attention that caused us to believe that the amended indicators were not reasonably stated in all material respects.

Conclusion
As a result of this we issued an unqualified conclusion on the Trust’s Quality Account on 29 June 2018.
A. Reports issued and fees

We confirm below our final reports issued and fees charged for the audit and provision of non-audit services

<table>
<thead>
<tr>
<th>Reports issued</th>
<th>Date issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Plan</td>
<td>February 2018</td>
</tr>
<tr>
<td>Audit Findings Report</td>
<td>May 2018</td>
</tr>
<tr>
<td>Annual Audit Letter</td>
<td>June 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fees for non-audit services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Audit related services</td>
</tr>
<tr>
<td>Review of the Trust’s Quality Account</td>
</tr>
</tbody>
</table>

Non-audit services

• For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.

• We have considered whether non-audit services might be perceived as a threat to our independence as the Trust’s auditor and have ensured that appropriate safeguards are put in place.

The above non-audit services are consistent with the Trust’s policy on the allotment of non-audit work to the auditor.
# TRUST CORPORATE POLICY

## STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS AND STANDING FINANCIAL INSTRUCTIONS

<table>
<thead>
<tr>
<th>APPROVAL</th>
<th>Barts Health Trust Board</th>
<th>Date approved:</th>
<th>14/09/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFECTIVE FROM</td>
<td>Date of approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISTRIBUTION</td>
<td>All Wards and Departments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RELATED DOCUMENTS**
- Standards of Business Conduct (COR/POL/003/2015-001)
- Disciplinary Policy, Procedure and Rules (COR/POL/009/2016-001)
- Employee Complaints and Grievance Policy (COR/POL/013/2016-001)
- Freedom of Information Act Policy (COR/POL/023/2015-001)
- Raising Concerns, Whistleblowing (COR/POL/005/2013-002)
- Risk Management Policy (COR/POL/004/2015-001)
- Fraud and Corruption Policy (COR/POL/064/2015-001)

**OWNER**
- Chief Financial Officer
- Trust Secretary

**AUTHOR/FURTHER INFORMATION**
- Chief Financial Officer
- Trust Secretary

**SUPERCEDED DOCUMENTS**
- (COR/POL/002/2015-001)

**REVIEW DUE**
- Three years from date of approval

**INTRANET LOCATION(S)**
- [http://bartshealthintranet/Policies/Policies.aspx](http://bartshealthintranet/Policies/Policies.aspx)

**CONSULTATION**
- Barts Health Working Groups
- Audit and Risk Committee
- Trust Board
- External Partner(s) -

**APPLICATION**
- Included in policy:
  - For the groups listed below, compliance with this policy is a contractual requirement and failure to follow the policy may result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees, and other action in relation to organisations contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement.
- All Trust staff, working in whatever capacity
- Other staff, students and contractors working within the Trust

**Exempted from policy:**
- No staff groups are exempt from this policy.
FOREWORD AND APPLICATION

The Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, which all NHS trusts are required to produce, have been compiled in accordance with the requirements and provisions of the NHS and Community Care Act 1990 and are based on the model document issued by the Department of Health and Social Care in March 2006.

The Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions together provide a regulatory framework for the business conduct of the Trust. They represent the governing instruments of the Trust, upon which all Trust policies, guidelines and procedures are founded and shall be reviewed annually by the Trust.

The policy applies to all those working in the Trust, in whatever capacity. A failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement.

Together with the Disciplinary Policy, Maintaining High Professional Standards policy and the Grievance Policy and Procedure, the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions make up the Trust's Articles of Corporate Governance.
**CONTENTS**

**SECTION A**

**INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS**

10

**SECTION B: STANDING ORDERS**

1. **INTRODUCTION**

1.1 Statutory Framework 12
1.2 NHS Framework 12
1.3 Delegation of Powers 13
1.4 Integrated Governance 13

2. **THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS**

2.1 Composition of the membership of the Trust Board 13
2.2 Appointment of Chairman and Members of the Trust 13
2.3 Terms of Office of the Chairman and Members 14
2.4 Appointment and Powers of Vice Chairman 14
2.5 Joint Members 14
2.6 Healthwatch 15
2.7 Role of Members 15
2.8 Disqualification from Appointment as Chairman or Non-Executive director 16
2.9 Cessation of Disqualification 17
2.10 Corporate Role of the Board 18
2.11 Schedule of Matters Reserved to the Board and Scheme of Delegation 18
2.12 Lead Roles for Board Members 18

3. **MEETINGS OF THE TRUST**

3.1 Calling Meetings 18
3.2 Notice of Meetings and the Business to be Transacted 18
3.3 Agenda and Supporting Papers 19
3.4 Petitions 19
3.5 Notice of Motion 19
3.6 Emergency Motions 19
3.7 Motions: Procedure at and during a Meeting 19
3.8 Motion to Rescind a Resolution 21
3.9 Chairman of Meeting 21
3.10 Chairman’s Ruling 21
3.11 Quorum 21
3.12 Voting 22
3.13 Suspension of Standing Orders 22
3.14 Waiver, Variation and Amendment of Standing Orders 23
3.15 Reporting of Waivers of Standing Orders and Standing Financial Instructions 23
3.16 Record of Attendance 23
3.17 Secretariat and Minutes 23
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.18</td>
<td>Attendance at Meetings and Admission of Public and the Press</td>
<td>23</td>
</tr>
<tr>
<td>3.19</td>
<td>Annual Public Meeting</td>
<td>24</td>
</tr>
<tr>
<td>4.</td>
<td><strong>APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES</strong></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Appointment of Committees</td>
<td>25</td>
</tr>
<tr>
<td>4.2</td>
<td>Joint Committees</td>
<td>25</td>
</tr>
<tr>
<td>4.3</td>
<td>Applicability of Standing Orders and Standing Financial Instructions to Committees</td>
<td>25</td>
</tr>
<tr>
<td>4.4</td>
<td>Terms of Reference</td>
<td>25</td>
</tr>
<tr>
<td>4.5</td>
<td>Delegation of powers by Committees to Sub-Committees</td>
<td>25</td>
</tr>
<tr>
<td>4.6</td>
<td>Approval of Appointments to Committees</td>
<td>25</td>
</tr>
<tr>
<td>4.7</td>
<td>Appointments for Statutory Functions</td>
<td>26</td>
</tr>
<tr>
<td>4.8</td>
<td>Committees Established by the Trust Board</td>
<td>26</td>
</tr>
<tr>
<td>4.9</td>
<td>Confidential Proceedings</td>
<td>27</td>
</tr>
<tr>
<td>5.</td>
<td><strong>ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION</strong></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Delegation of Functions to Committees, Officers or Other Bodies</td>
<td>27</td>
</tr>
<tr>
<td>5.2</td>
<td>Emergency Powers and Urgent Decisions</td>
<td>28</td>
</tr>
<tr>
<td>5.3</td>
<td>Delegation of Committees</td>
<td>28</td>
</tr>
<tr>
<td>5.4</td>
<td>Delegation to Officers</td>
<td>28</td>
</tr>
<tr>
<td>5.5</td>
<td>Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers</td>
<td>29</td>
</tr>
<tr>
<td>5.6</td>
<td>Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions</td>
<td>29</td>
</tr>
<tr>
<td>6.</td>
<td><strong>OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Policy Statements: General Principles</td>
<td>29</td>
</tr>
<tr>
<td>6.2</td>
<td>Specific Policy Statements</td>
<td>29</td>
</tr>
<tr>
<td>6.3</td>
<td>Standing Financial Instructions</td>
<td>30</td>
</tr>
<tr>
<td>6.4</td>
<td>Specific Guidance</td>
<td>30</td>
</tr>
<tr>
<td>7.</td>
<td><strong>DUTIES AND OBLIGATIONS OF BOARD MEMBERS, MEMBERS, DIRECTORS AND SENIOR MANAGERS UNDER THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td>Declaration of Interests</td>
<td>30</td>
</tr>
<tr>
<td>7.2</td>
<td>Advice on Interests</td>
<td>31</td>
</tr>
<tr>
<td>7.3</td>
<td>Recording of Interests in Trust Board minutes</td>
<td>31</td>
</tr>
<tr>
<td>7.4</td>
<td>Publication of Declared Interests in Annual Report</td>
<td>31</td>
</tr>
<tr>
<td>7.5</td>
<td>Conflicts of Interest which Arise During the Course of a Meeting</td>
<td>31</td>
</tr>
<tr>
<td>7.6</td>
<td>Register of Interests</td>
<td>31</td>
</tr>
<tr>
<td>7.7</td>
<td>Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest</td>
<td>32</td>
</tr>
<tr>
<td>7.8</td>
<td>Waiver of Standing Orders made by the Secretary of State for Health</td>
<td>33</td>
</tr>
<tr>
<td>7.9</td>
<td>Failure to Declare an Interest</td>
<td>34</td>
</tr>
</tbody>
</table>
CONTENTS

7.10 Standards of Business Conduct 34
7.11 Acceptance of Gifts and Donations 35

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS
8.1 Custody of Seal 36
8.2 Sealing of Documents 36
8.3 Register of Sealings 37
8.4 Signature of Documents 37

9. MISCELLANEOUS
9.1 Joint Finance Arrangements 37
9.2 Conflict 37
9.3 Report on Trust Performance 37
Appendix A: Nolan Principles of Public Life 38
Appendix B: Codes of Conduct and Accountability for NHS Boards 39

SECTION C: RESERVATION and DELEGATION of POWERS

Scheme of Reservation 47
Decisions Reserved to the Board 47
Delegation by Board to Committees 51
Schemes of Delegation Derived from the Accountable Officer 53
Schemes of Delegation Derived from the Codes of Conduct and Accountability 55
Scheme of Delegation from Standing Orders 58
Other Delegated Functions 60
Scheme of Delegation from Standing Financial Instructions 62
Scheme of Delegation New Hospitals Programme 76

SECTION D: STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION
10.1 General 78
10.2 Responsibilities and delegation 78
10.2.1 The Trust Board 78
10.2.4 The Chief Executive and Chief Financial Officer 79
10.2.6 The Chief Financial Officer 79
10.2.7 Board Members and Employees 79
10.2.8 Contractors and their employees 80

11. AUDIT
11.1 Audit and Risk Committee 80
11.2 Chief Financial Officer 81
11.3 Role of Internal Audit 82
11.4 External Audit 83
11.5 Fraud, Bribery and Corruption 83
11.6 Security Management 83
# CONTENTS

## 12. ALLOCATIONS, PLANNING, BUDGETS, AND MONITORING

**BUDGETARY CONTROL**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Preparation and Approval of Plans and Budgets</td>
<td>83</td>
</tr>
<tr>
<td>12.2</td>
<td>Budgetary Delegation</td>
<td>84</td>
</tr>
<tr>
<td>12.3</td>
<td>Non-Budget Expenditure</td>
<td>85</td>
</tr>
<tr>
<td>12.4</td>
<td>Capital Expenditure</td>
<td>85</td>
</tr>
<tr>
<td>12.6</td>
<td>Budget Control and Reporting</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Monitoring Returns</td>
<td>86</td>
</tr>
</tbody>
</table>

## 13. ANNUAL ACCOUNTS AND REPORTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>The Chief Financial Officer</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Appointment of Auditors</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Annual Report</td>
<td>87</td>
</tr>
</tbody>
</table>

## 14. BANK AND GBS ACCOUNTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>General</td>
<td>87</td>
</tr>
<tr>
<td>14.2</td>
<td>Bank and GBS Accounts</td>
<td>87</td>
</tr>
<tr>
<td>14.3</td>
<td>Banking Procedures</td>
<td>88</td>
</tr>
<tr>
<td>14.4</td>
<td>Tendering and Review</td>
<td>88</td>
</tr>
<tr>
<td>14.5</td>
<td>Signatories</td>
<td>88</td>
</tr>
<tr>
<td>14.6</td>
<td>Charitable Fund/Special Trustees</td>
<td>88</td>
</tr>
<tr>
<td>14.7</td>
<td>External Borrowing</td>
<td>88</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1</td>
<td>Income Systems</td>
<td>89</td>
</tr>
<tr>
<td>15.2</td>
<td>Fees and Charges</td>
<td>89</td>
</tr>
<tr>
<td>15.3</td>
<td>Debt Recovery</td>
<td>89</td>
</tr>
<tr>
<td>15.4</td>
<td>Security of Cash, Cheques and other Negotiable Instruments</td>
<td>89</td>
</tr>
</tbody>
</table>

## 16. TENDERING AND CONTRACTING PROCEDURE

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1</td>
<td>Duty to comply with Standing Orders and Standing Financial Instructions</td>
<td>90</td>
</tr>
<tr>
<td>16.2</td>
<td>EU Directives Governing Public Procurement</td>
<td>91</td>
</tr>
<tr>
<td>16.3</td>
<td>Reverse e-Auctions</td>
<td>91</td>
</tr>
<tr>
<td>16.4</td>
<td>Capital Investment Manual and other Department of Health and Social Care guidance</td>
<td>91</td>
</tr>
<tr>
<td>16.5</td>
<td>Formal Competitive Tendering</td>
<td>91</td>
</tr>
<tr>
<td>16.5.1</td>
<td>General Applicability</td>
<td>92</td>
</tr>
<tr>
<td>16.5.3</td>
<td>Health Care Services</td>
<td>92</td>
</tr>
<tr>
<td>16.5.4</td>
<td>Exceptions and instances where formal tendering need not be applied</td>
<td>94</td>
</tr>
<tr>
<td>16.5.5</td>
<td>Fair and Adequate Competition</td>
<td>95</td>
</tr>
<tr>
<td>16.5.6</td>
<td>Building and Engineering Construction Works Approved Firms</td>
<td>95</td>
</tr>
<tr>
<td>16.5.7</td>
<td>Items which subsequently breach thresholds after original approval</td>
<td>95</td>
</tr>
<tr>
<td>16.6</td>
<td>Contracting/Tendering Procedure</td>
<td>95</td>
</tr>
<tr>
<td>16.6.1</td>
<td>Invitation to tender</td>
<td>95</td>
</tr>
<tr>
<td>16.6.2</td>
<td>Receipt and safe custody of tenders</td>
<td>96</td>
</tr>
<tr>
<td>16.6.3</td>
<td>Opening tenders and Register of tenders</td>
<td>96</td>
</tr>
</tbody>
</table>
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.6.4</td>
<td>Retention Tender Documents</td>
</tr>
<tr>
<td>16.6.5</td>
<td>Admissibility of Tenders</td>
</tr>
<tr>
<td>16.6.6</td>
<td>Acceptance of formal tenders</td>
</tr>
<tr>
<td>16.6.7</td>
<td>List of approved firms Building and Engineering Construction Work</td>
</tr>
<tr>
<td>16.6.8</td>
<td>Exceptions to using approved contractors</td>
</tr>
<tr>
<td>16.7</td>
<td>Quotations: Competitive and Non-Competitive</td>
</tr>
<tr>
<td>16.7.1</td>
<td>Competitive Quotations</td>
</tr>
<tr>
<td>16.7.2</td>
<td>Non-Competitive Quotations</td>
</tr>
<tr>
<td>16.7.3</td>
<td>Quotations to be within Financial Limits</td>
</tr>
<tr>
<td>16.8</td>
<td>Authorisation of Tenders and Competitive quotations</td>
</tr>
<tr>
<td>16.9</td>
<td>Instances where formal competitive tendering or competitive quotation is not required</td>
</tr>
<tr>
<td>16.10</td>
<td>Private finance for capital procurement (see overlap with SFI No. 24)</td>
</tr>
<tr>
<td>16.11</td>
<td>Compliance requirements for all contracts</td>
</tr>
<tr>
<td>16.12</td>
<td>Personnel and Agency or temporary staff contracts</td>
</tr>
<tr>
<td>16.13</td>
<td>Cancellation of Contracts</td>
</tr>
<tr>
<td>16.14</td>
<td>Determination of contracts for failure to deliver goods or materials and liquidated damages</td>
</tr>
<tr>
<td>16.15</td>
<td>National Contracts</td>
</tr>
<tr>
<td>16.16</td>
<td>Healthcare Services Agreement</td>
</tr>
<tr>
<td>16.17</td>
<td>Disposals</td>
</tr>
<tr>
<td>16.18</td>
<td>In-house services</td>
</tr>
<tr>
<td>16.19</td>
<td>Research and Development</td>
</tr>
<tr>
<td>16.20</td>
<td>ICT Procurement</td>
</tr>
<tr>
<td>16.21</td>
<td>Leases</td>
</tr>
</tbody>
</table>

### 17. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.1</td>
<td>Service Level Agreements (SLAs)</td>
</tr>
<tr>
<td>17.2</td>
<td>Involving Partners and Jointly Managing Risk</td>
</tr>
<tr>
<td>17.3</td>
<td>Reports to Board on SLAs</td>
</tr>
</tbody>
</table>

### 18. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EMPLOYEES

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.1</td>
<td>Remuneration And Terms Of Service</td>
</tr>
<tr>
<td>18.2</td>
<td>Funded Establishment</td>
</tr>
<tr>
<td>18.3</td>
<td>Staff Appointments</td>
</tr>
<tr>
<td>18.4</td>
<td>Processing Payroll</td>
</tr>
<tr>
<td>18.5</td>
<td>Contracts Of Employment</td>
</tr>
<tr>
<td>18.6</td>
<td>Ex-Gratia Payments</td>
</tr>
<tr>
<td>18.7</td>
<td>Managers Responsibility</td>
</tr>
</tbody>
</table>

### 19. NON-PAY EXPENDITURE (see overlap with SFI No. 17)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1</td>
<td>Delegation Of Authority</td>
</tr>
<tr>
<td>19.2</td>
<td>Choice, requisitioning, Ordering, Receipt and Payment for Goods and Service</td>
</tr>
<tr>
<td>19.3</td>
<td>Joint Finance Arrangements with Local Authorities and Voluntary Bodies</td>
</tr>
<tr>
<td>19.4</td>
<td>Responsibilities of All Employees</td>
</tr>
<tr>
<td>19.5</td>
<td>Supplies</td>
</tr>
<tr>
<td>19.6</td>
<td>Petty Cash</td>
</tr>
</tbody>
</table>
CONTENTS

20. EXTERNAL BORROWING
   20.1 General 116
   20.2 Investments 117

21. FINANCIAL FRAMEWORK
   21.1.1 Chief Financial Officer 117

22. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS
   22.1 Capital Investment 117
   22.2 Private Finance 119
   22.3 Asset Registers 119
   22.4 Security Of Assets 120

23. STORES AND RECEIPT OF GOODS
   23.1 General Position 120
   23.2 Control Of Stores, Stocktaking, condemnations and disposal 121
   23.3 Goods Supplied by NHS Supply Chain 122

24. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENT
   24.1 Disposal and Condemnations 122
   24.2 Losses and Special payments 122

25. INFORMATION TECHNOLOGY
   25.1 Responsibilities and Duties of the Chief Financial Officer 123
   25.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application 124
   25.3 Contracts for Computer Services with other health bodies or outside agencies 124
   25.4 Risk Assessment 124
   25.5 Requirements for Computer Systems which have an impact on Corporate Financial Systems. 125

26. PATIENTS’ PROPERTY
   26.1 General 125
   26.2 Chief Executives Responsibilities 125
   26.3 Management of Property 125

27. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT
   27.1 Chief Financial Officer Responsibilities 126

28. RETENTION OF RECORDS
   28.1 Chief Executives Responsibilities 126
   28.2 General 126
   28.3 Records Destruction 126
## CONTENTS

<table>
<thead>
<tr>
<th>29. RISK MANAGEMENT AND INSURANCE</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.1 Programme of Risk Management</td>
<td>127</td>
</tr>
<tr>
<td>29.2 Insurance: Risk Pooling Schemes administered by NHSLA</td>
<td>127</td>
</tr>
<tr>
<td>29.3 Insurance arrangements with commercial Insurers</td>
<td>127</td>
</tr>
<tr>
<td>29.4 Arrangements to be followed by the Board in agreeing Insurance cover</td>
<td>128</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30. FUNDS HELD ON TRUST</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.1 General</td>
<td>128</td>
</tr>
<tr>
<td>30.2 Establishment of charitable funds by the Trust</td>
<td>128</td>
</tr>
<tr>
<td>30.2.1 Accountability to Charity Commission and Secretary of State for Health</td>
<td>128</td>
</tr>
<tr>
<td>30.2.2 Applicability of Standing Financial Instructions to funds held on trust</td>
<td>128</td>
</tr>
</tbody>
</table>

## SCHEDULES TO STANDING FINANCIAL INSTRUCTIONS

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Bank accounts and GBS accounts</td>
<td>129</td>
</tr>
<tr>
<td>II Non pay expenditure</td>
<td>130</td>
</tr>
<tr>
<td>III Losses and special payments</td>
<td>132</td>
</tr>
</tbody>
</table>
SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 "Accountable Officer" means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 “Appointing Authority” means the Secretary of State for Health, NHS Improvement or the relevant body or committee appointing the director.

1.2.3 "Trust" means Barts Health NHS Trust.

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

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

1.2.6 “Budget holder” means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

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

1.2.8 "Chief Executive" means the chief officer of the Trust.

1.2.9 “Quality Assurance Committee” means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which Barts Health NHS Trust has responsibility.

1.2.10 "Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.11 "Committee" means a committee or sub-committee created and appointed by the Trust.
"Committee members" means persons formally appointed by the Board to sit on or to chair specific committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Chief Financial Officer" means the Chief Financial Officer of the Trust.

"Executive director" means a member of the Trust Board who is an officer of the Trust.

"Charitable funds" shall mean those funds which are associated to the Trust and administered by Barts Charity and any charitable funds held and administered by the Trust.

"Member" means Executive or Non-Executive director of the Board as the context permits. Member in relation to the Board does not include its Chairman.

“Associate Member” means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

"Membership, Procedure and Administration Arrangements Regulations" means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive director" means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

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

"Officer member" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

"Secretary" means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders and Department of Health and Social Care guidance. The Trust Secretary performs this function on behalf of Barts Health NHS Trust.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"Vice Chairman" means the Non-Executive director appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason.
Any references in this document to one gender alone are made for ease of reference only and should be read as equally applicable to both male and female persons.
SECTION B: STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

Barts Health National Health Service Trust is a statutory body which came into existence on 1 April 2012 under The Barts Health National Health Service Trust (Establishment) and the Barts and The London National Health Service Trust, the Newham University Hospital National Health Service Trust and the Whips Cross University Hospital National Health Service Trust (Dissolution) Order 2012 (SI 2012 No. 796).

(1) The principal place of business of the Trust is the Trust Offices, Pathology and Pharmacy, The Royal London Hospital, 80 Newark St, London E1 2ES.


(3) The functions of the Trust are conferred by this legislation.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(6) The Code of Accountability for NHS Boards (see Appendix B) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements, the Secretary of State through the Department of Health and Social Care issues further directions and guidance.

(2) The Code of Accountability (see Appendix B) requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Freedom of Information Act sets out the requirements for public access to information on the NHS.
1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order (SO) relating to the Arrangements for the Exercise of Trust Functions by Delegation (SO 5), the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of SO 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct".

Reservation of Powers to the Board and Delegation of Powers are covered in Section C. These documents have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information, education and research governance. Guidance from the Department of Health and Social Care on the move toward and implementation of integrated governance has been issued and has been incorporated in the Trust's governance framework and committee structure. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Trust's Establishment Order (see SO1.1) and the Membership, Procedure and Administration Arrangements regulations, the composition of the Board shall be:

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

(2) 7 Non-Executive directors (excluding the Chairman, and appointed by NHS Improvement). This will include one Non-Executive director appointed from Queen Mary Westfield University of London (QMUL);

(3) 5 Executive directors including:

- The Chief Executive;
- The Chief Financial Officer;
- A Medical or Dental Practitioner; and
- A Registered Nurse or Midwife, as defined in Section 10(7) of the Nurses, Midwives and Health Visitors Act 1979(a).

2.2 Appointment of Chairman and Members of the Trust

(1) Appointment of the Chairman and Members of the Trust - Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman is appointed by the Secretary of State upon the advice of NHS Improvement, but otherwise the appointment and tenure of office of the
Chairman and members are set out in the Membership, Procedure and Administration Arrangements Regulations, and subsequent amendments.

2.3 Terms of Office of the Chairman and Members

(1) The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

(2) The tenure of office for directors shall be:

(a) Chairman and Non-Executive directors – as determined by NHS Improvement, but usually for a maximum period of four years, which may be renewable, subject to the provisions of SO 2.8.

(b) Chief Executive and Chief Financial Officer – for the period of their employment in those posts.

(c) Other Executive directors – for such period as specified by the Appointing Authority or as long as they hold a post in the Trust.

(3) The Chairman or a Non-Executive director may resign his/her office at any time during the period for which they were appointed by giving notice in writing to the Appointing Authority.

(4) Where a Non-Executive director is appointed to be the Chairman of the Trust, his/her tenure of office as a Non-Executive director shall terminate when his/her appointment as Chairman takes effect.

2.4 Appointment and Powers of Vice Chairman

(1) Subject to SO 2.4(2) below, for the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman, the Chairman and members of the Trust shall appoint a Non-Executive director from among them to be Vice Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him/her.

(2) Any member so appointed may at any time resign from the office of Vice Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another Non-Executive director as Vice Chairman in accordance with the provisions of Standing Order 2.4(1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice Chairman.

(4) The Chairman and members of the Trust shall appoint one of the independent Non-executive Directors to be the Senior Independent Director (see SO 2.7(6)). The Senior Independent Director could be the Vice Chairman.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements
Regulations, those persons shall count for the purpose of SO 2.1 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

(a) Either or both of those persons may attend or take part in meetings of the Board;
(b) If both are present at a meeting they should cast one vote if they agree;
(c) In the case of disagreements no vote should be cast; and
(d) The presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.11 (Quorum).

2.6 Healthwatch

The Health and Social Care Act 2012 required local authorities to establish Healthwatches as social enterprises, replacing previous Local Involvement Networks (LINks), from April 2013. Healthwatches are made up of users of local health and social services and members of the public who work together to influence and challenge how local health and social care services are provided. Healthwatches are independent of the local authority and health services.

2.7 Role of Members

The Board will function as a corporate decision-making body. Executive and Non-Executive directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. All Board members shall subscribe to the Nolan Committee’s Seven Principles of Public Life (see Appendix A) and the Codes of Conduct and Accountability for NHS Boards (see Appendix B).

(1) Executive directors

Executive directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation. Executive directors are normally employees of the Trust. However, a person holding a post in a university or a person seconded to work for the Trust may be appointed as an Executive director. Executive directors (apart from the Chief Executive and the Chief Financial Officer) may be removed from the Trust Board if, in the view of the appointing committee, it is not in the interest of the Trust for them to continue as a Director. If any Executive director is suspended from his post with the Trust, he will also be suspended from being a director for the period of his suspension.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) Chief Financial Officer

The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief
Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive directors**
The Non-Executive directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chairman**
The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers and must comply with the terms of appointment and with these Standing Orders. The Chairman shall liaise with the NHS Improvement over the appointment of the Non-Executive directors and, once appointed, shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

(6) **Senior Independent Director**
The Senior Independent Director shall be available to hear any issues or concerns that individuals feel unable to raise with the Chairman or any Executive Director.

2.8 **Disqualification from Appointment as Chairman or Non-Executive director**

(1) The following people are disqualified from appointment as the Chairman or Non-Executive directors:

- **Employees** of the NHS Trust with the vacancy
- **serving MPs** – including MEPs and candidates for election as MP or MEP.
- **Other circumstances:**
  - People who have received a prison sentence or suspended sentence of 3 months or more in the last 5 years;
  - People who are the subject of a bankruptcy restriction order or interim order;
  - Anyone who has been dismissed (except by redundancy) by any NHS body;
  - In certain circumstances, those who have had an earlier term of appointment terminated;
  - Anyone who is under a disqualification order under the Company Directors Disqualification Act 1986;
  - Anyone who has been removed from trusteeship of a charity;
- **In most circumstances, Civil Servants within the Department of Health and Social Care, or members/employees of the Care Quality Commission**
- **If you are a chair or member of the governing body of a clinical commissioning group – or an employee of such group**

The above disqualification criteria, also applies to those appointed to Chair posts with the addition of:
People who perform or provide primary dental services, primary medical services or primary ophthalmic services under the National Health Service Act 2006;
People who are partners or are in a partnership, or are legal and beneficial owners of shares in a company that, or a director of a body corporate that provides primary dental services, primary medical services or primary ophthalmic services;
Employees of any of the above

(2) If a Healthwatch member is appointed as a Non-Executive director of the Trust, he/she becomes disqualified from membership of the Healthwatch.

(3) Where the Non-Executive director drawn from Queen Mary Westfield University of London ceases to hold a post in the University, NHS Improvement shall terminate his/her appointment.

(4) The House of Commons Disqualification Act 1975, as amended by the National Health Service and Community Care Act 1990, prevents the Trust Chairman or any Non-Executive director from contesting an election to Parliament or from being a Member of Parliament. If a Non-Executive director is selected as a prospective parliamentary candidate, they must tender their resignation as a Non-Executive director with immediate effect.

(5) Where the Chairman or Non-Executive director has been appointed:

(a) If he become disqualified under SO 2.8(1), the Appointing Authority shall notify him in writing forthwith, or

(b) If he was so disqualified at the time of his appointment he shall be notified in writing that he was not duly appointed.

(6) The Secretary of State will terminate the term of office of the Chairman or a Non-Executive director who has not attended a meeting of the Trust for six months without reasonable cause. The appointing authority may, with the consent of NHS Improvement when necessary, terminate the appointment of the Chairman or a Non-Executive director if it considers that the individual's continuation in office would not be in the interests of the NHS.

(7) If it appears to NHS Improvement that the Chairman or a Non-Executive director has failed to comply with SO 7.1 (declaration of interests), they may terminate immediately his/her tenure of office.

2.9 Cessation of Disqualification

(1) Where a person is disqualified by reason of having been adjudged bankrupt this disqualification shall cease if:

(a) The bankruptcy is annulled on the ground that he ought not to have been adjudged bankrupt or on the ground that his debts have been paid in full, the disqualification shall cease on the date of the annulment; or

(b) He is discharged when the disqualification shall cease on the date of his discharge.

(2) Where a person is disqualified by reason of having made a composition or arrangement with his creditors, if he pays his debts in full the disqualification shall cease on the date on which the payment is completed. In any other case it shall
cease in the expiry of five years from the date on which the terms of the deed of composition or arrangement are fulfilled.

(3) Subject to SO 2.9(4), where person is disqualified as an employee he may, after the expiry period of not less than two years, apply in writing to the Secretary of State to remove the disqualification and the Secretary of State may direct that disqualification shall cease.

(4) Where the Secretary of State refuses an application to remove a disqualification no further application may be made by that person until expiration of two years from the date of the application.

(5) Where a person is disqualified as a Chairman or director by reason of appointments: where such appointments have been terminated, the disqualification shall cease on the expiry of a period of two years or such longer period as the Appointing Authority specifies when terminating his period of office but the Secretary of State may on application being made to him by that person or by that appointing authority, reduce the period of disqualification.

2.10 Corporate Role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in SO 3.

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

2.11 Schedule of Matters reserved to the Board and Scheme of Delegation

(1) The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the ‘Schedule of Matters Reserved to the Board’ and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation. Both are set out in Section C.

2.12 Lead Roles for Board Members

(1) The Chairman will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control).

3. MEETINGS OF THE TRUST

3.1 Calling Meetings

(1) Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Board may determine.

(2) The Chairman of the Trust may call a meeting of the Board at any time.
(3) One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

(1) Before each meeting of the Trust Board, a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. The validity of a meeting shall not be affected, however, by lack of service of notice on any person.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under SO 3.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman or the Trust Secretary at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

(5) Trust Board papers must be written in the required Trust Board format and be submitted to the Trust Office at least 10 clear days before the date of the Trust Board meeting to facilitate timely distribution of the papers. The Trust Secretary has the delegated authority of the Trust Board to remove an item from the agenda if not received in time or to a suitable standard.

(6) Details of Board meetings shall be displayed at the Trust's principal offices and on the Trust website at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened, as required by the Public Bodies (Admission to Meetings) Act 1960.

3.3 Agenda and Supporting Papers

(1) The Agenda will be sent to members at least 5 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency. Copies of the agenda and papers for meetings to be held in public will be placed on the Trust's website in advance of the meetings.

3.4 Petitions

(1) Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Trust Board.

3.5 Notice of Motion

(1) Subject to the provision of SO 3.7 and SO 3.8, a member of the Trust Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(2) The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are
in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of SO 3.7, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and During a Meeting

(1) Who may propose
A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

(2) Contents of motions
The Chairman may exclude from the debate at his/her discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(a) The reception of a report.
(b) Consideration of any item of business before the Trust Board.
(c) The accuracy of minutes.
(d) That the Board proceed to next business.
(e) That the Board adjourn.
(f) That the question be now put.

(3) Amendments to motions
A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(4) Rights of reply to motions

(a) Amendments
The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(b) Substantive/original motion
The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

(5) Withdrawing a motion
A motion, or an amendment to a motion, may be withdrawn.

(6) Motions once under debate
When a motion is under debate, no motion may be moved other than:

(a) An amendment to the motion.
(b) The adjournment of the discussion, or the meeting.
(c) That the meeting proceed to the next business.
(d) That the question should be now put.
(e) The appointment of an ‘ad hoc’ committee to deal with a specific item of business.
(f) That a member/director be not further heard.
(g) A motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public, including the press (see SO 3.18).

(7) In those cases where the motion is either that the meeting proceeds to the ‘next business’ or ‘that the question be now put’ in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

(8) If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of Meeting

(1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice Chairman (if the Board has appointed one), if present, shall preside.

(2) If the Chairman and Vice Chairman are both absent, the remaining Board members shall choose a Non-Executive director from among their number to act as Chair. An Executive director cannot take the chair.

(3) If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Vice Chairman, if present, shall preside. If the Chairman and Vice Chairman are absent, or are disqualified from participating, the remaining Board members shall choose a Non-Executive director from among their number to act as Chair.

3.10 Chairman’s Ruling

(1) The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum
No business shall be transacted at a meeting unless at least one third of the whole number of the Chairman and members (including at least two Executive directors and two Non-Executive directors) is present.

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

If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO 7.3) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The above requirement for at least two Executive directors to form part of the quorum shall not apply where the Executive directors are excluded from a meeting.

If after 15 minutes from the time appointed for a meeting of the Trust Board to take place no quorum is present, then there shall be no meeting. Likewise, if during a meeting the Chairman, after counting the number of directors present, declares that there is no quorum, the meeting shall stand adjourned to a time arranged by the Chairman or to the next ordinary meeting of the Trust Board.

3.12 Voting

Save as provided for in SO 3.13 and SO 3.14, every question put to a vote at a meeting shall be determined by a majority of the votes of the Chairman and members present and voting on the question. In the case of an equal vote, the person presiding, i.e. the Chairman of the meeting, shall have a second or casting vote.

At the discretion of the Chairman of the meeting, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

If a member so requests, his/her vote shall be recorded by name (except when conducted by paper ballot).

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

A manager who has been formally appointed 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.

A manager attending the Trust Board meeting 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.

For the voting rules relating to joint members see SO 2.5.
3.13 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two thirds of the whole number of the members of the Board are present (including at least one Executive director and one Non-Executive director of the Trust) and that at least two thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(2) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

(3) No formal business may be transacted while Standing Orders are suspended.

(4) The Audit and Risk Committee shall review every decision to suspend Standing Orders.

3.14 Waiver, variation and amendment of Standing Orders

(1) These Standing Orders shall not be waived or varied except in the following circumstances:

(a) Upon a notice of motion under SO 3.5.
(b) Upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting.
(c) That two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment.
(d) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Reporting of Waivers of Standing Orders and Standing Financial Instructions

(1) All waivers of Standing Orders should be reported to the Audit and Risk Committee after approval has been granted. The Audit and Risk Committee should ensure that waivers have only been granted in compliance with the regulations and where necessary. However, these provisions do not apply where the competitive tendering process is to be omitted or modified. Approval should then be sought as detailed in the relevant section of the Standing Financial Instructions. All such waivers will be reported retrospectively to the Trust's Audit and Risk Committee.

3.16 Record of Attendance

(1) The names of the Chairman and directors/members present at the meeting shall be recorded in the minutes.

3.17 Secretariat and Minutes

(1) The Trust Secretary or a nominated officer from the Trust Office shall attend the meetings of the Trust Board and its Committees. He/she will be permitted to participate in discussions but will not be entitled to vote. The Trust Secretary will be responsible for maintaining the records of such meetings. The minutes of the proceedings shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.
(2) No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.18 Attendance at Meetings and Admission of Public and the Press

(1) The Chairman and members of the Trust will decide what arrangements it feels are appropriate to offer in extending an invitation to other Trust directors, deputies and observers to attend and address any of the Trust Board’s meetings and may change, alter or vary these terms and conditions as it deems fit.

(2) Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw from Trust Board meetings as follows:

(a) “That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”, Section 1 (2), Public Bodies (Admission to Meetings) Act 1960.

(b) On matters to be included in the exclusion, due regard should be given to the Freedom of Information Act 2000.

(3) General disturbances

The Chairman (or Vice Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

(a) “That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public”, Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

(4) Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in SO 3.18(4) and SO 3.18(5) above, shall be confidential to the members of the Board. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked ‘In Confidence’ or minutes headed ‘Items Taken in Private’ outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Trust Board meeting which may take place on such reports or papers.

(5) Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committees thereof. Such permission shall be granted only upon resolution of the Trust.
Arrangements for the public to attend the Board's meetings shall not be construed as allowing them any right to speak at the meeting. However, at the discretion of the Chairman and with the agreement of directors, individuals may be invited to contribute views on specific matters.

3.19 Annual General Meeting

(1) Following publication of the annual report, the Board will hold a Public meeting in accordance with the NHS Trusts (Public Meetings) Regulations 1991 (SI(1991)482) and any subsequent amendments.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

(1) Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust Board.

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

4.2 Joint Committees

(1) Joint committees may be appointed by the Trust by joining together with one or more other health service bodies consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(2) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

(1) The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

(1) Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees
(1) Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

(1) The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance with national guidance. The appointment of directors to committees and sub-committees of the Trust comes to an end on the termination of their terms of office as directors.

4.7 Appointments for Statutory Functions

(1) Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the regulations and directions made by the Secretary of State. Executive directors may not be appointed to any committee or sub-committee set up to carry out the functions of "managers" under the Mental Health Act 1983. Most important of these is the hearing of appeals by detained patients under section 25 (3) (c) Schedule 9 of the 1990 Act.

4.8 Committees established by the Trust Board

(1) The principal committees, sub-committees and joint-committees established by the Board are listed below. Their Terms of Reference are available from the Trust Office and on the Trust website.

(2) Audit and Risk Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and the Higgs report, an Audit and Risk Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The Higgs report recommends a minimum of three Non-Executive directors be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

The Trust's Audit and Risk Committee will have overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. It will be supported in this role by the Quality Assurance Committee.

(3) Quality Assurance Committee

The purpose of the Quality Assurance Committee will be to monitor, review and report on the quality of services provided by the Trust. This will include review of governance, risk management and internal control systems to ensure the delivery of safe, high quality, patient-centred care; quality indicators flagged as of concern through escalation reporting or as requested by the Trust Board; and progress in implementing action plans to address shortcomings in the quality of services, should they be identified. Membership will comprise of three Non Executive Directors and
the Chairman of the Trust. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

(4) **Nominations and Remuneration Committee**
In line with the requirements of the NHS Codes of Conduct and Accountability, and the Higgs report, a Remuneration Committee and a Nominations Committee will be established and constituted. The Higgs report recommends the committees be comprised exclusively of Non-Executive directors, a minimum of three, who are independent of management. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The Nominations and Remuneration Committee shall have delegated authority from the Trust Board to appoint and remove the Chief Executive and, together with the Chief Executive, to appoint and remove the other Executive Directors;

to determine the broad remuneration policy and performance management framework; and
to decide the remuneration, allowances and other terms and conditions of office for the Trust's senior managers.

(5) **Finance and Investment Committee**
The purpose of the Finance and Investment Committee will be to undertake on behalf of the Trust Board objective scrutiny of the Trust’s financial plans, investment policy and major investment decisions. The Committee will review the Trust’s monthly financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board. Additionally, the Trust Board may request that the Committee reviews specific aspects of financial performance where the Board requires additional scrutiny and assurance.

Membership will include the Non Executive Director lead for finance, two additional Non Executive Directors, the Chief Executive, the Chief Financial Officer and the Deputy Chief Executive.

(7) **Other Committees**
The Board may also establish such other committees as required to discharge the Trust's responsibilities

### 4.9 Confidential Proceedings

(1) A director or officer of the Trust shall not disclose a matter considered by the Trust Board or a Committee in confidence without its permission until the Board or Committee has considered the matter in public or has resolved to make the matter public.

### 5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

#### 5.1 Delegation of Functions to Committees, Officers or Other Bodies

(1) Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of SO 4, or by an officer of the Trust, or by another body as defined in SO 5.1(2) below, in each case subject to such restrictions and conditions as the Trust thinks fit.

(2) Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of NHS trusts to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:
(a) By another Trust.

(b) Jointly with any one or more of the following: NHS trusts, NHS Improvement or Clinical Commissioning Groups (CCGs).

(c) By arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies.

(d) In relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with NHS Improvement, NHS Trusts or CCGs.

(3) Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and Urgent Decisions

(1) The powers which the Board has reserved to itself within these Standing Orders (see SO 2.11) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board for formal ratification. In respect of the award of contracts, the Chairman may take Chairman's Action between Trust Board meetings, subject to ratification of his/her decision at the next formal meeting of the Trust Board.

5.3 Delegation to Committees

(1) The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

(2) When the Board is not meeting as the Trust in public session, it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

(1) Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

(2) The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

(3) Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer or other Executive directors to provide information and advise the Board in accordance with statutory
or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers

(1) The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of Powers – see Section C - shall have effect as if incorporated in these Standing Orders.

5.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

(1) If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy Statements: General Principles

(1) The Trust Board has delegated the approval of most new and revised Trust core policies and guidelines to the Trust's Policies Committee. The Trust Policies Committee will agree and approve policy statements and procedures which will apply to all or specific groups of staff employed by Barts Health NHS Trust and others working in the Trust and have authority to delegate approval powers for clinical and local policies to other formal committees. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Policies Committee minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

(2) The Trust Board retains the responsibility for the review and approval of the following Trust core policies: the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions; the Risk Management Policy; the Standards of Business Conduct Policy; and the Whistleblowing Policy.

6.2 Specific Policy Statements

(1) Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

(a) The Standards of Business Conduct Policy for Barts Health NHS Trust staff.

(b) The Disciplinary Policy, Procedure and Rules, the Disciplinary Procedure for Medical and Dental Staff, and the Grievance Policy and Procedure for Barts Health NHS Trust.

(c) The Code of Conduct and the Code of Accountability for NHS Boards (2004) – see Appendix B.
The above Policy statements shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

(1) Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific Guidance

(1) Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

(a) Caldicott Guardian 1997.
(b) Human Rights Act 1998.
(c) Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND STAFF UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

(1) Requirements for Declaring Interests and Applicability to Board Members

(a) The NHS Code of Accountability (see Appendix B) requires Trust Board members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment. In addition to Board members, the requirements for other staff to declare interests are set out in the Trust's Standards of Business Conduct Policy.

(2) Interests which are Relevant and Material

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

(i) Directorships, including Non-Executive directorships held in private companies or PLCs (with the exception of those of dormant companies).
(ii) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(iii) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(iv) A position of authority in a charity or voluntary organisation in the field of health and social care.
(v) Any connection with a voluntary or other organisation contracting for NHS services.
(vi) Research funding/grants that may be received by an individual or their department.
(vii) Interests in pooled funds that are under separate management. Any relevant company included in this fund that has a potential relationship with the Trust must be declared.
(viii) Any other interest in relation to an issue to be considered by the Trust Board.
(b) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.7 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Chairman and the Trust Secretary as soon as practicable.

(c) There is no requirement in the Code of Accountability for the interests of Board members’ spouses or partners to be declared. However, SO 7.7 which is based on the Membership Procedure and Administration Regulations requires that the interests of members’ spouses, if living together, in contracts should be declared. Therefore the interests of Board members’ spouses and cohabiting partners should also be regarded as relevant.

7.2 Advice on Interests

(1) If Board members or staff have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Trust Secretary.

(2) 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.

7.3 Recording of Interests in Trust Board Minutes

(1) At the time Board members' interests are declared, they should be recorded in the Trust Board minutes. Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.4 Publication of Declared Interests in Annual Report

(1) Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

7.5 Conflicts of Interest which Arise During the Course of a Meeting

(1) During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.7)

7.6 Register of Interests

(1) 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 (as defined in SO 7.1(2) which have been declared by both Executive and Non-Executive directors of the Trust Board.

(2) These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.
(3) The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.7 Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest

(1) Definition of terms used in interpreting ‘Pecuniary’ interest
For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) “Spouse” shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse).

(b) “Contract” shall include any proposed contract or other course of dealing.

(c) “Pecuniary interest”
Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(i) He/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same; or

(ii) He/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) Exception to Pecuniary interests
A person shall not be regarded as having a pecuniary interest in any contract, proposed contract or other matter if:

(i) Neither he nor any person connected with him has any beneficial interest in the securities of a company or other body of which he or such person appears as a member; or

(ii) any interest that he or any person connected with him may have in the contract or other matter is so remote or insignificant that it cannot reasonably be regarded as likely to influence him in relation to considering, discussing or voting on that contract or matter; or

(iii) those securities of any company in which he (or any person connected with him) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided, however, that where paragraph (iii) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1(2)(b).

Exclusion in proceedings of the Trust Board

(2) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact
and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(3) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.8 on the ‘Waiver’ which has been approved by the Secretary of State for Health.)

(4) The Trust Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(5) Any remuneration, compensation or allowance payable to the Chairman or a member by virtue of paragraph 9 of Schedule 2 to the National Health Service and Community Care Act 1990 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(6) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.8 Waiver of Standing Orders made by the Secretary of State for Health

(1) Power of the Secretary of State to make waivers
Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 (“the Regulations”), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of ‘Chairman’ for the purpose of interpreting this waiver
For the purposes of paragraph 7.8(3) (below), the “relevant chairman” is:

(a) At a meeting of the Trust, the Chairman of that Trust.

(b) At a meeting of a Committee:
   
   (i) In a case where the member in question is the Chairman of that Committee, the Chairman of the Trust.

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

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

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

   (i) Services under the National Health Service Act 1977; or

   (ii) Services in connection with a pilot scheme under the National Health Service Act 1997;
for the benefit of persons for whom the Trust is responsible.

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

(i) Arises by reason only of the member’s role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons.

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

- Are members of the same profession as the member in question,
- Are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

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

The removal is subject to the following conditions:

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

(b) The relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.8(2)(b) above, except where that member is the Chief Executive.

(c) In the case of a meeting of the Trust:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded.

(ii) May not vote on any question with respect to it.

(d) In the case of a meeting of the Committee:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded.

(ii) May vote on any question with respect to it. But

(iii) The resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.9 Failure to Declare an Interest

(1) If a director of the Board fails to declare an interest, or is found to have used the position or knowledge for private advantage, disciplinary action may be taken by the Trust which could lead to dismissal.

7.10 Standards of Business Conduct

(1) Trust Policy and National Guidance

All Trust staff and members must comply with the Trust’s Standards of Business Conduct Policy and the national guidance contained in HSG(93)5 on ‘Standards of Business Conduct for NHS staff’ and the Code of Conduct for NHS Boards (see SO 6.2).
(2) **Interest of Officers in Contracts**

(a) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.8) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or the Trust Secretary as soon as practicable.

(b) An Officer should also declare to the Chief Executive or the Trust Secretary any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(c) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

(3) **Canvassing of and Recommendations by Directors and Officers in Relation to Appointments**

(a) Canvassing of directors of the Trust or members of any committee or officers of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(b) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate’s ability, experience or character for submission to the Trust.

(c) Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

(4) **Relatives of directors or officers**

(a) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

(b) The Chairman and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(c) On appointment (and prior to acceptance of an appointment in the case of Executive directors), directors should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

(d) Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed ‘Exclusion of Chairman and members in proceedings on account of pecuniary interest’ (SO 7.7) shall apply.

7.11 **Acceptance of Gifts and Donations**

(1) Staff should not accept gifts in any form, whether from patients, patients’ relatives or carers, or from potential or actual suppliers, other than as provided below. The
Trust’s Standards of Business Conduct Policy sets out the rules in relation to gifts and donations and should be read as if incorporated into Standing Orders.

(2) It is in order in certain circumstances for staff to accept small gifts to a maximum value of £25 but their senior officer must be informed and a record made.

(3) Any donated sums of money, cheques or gift vouchers given to a member of staff must be passed to the relevant charitable fund. A receipt should be issued and letter of thanks sent.

(4) Where the donor specifies how the money is to be spent, his/her wishes must be followed.

8. **CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS**

See the National Health Service and Community Care Act 1990 Schedule 2 paragraph 28.

8.1 **Custody of the Seal**

(1) The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

8.2 **Sealing of Documents**

(1) The Seal is a corporate signature. It may be interchangeable with the words “for and on behalf of the Trust” for documents of minor importance and/or value. The use of the Seal indicates that the document is important and/or valuable. No common law exists regarding any financial limits which require a Seal. However, a Seal must be used in the conveyancing of land.

(2) If the Trust gives an undertaking, the sealing of a document imposes an obligation. A signature does not reduce the obligation, but a Seal reaffirms the obligation expressed within the document. In cases where the Trust is uncertain, a signature could be offered “for and on behalf of the Trust” and if this is refused, the Seal can be used.

(3) The Trust or its officers may decide that a document shall be sealed, within the provisions of the NHS Acts.

(4) The following documents must be sealed:

   (a) All contracts for the purchase or lease of land and/or buildings.

   (b) All documents relating to the transfer or sale of shares, bonds and other financial instruments.

(5) The following documents may be sealed:

   (a) Legal agreements and licences.

   (b) When a Seal is requested by the other party or parties.

(6) The Trust Board has delegated the responsibility for the use of the Trust’s Seal to the Chief Executive and the Trust Secretary. However, in the absence of either of these two officers, the Chairman and/or another director (not from the originating
department) duly authorised by the Chief Executive may attest the use of the Seal. Amendments to documents under Seal should be initiated by those attesting the use of the Seal. Every instance of the use of the Seal must be reported to the Trust Board for ratification and recorded in the minutes of the meeting.

8.3 Register of Sealings

(1) The Trust Secretary shall keep a register in which he/she, or an officer from the Trust Office authorised by him/her, shall enter a summary record of the sealing of every document. Each record must be signed by those officers attesting the use of the Seal.

8.4 Signature of Documents

(1) Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or an Executive director.

(2) In land transactions, the signing of certain supporting documents will be delegated to Managers and set out in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS

9.1 Joint Finance Arrangements

(1) The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

9.2 Conflict

(1) In the event of any conflict between the Standing Orders and any statutory provision, regulation or direction by the Secretary of State, the latter shall prevail.

9.3 Report on Trust Performance

(1) The Trust Board will publish annually a report of the Trust’s performance and activities. This will include a statement of the annual accounts in compliance with the requirements of the NHS Manual of Accounts.
APPENDIX A: THE NOLAN PRINCIPLES OF PUBLIC LIFE

In its first report in May 1995, the Nolan Committee on Standards in Public Life set out Seven Principles of Public Life which all those working in public service, including NHS staff, should act in accordance with. Barts Health NHS Trust fully endorses these principles and requires its staff to act in accordance with them at all times.

Further details can be found at: https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

The Seven Principles of Public Life are as follows:

**Selflessness**
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

**Integrity**
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

**Objectivity**
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

**Accountability**
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

**Openness**
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

**Honesty**
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

**Leadership**
Holders of public office should promote and support these principles by leadership and example.
APPENDIX B: CODES OF CONDUCT AND ACCOUNTABILITY FOR NHS BOARDS

CODE OF CONDUCT FOR NHS BOARDS

1. PUBLIC SERVICE VALUES

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers’ money.

There are three crucial public service values which must underpin the work of the health service.

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

2. GENERAL PRINCIPLES

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board directors.

3. OPENNESS AND PUBLIC RESPONSIBILITIES

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that major changes are consulted upon before decisions are reached. Information supporting those decisions should be made available, in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As a large employer in the local community, NHS organisations should forge an open and positive relationship with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation’s activities on the environment.

The confidentiality of personal and individual patient information must, of course, be respected at all times.
4. **PUBLIC SERVICE VALUES IN MANAGEMENT**

It is unacceptable for the board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board directors have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards. Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

5. **PUBLIC BUSINESS AND PRIVATE GAIN**

Chairs and board directors should act impartially and should not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the board director should withdraw and play no part in the relevant discussion or decision.

6. **HOSPITALITY AND OTHER EXPENDITURE**

Board directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

7. **RELATIONS WITH SUPPLIERS**

NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship. Suppliers should be selected on the basis of quality, suitability, reliability and value for money. The Department of Health and Social Care has issued guidance to NHS organisations about standards of business conduct (ref: HSG(93)5); NHS England also published model conflicts of interest in 2017. This guidance is reflected in the Trust’s Standards of Business Conduct (declarations of interest) policy.

8. **STAFF**

NHS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board must establish a climate:

- that enables staff who have concerns to raise these reasonably and responsibly with the right parties;
that gives a clear commitment that staff concerns will be taken seriously and investigated; and

where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

(Ref: Whistleblowing in the NHS, letter dated 25 July 2003 from the Director of HR in the NHS)

9. COMPLIANCE

Board directors should satisfy themselves that the actions of the board and its directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct.

Originally published April 1994
Revision July 2004
CODE OF ACCOUNTABILITY FOR NHS BOARDS

This Code of Practice is the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

1. STATUS

NHS organisations, such as NHS trusts, primary care trusts, strategic health authorities and special health authorities, are established under statute as corporate bodies so ensuring that they have separate legal personality. Statutes and regulations prescribe the structure, functions and responsibilities of the boards of these bodies and prescribe the way chairs and directors of boards are to be appointed.

2. CODE OF CONDUCT

All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct by the chair or a non-executive director of the board should be drawn to the attention of the NHS Improvement. NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and non-executive directors of NHS boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct for NHS Managers.

3. STATUTORY ACCOUNTABILITY

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS organisations who are thus accountable to the Secretary of State and to Parliament. The Department of Health and Social Care is responsible for directing the NHS, ensuring national policies are implemented and for the effective stewardship of NHS resources.

NHS trusts provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children). Other main functions are to:

- Ensure services are of high quality and accessible; and
- Lead the development of new ways of working to fully engage patients and ensure a patient-centred service;

CCGs are expected to identify the health needs of the population, to work to improve the health of the community and to secure the provision of a full range of services. Other main functions are to:

- Maintain an effective public health function;
- Lead local planning;
- Manage and develop primary healthcare services;
- Develop and improve local services;
- Lead the integration of health and social care; and
- Deliver services within their remit.

NHS Improvement provides strategic leadership to ensure the maintenance of provision and the delivery of improvements in local health and health services by NHS trusts, within the national framework of developing a patient-centred NHS and supported by effective controls and clinical governance systems. Other main functions for which NHS Improvement is responsible are to:

- Lead the development and empowerment of uniformly excellent frontline NHS organisations committed to innovation and improvement;
Consider the overall needs of the health economy across primary, community, secondary and tertiary care, and working with primary care trusts and NHS trusts to deliver a programme to meet these needs;

- Performance manage and ensure accountability of local primary care trusts and NHS trusts;
- Lead on the creation and development of clinical and public health networks;
- Create capacity through the preparation and delivery of strategies for capital investment, information management and workforce development;
- Ensure effective networks and joint working exists between NHS organisations for the provision of health and social care; and
- Ensure the development and training of an adequate workforce of competent clinical personnel.

NHS trust finances are subject to external audit by the Audit Commission and, for the value for money element, by the Care Quality Commission.

NHS boards must co-operate fully with the Department of Health and Social Care, the Audit Commission and the Care Quality Commission when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State. The Chief Executive/Permanent Secretary of the Department of Health and Social Care, as Accounting Officer for the NHS, is accountable to Parliament. The work of the Department of Health and Social Care and its associated bodies is examined by the House of Commons Health Committee. Its remit is to examine the expenditure, administration and policy of the Department of Health and Social Care. Two other Parliamentary Committees, the Public Accounts Committee and the Public Administration Select Committee, scrutinise the work of the Department of Health and Social Care and the health service.

4. THE BOARD OF DIRECTORS

NHS boards comprise executive directors together with non-executive directors and a chair who are appointed by NHS Improvement on behalf of the Secretary of State. Together they share corporate responsibility for all decisions of the board. There is a clear division of responsibility between the chair and the chief executive; the chair’s role and board functions are set out below: the chief executive is directly accountable to the board for meeting their objectives, and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation.

Boards are required to meet regularly and to retain full and effective control over the organisation; the chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of these responsibilities. Strategic health authorities generally provide the line of accountability from local NHS organisations to the Secretary of State for the performance of the organisation. The appointments team at NHS Improvement will always be available to chairs and non-executive directors on matters of concern to them relating to the personal effectiveness of individual chairs and non-executives.

The duty of an NHS board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation. The role of an NHS board is to:

- Be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation’s affairs.
- Provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.
• Set the organisation’s strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance.
• Set the organisation’s values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Further details may be obtained from Governing the NHS: A Guide for NHS Boards at www.dh.gov.uk.

The Role of the Chair

The overall role of the chair is one of enabling and leading so that the attributes and specific roles of the executive team and the non executives are brought together in a constructive partnership to take forward the business of the organisation. The key responsibilities of the chair are:

• Leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda;
• Ensuring the provision of accurate, timely and clear information to directors;
• Ensuring effective communication with staff, patients and the public;
• Arranging the regular evaluation of the performance of the board, its committees and individual directors; and
• Facilitating the effective contribution of non executive directors and ensuring constructive relations between executive and non-executive directors.

A complementary relationship between the chair and chief executive is important. A complementary relationship between the chair and chief executive is important. The chief executive is accountable to the chair and non-executive directors of the board for ensuring that the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the board. Further details may be obtained from Governing the NHS: A Guide for NHS Boards.

Non-Executive directors

Non-executive directors are appointed by NHS Improvement on behalf of the Secretary of State to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care to Ministers and to the local community. The duties of non-executive directors are to:

• Constructively challenge and contribute to the development of strategy;
• Scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance;
• Satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible;
• Determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and
• Ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses. Non-executive directors also have a key role in a small number of permanent board committees such as the Audit and Risk Committee, Nominations and Remuneration Committee Finance and Investment Committee and the Quality Assurance Committee.

Further details may be obtained from Governing the NHS: A Guide for NHS Boards.

5. REPORTING AND CONTROLS
It is the board’s duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation’s performance to:

- The Department of Health and Social Care, on behalf of the Secretary of State.
- Its appointed auditors, and
- The local community.

Detailed financial guidance, including the role of internal and external auditors, issued by the Department of Health and Social Care must be observed. (Ref: the NHS Finance Manual at www.info.doh.gov.uk/doh/finman). The Standing Orders of boards should prescribe the terms on which committees and sub-committees of the board may be delegated functions, and should include the schedule of decisions reserved for the board.

6. DECLARATION OF INTERESTS

It is a requirement that chairs and all board directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS organisations maintain a register of member’s interests to avoid any danger of board directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All board members are therefore expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

7. EMPLOYEE RELATIONS

NHS boards must comply with legislation and guidance from the Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers’ money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure through the appointment of a remuneration and terms of service committee that executive board directors’ remuneration can be justified as reasonable. Board directors’ remuneration for the NHS organisation should be published in its annual report.

Originally published April 1994
Revised July 2004
SECTION C: SCHEMES OF RESERVATION AND DELEGATION

Introduction

Standing Order 5.1(1) states that “Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1(2), in each case subject to such restrictions and conditions as the Trust thinks fit. The Code of Accountability for NHS Boards (see Section B, Appendix B) also requires that the Standing Orders include a schedule of decisions reserved for the Board.

The Scheme of Reservation and Delegation of Powers clarifies the powers reserved to the Trust Board – generally matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies, guidelines and procedures. However, the Board remains accountable for all of its functions, even those delegated to the Chairman, individual directors or officers, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Role of the Chief Executive

The Chief Executive shall exercise all powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee on behalf of the Board. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other directors and officers. The Scheme of Delegation will be reviewed at least annually and changed as necessary if any of the duties or responsibilities of the specified Trust office changes.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer, the Chief Executive is accountable to the Accounting Officer of the Department of Health and Social Care for the funds entrusted to the Trust.

Caution over use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they will not exercise them in a matter that in their judgement is likely to be a cause for public concern.

Directors’ ability to delegate their own Delegated Powers

The Scheme of Delegation shows only the ‘top level’ of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.
**Absence of directors or officers to whom powers have been delegated**

In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director’s or officer’s superior unless alternative arrangements have been approved by the Trust Board. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Acting Chief Executive after taking appropriate advice from the Chairman.

**Reservation of powers to the Board**

The Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved unto it. These reserved matters are set out in the section below.

**SCHEME OF RESERVATION**

The Trust Board shall not delegate under Standing Order 5.1(1) its functions in respect of the following:

<table>
<thead>
<tr>
<th>DECISIONS RESERVED TO THE BOARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Enabling Provision</strong></td>
</tr>
<tr>
<td>The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulations and Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amendments to and annual approval of Standing Orders (SOs), the Schemes of Reservation and Delegation, and Standing Financial Instructions (SFIs); at least three-yearly review and approval of the Standards of Business Conduct Policy.</td>
</tr>
<tr>
<td>2. Suspension of Standing Orders.</td>
</tr>
<tr>
<td>3. Ratification of any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 5.2.</td>
</tr>
<tr>
<td>4. Require and receive directors’ declarations of interests and, where there is conflict with Trust business, determine the extent to which that director may remain involved with the matter under consideration.</td>
</tr>
<tr>
<td>5. Require and receive declarations of officers’ interests that may conflict with those of the Trust.</td>
</tr>
<tr>
<td>6. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.</td>
</tr>
<tr>
<td>7. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon.</td>
</tr>
</tbody>
</table>
### DECISIONS RESERVED TO THE BOARD

8. Confirm the recommendations of the Trust’s committees where the committees do not have executive powers.
9. Establish and regularly review the terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.
10. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive’s attention in accordance with SO 5.6.
11. Discipline members of the Board who are in breach of statutory requirements or Standing Orders.
12. Recognition or withdrawal of recognition of Specialist Advisory Committees.
13. Ratify use of the Trust Seal.
14. Approve arrangements relating to the discharge of the Trust’s responsibilities regarding funds held on trust.

### Appointments/Dismissal

1. Appoint and dismiss the Vice Chairman of the Board.
2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.
3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.

### Strategy, Plans and Budgets

1. Define the mission statement and strategic aims and objectives of the Trust.
2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.
3. Approve the Trust’s Risk Management Policy following annual review.
4. Approve annual revenue budgets and the Trust’s capital programme.
5. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
6. Approve PFI proposals.
7. Approve the banking arrangements.
8. Approve the award of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, £1,000,000 (excluding VAT) or over during the period of the contract.
9. Authorise the arrangement of operational or finance leases with a total lifecycle value (including residual value) of more than £1,000,000.
10. Approve waivers of competition or waivers of Standing Financial Instructions where it is proposed not to accept the lowest priced tender in respect of the award of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to £100,000 (excluding VAT).
### DECISIONS RESERVED TO THE BOARD

- VAT) or above during the period of the contract.
- Approve expenditure in excess of approved revenue and capital budgets or cash limits above £100,000.
- Approve virements between Sites and Directorates equal to or above £1,000,000.
- The discontinuation of any significant activity or operation.
- Approve Trust responses to consultations on major changes in health policy and health care provision both nationally and locally.
- Approve decisions to make formal representations to government or other authorities on matters of major policy.

### Policy Determination
1. Review and approval of the following Trust core policies: the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions; the Standards of Business Conduct Policy; and the Whistleblowing Policy.

### Audit
1. Approve the appointment (and where necessary dismissal) of External Auditors (informed by recommendations of the Auditor Panel).
2. Receive the annual audit letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit and Risk Committee.
3. Receive the Annual Governance Statement and agree action on recommendations, where appropriate, of the Audit and Risk Committee.
**DECISIONS RESERVED TO THE BOARD**

### Annual Reports and Accounts
1. Receipt and approval of the Trust's Annual Report and Annual Accounts and Quality Account.
2. Receipt and approval of the Annual Report and Accounts for any funds held on trust.

### Financial and performance monitoring and reporting
1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.
2. Continuous appraisal of the affairs of the Trust by means of the receipt of reports from directors, committees and officers of the Trust. Monitoring returns required by the Department of Health and Social Care or Charity Commission shall be reported, at least in summary form, to the Board.
3. Receive reports from the Chief Financial Officer on financial performance against budget/financial plans.
4. Receive reports from the Chief Financial Officer on actual and forecast income from SLAs.
5. Approval of the Trust's annual end-year Information Governance Toolkit submission.
### DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES IN STANDING ORDERS

<table>
<thead>
<tr>
<th>REF</th>
<th>COMMITTEE</th>
<th>DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO 4.8.2</td>
<td>Audit and Risk Committee</td>
<td>The Committee will:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Oversee Internal (including Counter Fraud) and External Audit services;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Review financial and information systems and monitor the integrity of the financial statements and review significant financial reporting judgments;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Review the establishment and maintenance of an effective system of integrated governance, risk management (including risk management policy and risk management strategy) 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;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Monitor compliance with Standing Orders and Standing Financial Instructions;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Approve schedules of losses and compensations;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Act as the Trust’s Auditor Panel to advise the Trust Board on the appointment and removal of external auditors;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Review the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Periodically (as defined in its Terms of Reference) review the Waiver Register.</td>
</tr>
<tr>
<td>SO 4.8.3</td>
<td>Quality Assurance Committee</td>
<td>The Committee will monitor, review and report on the quality of service provided by the Trust. The Committee will receive reports on complaints investigated by the Health Service Ombudsman.</td>
</tr>
<tr>
<td>SO 4.8.4</td>
<td>Nominations and Remuneration Committee</td>
<td>The Committee will have powers to appoint and remove the Chief Executive and, together with the Chief Executive, to appoint and remove other Executive Directors. The Committee shall have delegated authority from the Trust Board to determine the broad remuneration policy and performance management framework and to decide the remuneration, allowances and other terms and conditions of office for the Trust’s senior managers.</td>
</tr>
<tr>
<td>SO 4.8.5</td>
<td>Finance and Investment Committee</td>
<td>The Committee will 1. Undertake objective scrutiny of the Trust’s financial plans, investment policy and major investment decisions;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Review the Trust’s monthly financial performance and identify key issues and risks requiring discussion or decision by the Trust Board.</td>
</tr>
</tbody>
</table>
### DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

<table>
<thead>
<tr>
<th>REF</th>
<th>COMMITTEE</th>
<th>DECISIONS/DUTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3. Approve Outline and Final Business Cases for capital investment, including</td>
</tr>
<tr>
<td></td>
<td></td>
<td>leased assets, above £1 million subject to Trust Board approval of the Trust's</td>
</tr>
<tr>
<td></td>
<td></td>
<td>overall Capital Programme.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Approve business case proposals with a cost implication in excess of £5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>million over five years.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Approve proposed asset disposals where value of asset exceeds £1 million.</td>
</tr>
<tr>
<td>SO 6.1</td>
<td>Trust Policies Committee</td>
<td>The approval of those new and revised Trust core policies and guidelines not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reserved to the Trust Board (including powers to delegate authority for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>approval of clinical or local policies to other formal committees).</td>
</tr>
</tbody>
</table>

53
SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

<table>
<thead>
<tr>
<th>REF</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>CHIEF EXECUTIVE (CE)</td>
<td>Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources.</td>
</tr>
<tr>
<td>9</td>
<td>CE AND CHIEF FINANCIAL OFFICER (CFO)</td>
<td>Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State for Health. Accounts must disclose a true and fair view of the Trust’s income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.</td>
</tr>
<tr>
<td>10</td>
<td>CHIEF EXECUTIVE</td>
<td>Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign an annual governance statement in the accounts outlining responsibilities in respect of systems of internal control.</td>
</tr>
</tbody>
</table>
| 12 & 13 | CHIEF EXECUTIVE | Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:  
- “have a clear view of their objectives and the means to assess achievements in relation to those objectives  
- be assigned well defined responsibilities for making best use of resources  
- have the information, training and access to the expert advice they need to exercise their responsibilities effectively.” |
| 12  | CHAIRMAN | Implement requirements of corporate governance. |
| 13  | CHIEF EXECUTIVE | Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation’s activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office (NAO). |
| 14  | CHIEF FINANCIAL OFFICER | Approve the opening of bank accounts  
Managing banking arrangements, including provision of banking services, operation of accounts,
<table>
<thead>
<tr>
<th>REF</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>preparation of instructions and list of cheque signatories. Review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money. Ensure competitive tenders are sought at least every 5 years for commercial accounts. (Board approves arrangements.)</td>
</tr>
<tr>
<td>15</td>
<td>CFO</td>
<td>Operational responsibility for effective and sound financial management and information.</td>
</tr>
<tr>
<td>15</td>
<td>CHIEF EXECUTIVE</td>
<td>Primary duty to see that CFO discharges this function.</td>
</tr>
<tr>
<td>16</td>
<td>CHIEF EXECUTIVE</td>
<td>Ensuring that expenditure by the Trust complies with Parliamentary requirements.</td>
</tr>
<tr>
<td>18</td>
<td>CE and CFO</td>
<td>Chief Executive, supported by Chief Financial Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.</td>
</tr>
<tr>
<td>19</td>
<td>CHIEF EXECUTIVE</td>
<td>If CE considers the Board or Chairman is doing something that might infringe probity or regularity, he should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit and Risk Committee to inquire and if necessary NHS Improvement and the Department of Health and Social Care</td>
</tr>
<tr>
<td>21</td>
<td>CHIEF EXECUTIVE</td>
<td>If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE’s responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform NHS Improvement and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.</td>
</tr>
</tbody>
</table>
### Scheme of Delegation Derived from the Codes of Conduct and Accountability

<table>
<thead>
<tr>
<th>REF</th>
<th>Delegated To</th>
<th>Authorities/Duties Delegated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Board</td>
<td>Approve procedure for declaration of hospitality and sponsorship (within Standards of Business Conduct Policy).</td>
</tr>
<tr>
<td>2</td>
<td>Board</td>
<td>Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.</td>
</tr>
<tr>
<td>3</td>
<td>All Board Members</td>
<td>Subscribe to Code of Conduct.</td>
</tr>
<tr>
<td>4</td>
<td>Board</td>
<td>Board members share corporate responsibility for all decisions of the Board.</td>
</tr>
<tr>
<td>5</td>
<td>Chair and Non Executive/Officer Members</td>
<td>Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health for the discharge of those responsibilities.</td>
</tr>
</tbody>
</table>
| 6   | Board        | The Board has six key functions for which it is held accountable by the Department of Health and Social Care on behalf of the Secretary of State:  
1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;  
2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;  
3. to appoint, appraise and remunerate senior executives;  
4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them;  
5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;  
6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs. |
<table>
<thead>
<tr>
<th>REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>BOARD</td>
<td>It is the Board’s duty to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. act within statutory financial and other constraints;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. establish performance and quality measures that maintain the effective use of resources and provide value for money;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.</td>
</tr>
<tr>
<td>8</td>
<td>CHAIRMAN</td>
<td>It is the Chairman's role to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. provide leadership to the Board;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. ensure that key and appropriate issues are discussed by the Board in a timely manner,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. appoint Non-Executive Board members to an Audit Committee of the main Board;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. advise the Secretary of State on the performance of Non-Executive Board members.</td>
</tr>
<tr>
<td>9</td>
<td>CHIEF EXECUTIVE</td>
<td>The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in</td>
</tr>
<tr>
<td>REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.</td>
</tr>
<tr>
<td>10</td>
<td><strong>NON EXECUTIVE DIRECTORS</strong></td>
<td>Non-Executive Directors are appointed by NHS Improvement to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health and Social Care Ministers and to the local community.</td>
</tr>
<tr>
<td>11</td>
<td><strong>CHAIR AND DIRECTORS</strong></td>
<td>Declaration of conflict of interests.</td>
</tr>
<tr>
<td>12</td>
<td><strong>BOARD</strong></td>
<td>NHS Boards must comply with legislation and guidance issued by the Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.</td>
</tr>
</tbody>
</table>
# Scheme of Delegation from Standing Orders

<table>
<thead>
<tr>
<th>SO REF</th>
<th>Delegated To</th>
<th>Authorities/Duties Delegated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>CHAIRMAN</td>
<td>Final authority in interpretation of Standing Orders (SOs).</td>
</tr>
<tr>
<td>2.4</td>
<td>BOARD</td>
<td>Appointment of Vice Chairman.</td>
</tr>
<tr>
<td>3.1</td>
<td>CHAIRMAN</td>
<td>Call meetings.</td>
</tr>
<tr>
<td>3.2</td>
<td>TRUST SECRETARY</td>
<td>Remove an item from the agenda of the Trust Board if not received in time or to a suitable standard.</td>
</tr>
<tr>
<td>3.9</td>
<td>CHAIRMAN</td>
<td>Chair all Board meetings and associated responsibilities.</td>
</tr>
<tr>
<td>3.10</td>
<td>CHAIRMAN</td>
<td>Give final ruling in questions of order, relevancy and regularity of meetings.</td>
</tr>
<tr>
<td>3.12</td>
<td>CHAIRMAN</td>
<td>Having a second or casting vote.</td>
</tr>
<tr>
<td>3.13</td>
<td>BOARD</td>
<td>Suspension of Standing Orders.</td>
</tr>
<tr>
<td>3.13</td>
<td>AUDIT AND RISK COMMITTEE</td>
<td>Review every decision to suspend Standing Orders</td>
</tr>
<tr>
<td>3.14</td>
<td>BOARD</td>
<td>Waiver, variation or amendment of Standing Orders.</td>
</tr>
<tr>
<td>4.1</td>
<td>BOARD</td>
<td>Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference.</td>
</tr>
<tr>
<td>5.2</td>
<td>CHAIRMAN &amp; CHIEF EXECUTIVE</td>
<td>The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.</td>
</tr>
<tr>
<td>5.4</td>
<td>CHIEF EXECUTIVE</td>
<td>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.</td>
</tr>
<tr>
<td>5.6</td>
<td>ALL</td>
<td>Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.</td>
</tr>
<tr>
<td>SO REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7.1</td>
<td>THE BOARD</td>
<td>Declare relevant and material interests.</td>
</tr>
<tr>
<td>7.6</td>
<td>TRUST SECRETARY</td>
<td>Maintain Register(s) of Interests.</td>
</tr>
<tr>
<td>7.10</td>
<td>ALL</td>
<td>Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)</td>
</tr>
<tr>
<td>8.1/8.3</td>
<td>TRUST SECRETARY</td>
<td>Keep the Trust Seal in a safe place and maintain a Register of Sealings.</td>
</tr>
<tr>
<td>8.4</td>
<td>CHIEF EXECUTIVE/EXECUTIVE DIRECTOR</td>
<td>Approve and sign all documents which will be necessary in legal proceedings.</td>
</tr>
</tbody>
</table>
## OTHER DELEGATED FUNCTIONS

<table>
<thead>
<tr>
<th>REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chief Executive and Director of Estates</td>
<td>Arrangements for the management of land, buildings and other assets belonging to or leased by the Trust.</td>
</tr>
<tr>
<td>2</td>
<td>Director of Estates and Facilities</td>
<td>Preparation of tenancy agreements.</td>
</tr>
<tr>
<td>3</td>
<td>Chief Medical Officer and Director of R&amp;D</td>
<td>Authorisation of sponsorship deals and research projects.</td>
</tr>
<tr>
<td>4</td>
<td>Site Managing Director</td>
<td>Management and control of stocks.</td>
</tr>
<tr>
<td>5</td>
<td>Deputy Chief Executive</td>
<td>Management and control of IT systems and facilities. Health and safety arrangements including statutory compliance and fire.</td>
</tr>
</tbody>
</table>
| 6   | Director of Development, Trust Secretary, New Hospitals Programme Director, Director of People Director, Chief Medical Officer and Chief Nurse | Engaging the Trust's legal advisers  
- Commercial legal issues  
- Property issues  
- HR issues  
- Medical staff and clinical litigation issues |
<p>| 7   | Director of Corporate Development | Compliance with the Data Protection Act and the Freedom of Information Act. |
| 8   | Chief Medical Officer and Chief Nurse | Management of the NHS Litigation Authority's clinical negligence scheme, medical litigation and personal injury claims. |
| 9   | Trust Secretary | Membership of the NHSLA non-clinical insurance schemes and other non-clinical insurance arrangements. |
| 10  | Director of Communications | Arrangements for dealing with the media. |
| 11  | Chief Financial Officer | Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. |</p>
<table>
<thead>
<tr>
<th>REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Chief Financial Officer</td>
<td>Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) previously approved by the Board.</td>
</tr>
<tr>
<td>13</td>
<td>Chief Financial Officer and Director of People</td>
<td>Approve individual compensation payments.</td>
</tr>
</tbody>
</table>
## Scheme of Delegation from Standing Financial Instructions

<table>
<thead>
<tr>
<th>SFI REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Approval of all financial procedures.</td>
</tr>
<tr>
<td>10.1.4</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Advice on interpretation or application of SFIs.</td>
</tr>
<tr>
<td>10.1.6</td>
<td>ALL MEMBERS OF THE BOARD AND EMPLOYEES</td>
<td>Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.</td>
</tr>
<tr>
<td>10.2.4</td>
<td>CHIEF EXECUTIVE</td>
<td>Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the system of Internal Control.</td>
</tr>
<tr>
<td>10.2.4</td>
<td>CHIEF EXECUTIVE &amp; CHIEF FINANCIAL OFFICER</td>
<td>Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.</td>
</tr>
<tr>
<td>10.2.5</td>
<td>CHIEF EXECUTIVE</td>
<td>To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.</td>
</tr>
</tbody>
</table>
| 10.2.6  | CHIEF FINANCIAL OFFICER | Responsible for:  
   a) Implementing the Trust's financial policies and coordinating corrective action;  
   b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented;  
   c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position;  
   d) Providing financial advice to members of Board and staff;  
   e) The design, implementation and supervision of systems of internal control.;  
   f) Maintaining such accounts, certificates, etc. as required for the Trust to carry out its statutory duties. |
<p>| 10.2.7  | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation. |
| 10.2.8  | CHIEF EXECUTIVE | Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1.1</td>
<td>AUDIT AND RISK COMMITTEE</td>
<td>Provide independent and objective view on internal control and probity.</td>
</tr>
<tr>
<td>11.1.2</td>
<td>CHAIR OF AUDIT AND RISK COMMITTEE</td>
<td>Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.</td>
</tr>
<tr>
<td>11.1.3 &amp; 11.2.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed. Ensure the annual audit report is prepared for consideration by the Audit Committee.</td>
</tr>
<tr>
<td>11.2.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud, bribery or corruption.</td>
</tr>
<tr>
<td>11.4</td>
<td>AUDIT AND RISK COMMITTEE</td>
<td>Ensure cost-effective External Audit.</td>
</tr>
<tr>
<td>11.5</td>
<td>CHIEF EXECUTIVE &amp; CHIEF FINANCIAL OFFICER</td>
<td>Monitor and ensure compliance with SoS Directions on fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.</td>
</tr>
<tr>
<td>11.6</td>
<td>CHIEF EXECUTIVE &amp; CHIEF FINANCIAL OFFICER</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 12.1.1  | CHIEF EXECUTIVE | Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain:  
- a statement of the significant assumptions on which the plan is based;  
- details of major changes in workload, delivery of services or resources required to achieve the plan. |
| 12.1.2 & 12.1.3 | CHIEF FINANCIAL OFFICER | Submit revenue and capital budgets to the Board for approval.  
Monitor performance against budget; submit to the Board financial estimates and forecasts. |
<p>| 12.1.6  | CHIEF FINANCIAL OFFICER | Ensure adequate training is delivered on an ongoing basis to budget holders. |
| 12.2.1  | CHIEF EXECUTIVE | Delegate budget to budget holders. |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.2.3</td>
<td>ANY EXECUTIVE DIRECTOR OR SITE MANAGING DIRECTOR/CORPORATE DIRECTOR</td>
<td>Approve virements between Sites and Directorates up to £1,000,000</td>
</tr>
<tr>
<td>12.2.3</td>
<td>BOARD</td>
<td>Approve virements between Sites and Directorates above £1,000,000</td>
</tr>
<tr>
<td>12.3</td>
<td>Chief Executive or Chief Financial Officer</td>
<td>Authorisation of unbudgeted expenditure up to £100,000</td>
</tr>
<tr>
<td>12.4.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Devise and maintain systems of budgetary control.</td>
</tr>
</tbody>
</table>
| 12.4.2  | BUDGET HOLDERS | Ensure that  
|         |               | a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;  
|         |               | b) approved budget is not used for any other than specified purpose subject to rules of virement;  
|         |               | c) with the exception of Medical and Dental Consultants, no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.  
|         |               | (d) no new Medical or Dental Consultant posts can be created other than those agreed to in the Annual Business Plan or by approval of a business case by the relevant Trust committee according to terms of reference.  
|         |               | (e) identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a balanced budget; and  
<p>|         |               | (f) effective systems exist within the directorate to ensure that all expenditure is authorised in advance of commitment (e.g. operation of authorised signatory systems) and that the individuals incurring expenditure fully understand their budgetary control responsibilities. |
| 12.4.3  | CHIEF EXECUTIVE | Identify and implement cost improvements and income generation activities in line with the Annual Plan. |
| 12.6.1  | CHIEF EXECUTIVE | Submit monitoring returns |
| 13.1    | CHIEF FINANCIAL OFFICER | Preparation of annual accounts and reports. |
| 14      | CHIEF FINANCIAL OFFICER | Approve the opening of bank accounts |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. Review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money. Ensure competitive tenders are sought at least every 5 years for commercial accounts. (Board approves arrangements.)</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>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.</td>
</tr>
<tr>
<td>15.2.</td>
<td>ALL EMPLOYEES</td>
<td>Duty to inform CFO of money due from transactions which they initiate/deal with. An advanced deposit must be obtained for all self pay elective activity equivalent to the estimated cost of the treatment in advance of any treatment being provided.</td>
</tr>
<tr>
<td>16.</td>
<td>CHIEF EXECUTIVE</td>
<td>Tendering and contract procedure.</td>
</tr>
<tr>
<td>16.5.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Waive formal tendering procedures for contracts up to £100,000.</td>
</tr>
<tr>
<td>16.5.3</td>
<td>DIRECTOR OF PROCUREMENT &amp; E-COMMERCE</td>
<td>Waive formal tendering procedures for contracts up to £25,000.</td>
</tr>
<tr>
<td>16.5.3</td>
<td>TRUST BOARD</td>
<td>Waive formal tendering procedures for contracts above £100,000.</td>
</tr>
<tr>
<td>16.5.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Report waivers of tendering procedures to the Audit and Risk Committee.</td>
</tr>
<tr>
<td>16.5.5</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Approve seeking tenders from building or engineering construction works supplier not on the approved list and record in waivers register and report to Audit and Risk Committee.</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>16.6.6</td>
<td>CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER</td>
<td>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 as advised by the Chief Financial Officer.</td>
</tr>
<tr>
<td>16.6.7</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Will appoint a manager to maintain a list of building and engineering construction works approved firms.</td>
</tr>
<tr>
<td>16.6.8</td>
<td>CHIEF FINANCIAL OFFICER AND DIRECTOR OF PROCUREMENT AND ECOMMERCE</td>
<td>Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.</td>
</tr>
<tr>
<td>16.7</td>
<td>DIRECTOR OF PROCUREMENT AND ECOMMERCE</td>
<td>Responsible for the provision and updating of the Procurement of Goods and Services policy.</td>
</tr>
<tr>
<td>16.7.1</td>
<td>DIRECTOR OF PROCUREMENT AND ECOMMERCE</td>
<td>The Director of Procurement and eCommerce or his nominated officer and the respective Directorate should evaluate the tender/quotation and select the quote which gives the best value for money.</td>
</tr>
<tr>
<td>16.7.3</td>
<td>CHIEF EXECUTIVE OR CHIEF FINANCIAL OFFICER</td>
<td>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 advised by the Chief Financial Officer.</td>
</tr>
<tr>
<td>16.8</td>
<td>ANY EXECUTIVE DIRECTOR AND SITE MANAGING DIRECTOR/CORPORATE DIRECTOR</td>
<td>Authorisation of Tenders and Competitive Quotations; Under £600,000 (excluding VAT and over the life of the contract), with professional guidance from the Director of Procurement and e-Commerce.</td>
</tr>
<tr>
<td>16.8</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Authorisation of Tenders; Between £600,000 and £1,000,000 (excluding VAT and over the life of the contract), with professional guidance from the Director of Procurement and e-Commerce.</td>
</tr>
<tr>
<td>16.8</td>
<td>TRUST BOARD</td>
<td>Authorisation of Tenders over £1,000,000</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16.10</td>
<td>CHIEF EXECUTIVE</td>
<td>The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.</td>
</tr>
<tr>
<td>16.10</td>
<td>TRUST BOARD</td>
<td>All PFI proposals must be agreed by the Board.</td>
</tr>
<tr>
<td>16.11</td>
<td>CHIEF EXECUTIVE</td>
<td>The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.</td>
</tr>
<tr>
<td>16.12</td>
<td>CHIEF EXECUTIVE</td>
<td>The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. With the exception of Medical Consultant staff and, subject to compliance with existing HR and financial controls, this will be the Trust’s Budget Holders.</td>
</tr>
<tr>
<td>16.18</td>
<td>CHIEF EXECUTIVE</td>
<td>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.</td>
</tr>
<tr>
<td>16.22</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Authorise the arrangement of operational or finance leases with a total lifecycle value (including residual value) of less than £1,000,000.</td>
</tr>
<tr>
<td>16.22</td>
<td>BOARD</td>
<td>Authorise the arrangement of operational or finance leases with a total lifecycle value (including residual value) of more than £1,000,000.</td>
</tr>
<tr>
<td>17.1.1</td>
<td>CHIEF EXECUTIVE</td>
<td>Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services.</td>
</tr>
<tr>
<td>17.3</td>
<td>CHIEF EXECUTIVE</td>
<td>As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA.</td>
</tr>
<tr>
<td>18.1.1</td>
<td>BOARD</td>
<td>Establish a Nominations and Remuneration Committee.</td>
</tr>
<tr>
<td>18.1.2</td>
<td>NOMINATIONS AND REMUNERATION COMMITTEE</td>
<td>Agree the remuneration and terms of service of the Chief Executive, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust’s circumstances and any national agreements. Monitor and evaluate the performance of individual senior employees.</td>
</tr>
<tr>
<td>18.2.2</td>
<td>CHIEF EXECUTIVE</td>
<td>Approval of variation to funded establishment of any department.</td>
</tr>
<tr>
<td>18.3</td>
<td>DIRECTOR OF PEOPLE</td>
<td>Staff, including agency staff, appointments and re-grading.</td>
</tr>
<tr>
<td>18.3.5</td>
<td>DIRECTOR OF PEOPLE AND</td>
<td>Approve redundancy payments, non contractual payments and compromise agreements less than</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td></td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>£100,000</td>
</tr>
<tr>
<td>18.3.5</td>
<td>NOMINATIONS AND REMUNERATION COMMITTEE</td>
<td>Agree those Compromise Agreements, Settlements and Redundancy Payments which require final approval by NHS London/HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director. Approve redundancy payments, non contractual payments and compromise agreements above £100,000. Receive reports on all other redundancy payments, non-contractual payments and compromise agreements.</td>
</tr>
</tbody>
</table>
| 18.4.1 and 18.4.2 | CHIEF FINANCIAL OFFICER | Payroll:  
  a) specifying timetables for submission of properly authorised time records and other notifications;  
  b) final determination of pay and allowances;  
  c) making payments on agreed dates;  
  d) agreeing method of payment;  
  e) issuing instructions (as listed in SFI 18.4.2). |
<p>| 18.4.3  | BUDGET HOLDER | 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. |
| 18.4.4  | CHIEF FINANCIAL OFFICER | Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies. |
| 18.5    | BUDGET HOLDER | Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment. |
| 19.1    | 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. |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1.3</td>
<td>CHIEF EXECUTIVE</td>
<td>Set out procedures on the seeking of professional advice regarding the supply of goods and services.</td>
</tr>
<tr>
<td>19.2.1</td>
<td>BUDGET HOLDER</td>
<td>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.</td>
</tr>
<tr>
<td>19.2.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Shall be responsible for the prompt payment of accounts and claims.</td>
</tr>
</tbody>
</table>
| 19.2.3  | CHIEF FINANCIAL OFFICER | a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;  
|  |  | b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds;  
|  |  | c) Be responsible for the prompt payment of all properly authorised accounts and claims;  
|  |  | d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;  
|  |  | e) Be responsible for a timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;  
|  |  | f) Instructions to employees regarding the handling and payment of accounts within the Finance Department;  
<p>|  |  | g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received |
| 19.2.3  | CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL OFFICER | Approve requisitions within budgets approved by the Board |
| 19.2.4  | APPROPRIATE EXECUTIVE DIRECTOR | Make a written case to the CFO to support the need for a prepayment. |
| 19.2.4  | CHIEF FINANCIAL OFFICER | Approve proposed prepayment arrangements. |
| 19.2.4  | BUDGET HOLDER | Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered). |
| 19.2.5  | CHIEF EXECUTIVE | Authorise who may use and be issued with official orders. |</p>
<table>
<thead>
<tr>
<th>SFI REF</th>
<th>DELEGATED TO</th>
<th>AUTHORITIES/DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.2.6</td>
<td>MANAGERS AND OFFICERS</td>
<td>Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer.</td>
</tr>
<tr>
<td>19.2.8</td>
<td>CHIEF EXECUTIVE CHIEF FINANCIAL OFFICER</td>
<td>Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.</td>
</tr>
<tr>
<td>19.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.</td>
</tr>
<tr>
<td>20.1.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>The CFO will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.</td>
</tr>
<tr>
<td>20.1.2</td>
<td>BOARD</td>
<td>Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and CFO.)</td>
</tr>
<tr>
<td>20.1.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Prepare detailed procedural instructions concerning applications for loans and overdrafts.</td>
</tr>
<tr>
<td>20.1.5</td>
<td>CHIEF EXECUTIVE OR CHIEF FINANCIAL OFFICER</td>
<td>Be on an authorising panel comprising one other member for short term borrowing approval.</td>
</tr>
<tr>
<td>20.2.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Will advise the Board on investments and report, periodically, on performance of same.</td>
</tr>
<tr>
<td>20.2.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Prepare detailed procedural instructions on the operation of investments held.</td>
</tr>
<tr>
<td>21</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Ensure that Board members are aware of the Financial Framework and ensure compliance.</td>
</tr>
<tr>
<td>22.1.1 &amp; 2</td>
<td>CHIEF EXECUTIVE</td>
<td>Capital investment programme:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) ensure that a business case is produced for each proposal.</td>
</tr>
<tr>
<td>22.1.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Certify professionally the costs and revenue consequences detailed in the business case for capital investment.</td>
</tr>
<tr>
<td>22.1.3</td>
<td>CHIEF EXECUTIVE</td>
<td>Issue procedures for management of contracts involving stage payments.</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>22.1.4</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Assess the requirement for the operation of the construction industry taxation deduction scheme.</td>
</tr>
<tr>
<td>22.1.5</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.</td>
</tr>
<tr>
<td>22.1.6</td>
<td>CHIEF EXECUTIVE</td>
<td>Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.</td>
</tr>
<tr>
<td>22.1.7</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.</td>
</tr>
<tr>
<td>22.2.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.</td>
</tr>
<tr>
<td>22.2.1</td>
<td>BOARD</td>
<td>Proposal to use PFI must be specifically agreed by the Board.</td>
</tr>
<tr>
<td>22.3.1</td>
<td>CHIEF EXECUTIVE</td>
<td>Maintenance of asset registers (on advice from CFO).</td>
</tr>
<tr>
<td>22.3.5</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.</td>
</tr>
<tr>
<td>22.3.8</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Calculate and pay capital charges in accordance with Department of Health and Social Care requirements.</td>
</tr>
<tr>
<td>22.4.1</td>
<td>CHIEF EXECUTIVE</td>
<td>Overall responsibility for fixed assets.</td>
</tr>
<tr>
<td>22.4.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Approval of fixed asset control procedures.</td>
</tr>
<tr>
<td>22.4.4</td>
<td>BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF</td>
<td>Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.</td>
</tr>
<tr>
<td>23.2</td>
<td>CHIEF EXECUTIVE</td>
<td>Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)</td>
</tr>
<tr>
<td>23.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Responsible for systems of control over stores and receipt of goods.</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23.2</td>
<td>DIRECTOR OF PHARMACY</td>
<td>Responsible for controls of pharmaceutical stocks</td>
</tr>
<tr>
<td>23.2</td>
<td>NEW HOSPITALS PROGRAM DIRECTOR</td>
<td>Responsible for control of stocks of fuel oil and coal.</td>
</tr>
<tr>
<td>23.2</td>
<td>BUDGET HOLDER</td>
<td>Security arrangements and custody of keys.</td>
</tr>
<tr>
<td>23.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Set out procedures and systems to regulate the stores.</td>
</tr>
<tr>
<td>23.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Agree stocktaking arrangements.</td>
</tr>
<tr>
<td>23.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Approve alternative arrangements where a complete system of stores control is not justified.</td>
</tr>
<tr>
<td>23.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.</td>
</tr>
<tr>
<td>23.2</td>
<td>BUDGET HOLDER</td>
<td>Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking.</td>
</tr>
<tr>
<td>23.3</td>
<td>CHIEF EXECUTIVE</td>
<td>Identify persons authorised to requisition and accept goods from NHS Supplies stores.</td>
</tr>
<tr>
<td>24.1.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.</td>
</tr>
<tr>
<td>24.2.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.</td>
</tr>
<tr>
<td>24.2.2</td>
<td>ALL STAFF</td>
<td>Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and CFO.</td>
</tr>
<tr>
<td>24.2.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Where a criminal offence is suspected, CFO must inform the police if theft or arson is involved. In cases of fraud, bribery and corruption CFO must inform the relevant LCFS in line with SoS directions.</td>
</tr>
<tr>
<td>24.2.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Notify NHS Counter Fraud Authority (NHS CFA) and External Audit of all frauds.</td>
</tr>
<tr>
<td>24.2.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>24.2</td>
<td>SEE SCHEDULE III</td>
<td>Authority to write off losses and make and Special Payments</td>
</tr>
<tr>
<td>24.2.4</td>
<td>BOARD</td>
<td>Approve write of losses (within limits delegated by DH).</td>
</tr>
<tr>
<td>24.2.6</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Consider whether any insurance claim can be made.</td>
</tr>
<tr>
<td>24.2.7</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Maintain losses and special payments register.</td>
</tr>
<tr>
<td>25.1</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Responsible for accuracy and security of computerised financial data.</td>
</tr>
<tr>
<td>25.1.3</td>
<td>DIRECTOR OF CORPORATE DEVELOPMENT</td>
<td>Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.</td>
</tr>
<tr>
<td>25.2.1</td>
<td>BUDGET HOLDERS</td>
<td>Send proposals for general computer systems to Director responsible for IT</td>
</tr>
<tr>
<td>25.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>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.</td>
</tr>
<tr>
<td>25.4</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery and business continuity plans are in place.</td>
</tr>
<tr>
<td>25.5</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) CFO and staff have access to such data; d) such computer audit reviews as are considered necessary are being carried out.</td>
</tr>
<tr>
<td>26.2</td>
<td>CHIEF EXECUTIVE</td>
<td>Responsible for ensuring patients and guardians are informed about patients’ money and property procedures on admission.</td>
</tr>
<tr>
<td>SFI REF</td>
<td>DELEGATED TO</td>
<td>AUTHORITIES/DUTIES DELEGATED</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26.3</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>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.</td>
</tr>
<tr>
<td>26.3.4</td>
<td>DEPARTMENTAL MANAGERS</td>
<td>Inform staff of their responsibilities and duties for the administration of the property of patients.</td>
</tr>
<tr>
<td>27</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff.</td>
</tr>
<tr>
<td>28</td>
<td>CHIEF EXECUTIVE</td>
<td>Retention of document procedures in accordance with HSC 1999/053.</td>
</tr>
<tr>
<td>29.1</td>
<td>CHIEF EXECUTIVE</td>
<td>Risk management programme.</td>
</tr>
<tr>
<td>29.1</td>
<td>BOARD</td>
<td>Approve and monitor risk management programme.</td>
</tr>
<tr>
<td>29.2</td>
<td>BOARD</td>
<td>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.</td>
</tr>
<tr>
<td>29.4</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority, the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.</td>
</tr>
<tr>
<td>29.4</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>Ensure documented procedures cover management of claims and payments below the deductible.</td>
</tr>
<tr>
<td>30.2</td>
<td>CHIEF FINANCIAL OFFICER</td>
<td>The Chief Financial Officer shall ensure that each trust fund which the Trust acts as Corporate Trustee is managed appropriately with regard to its purpose and to its requirements.</td>
</tr>
</tbody>
</table>
SECTION D: STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust’s financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Financial Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust’s Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

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

10.2 Responsibilities and delegation

10.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the ['Reservation of Matters Reserved to the Board'] document. All other powers have been delegated to such other committees as the Trust has established.

10.2.4 **The Chief Executive and Chief Financial Officer**

The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

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

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

10.2.6 **The Chief Financial Officer**

The Chief Financial Officer is responsible for:

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

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

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

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include:

(d) the provision of financial advice to other members of the Board and employees;

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

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

10.2.7 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:
(a) the security of the property of the Trust;
(b) avoiding loss;
(c) exercising economy and efficiency in the use of resources;
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.8 Contractors and their employees

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

10.2.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

STANDING FINANCIAL INSTRUCTION 1

11. AUDIT

11.1 Audit and Risk Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (May 2011), which will provide an independent and objective view of internal control by:

(a) overseeing Internal (including Counter Fraud) and External Audit services;
(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
(c) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives;
(d) monitoring compliance with Standing Orders and Standing Financial Instructions;
(e) approve schedules of losses and compensations;
(f) act as the Trust’s Auditor Panel to advise the Trust Board on the appointment and removal of external auditors;
(g) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;
(h) the Audit and Risk Committee will periodically (as defined in its Terms of Reference) review the Waiver Register.
11.1.2 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care. (To the Chief Financial Officer in the first instance.)

11.1.3 It is the responsibility of the Chief Financial Officer to ensure an adequate Internal Audit service is provided and the Audit and Risk Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Chief Financial Officer

11.2.1 The Chief Financial Officer is responsible for:

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

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit and Risk Committee and the Accountable Officer;

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

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

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming five years;
(vi) a detailed plan for the coming year.

11.2.2 The Chief Financial Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

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

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

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

(d) explanations concerning any matter under investigation.
11.3 **Role of Internal Audit**

11.3.1 Internal Audit will review, appraise and report upon:

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

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

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

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

(i) fraud and other offences;

(ii) waste, extravagance, inefficient administration;

(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Framework and the Statement of Internal Control in accordance with Department of Health and Social Care guidance.

(f) Detailed guidance on the powers and responsibilities of Internal Audit and Counter Fraud are set out in the Terms of Reference of the Audit and Risk Committee.

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

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

11.3.4 The Director of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit and Risk Committee and the Director of Internal Audit. 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. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Director of Audit shall seek advice of the Board Chairman or Chairman of the Audit and Risk Committee.

11.3.5 The designated officers must carry out agreed audit recommendations within the timescale for action agreed with the Director of Internal Audit. Failure to do so shall be reported to the Chief Executive who shall take necessary action to ensure compliance with such recommendations.

11.3.6 The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Audit and Risk Committee.
11.4 External Audit

11.4.1 Under the Local Audit and Accountability Act 2014, the External Auditor is appointed, and paid for, by the Trust.

11.4.2 The Local Audit and Accountability Act 2014 requires that Trusts establish Auditor Panels with responsibility for appointment, contract arrangements and relationship management. The Auditor Panel must ensure a cost-efficient service and ensure that if there are any problems relating to the service provided by the External Auditor, that this is addressed and resolved.

11.5 Fraud, Bribery and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Chief Financial Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud, bribery and corruption.

11.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Manual. The LCFS will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairman and Chief Executive of the Trust.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Chief Financial Officer and shall work with staff in the NHS Counter Fraud Authority (NHS CFA) in accordance with the NHS Counter Fraud Manual.

11.5.4 The Local Counter Fraud Specialist will provide an annual written report, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

STANDING FINANCIAL INSTRUCTION 2

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

12.1 Preparation and Approval of Plans and Budgets

12.1.1 The Chief Executive will compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain:
12.1.2 Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit revenue and capital budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds;
(e) identify potential risks.

12.1.3 The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

12.1.4 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled and monitored.

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

12.1.6 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

12.2 Budgetary Delegation

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

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

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

12.2.3 Authority for virement within Sites and Directorates are as follows;

- Any Executive Director or Site/Directorate Director up to £1,000,000 with ability to sub delegate up to £50,000.
- Trust Board above £1,000,000. Virements between Sites and Directorates require joint authority from respective officers.

12.2.4 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.
12.2.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer.

12.3 Non-Budget Expenditure

12.3.1 Budget holders must obtain the prior authorisation of the Chief Executive or the Trust Board before incurring (or authorising to be incurred) any planned expenditure which has not been provided for in an approved budget. Authorisation is required as follows:

<table>
<thead>
<tr>
<th>a)</th>
<th>Expenditure up to £100,000</th>
<th>Chief Executive or Chief Financial Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>c)</td>
<td>Expenditure above £100,000</td>
<td>Trust Board or Delegated Committee (prior approval by Chief Executive Team)</td>
</tr>
</tbody>
</table>

12.4 Budgetary Control and Reporting

12.4.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:
   (i) income and expenditure to date showing trends and forecast year-end position;
   (ii) movements in working capital;
   (iii) Movements in cash and capital;
   (iv) capital project spend and projected outturn against plan;
   (v) explanations of any material variances from plan;
   (vi) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

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

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

12.4.2 Each Budget Holder is responsible for ensuring that:
any likely overspending or reduction of income which cannot be met by
virement is not incurred without the prior consent of the Board;

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

(c) with the exception of Medical and Dental Consultants, no permanent
employees are appointed without the approval of the Chief Executive other
than those provided for within the available resources and manpower
establishment as approved by the Board;

(d) new Medical and Dental Consultant posts are identified and agreed to as part
of the Annual Business Plan or via approval of a business case.

(e) identifying and implementing cost improvements, cost savings and income
generation initiatives to achieve a balanced budget; and

(f) effective systems exist within the directorate to ensure that all expenditure is
authorised in advance of commitment (e.g. operation of authorised signatory
systems) and that the individuals incurring expenditure fully understand their
budgetary control responsibilities.

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

12.4.4 The Performance Framework requires Directorates to consider the directorate
finance report each month and take any corrective action to meet their delegated
budget and Best Value and Cost Improvement targets.

12.5 Capital Expenditure

12.5.1 The general rules applying to delegation and reporting shall also apply to capital
expenditure. (The particular applications relating to capital are contained in SFI 12).

12.6 Monitoring Returns

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

STANDING FINANCIAL INSTRUCTION 3

13. ANNUAL ACCOUNTS AND REPORTS

13.1 The Chief Financial Officer

13.1.1 The Chief Financial Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and
guidance given by the Department of Health and Social Care and the
Treasury, the Trust’s accounting policies, and generally accepted accounting
practice;
(b) prepare and submit annual financial reports to the Department of Health and Social Care certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

(e) responsible for the issue of full guidance and timetables relating to the preparation of the financial returns and annual report to all finance and non finance staff identified as stakeholders in the process.

(f) will ensure that an adequate audit trail exists for the financial returns.

(g) liaise with the Trust secretariat to ensure that the financial returns are examined by the Audit Committee and considered by and adopted by the Trust Board in accordance with the timetable.

13.2 Appointment of Auditors

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

13.3 Annual report and Quality Accounts

13.3.1 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care’s Manual for Accounts.

13.3.2 The draft management letter will be discussed with the Chief Executive and Chief Financial Officer. It will also be discussed at a meeting of the Audit Committee prior to submission to the Board. In its final form, the management letter will be addressed and submitted to all members of the Board.

STANDING FINANCIAL INSTRUCTION 4

14. BANK AND GBS ACCOUNTS

14.1 General

14.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health and Social Care. As per DH guidance, Trusts should minimize the use of commercial bank accounts and using the Government Banking Service (GBS) for all banking services where possible.

14.1.2 The Board shall approve the banking arrangements.

14.2 Bank and GBS Accounts

14.2.1 The Chief Financial Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;
(b) establishing separate bank accounts for the Trust's non-exchequer funds;
(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
(e) monitoring compliance with DH guidance on the level of cleared funds.
(f) all funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer shall open any bank account in the name of the Trust.

14.3 Banking Procedures

14.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;
(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

14.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

14.4 Tendering and Review

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

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

14.5 Signatories

14.5.1 SFI Schedule I sets out the authority limits for cheque and other payments methods. The Chief Financial Officer will advise the bankers in writing of the officers authorised to release money from or draw cheques on each bank account of the Trust. Cancellation of authorisation will be notified promptly to the bankers.

14.6 Charitable Funds/Special Trustees

14.6.1 Charitable funds associated with the Trust are administered by Barts Charity. Guidance on the handling and management of donations etc are contained in the Trust's Policy Manuals (Donations and Gifts).

14.7 External Borrowing - see section 20

STANDING FINANCIAL INSTRUCTION 5
15. **INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS**

15.1 **Income Systems**

15.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

15.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

15.2 **Fees and Charges**

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

15.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care 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 and Social Care’s Commercial Sponsorship – Ethical standards in the NHS shall be followed.

15.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. Relevant and full supporting details must be supplied.

15.2.4 An advanced deposit must be obtained for all self pay elective activity equivalent to the estimated cost of the treatment in advance of any treatment being provided.

15.2.5 No officer of the Trust, except within the boundaries of any delegated authority, is allowed to confirm or agree with a third party (whether NHS or Non-NHS), any reduction to or waiver of the Trusts normal charges, without the prior express authority of the Chief Financial Officer if less than £100,000, the Board if over £100,000.

15.3 **Debt Recovery**

15.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

15.3.2 Income not received should be dealt with in accordance with losses procedures (Instruction 14 Disposals And Condemnations, Losses And Special Payments).

15.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated. Any phasing of agreed overpayment must be authorised by Chief Financial Officer.

15.3.4 No officer without prior approval from the Chief Financial Officer is allowed to agree with any third party to the cancellation or reduction of a legitimate debt owed to the Trust.

15.4 **Security of Cash, Cheques and other Negotiable Instruments**

15.4.1 The Chief Financial Officer is responsible for:
(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

15.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

15.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss (Instruction 16 Patients Property).

15.4.5 Duties of Managers and Officers required to manage and handle cash

Must ensure that;

(a) cash is recorded upon receipt, and that there is secure storage available for that cash until it is transferred to the Cashiers Office for banking.

(b) where practically possible all transactions are adequately witnessed and that amounts received are identical to those deposited in Finance.

(c) staff are not put at unnecessary risk while handling or transporting cash.

(d) adhere at all times to the guidance set out in the “Cash Handling” procedure.

**STANDING FINANCIAL INSTRUCTION 6**

**16. TENDERING AND CONTRACTING PROCEDURE**

**16.1 Duty to comply with Standing Orders and Standing Financial Instructions**

16.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied), supplemented by such operational procedures as deemed necessary by the Chief Executive and the Chief Financial Officer. These operational procedures shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

16.1.2 For all procurements, the Trust's Procurement of Goods and Services Policy must be followed. For procurement in relation to IT equipment or systems/Medical Equipment, regardless of value, the Director of ICT/Head of Clinical Engineering
respectively must approve the specification prior to commencement of the procurement process.

16.1.3 Prior to tenders being invited, it must be confirmed that funding approval has been granted by the relevant board or committee; the proposed goods, services or works have been adequately specified; as appropriate, the design brief and drawings have been approved and signed off by the primary users; any required statutory approvals have been obtained.

16.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. In the event of any conflict between these SFIs and such Directives, the Directives shall prevail.

16.3 Reverse eAuctions

Tendering activity carried out by Reverse eAuction shall adhere to the Procurement of Goods and Services Policy. The operational procedure shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

16.4 Capital Investment Manual and other Department of Health and Social Care Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care and NHS Improvement guidance.

16.5 Formal Competitive Tendering (contract value of £100,000 excluding VAT or more)

16.5.1 General Applicability

Unless national contracts, Framework Agreements, Procure 21, or similar procedures are followed, quotes or tenders must be obtained for the following services:

- the supply of goods, materials, equipment and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care or NHS Improvement);
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- disposals.

The number of quotes or tenders required are set out in the following table:
<table>
<thead>
<tr>
<th>Goods &amp; Services (including Capital)*</th>
<th>Works (including Capital)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £5,000: 1 verbal quotation (minimum)</td>
<td>Up to £50,000: 3 written quotations (minimum)</td>
</tr>
<tr>
<td>Between £5,000 and £50,000: 2 written quotations (minimum)</td>
<td>Between £50,000 and £100,000: 4 written quotations (minimum)</td>
</tr>
<tr>
<td>Between £50,000 and OJEU Limit: 3 written quotations (minimum)</td>
<td>Between £100,000 to OJEU Limit: 4 tenders (minimum)</td>
</tr>
<tr>
<td>Over OJEU Limit: EU directive applies</td>
<td>Over OJEU Limit: EU directives apply</td>
</tr>
</tbody>
</table>

- Values exclude VAT and are over the life of the contract

16.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of health care services, these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

16.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income is, or is reasonably expected to be, less than the prevailing OJEU threshold for Goods & Services (excluding VAT) over the life of the contract, Standing Financial Instruction No 6: 16.7 covering verbal and written quotations applies instead;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 14;

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

(e) where NHS Supply Chain, Crown Commercial Services (CCS) or any other public sector body led (e.g. NHS collaborative procurement hubs) agreements are in place which are legally constructed to permit the Trusts participation;

(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 where the Director of Procurement is satisfied that the consortium procurement arrangements conform to current statute and deliver value for money;

(g) where allowed and provided for in the Capital Investment Manual;

(h) where payment is being made to a current Founding Partner, Executive Partner or Member of the UCL Partners (Academic Health Science Partnership), the requisition and supporting purchase order must state
‘Payment made under UCL Partners (Academic Health Science Partnership)’ along with a description of what the payment is for.

(i) Where a statutory payment can only be made to a specific statutory body (e.g. rates), authorisation of the bodies considered in this category will be determined by the Chief Financial Officer, Director of Procurement and eCommerce or Director of Corporate Development.

(j) Where payment is to another NHS body and the Director of Procurement and eCommerce is satisfied that the procurement arrangements conform to current statute and deliver value for money;

(k) Where payment is less than the current OJEU threshold for Goods & Services and is for the renewal of maintenance services under an original supplier contract to provide equipment or IT and the Director of Procurement and eCommerce is satisfied that the procurement arrangements conform to current statute and deliver value for money;

(l) Where payment is less than the current OJEU threshold for Goods & Services and is for the renewal of software license agreements under an original supplier contract to provide software licenses and the Director of Procurement and eCommerce is satisfied that the procurement arrangements conform to current statute and deliver value for money;

(m) Where payment is less than the current OJEU threshold for Goods & Services and is for the purchase of replacement equipment parts under an original supplier contract to provide medical equipment and the Director of Procurement and eCommerce is satisfied that the procurement arrangements conform to current statute and deliver value for money;

(n) Formal tendering procedures may only be waived in very exceptional circumstances detailed in (a) to (h) below (up to the current Official Journal of The European Union limit for goods and services) in accordance with the procedure defined by the Chief Financial Officer. The full circumstances for the waiver must be detailed in an appropriate Trust record maintained by the Chief Financial Officer and reported to the Trust’s Audit committee for scrutiny.

(a) were the timescale genuinely precludes competitive tendering. However, failure to plan the work properly is not a justification for a waiver of competitive tendering;

(b) where there is only one supplier of the goods or services required or where specialist expertise is required and is available from only one source;

(c) 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;

(d) where there is a clear benefit to be gained from maintaining continuity with an earlier project/equipment procurement exercise. In all cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(e) where it is necessary to place an emergency ‘out of hours’ order or commit expenditure the on-call estates manager can agree with the Executive on-call to contract on the basis of a single verbal quote up to £10,000 and report this to the Director of Finance and Director of Estates the next day.
(f) where it is necessary to place an emergency ‘out of hours’ order for ex formulary drugs the governing Pharmacy authorisation practice must be followed.

(g) for renewal of maintenance services under an original supplier contract to provide equipment or IT, where the value exceeds the current OJEU threshold for Goods & Service.

(h) for the provision of legal advice and services providing that any legal form 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 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 proposed that the circumstances in SFI 6, 16.5.3 apply, a formal request for a waiver of competition must be made in writing to the Director of Procurement and E-Commerce using the required application form. This shall set out the nature of the goods and services, reasons why a waiver is deemed necessary, the proposed supplier and an estimate of the value of the contract concerned.

In considering waiver requests, the Director of Procurement and E-Commerce must, and will, have regard for specific European Union legislation regarding requirements for competition and exemption from the specified processes where the value of the procurement exceeds the EU threshold.

Where the proposed waiver is for a contract with a value of less than £25,000 approval can be sought from Finance Director - Operational or Director of Procurement & E-Commerce or Chief Financial Officer. If the contract value is between £25,000 and £100,000, the waiver must be approved by the Chief Financial Officer. If the contract value exceeds £100,000, the waiver must be approved by the Trust Board. Only after approval may the waiver be granted.

16.5.4 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 6, 16.1 and 16.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as set out in section 16.5.1 above. No firm should be formally invited to tender unless they have expressed a willingness to do so.

16.5.5 Building and engineering construction works approved firms

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists, where approved lists are held either by the Trust or third parties. Seeking of tenders from suppliers not on the approved lists shall be treated as a waiver of these SFIs. Such instances must be approved in writing by the Chief Financial Officer, recorded in the Tender
Waivers Register and reported to the Audit Committee (see also SFI 6, 16.6.7 List of Approved Firms). Where Framework Agreements have been tendered, the rotation of firms may depend upon particular expertise otherwise on a fair basis. Under EU procurement regulations the restriction of competition to approved lists of companies is not permitted and therefore such lists should not be held for goods/services where the threshold captures a significant proportion of tendered business.

16.5.6 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

16.5.7 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used and which subsequently prove to have a value above such limits shall be reported to the Director of Procurement via a retrospective waiver and approved via the process in 16.5.3 (n). Retrospective waivers are recorded and reported by to the Audit Committee.

16.6 Contracting/Tendering Procedure

16.6.1 Invitation to tender

(i) All invitations to tender shall be in electronic format, either email or via the electronic e-sourcing tool unless agreed in writing with the Director of Procurement.

(j) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(k) If the contract value is over OJEU threshold, the electronic portal must be used.

(ii)

(v)

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

(vii) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.
(ix) The identity of firms being invited to tender shall not be revealed to other tenderers for that work (any exception to this as part of an eProcurement arrangement will need to follow procedural requirements set out in the Procurement of Goods and Services policy and require endorsement by the Director of Procurement and eCommerce).

(x) Every tender must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practice.

16.6.2
16.6.3

16.6.4 Retention of tender documentation

The returned tender responses, the specification and evaluation notes and Minutes must be retained electronically for audit purposes for the financial year in which the tender exercise falls plus seven financial years. Internal and External Audit will periodically review all aspects of procurement, including the choice of companies invited to tender and the operation of these procedures. The process may also be challenged by unsuccessful bidders. It is therefore vital that complete documentation demonstrating the decision making process is produced and retained.

16.6.5 Admissibility of tenders

(i) If all tenders received exceed the approved estimate, the procuring officer, taking into account the advice of the appropriate senior manager and the Chief Financial Officer, shall determine how best to proceed.

(ii) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified), the Director of Procurement and E-Commerce shall determine how best to proceed. The ultimate decision shall be recorded, together with any reasons.

(iii) Tenders received after the due time and date, but prior to the opening of the other tenders, may be regarded as having arrived in due time only if the Director of Procurement decides that the tender was dispatched in good time but delayed through no fault of the tenderer.

(iv) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if process of evaluation and adjudication has not started. The reason for admitting a tender under such circumstances must be formally minuted and retained with the tender documentation.

(v) Qualified tenders (i.e. where a contractor proposed conditions which differ from those laid down by the Board), incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing), amended tenders (i.e. those amended by the tenderers upon his own initiative either orally or in writing after the due time for receipt) and those accidentally opened in error, shall be considered by the Chief Executive. He, taking into account advice of the Chief Financial Officer, shall decide whether they are admissible and minute decisions taken, together with any reasons.
(vii) While decisions as to the admissibility of late, qualified, incomplete or amended tenders or tenders opened in error are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Trust Secretary or his nominated officer.

(viii) Any tender received which has not been invited by the Trust shall be returned to the tenderer.

16.6.6 Acceptance of formal tenders

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

(ii) 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.

(iii) The lowest tender (if payment is to be made by the Trust) or the highest tender (if payment is to be received by the Trust) shall be accepted unless there are good and sufficient reasons to the contrary. Exceptions to this provision will require a waiver of Standing Financial Instructions. Application for such a waiver must be made in writing to the Director of Procurement and E-Commerce, setting out the reasons for the request. Such waivers will be recorded in a Tender Waivers Register held by the Chief Financial Officer and reported to the Trust's Audit Committee at each meeting. Where the proposed waiver is for a contract with a value exceeding £100,000, the Chief Financial Officer must submit the request for a waiver, in advance, to the Trust Board for approval. Only after Board approval may the waiver be granted.

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

(v) Tenders for contracts shall only be awarded after they have been approved by the appropriate authority as set out in section 16.8 and following confirmation from the Director of Procurement and E-commerce that correct procedures have been adhered to for the particular procurement process.

(vi) 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 as advised by the Chief Financial Officer.

(vii) The use of these procedures must demonstrate that the award of the contract was:

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

(b) that best value for money was achieved.

(viii) All tenders should be treated as confidential and should be retained for inspection.
16.6.7 List of approved firms building and engineering construction works (see SFI No. 6, 16.5.5)

(a) Responsibility for maintaining list

If appropriate a manager nominated by the Chief Financial Officer shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust’s terms and conditions of contract and their requirement to adhere to the Trust’s Standing Orders and Standing Financial Instructions. All approved suppliers/contractors must be provided with a copy of the Trust’s Standing Orders and Standing Financial Instructions prior to contract.) Under EU procurement rules it is not permitted to restrict competition to an approved list where the expenditure exceeds the relevant threshold.

(b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) Financial Standing and Technical Competence of Contractors

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

16.6.8 Exceptions to using approved contractors

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

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

16.7 Quotations: Competitive and non-competitive

Quotations can be handled entirely by the Procurement and Supplies Department in liaison with the respective Directorate. Further details are provided in the Trust’s Tendering for Goods and Services Policy. The policy is complementary to the Standing Financial Instructions and use is mandatory for all staff involved in any aspect of procurement. The Director of Procurement and eCommerce is responsible for the provision and updating of the policy.

16.7.1 Competitive Quotations *(contract value less than £100,000 excluding VAT over the life of the contract)*

(i) Competitive quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to be between less than £100,000 (excluding VAT). If the actual expenditure later becomes £100,000 or more (excluding VAT), the Chief Financial Officer must be requested to approve the allocation of work without the use of competitive tendering. The Director of Procurement and eCommerce is responsible for ensuring that a process is in place to ensure that declarations of interest forms have been received for all individuals involved in evaluating the quotations prior to any contract award, where the contract value exceeds £50,000 and in the case of management consultancy services, above £25,000.

(ii) Quotations should be obtained per section 16.5.1. In all cases adhering to Trust Terms and conditions unless agreed by the Director of Procurement and E-Commerce.

(iii) All quotations should be in writing.

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

(v) The Director of Procurement and eCommerce or his nominated officer and the respective Directorate should evaluate the competitive quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record electronically.

16.7.2 Non Competitive Quotations

For the circumstances set out in section 16.5.3 competitive quotes are not required. However, a written quotation must be obtained from the preferred supplier.
16.7.3 Quotations to be within Financial Limits

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

16.8 Authorisation of Tenders and Competitive Quotations

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

- Any Director voting or otherwise and persons directly reporting to Chief Executive under £600,000 (excluding VAT) with professional guidance from the Director of Procurement and e-Commerce.

- Chief Financial Officer between £600,000 and £1,000,000 (excluding VAT) with professional guidance from the Director of Procurement and eCommerce.

- Trust Board £1,000,000 or more (excluding VAT). Contracts will be signed on behalf of the Board by:
  - (a) An Executive Director where a contract has been approved for award by the Trust Board.
  - (b) The Chief Financial Officer where a contract has been approved for award by Chairman's Action and this is awaiting Trust Board ratification;

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

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

Contracts for standard clinical consumables and related services against national approved frameworks do not need to follow the above process and may be signed by the Director of Procurement.

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

Where competitive tendering or a competitive quotation is not required, the Trust shall use in preference and where possible the NHS supply chain or any other procurement public sector body whose agreements are legally constructed to permit the trust's participation unless the Director of Procurement or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

16.10 Private Finance for capital procurement (see overlap with SFI No. 12)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:
(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the Department of Health and Social Care for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

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

16.11 Compliance requirements for all contracts

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

(a) The Trust’s Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable;

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

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

(g) In all contracts made by the Trust, the Board shall endeavor to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

16.11.2 Every contract shall specify:

(a) The same terms and conditions of contract as was the basis on which tenders or quotations were invited. Letters of intent should include all the tender conditions to preserve the contractual relationship before formal execution;

(b) The work, materials to be used, quality specification and service specification (where applicable);

(c) The price to be paid with a statement of discounts or other deductions if any;

(d) The time or times within which the contract is to be performed (where applicable);

(e) Quality standards and compliance monitoring arrangements.

16.11.3 Only Corporate Directors reporting directly to the Chief Executive and procurement staff are permitted to sign contracts following approval as described in this section.
16.12 **Personnel and Agency or Temporary Staff Contracts**

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

16.13 **Cancellation of Contracts**

16.13.1 Except where specific provision is made in model Forms or Contracts or standard Schedules of Conditions approved for use within the National Health Service, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor or a member of his employ (whether with or without his knowledge) has offered, given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for carrying out or failing to carry out any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts 1906 and 1916 and other appropriate legislation.

16.14 **Determination of Contracts for Failure to Deliver Goods or Material and liquidated damages**

16.14.1 There shall be inserted in every written contract for the supply of goods or materials, a clause to ensure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined, the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

16.14.2 All contracts for building and engineering works shall include provision for liquidated damages having regards to the CONCODE provisions. Where a sum above the minimum is required, this shall be determined by the Project Officer in accordance with an estimate of the damages the Trust is likely to incur through late completion of the works by the contractor provided that the amount so derived does not in the opinion of the Project Director or their nominee amount to a penalty.

16.14.3 The Project Director shall determine when liquidated damages shall be enforced after consultation with the Design Team and, if the Project Director considers it necessary, with lawyers.

16.15 **National Contracts**

16.15.1 Where national contracts exist for the supply of goods or services, the use of these contracts shall be mandatory unless the goods or services required are of such a nature i.e. highly specialised as to render the use of these contracts impracticable,
or better value for money can be obtained elsewhere. In the latter case, the contract should be referred back to the Procurement and Supplies Department for confirmation before the contract is let. The Procurement team shall monitor orders placed by Procurement and Supplies Department in the Trust to ensure that proper use is made of negotiated contracts.

16.16 Healthcare Services Agreements (see overlap with SFI No. 7)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with an NHS Foundation Trust, being a Public Benefit Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

16.17 Disposals (See overlap with SFI No. 14)

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

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

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

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

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

(e) land or buildings concerning which Department of Health and Social Care guidance has been issued but subject to compliance with such guidance.

For any item which is to be disposed of by sale, in any form, i.e. competitive tender, quotation, non-competitive quotation or advertisement, the Trust’s Recording and Disposal of Fixed Assets Policy must be followed.

16.18 In-house Services

16.18.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

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

a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).
b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

c) Evaluation group, comprising normally a specialist officer, a member of the Procurement and Supplies department and a Chief Financial Officer representative.

16.18.3 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

16.18.4 The evaluation group shall make recommendations to the Board.

16.18.5 The Chief Executive shall nominate an officer to oversee and manage the contract.

16.19 Research and Development

16.19.1 All research activities (sponsored or unsponsored), to be undertaken by Trust employees, or staff paid directly or indirectly by the Trust and/or using Trust premises, facilities or resources of any kind and/or involving Trust patients or volunteers, must be reported to the Trust’s Research & Development (R&D) Office.

16.19.2 This office has been established to support staff in their research activities, assist them in securing the most beneficial contracts, and ensuring intellectual property rights are properly protected for the benefit of the individual and the Trust. Individuals who do not take projects (which utilise Trust resources) through the R&D Office, shall be liable to reimburse the Trust a sum for overhead costs as determined by the Director of Research & Development.

16.19.3 The R&D Office will have a number of standard operating procedures.

16.20 ICT procurement

16.20.1 There is a need for a consistent approach to ICT procurement, security, development and practice in the Trust, to ensure value for money and that opportunity and risks associated with the above are properly managed. The Trust will have a number of standard policies and procedures.

16.20.2 Compliance with these policies and procedures is compulsory. Systems (hardware/software) purchased or in use without due authority from the Director of ICT will not be supported and may result in disciplinary action being taken.

16.21 Leases

16.21.1 Chief Financial Officer can authorise the arrangement of operational or finance leases with a total lifecycle value (including residual value) of less than £1,000,000. Leases with a lifecycle cost of more than £1,000,000 must be authorised by the Board.
STANDING FINANCIAL INSTRUCTION 7

17. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

17.1 Service Level Agreements (SLAs)

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

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

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

17.2 Involving Partners and jointly managing risk

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

17.3 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.
18. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

18.1 Remuneration and Terms of Service

18.1.1 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.

18.1.2 The Committee shall have delegated authority from the Trust Board to determine the broad remuneration policy and performance management framework and to decide the remuneration, allowances and other terms and conditions of office for the Trust’s senior managers; to monitor and evaluate the performance of individual officer members (and other senior employees); and to oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

18.1.3 The Remuneration Committee Chair shall report orally to the Board after each of its meetings.

18.1.4 The Remuneration Committee will receive reports detailing all Trust employees who have been made redundant or taken early retirement. These reports will include the cost of the redundancy or early retirement.

18.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

18.2 Funded Establishment

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

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

18.3 Staff Appointments

18.3.1 All new Medical and Dental Consultant posts must form part of the Division’s annual Business Plan. Exceptionally the relevant Trust committee may approve business cases to grant funding for a new post in year.

18.3.2 For all other Staff groups, no officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

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

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

18.3.4 No officer or employee of the Trust may commit the Trust to any redundancy, early retirement, or negotiated employment termination settlement without the approval in
advance of the Chief Financial Officer and Director of Human Resources subject to prevailing Treasury approval requirements.

18.3.5 Approve redundancy payments, non contractual payments and compromise agreements.
- Total package less than £100,000 - Director of HR and Chief Financial Officer.
- Total package exceeding £100,000 - Remuneration Committee.

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

18.4 Processing Payroll

18.4.1 The Chief Financial Officer is responsible for:
- (a) specifying timetables for submission of properly authorised time records and other notifications;
- (b) the final determination of pay and allowances;
- (c) making payment on agreed dates;
- (d) agreeing method of payment.

18.4.2 The Chief Financial Officer will issue instructions regarding:
- (a) verification and documentation of data;
- (b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- (c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- (d) security and confidentiality of payroll information;
- (e) checks to be applied to completed payroll before and after payment;
- (f) authority to release payroll data under the provisions of the Data Protection Act;
- (g) methods of payment available to various categories of employee and officers;
- (h) procedures for payment by cheque, bank credit, or cash to employees and officers;
- (i) procedures for the recall of cheques and bank credits;
- (j) pay advances and their recovery;
- (k) maintenance of regular and independent reconciliation of pay control accounts;
- (l) separation of duties of preparing records and handling cash;
(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

(n) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement

(o) Where the payroll service has been contracted out, these instructions will be agreed between the parties concerned and documented as part of the SLA.

18.4.3 Appropriately nominated managers have delegated responsibility for:

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

(b) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;

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

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

18.4.5 The dates on which the payments of salaries and wages are to be made, including special circumstances (e.g. Christmas and other bank holidays), will be in accordance with agreed timetables, having regard to the general rule that it is undesirable to make payments in advance. Payment to an individual shall not be made in advance of the normal pay day, except as authorised by the Chief Financial Officer to meet special circumstances and limited to the net pay due at the time of payment.

18.5 **Contracts of Employment**

18.5.1 The Board shall delegate responsibility to an nominated manager for:

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

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

18.6 **Ex-Gratia Payments**

18.6.1 Ex-gratia payments can only be made after approval has been obtained in accordance with schedule III of the SFI's.
18.7 **Managers Responsibility**

18.7.1 Managers are responsible for:

(a) following the procedures and guidance relating to the completion and submission of payroll documentation.

(b) submission of termination forms submitted to payroll as soon as an employee within their establishment resigns, is terminated or gives notice of retirement.

(c) ensuring that there are appropriate systems of internal check and control in place within their directorate etc, to ensure that time records, expense claims etc are capable of meaningful certification.

**STANDING FINANCIAL INSTRUCTION 9**

19. **NON-PAY EXPENDITURE**

19.1 **Delegation of Authority**

19.1.1 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.

19.1.2 The Chief Executive will set out:

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

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

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

19.1.4 A Trust Purchase Order (PO) must be raised before any expenditure can be incurred on behalf of the Trust.

19.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 6)**

19.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust’s adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

19.2.2 System of Payment and Payment Verification

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

19.2.3 The Chief Financial Officer will:

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

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

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

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

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

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

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

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

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 9, 19.2.4 below.

19.2.4 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages;
(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

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

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

19.2.5 Official orders

All official orders must be generated from the Trust financial system, except Pharmacy orders, which must be generated from the Pharmacy system, and temporary staffing orders, known as BRNs (Booking Reference Number), which must be generated from the Temporary Staffing booking system.

Orders must:

(a) be consecutively and uniquely numbered;

(b) be in a form approved by the Chief Financial Officer;

(c) state the Trust’s terms and conditions of trade.

19.2.6 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

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

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

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;
(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 93(5) Standards of Business Conduct for NHS Staff, the Code of Conduct for NHS Managers 2002 and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order purchases from petty cash or a purchase card;

(g) all orders must time and or value limited with an annual renewal unless clear advantages in achieving value for money can be demonstrated from longer term agreements.

(h) 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”;

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

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

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Financial Officer;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

(m) petty cash records are maintained in a form as determined by the Chief Financial Officer.

(n) No officer shall place any order with an individual to whom the officer is related or with any firm in which the officer has a financial interest without first making a declaration of interest in writing to the Trust in accordance with guidance on “Standards of Business Conduct for NHS Staff”.

19.2.7 Receipting of goods and services

All departments must have arrangements in place that ensure that:

a) Goods and services ordered are received and checked for quality and acceptability against the order specification.

b) That a goods are receipted on the Oracle electronic finance and procurement system.

19.2.8 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
19.2.9 The Chief Financial Officer is responsible for maintaining and updating a register of financial authorities.

19.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

19.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.)

19.4 Responsibilities of All Employees

19.4.1 All employees must:

a. prior to raising or authorising any requisition ensure that adequate budgetary provision exists against the budget code they are using, or they have made appropriate arrangements for virement or reporting the expected over commitment. If these checks have not been undertaken or budgetary provision does not exist, they should draw this to the attention of the signatory/line manager.

b. follow the Trust’s procedures when obtaining goods, works and services (e.g. Tendering for Goods and Services Procedure) and obtain best value for money,

c. follow the Trust’s procedures on certifying receipt of goods, works and services to enable invoices to be paid (relevant management procedures);

d. and in particular note and comply with the following points:

   i) prepayments are permitted only in exceptional circumstances and must be approved in advance by the Chief Financial Officer;

   ii) all non-stock orders (ie orders to be satisfied by means other than NHS Supply Chain orders) must be placed via Procurement “self service” and passed to Supplies (except where the employee has been issued specifically with a Trust-authorised purchase card),

   iii) ensure that “stock” requisition items (ie those obtained via NHS Supply Chain) are used wherever possible,

   iv) budgetary provision exists, unless the transaction is specifically authorized by the Chief Financial Officer on behalf of the Chief Executive,

   v) not seek to place orders with firms who have made offers of gifts, rewards or benefits (see Standards of Business Conduct),

   vi) not take goods on trial or loan where this commits the Trust to a future purchase,

   vii) split requisitions to avoid financial thresholds, enter contracts, including rental and leasing agreements, that are for items of a capital nature without the express approval of the Chief Executive and Chief Financial Officer (see SF 6),
vii) Only place orders via Oracle iProcurement. Telephone and direct orders to suppliers are not permitted unless specific arrangements have been agreed in advance with the Director of Procurement and E-Commerce or Chief Financial Officer.

19.5 Supplies

19.5.1 The Trust Supplies department will:

(a) only process properly authorised requisitions and ensure that competition is (or has been) appropriately taken in accordance with the Trust’s Tendering for Goods and Services Procedure;

(b) liaise with the Chief Financial Officer on issues regarding the systems for ordering, receipt and payment;

(c) place sequentially numbered Purchase Orders incorporating the Trust’s terms and conditions of trade.

19.6 Petty Cash

19.6.1 Purchases that will be reimbursed from petty cash are restricted in type (see Schedule II part b) and value (currently £75, see Schedule II part a) and must be supported by receipt(s) and certified by an authorised signatory. Other types of expenditure and financial limits that can be reimbursed from petty cash are listed in Schedule II to the SFIs.

19.6.2 The Chief Financial Officer will determine record-keeping and other instructions relating to petty cash.

STANDING FINANCIAL INSTRUCTION 10

20. EXTERNAL BORROWING

20.1 General

20.1.1 The Chief Financial Officer will advise the Board concerning the Trust’s ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

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

20.1.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

20.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care. Any short term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.
20.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

20.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board.

20.1.7 All loans, or changes to loans, must be approved by the Chief Financial Officer or Finance and Investment Committee.

20.1.8 Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee so delegated by him.

20.1.9 The Chief Financial Officer will include any key balance sheet changes in the “Balanced Scorecard” report prepared for the Trust Board. This will include changes to public dividend capital and other borrowings.

20.2 INVESTMENTS

20.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

20.2.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

20.2.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

STANDING FINANCIAL INSTRUCTION 11

21. FINANCIAL FRAMEWORK

21.1 Chief Financial Officer

21.1.1 The Chief Financial Officer should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to Trust’s. The Chief Financial Officer should also ensure that the direction and guidance in the framework is followed by the Trust.

STANDING FINANCIAL INSTRUCTION 12

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

22.1 Capital Investment

22.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

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

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

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

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

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

22.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estatecode”.

22.1.4 The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

22.1.5 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

22.1.6 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.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with “Estatecode” guidance and the Trust’s Standing Orders.

22.1.7 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 226 and subsequent guidance issued by the Department of Health and Social Care.
22.2 Private Finance (see overlap with SFI No. 6, 16.10)

22.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

22.3 Asset Registers

22.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted every 3 years. Medical and ICT Equipment and will be identified and managed by the Medical Equipment and ICT departments respectively.

22.3.2 The Trust shall maintain an asset register recording fixed assets with sufficient details to enable the assets identification, type of asset, location, budget holder and asset manager.

The minimum data set to be held within these registers shall be as specified under International Financial Reporting Standards (IFRS), the Manual for Accounts and other guidance as issued by the Department of Health and Social Care.

22.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

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

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

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

22.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

22.3.6 The value of each asset shall be indexed to current values in accordance with methods specified by the Department of Health and Social Care in the NHS Manual for Accounts.
22.3.7 The value of each asset shall be depreciated using methods and rates as specified by the Department of Health and Social Care in the NHS Manual for Accounts.

22.3.8 The Chief Financial Officer of the Trust shall calculate and pay capital charges as specified by the Department of Health and Social Care in the NHS Manual for Accounts.

24.3.9 The financial value of a project is the total cost, including all works, furniture, equipment, fees, land and VAT. The procurement of a project in parts, such that any part is below the financial limits, is expressly forbidden.

22.4 Security of Assets

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

22.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

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

22.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

22.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

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

22.4.6 Where practical, assets should be marked as Trust property.

STANDING FINANCIAL INSTRUCTION 13
23. STORES AND RECEIPT OF GOODS

23.1 General position

23.1.2 A controlled store is one which is subject to formal control over access to stocks and detailed records are kept of stock, issues and receipts. Stock is subject to an annual stocktake and subject to formal valuation at the lower of cost and net realisable value. Transactions are only charged to departmental budgets when stock is issued from the store.

23.1.3 Departmental stores are unlikely to have the same level of control as controlled stores and transactions are charged to departmental budgets on receipt of goods. Stock should be subject to periodic stocktake and material differences between year-end figures notified to the Chief Financial Officer.

23.1.4 A number of principles apply to the operation of all stores; managers of stores and stock are responsible for ensuring:

(a) kept to a minimum commensurate with delivery and cost effective purchasing;
(b) subjected to annual stock take, which complies with Year End procedures and timetable issued by the Finance Department;
(c) valued at the lower of cost and net realisable value.
(d) losses and the disposal of obsolete stock are reported to the Chief Financial Officer (and Local Counter Fraud Officer/Risk Management where there is loss due to theft, criminal damage or other untoward incident). (See also SFI 12).

23.2 Control of Stores, Stocktaking, condemnations and disposal

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

23.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

23.2.3 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

23.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

23.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

23.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.
The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 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.

23.3 Goods supplied by NHS Supply Chain

23.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to Accounts Payable who shall satisfy himself that the goods have been received before accepting the recharge.

STANDING FINANCIAL INSTRUCTION 14

24. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

24.1 Disposals and Condemnations

24.1.1 Procedures

The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to all relevant managers. In the case of Medical and ICT equipment the notification of disposal will be received from the medical equipment or ICT equipment management databases.

24.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

24.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

(b) recorded by the Condemning Officer in a form or other notification approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

24.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

24.1.5 Sales to 3rd parties must be accompanied by an indemnity in accordance with Trust Disposal Procedures.

24.2 Losses and Special Payments

24.2.1 Procedures
The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

24.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud, bribery or corruption, the Chief Financial Officer must inform the relevant LCFS in accordance with Secretary of State for Health’s Directions.

The Chief Financial Officer must notify the NHS Counter Fraud Authority (NHS CFA) and the External Auditor of all frauds.

24.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

24.2.4 Following processes notified by the Department of Health and Social Care and within limits delegated to it by the Department of Health and Social Care, the Board shall approve the write-off of losses.

24.2.5 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust’s interests in bankruptcies and company liquidations.

24.2.6 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

24.2.7 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

24.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

24.2.9 All losses and special payments must be reported to the Audit and Risk Committee at every meeting.

24.2.10 Delegation of authority to approve losses and special payments is set out in schedule III.

STANDING FINANCIAL INSTRUCTION 15

25. INFORMATION TECHNOLOGY

25.1 Responsibilities and duties of the Chief Financial Officer

25.1.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

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

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

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

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

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

25.1.3 The Director of Corporate Development shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

25.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

25.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust’s in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director responsible for IT.

(a) details of the outline design of the system;

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

25.3 Contracts for Computer Services with other health bodies or outside agencies

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

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

25.4 Risk Assessment

The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to
mitigate or control risk. This shall include the preparation and testing of appropriate
disaster recovery and business continuity plans.

25.5 Requirements for Computer Systems which have an impact on corporate
financial systems

Where computer systems have an impact on corporate financial systems the Chief
Financial Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate
policies such as an Information Technology Strategy;

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

(c) Chief Financial Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried
out.

STANDING FINANCIAL INSTRUCTION 16

26. PATIENTS’ PROPERTY

26.1 General

26.1.1 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.

26.2 Chief Executive Responsibilities

26.2.1 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;
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought
into Health Service premises, unless it is handed in for safe custody and a copy of
an official patients' property record is obtained as a receipt.

26.3 Management of Property

26.3.1 The Chief Financial Officer must provide detailed written instructions on the
collection, custody, investment, recording, safekeeping, and disposal of patients’
property (including instructions on the disposal of the property of deceased patients
and of patients transferred to other premises) for all staff whose duty is to
administer, in any way, the property of patients. Due care should be exercised in
the management of a patient's money in order to maximise the benefits to the
patient.
26.3.2 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

26.3.3 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.

26.3.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

26.3.5 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.

STANDING FINANCIAL INSTRUCTION 17

27. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

27.1 Chief Financial Officer Responsibilities

27.1.1 The Chief Financial Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health and Social Care circular HSG (93) 5 Standards of Business Conduct for NHS Staff; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

STANDING FINANCIAL INSTRUCTION 18

28. RETENTION OF RECORDS

28.1 Chief Executive responsibilities

28.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines.

28.2 General

28.2.1 The records held in archives shall be capable of retrieval by authorised persons.

28.3 Records Destruction
28.3.1 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.
29. RISK MANAGEMENT AND INSURANCE

29.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;
b) engendering among all levels of staff a positive attitude towards the control of risk;
c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
f) a clear indication of which risks shall be insured;
g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

29.2 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.

29.3 Insurance arrangements with commercial insurers

29.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust’s may enter into insurance arrangements with commercial insurers. The exceptions are:

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

(2) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the
income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health and Social Care.

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

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

STANDING FINANCIAL INSTRUCTION 20

30. FUNDS HELD ON TRUST

30.1 General
In general, charitable funds associated with the Trust are administered by Barts Charity. Guidance should be sought from Barts Charity for funds under their management.

30.2 Establishment of Charitable Funds by the Trust
If a specific charitable fund is established by the Trust, the Chief Financial officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

30.2.1 Accountability to Charity Commission and Secretary of State for Health
(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where responsibility for approval of arrangements lie. All Trust Board members and Trust officers must take account of that guidance before taking action.

30.2.2 Applicability of Standing Financial Instructions to funds held on Trust
(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.
(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.
SCHEDULES TO STANDING FINANCIAL INSTRUCTIONS

SCHEDULE I

SFI NO. 4
BANK ACCOUNTS AND GBS ACCOUNTS

<table>
<thead>
<tr>
<th>SFI Section</th>
<th>Description</th>
<th>Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5.1</td>
<td><strong>Cheque and Other Non-GBS Payments Signatories:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single signature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Open Cheques</td>
<td>£2000</td>
</tr>
<tr>
<td></td>
<td>Crossed Cheques</td>
<td>£25,000</td>
</tr>
<tr>
<td></td>
<td>Double signature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Open Cheques - Any Two Signatories</td>
<td>£5000</td>
</tr>
<tr>
<td></td>
<td>Crossed Cheques - Any Two Signatories</td>
<td>£250,000</td>
</tr>
<tr>
<td></td>
<td>Crossed Cheques - Chief Financial Officer/Chief Executive and another signatory</td>
<td>No Limit</td>
</tr>
<tr>
<td></td>
<td><strong>GBS Signatories:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Two Signatories</td>
<td>No Limit</td>
</tr>
<tr>
<td></td>
<td><strong>BACS Transfer:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Requiring pre payment review and certification of individual invoice payment by BACS transfers by any authorised signatory for cheques</td>
<td>above £250,000</td>
</tr>
</tbody>
</table>
SCHEDULE II
SFI NO. 8  NON-PAY EXPENDITURE

Part A

<table>
<thead>
<tr>
<th>SFI Section</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5.1</td>
<td>Petty Cash Payments:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Return of Patients Cash</td>
<td>Up to the amount of cash deposited for Safe-keeping</td>
</tr>
<tr>
<td></td>
<td>Payment of Patients Fares:</td>
<td>Up to the amount of fares paid</td>
</tr>
<tr>
<td></td>
<td>Return of Rental Accommodation Key Deposits</td>
<td>Up to the amount of deposit</td>
</tr>
<tr>
<td></td>
<td>Cremation Fees</td>
<td>£750</td>
</tr>
<tr>
<td></td>
<td>Payments to individuals participating in research projects</td>
<td>£125</td>
</tr>
<tr>
<td></td>
<td>ALL other Petty Cash Payments</td>
<td>£75</td>
</tr>
</tbody>
</table>

Part B

<p>| | Hospitality | This includes all supplies of catering, restaurant or bar bills, and purchases of food and drink from supermarkets. Hospitality must be ordered from the Trust’s catering department |
| | Phone Cards | Mobile phones are supplied by the Trust for staff who need them as part of their job. If someone has used their own phone for Trust business the cost of individual calls must be claimed from the Expenses unit using a Staff Expenses Claim Form. |
| | Postage | All postage should be submitted to the Post Rooms on each site to be franked. |
| | Staff Gifts, Flowers etc | Gifts can only be funded by staff collections, not by the Trust. |
| | Staff Pay | Any extra pay for additional duties must be paid via payroll |</p>
<table>
<thead>
<tr>
<th><strong>Staff Refreshments</strong></th>
<th>The Trust is not responsible for the provision of tea, coffee, milk etc for staff. It is the responsibility of each staff member to obtain their own refreshments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Travel and Staff Subsistence</strong></td>
<td>All costs should be claimed from the Expenses unit using a Staff Expenses Claim Form.</td>
</tr>
<tr>
<td><strong>Toasters</strong></td>
<td>Purchase of toasters is not permitted by the Trust as they are a fire hazard</td>
</tr>
<tr>
<td><strong>Training Fees</strong></td>
<td>All fees should be paid in advance by submitting a request to Accounts Payable. Books for study must be claimed from the Expenses unit using a Staff Expenses Claim Form.</td>
</tr>
<tr>
<td><strong>USB Data Sticks</strong></td>
<td>Must be obtained in accordance with IT policy and be appropriately encrypted</td>
</tr>
</tbody>
</table>
SCHEDULE III

LOSSES AND SPECIAL PAYMENTS

Prior NHS executive approval is required to make payments or write off losses in excess of the Trust limits.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>TRUST LIMIT</th>
<th>SUMMARY OF INTERNAL DELEGATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Write off NHS debtors</strong></td>
<td>Full Delegation</td>
<td>0-100</td>
</tr>
<tr>
<td><strong>Write Off non NHS Debtors</strong></td>
<td>Subject to prevailing DH guidance</td>
<td>0-100</td>
</tr>
<tr>
<td><strong>Cash Losses (Theft, Fraud, Salary Overpayments, Loss of Cash), and Abandoned Claims</strong></td>
<td>Full Delegation</td>
<td>0-10 ADFS</td>
</tr>
<tr>
<td><strong>Fruitless Payments (including Abandoned Capital Schemes)</strong></td>
<td>Full Delegation</td>
<td>0-100 CFO</td>
</tr>
<tr>
<td><strong>Loss or Damage to Buildings, Property, Equipment and stock including Linen</strong></td>
<td>Full Delegation</td>
<td>0-50 DoE</td>
</tr>
<tr>
<td><strong>Compensation under legal obligation</strong></td>
<td>Full Delegation</td>
<td>0-50 LSM(PLS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-250 LSM(Med.Lit)</td>
</tr>
<tr>
<td><strong>Extra Contractual Payments to Contractors</strong></td>
<td>Full Delegation</td>
<td>0-50 CFO</td>
</tr>
<tr>
<td><strong>Ex-Gratia payments for clinical negligence and personal injuries involving negligence (i.e. negotiated or agreed settlements following legal advice)</strong></td>
<td>1000 (including plaintiff costs)</td>
<td>0-50 LSM(PLS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-250 LSM(Med.Lit)</td>
</tr>
<tr>
<td><strong>Ex-Gratia payments to patients and staff for loss of personal effects; clinical negligence and personal injuries not covered under Type III and most other ex-gratia payments (not covered by above)</strong></td>
<td>50 (including costs)</td>
<td>0-10 DHR(Staff)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SDNG(Non Staff)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key to officers with delegated authority to approve write offs and special payments

<table>
<thead>
<tr>
<th>Abbr</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>ADFS</td>
<td>Associate Director of Finance - Financial Services</td>
</tr>
<tr>
<td>DoE</td>
<td>Director of Estates</td>
</tr>
<tr>
<td>LSM</td>
<td>Legal Services Manager</td>
</tr>
<tr>
<td>SDNG</td>
<td>Site Director of Nursing and Governance</td>
</tr>
<tr>
<td>DHR</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>ARC</td>
<td>Audit and Risk Committee</td>
</tr>
<tr>
<td>FIC</td>
<td>Finance and Investment Committee</td>
</tr>
<tr>
<td>Med Lit</td>
<td>Medical Litigation</td>
</tr>
</tbody>
</table>