The BayWay SHAPING A BETTER FUTURE | bettercare together | NHS University Hospitals of Morecambe Bay NHS Foundation Trust

PUBLIC TRUST BOARD OF DIRECTORS' MEETING

Wednesday 30 March 2022 in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

Please note the meeting will also take place via Microsoft Teams to ensure safe social distancing and to accommodate those members of the Board who are unable to attend in person.

Commencing at 9am

Reference Document Pack			
Item		**Lead**	**Paper**
Patients			
243	Patient Story Presentation	Executive Chief Nurse	Attached
246	Recovery Support Programme Highlight Report Presentation and Recovery Support Programme Exit Criteria Presentation	Deputy Chief Executive / Intensive Support Director	Attached
247	Care Quality Commission Improvement Plan Dashboard	Director of Governance	Attached
Performance			
250	Assurance Committee Minutes	Chairs of the Assurance Committees	Attached
256	Standing Financial Instructions and Scheme of Delegation	Company Secretary	Attached

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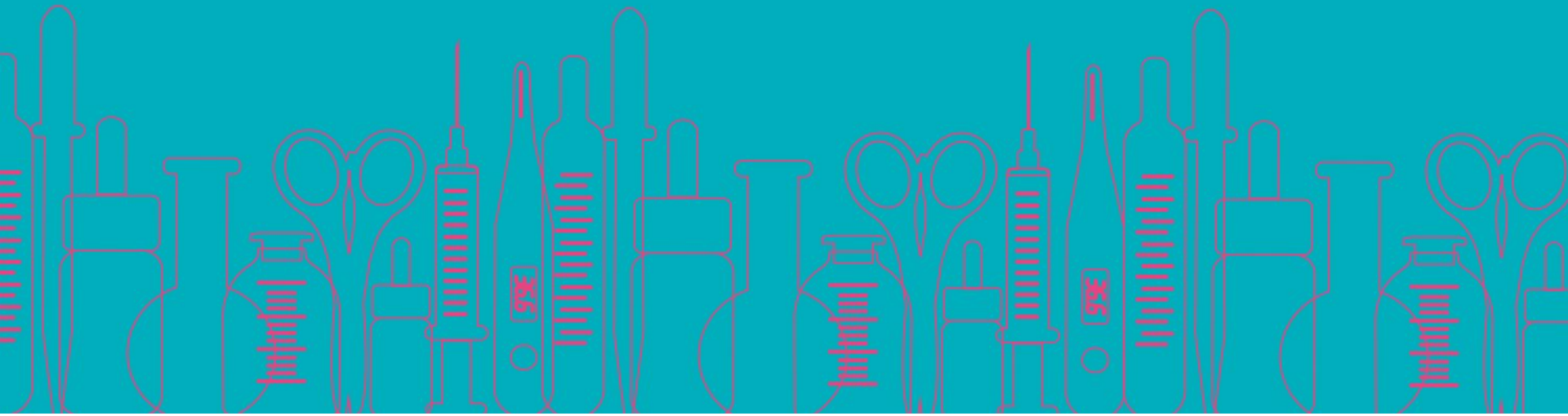
Stroke Services update
March 2022



bettercare together

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

The Bay Way

Background / Summary

- CQC inspection of Stroke services in April 2021
- Section 31 Notice received from CQC 14th May 2021
- Improvement programme established and has now been running for 10 months with Exec Task & Finish group oversight.
- Presentation on the improvements, challenges and further improvements to come in our Stroke Services since the last TMG update in Oct-21.

SSNAP Data

The latest SSNAP data was published 8th March 2022 for the period Oct-Dec 2021 with both RLI & FGH achieving a C.

Over the last 5 quarters, RLI has seen their SSNAP score increase every quarter moving from E to C.

FGH has also seen significant improvement over the last 5 quarters, achieving a B overall in Jul-Sep 21 and a high C in Oct-Dec 21.

RLI:

Team	Royal Lancaster Infirmary	Royal Lancaster Infirmary	Royal Lancaster Infirmary	Royal Lancaster Infirmary	Royal Lancaster Infirmary
Time period	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021
SSNAP level	E	D	D	D	C
SSNAP score	32.3	41.8	51.0	55.1	60.8
Case ascertainment band	A	A	A	A	A
Audit compliance band	B	B	A	B	B
Combined Total Key Indicator level	E	D	D	D	C
Combined Total Key Indicator score	34	44.0	51.0	58.0	64.0

FGH:

Team	Furness General Hospital	Furness General Hospital	Furness General Hospital	Furness General Hospital	Furness General Hospital
Time period	Oct-Dec 2020	Jan-Mar 2021	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021
SSNAP level	D	D	C	B	C
SSNAP score	47.5	57.0	69.0	74.1	68.4
Case ascertainment band	A	A	A	A	A
Audit compliance band	B	B	A	B	B
Combined Total Key Indicator level	D	C	C	B	B
Combined Total Key Indicator score	50	60.0	69.0	78.0	72.0

Improvements since Oct-2021

RLI

- Successful Therapy recruitment since Jan-22 with 3 new therapists
- Recruited a substantive Consultant
- Successful nursing recruitment in support of expanded Huggett Suite
- New clinical educator / mentor role supporting new starters and international recruits which has seen a decrease in staff turnover
- 71% reduction in falls since September from improved staffing
- Ambulatory Pathway trial commenced – Project group established to embed pathway

FGH

- New dedicated Therapy area for Ward 6
- New dedicated Acute Stroke bay
- Successful Therapy recruitment since Jan-22 with 2 new recruits
- Recruited to Nurse Consultant post
- Additional Stroke trainee ANP appointed

Cross Bay

- Stroke tracker dashboard embedded and continues to develop

Challenges that remain

- Site pressures at RLI & FGH continue to challenge time to ward.
- Substantive recruitment to medical staffing posts (2x Consultant vacancy at RLI, 1x Consultant vacancy at FGH). Lack of clarity around regional stroke plans has the potential to impact on recruitment and staff retention.
- Service instability with locum agency consultants - multiple changes over the last 6 months.
- 8 RN vacancies still remain on Huggett and skill mix challenge as a result of agency & international nurses
- We are still suboptimal against the national standard for community stroke pathways. CCG business case in progress to address this.
- Capacity in reablement, social care and intermediate beds remains a challenge across the bay
- Lack of 24hr thrombectomy service across the region

Improvements still to come

RLI

- Dedicated Therapy space on Huggett Suite. Estimate completion Jul-22
- Fully embedded Ambulatory pathway
- 6 day consultant service – SSNAP improvement

FGH

- Fully established Ambulatory pathway within ward 6
- Acute Thrombolysis – post thrombolysis first 24hrs on ward 6
- Further therapy improvement outcomes on SSNAP as a result of successful recruitment

Cross Bay

- Dashboard development – further data analysis and alignment to SSNAP measures
- MDT board round improvement – supporting SSNAP
- Embedding of quarterly Cross Bay Stroke Governance meeting (first held 03/03/22)
- Refocus on substantive medical recruitment – additional support from Retinue
- Continued focus on substantive recruitment across all roles

Patient Feedback

- Felt the care they received was first class, and the staff show a great deal of patience.
- Food is nice
- Kept informed of decisions about their care
- Couldn't fault anything or suggest improvements.
- Stroke Patient Feedback.mp4

Prompt response in A&E. Excellent care in AMU/Ward 6. Cannot fault FGH.

The response from both first responders and paramedics was prompt and professional. The handover to medical teams was seamless. Within the golden hour my husband was well on the way to recovery. Everyone who dealt with us was professional, reassuring and caring- despite being extremely busy and working within COVID restrictions.

Staff Experience

- New to stroke care since October 2021, finding all the bits you need to know about stroke care challenging but thoroughly enjoying it on the ward.
- Felt that the international staff are yet to understand how the ward works and the way patients are cared for in England is different to that of their country.
- Senior managers are telling us we have enough staff but how ward is very heavy and concentrated at times that we do need more staff. We often have a CSW moved to manage staffing elsewhere.
- CSW who has worked on the ward as bank for 5 months but recently been given a contract feels there is a lack of appropriate training, and they don't have time to do TMS.
- The ward weights for risk assessments have now been moved to a weekend but this take away the individualised care of patients and staff then don't think that patients may need to be weighed outside of these days as their condition changes, staff then don't do this.
- Ward manager is approachable, and they feel they have a good ward manager.
- Feels staffing was good 5 months ago, then the ward went through a rough patch over xmas and new year but it seems to be slowly improving.

University Hospitals of Morecambe Bay
NHS Foundation Trust

UHMB RSP Programme Highlight Report
March 2022

"Creating a great place to work and a great place to be cared for"

Executive Summary

Alert

- **High level off/on track workstream/project milestones – Red RAG Status**
  - **'Safe Staffing Governance'** - Downloading Data extracted from Allocate by 11/03. UHMB Data Analysis to follow as BAU.
  - **'Safe Staffing Recruitment'** - Awaiting Business Case Approval – targeted for completion Mar/Apr 22. Temporary arrangements in place. Mitigations include Recruitment, Utilisation of Rota and Bank (Rosters open) and Sickness absence management.
  - **'OP Pathways - 5 Priority Pathways'** - Analysis done for 2 services but not yet implemented. (T&O/Urology). Capacity.
  - **'Booking Rules Pilot (Gen Surgery)'** - Coding / Data Quality Issues found in testing. Ortho will now be the 1st Specialty to pilot booking rules.

- **High level off/on track workstream/project milestones – Amber RAG Status**
  - **'Criteria to Reside linked to all ward/board rounds (all sites)'** – NHSEI Workstream lead leaves at the End of March – Need a Handover Plan to Trust Resources. Clinical Lead to be identified and governance established. Board Round Improvement to be evaluated and rolled out at scale
  - **'Commercial'** – Workstream Lead TBC.

Assure

- SDEC Pilot - Live for Medicine in Feb 2022.
- Frailty Intervention Team - Business case approved in Feb 2022.
- Clinical Accredited Service Reviews - On track to complete by 31st March 2022.

Advise

- Implementation Plans for Culture and OD on plan for approval by the end of March 2022.
- Implementation of the Frailty Integrated Pathways – April 2022
- Community MDT now being managed as part of 2 hr Crisis Response Project

Programme Dashboard

Recovery Support Programme Dashboard - W.C. 14th March 2022

PROGRAMME RAG STATUS: AMBER

Programme Commentary

29 Projects are tracked due for delivery before 31/03/2022.
11 Projects have been delivered as follows:
- ED - SDEC Commenced a 4 month trial period at RLI.
- OP - eLetters - now live with 27 Priority Services.
- OP - eBooking – now live with 21 Priority Services.
- OP - Non-Face to Face – Roll Out to 20 Priority Services
- OP - Non-Face to Face – All Suitable Services (Mar 2023)
- Theatres - Implementation of Next Day Discharge
- Theatres - Improvements in Start, Turnaround & Finish times
- Theatres - Theatre Right T&O Minor Procedures Pilot (WGH)
- Leadership and Culture - Cultural Engagement
- SFIP - Business Case Process and System Reform

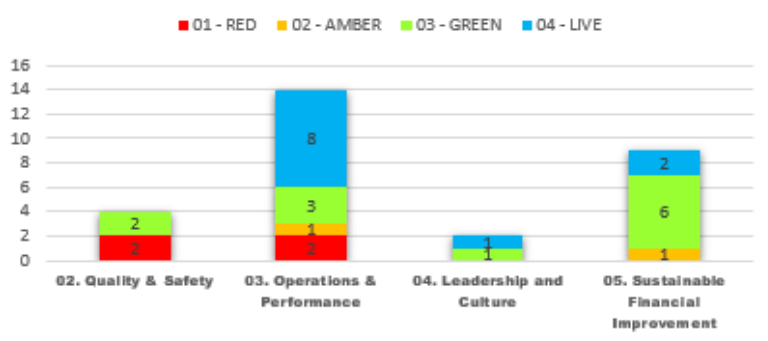
Of the remaining projects, 4 have a Red RAG Status as follows
- 'Safe Staffing Governance - Downloading and Analysing Data from Allocate.
- 'Safe Staffing Recruitment - Awaiting Business Case approval - Mar/Apr 22.
- 'OP Pathways - 5 Priority Pathways' - Analysis done for 2 services but not implemented.
- 'Booking Rules Pilot (Gen Surg)' - Coding / Data Quality Issues found in test.

Delivery Performance Summary

Short Term Projects					
29	Red	4	Green	12	
	Amber	2	Live	11	

Status TBC	5
Other Projects	44

Delivery Performance - Short Term Projects



Exception Reporting - Short Term Projects - Red RAG

Safe Staffing Governance	Live with Interim solution / Currently downloading and analysing data.
Safe Staffing - Recruitment	Business Case now due to be complete Mar/Apr 22.
OP Pathways - 5 Priority Pathways	T&O / Urology Analysis Done - not implemented. Capacity.
Booking Rules Pilot (Gen Surg)	On Hold due to Coding / Data Quality Issues found in test.

Exception Reporting - Short Term Projects - Amber RAG

Criteria to reside linked to ward/board rounds (all sites)	NHSI Workstream lead leaves end of March - need handover.
Commercial	Workstream Lead TBC

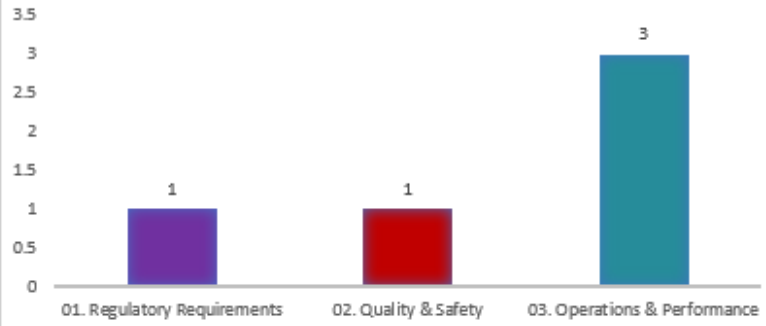
TBC

5 Projects have a delivery status to be confirmed (No Go-Live dates confirmed)

Of these 5 Projects,

1 Relate to Regulatory Requirements
1 Relates to Quality and Safety
3 Relate to Operations and Performance

Delivery Performance - TBC Projects



Exception Reporting - TBC Term Projects

Maternity - Policies and Guidelines	Kick Off Meeting 08/03 - Timelines TBC
Digital Solution for Contemperaneous Documentation	Scoping Phase - Timelines TBC
ED - Improving Streaming RLI	Surge and Escalation Plan to be approved by 13th May
ED - Mental Health	Scoping Phase - KO Meeting W.C. 21/03
ED - Paed's Assessment Units / Pathways from ED	Scoping Phase - Timelines TBC

Improvement Measures

- **A summary of agreed metrics with SRO's**

Workstream	Programme of Work	Status	Comments
01. Regulatory Requirements	Leadership	WIP	An initial set of metrics have been identified by the project lead. Additionally, the relevant Business Intelligence Analyst is exploring building a set of metrics aimed at pinpointing compliance to policy and associated metrics Leadership metrics will cross identified in workstream 4
	Vision and Strategy for Maternity Services		
	Maternity Risk Strategy		
	Cultural Strategy		
	Vision		
	Up to date Policies and Guidelines		
	Digital Transformation		
	1.2 Patient Safety Investigations	WIP	There is an agreed draft in place
	1.3 Risk Management	Draft Metrics Agreed	
02. Quality & Safety	2.1 Mortality	Agreed	
	2.2 Clinical effectiveness	Not Started	
	2.3 Deteriorating Patient	WIP	There is an agreed draft in place
	2.4 Fundamentals of Care	WIP	There are metrics in place for FoC however these are evolving as the Clinical Service Review project progresses
	2.5 QI Skills for matrons and ward managers (Prod. Ward)	WIP	List metrics, not agreed yet
	2.6 Clinical Service Reviews	WIP	List of metrics, not agreed yet
	2.7 Safe Staffing	Draft Metrics Agreed	
03. Operations & Performance	3.1 Urgent Care Improvement	Draft Metrics Agreed	
	COM	Draft Metrics Agreed	
	Outpatients	Draft Metrics Agreed	
	Theatres	Draft Metrics Agreed	
	3.3 Stroke Improvement Plan and Section 31	Draft Metrics Agreed	
04. Leadership & Culture	4.1 Cultural Engagement	Draft Metrics Agreed	Derived from spider diagrams based on National Staff Survey Measures will come out of/be refined as the L&C Programme finalises Additional metrics have been suggested by BI colleagues for further thought
	4.2 Organisational Development Strategy	WIP	
	4.3 Leadership & Management		
05. Sustainable Financial Improvement	5.1 H1/H2 Roadmap	Draft Metrics Agreed	Plan for Success' will emerge fully following engagement with the Care Groups
	5.2 Financial Control Environment	Draft Metrics Agreed	
	5.3 Financial Skills Development	Draft Metrics Agreed	
	5.4 Plan for Success	WIP	
	5.5 System Reform	Draft Metrics Agreed	
	5.6 Commercial	Draft Metrics Agreed	
06. Clinical Strategy	6.1 TBC	Not Started	

Example Measures (Aligned to IPR)

MSSP 1: % of Antenatal, Intrapartum and Postnatal risk assessments completed in line with policy (reported via EPR) – *Ambition*
MSSP 2: % of mothers who's EPR record indicates all 'Compliance Check Points' have a positive result – *Ambition*

FOC 1: Inpatient Falls per 1k Bed Day
FOC 2: % of Inpatient episodes where agreed FOC 'Compliance Check Points' have been met and have no associated patient safety incidents recorded

UEC 1: Volume of instances of corridor care &/or number of hours of corridor care
UEC 2: % of patients spending over 12 hours in ED (with a target of under 1%) for both mental and physical health

Top 3 risks to the trust exiting RSP on schedule

Risk descriptor	Mitigating actions	RAG
1. Leadership team capacity and capability (Vacancy in key posts).	Interim MD started 1 November 2021 Substantive MD recruitment underway Substantive Executive Chief Nurse started Jan 2022 Recruitment of substantive Chief Operating Officer end Feb 2022. Director of Midwifery appointed - start April 22 Clinical leadership recruitment underway (Clinical leads /Clinical directors)	
2. Ensuring priorities have robust delivery plans, QI support and clinical leadership.	Priority initiatives identified and programme approach in development and strengthened through recruitment of Programme Director, Clinical Director and allocation of project management support to all priority areas. Revised clinical leadership structure in place with recruitment commenced March 22	
3. U&EC programme – resourcing and development of business case for new models and system flow.	ECIST, regional and ICS support required for U&EC, expedited by region. Key projects identified for priority SDEC implemented 7 Feb 22 with 7/7 service planned for April 22. Frailty Business Case approved – continued focused support required for each area. Initial scoping for Paediatric Assessment Unit.	

Appendices

1. Simplified milestones (by workstream)

2. Workstream metrics

Simplified Version of Milestones

Regulatory Requirements	February 22	March 22	April 22
Maternity MSSP	• Leadership - Ockenden Self Assessment • Leadership - Weekly Task & Finish Group established • Leadership – Head of Midwifery Recruited (in post) • Leadership – Director of Midwifery Recruited • Digital Transformation – Birth Rate Plus App Procured. (Birth Rate Plus will ensure that staffing levels on our maternity units meet national recommendation, which will enable the service to provide safe and quality care – due for implementation in May) •Culture - MIA facilitated session for the maternity senior leadership team looking at personality psychometrics. •Culture Speed coaching sessions for 8A managers within Maternity Services. These will bring about greater employee satisfaction.	• Leadership - Board Report - Ockenden Self Assessment • Maternity Risk Strategy - Draft Maternity Risk Strategy Developed • Leadership – 4 Students to be interviewed 16/03. • Maternity Voices Partnership - Quarterly meetings with service users in progress to create a maternity service co-designed by users and providers.	• Leadership - Rolling recruitment of 10 Midwives - Completed 4 Month Recruitment cycle • Vision and Strategy for Maternity Services - Patient Engagement • Digital Transformation - Badgernet System due to be fully rolled out by Mid April 2022. Badgernet designed for Maternity Services and has been adopted by the Local Maternity System. This gives women ownership of information on their pregnancy via their smart phone, which can be shared as they wish. • Leadership – new recruits to start in july. When all posts are filled, it will enable Maternity Services to provide safer care for women and will allow more time for training and team building work within the department.

Simplified Version of Milestones

Regulatory Requirements	February 22	March 22	April 22
Patient Safety Incident Response Framework	• Compliant version of Ulysses installed to ensure ability to report incidents on the new Learning From Patient Safety Events (LFPSE) System (replaces NRLS) • Awareness raising sessions with operational teams in respect of changes to incident report forms.	• Revise Terms of Reference for ERG as part of PDSA cycle. • Develop and launch Communications regarding Intranet Site / Tools available • Allocation of training to be delivered by HSIB in investigation science	• New national PSIRF to be published setting out new approach to responding to patient safety incidents • Patient Safety Incident Response Plan to be developed to identify areas of focus for system level investigations. PSIRF will introduce a different emphasis with regards to patient safety investigations. - Emphasis on system level improvements, - Increase/improve support and involvement of patients and families in the process, - Increase/improve support for staff in the process with a focus on just culture - Focus on learning and improvement over investigation process • Consider Phase 1 Project Closure Report based on current method of working.
Risk Management	• Training continuing to be delivered • Risk Management Strategy and Policy reviewed (at 6 months post implementation) - minor amendments identified and actioned.	• Develop and launch SOP on Communicating Risk • Undertake re assessment of position against HM Treasury Risk Maturity Assessment Framework to confirm achievement of Level 3 (good) meaning risk management is implemented in key areas across the organisation.	• Develop action plan of focus for next phase of work based in the outcome of the self assessment to continue to improve organisations maturity in respect of risk management.

Simplified Version of Milestones

Quality and Safety	February 22	March 22	April 22
Mortality	• Meeting with NHSEI Team to help scope out the plan - Feb 2022 • Mortality Metrics agreed	• Desktop Review with NHSEI colleagues in March 2022 with feedback • Patient Representation	• NHSEI Completing Cultural Engagement (By attending Key Trust / Care Group Meetings – prior to delivery of Retrospective Case Review, Bespoke Mortality Training and Associated Comms in May 22).
Clinical effectiveness / Deteriorating patient		Advertisement for clinical Lead roles	Recruitment to Clinical Lead/workstream lead posts Programme initiation
Fundamentals of Care	• Weekly Harm Care Panel Introduced with Theme Identification of lying and standing BP, lack of early interventions when high risk of falls/ pressure damage is known, multiple moves, long lengths of stay. • Weekly Matrons Audits introduced • Protected Friday walk around introduced • IPC Business Case - for additional domestic support in clinical areas. Early problems with recruitment have been addressed with an additional 38 domestics going through checks and clearances. • Chief Nurse Information Officer in post 1st February	• Completion of Clinical Service Reviews across RLI, WGH and FGH. • Nutrition and Hydration Mouth Care Matters • Measures of Success for Meds Management	• Ward owned Improvement Plans developed built on CSR's and analysis of data • Ward Dashboards Phase 1 – Specified. Proposed Go-Live June 2022 • Staff trained in QI approach by the end of April 2022.

Simplified Version of Milestones

Quality and Safety	February 22	March 22	April 22
Safe Staffing	• 42 SNCT training sessions delivered so far with 150 staff trained. • Data collection.	• SNCT - Go-Live of Establishment Reviews via SNCT - 31st March 2022 • Reporting - New Safe Staffing Reporting Process in Place - 31st March 2022 • Go-Live of Recruitment and Retention Strategy (Oversea recruitment Timescales tbc) • First cycle of safe staffing will complete in March 2022 with report to board NHSEI actions managed within the safe staffing workbook with weekly review of actions and progress. • Rosters Open	• Safe Staffing Reporting - Introduce Monthly Board Report • Safe Staffing Business Case – Presentation to Finance Committee
Operations and Performance	**February 22**	**March 22**	**April 22**
Urgent Care Improvement	• 5 day SDEC 8am - 5pm commenced Feb 2022 • 5 day SDEC 8am - 10pm commenced Feb2022 • SDEC - second phase is to develop additional trolleyed assessment capacity - business case approval W.C. 27 February 2022. • Frailty - Business Case Approved – approved by Trust Management Group. Substantive recruitment is underway.	• No Corridor Care - Completion of planning - end of March 2022. • Frailty - Implementation plan confirmed and mobilised with delivery milestones. • Criteria to Reside - Test of Change Completion.	• 7 day SDEC 8am – 10pm planned to start 1 April 2022

Simplified Version of Milestones

Operations and Performance	February 22	March 22	April 22
Stroke Improvement Plan and Section 31	• Stroke - Discharge Re-admission - Monthly monitoring of re-admitted patients implemented (Stroke, Myocardial infarction, #NOF)	• Stroke - In Hospital - Sustainability of Board round across the Trust Delivered • Stroke - Discharge Therapies - Implement Therapy Space at FGH • Stroke - Documentation - Stroke and Thrombolysis pathway / guidelines in place • Stroke - Staff and Patient Experience - new feedback mechanisms live	• Stroke - Enhance Stroke specialist workforce to deliver 7 day Amb care • Stroke - In Hospital - Stroke Unit Staffing to achieve 7 Day Service - 7 day diagnostics working • Stroke - In Hospital - Stroke Unit Staffing to achieve 7 Day Service - 7 day pharmacy working
Leadership and Culture	**February 22**	**March 22**	**April 22**
Cultural Engagement	• Comprehensive action plan developed to address feedback received - end of February 2022	• Sign off of Culture Change Programme via Change Board and Cultural transformation programme Board - 31st March 2022	• Implementation plan for Culture programme (2022-2025) developed end of March 2023
Revision and refresh of Organisational Development Strategy		• Revised OD Strategy Delivered by end of March 2022	• Implementation plan for OD Programme (2022-2025) developed end of March 2023
Revised Leadership & Management Development Strategy & Plan	• Creation of revised proposal for Leadership Programme	• Deep Dives across the Trust – to help establish what good leadership looks like • Socialising the High 3 year leadership development Plan • Agree KPI's and CSF's • Presentation of revised leadership proposal to People committee, culture board and executive	• Commence Board Development Programme by Beginning of April 2022 • Commence Design and development of an internal programme designed to deliver the following: - Aspirant to Senior Leadership Development of 3 year Programme – Live from to June 2022 - Triumvirate Development Programme – live from end of May / Beginning of June 2022 – (implementation of new operating model) - to May 2023 - Medical Leadership Development Programme – Live from June 2022

Simplified Version of Milestones

SFIP	February 22	March 22	April 22
H1/H2 Roadmap	• Determine efficiency requirement by Care Group - GAP Analysis following existing strategy and change alignment	• Facilitate Ongoing weekly meetings to agree schemes and deliver the 21/22 financial challenge	• Agree and implement Trust Ongoing weekly meetings for 22/23 to identify/deliver the 22/23 financial challenge
Financial Control Environment	• Review of the new Business Case process at 6months (Implemented Sept 2021). REVIEW COMPLETE. • Review and approval of Consultation on Revised scheme of Delegation and SFI's • Establish workstream leadership and associated project support requirements	• Business Case Dev't - Establish reporting from IPG to TMG on a monthly basis via 3As report and 6 monthly review agreed (review Jun 22) • High Cost Locums - Procurement/HR process and delivery plan in place • Scheme of Delegation Process for Identifying and Escalating Exceptions Reviewed, delivery plan in place, signed off and operational • 2nd 6 Monthly review of NHSI Checklist in place (1st Review of Checklist Completed and report completed and sent to Workstream Lead- AUGUST 21) • Workstream Refresh - Develop refreshed objectives for 22-23 in context of and aligned to the requirements of the "Plan for Success" and longer term transformation and improvement trajectories • Workstream Refresh - Achieve alignment / interdependency to Cultural and OD components of RSP	• Business Case Dev't - Project Closure and Lessons Learnt Report through RSP programme governance • Scheme of Delegation - Establish alignment/inputs to the to the design and operation of the Trust's new performance and accountability framework to complete by end of April 2022 • NHSEI Checklist - Output report of the checklist review prepared, signed off by SRO and submitted into April 22 Finance and Performance Committee. • Workstream Refresh - Milestone placeholder (Tbc) to agree a review of skills, capacity, resources and capability as part of the RSP culture and OD work, establish scope and timeline • Workstream Refresh – Week 1 SFIP Programme Board/Steering Review of workstream structure and key milestones, and SRO Sign-off. Week 2-4: Recovery Support Programme - Programme Board Sign-off.

Simplified Version of Milestones

SFIP	February 22	March 22	April 22
Financial Skills Development	• Non Finance Training for Finance Staff - Agree method for delivering training i.e., use Finance Staff Meeting • Non Finance Training for Finance Staff - Agree content for training sessions	• Finance Training For Non Finance Staff - Sustainability & monitoring process in place • Finance Training For Non Finance Staff - Go-Live with training across the Trust. • Financial training for finance staff - review session completed 07/03/22, • Financial training for finance staff - Further FSD review session has been scheduled for 14/03 to review the agreed milestones and tasks • Workstream Refresh - Develop refreshed objectives for 22-23 in context of and aligned to the requirements of the "Plan for Success" and longer term transformation and improvement trajectories • Workstream Refresh - Achieve alignment / interdependency to Cultural and OD components of RSP	• Finance Training For Non Finance Staff - Monitor the process to identify if training has been successful • Finance Training For Non Finance Staff - Agree and Implement Trust wide training plan • Finance Training For Non Finance Staff - Agree and establish impact assessment schedule . • Financial (and Non Financial) training for finance staff - Develop, Agree & Implement Trust wide training plan • Workstream Refresh - Milestone placeholder (Tbc) to agree a review of skills, capacity, resources and capability as part of the RSP culture and OD work, establish scope and timeline • Workstream Refresh

Simplified Version of Milestones

SFIP	February 22	March 22	April 22
Plan for Success	• Baseline position translated to Operational Planning Framework Envelope for 2022/23 Annual Planning. • Care Group and Corporate Financial control totals proposed. • Initial discussions within system to commence negotiation of required system support	• Operational Planning Framework 2022/23 aligned as delivery vehicle of plan envelope and flexed to reflect organisational priorities. Review achievement of 21-22 workstream objectives and deliverables - Lessons Learnt and establish workstream SRO view of 22/23 Priorities • Performance and Accountability Framework alignment and supporting governance finalised. • Efficiency/'Value' Programme briefs and plans completed. Final Plan agreed by end of March 2022 to support Annual Plan 2022/23 and frame planning to 2026/27 - align to LTFM	• PMO/Resourcing and Support process and systems finalised and launched. • Alignment of enabling strategies (Estates, People, Clinical, Partnerships, Digital) • Alignment to Board Assurance Framework / Corporate Governance Framework.
System Reform	• Live with Phase 1 - 7th Feb • Summarise Current Position		
Commercial	• Align commercial opportunity analysis to draft sustainability trajectory programme overviews and further Care Group and Corporate plan developments during February and March		• Staggered / Phased Implementation of Commercial Schemes for 22/23 • Final - Agree Improvement Trajectory aligned commercial income phasing and submit to Performance and Assurance Framework

Workstream Metrics

A model for measuring quality care (Donabedian Model)

What is it?

Donabedian's (2005) three components approach for evaluating the quality of care underpins measurement for improvement. The three components are structure, process and outcomes. Measurement for improvement has an additional component – balancing measures.

When to use it

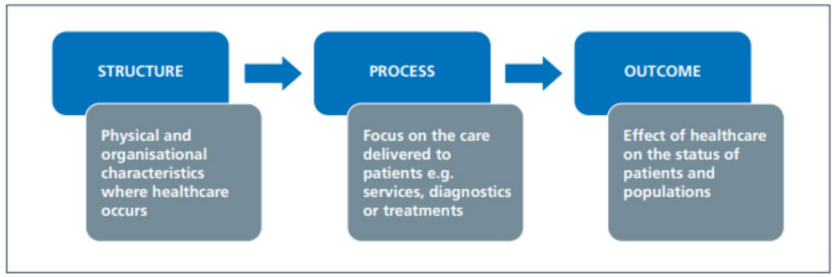
It is really important for improvement projects to have outcome, process, structure and balancing measures. It is not an either/or decision. Each of the different types of measures has a different purpose in determining whether the improvement project has had the desired impact.

Outcome measures: these reflect the impact on the patient and demonstrate the end result of your improvement work and whether it has ultimately achieved the aim(s) set. Examples of outcome measures are reduced mortality, reduced length of stay, reduced hospital acquired infections, adverse incidents or harm, reduced emergency admissions and improved patient experience.
Process measures: these reflect the way your systems and processes work to deliver the desired outcome. For example, the length of time a patient waits for a senior clinical review, if a patient receives certain standards of care or not, if staff wash their hands, recording of incidents and acting on the findings and whether patients are kept informed of the delays when waiting for an appointment.
Structure measures: these reflect the attributes of the service/provider such as staff to patient ratios and operating times of the service. These are otherwise known as input measures.
Balancing measures: these reflect unintended and/or wider consequences of the change that can be positive or negative. It is about recognising these and attempting to measure them and/or reduce their impact if necessary. An example of a balancing measure would be monitoring emergency re-admission rates following initiatives to reduce length of stay.

According to Donabedian, outcome measures remain the 'ultimate validators' of the effectiveness and quality of healthcare but can sometimes be difficult to define and have time lags.

Source: NHS England and NHS Improvement - "Model for measuring quality care"
https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-measuring-quality-care-model.pdf

Figure 1: The Donabedian model for quality of care



N.B. Not all metrics have been marked as Outcome, Process Structure or Balancing as yet, and may sit a nominal category

Workstream Metrics

WS	Project	Metric
Regulatory Requirements	1.1 MSSP	***Structure*** Birth rate plus establishment (WTE) Vacancy Rate Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training
		Process Continuity of care Escalation Observations
		Outcome Post partum haemorrhage Pre-term live Births C Section delivery rate
	1.2 Safety investigations	***Structure*** Cascade Lessons Learned Compliance with New Framework Investigation rates HED based metrics around incident reporting as relates to Investigation requirement definitions
		Process Zero backlog of incidents Max days overdue - investigation Longest working days to investigation completion Average working days to investigation completion 72 Hour Reports Completed and Submitted to the CCG within 72 Hours of Reporting on StEIS

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Workstream Metrics

Regulatory Requirements	1.2 Safety investigations	Oldest overdue investigation action
		% of Investigations being run by staff who have completed RCA methodology training
		% of Investigations with no DQ issues
		% of Investigation Actions with no DQ issues
		Outcome
		% of Investigations with no addendum request from CCG
		% of Investigations ok first stage
		% Investigations completed within target
		Number of overdue investigations
		% Investigation actions completed within target
		Number of overdue investigation actions
		% of Investigations receiving a QA review
	1.3 Risk Management	***Structure***
		KPI 1 - Define the organisation's risk appetite
		KPI 2 - Ensure a single and comprehensive risk management process
		KPI 3 - Increase the coverage and utilisation of appropriate risk assessments throughout the Trust
		KPI 5 - Enhance the knowledge and skills base of staff in risk management across the Trust, thereby also further encouraging an open and transparent reporting culture
		KPI 6 - Strengthen the system of assurance regarding risk through to Board level
		% of staff completing IOSH Risk Management training as required
		Process
		KPI 4 - Increase the use of Trust wide data to inform the risk management process
		Volume of New Risks by Month
		Volume of Closed Risks by Month
		Corporate risk register going to board

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Workstream Metrics

Regulatory Requirements	**1.3 Risk Management**	***Outcome*** Volume of Tolerated Risks Risk Maturity Matrix Outcome - Internal Risk Maturity Matrix Outcome - External (MIAA) Extreme Risks that have been extreme for 12 or more months Risks (exc Extreme Risks) that have remained at the same risk score for 12 or more months
Quality & Safety	**2.1 Mortality**	***Structure*** Delivery of a Mortality dashboard % Requirement for Appropriate staff to conduct SJR's in place Medical Examiner referral process in place Medical Examiner referral process in place
		Process Referral for DoC % of services completing meaningful regular mortality meeting Medical Examiner referral Link in to Incident and Never Events % Compliance to SJR inclusion criteria % Compliance to SJR Thematic review process % of Mortality cases passed to MaMR where an SJR has been completed (primary SJR) HOGAN (% of SJRs rated as possibly & probably preventable) HOGAN (% of SJRs rated as strong evidence for/definitely preventable) NCEPOD (% of SJRs rated as receiving good care) NCEPOD (% of SJRs rated as room for improvement) NCEPOD (% of SJRs rated as less than satisfactory)

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Workstream Metrics

Quality & Safety	2.1 Mortality	% of QA reviews conducted on SJR
		% External QA conducted on SJRs
		Outcome
		Deteriorating patient
		Deteriorating patient
		Links/triangulation to Serious Incident and Never Events
		SHMI - split by service or No and % of services above 100
		HMSR - split by service or No and % of services above 100
	2.2 Clinical Effectiveness	***Outcome***
		Clinical Audits
	2.3 Deteriorating patient	***Structure***
		Access to acute team (24/7)
		Deteriorating patient policy
		Training (ILS, PILS)
		Process
		Patient observations
		Referral to outreach team
		Response to escalation
		Timeliness of observations
		Outcome
		Accuracy of NEWS2 Scores
		Escalation at 3 and above
		LOS
		Mortality

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Workstream Metrics

Quality & Safety		Observations within 4Hrs Transfer to ITU
	2.4 Fundamentals of care	***Structure*** 6 Improvement cycles implemented on time
		Process Medicines management – improvement in safe secure audits NEWS2/E-Observations - 95% compliance with contemporaneous recording of E-Obs 95% completion of Safety Bundles (Lorenzo) - to be broken down by component metrics E-Obs average time delay Improvements in Hand Hygiene reported to IPCC >85% by end of March 22 Improvements in ANTT compliance reported to IPCC >85% by end of March 22 Improvements in PPE compliance reported to IPCC >85% by end of March 22 % VTE Assessments completed as required % Prescription issued where requirement identified by VTE assessment
		Outcome % Medicine Administration Errors Hospital acquired infections - % patients who don't get infected (broken down by infection type) IP Falls per 1k bed day Contemporaneous Documentation Incidents - Reduce the number of incident investigations which name documentation as a cause whilst under the care of UHMBT % Medicine Administration Errors Related to Critical Medications SEPSIS AKI Acute IP Pressure Ulcer per 1k bed day Community IP Pressure Ulcer per 1k bed day

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Workstream Metrics

Quality & Safety		Community Pressure Ulcers Non-UHMB Pressure Ulcer Harms
	2.5 Productive Ward	***Structure*** Wards Enrolled in Programme 80% of ward managers skilled in QI/productive methodology by end of Q1 2022 Ward manager identifies an Improvement scheme in every ward/dept related to environment
		Process Environmental Audits
		Outcome ??? to be developed following driver diagram
	2.6 Clinical Service Reviews	***Structure*** Proportion of the team multi-disciplinary Proportion of WTE roles required in the team filled? Service review completed in every IP area by March 22
		Process Improvements in Hand Hygiene reported to IPCC >85% by end of March 22 Improvements in ANTT compliance reported to IPCC >85% by end of March 22 Improvements in PPE compliance reported to IPCC >85% by end of March 22 Immediate actions at the time of the review Support in place to ensure ongoing improvement plan monitored through AMaT (Service review team) Return Review % Wards reaching acceptable standard following review
	2.7 Safe staffing	***Structure*** Safer Nursing Care Team (SNCT) Fellow supporting Trust - what is this?

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Workstream Metrics

Quality & Safety	2.7 Safe staffing	***Process*** E-Job Plans Bank and Agency Use - figures from ESR Six monthly reviews to Board - following the data collection in Feb and Jul % of Wards Contributing data to establishment reviews RN Day Fill Rate (Trust - SPC) RN Night Fill Rate (Trust - SPC) CSW Day Fill Rate (Trust - SPC) CSW Night Fill Rate (Trust - SPC) Lowest Individual Ward RN Day Fill Rate (summary table, prev month & prev rolling 12) Lowest Individual Ward RN Night Fill Rate (summary table, prev month & prev rolling 12) Lowest Individual Ward CSW Day Fill Rate (summary table, prev month & prev rolling 12) Lowest Individual Ward CSW Night Fill Rate (summary table, prev month & prev rolling 12) Lowest Individual Ward CHPPD Registered midwives/ nurses (summary table, prev month & prev rolling 12) Lowest Individual Ward CHPPD Care Staff (summary table, prev month & prev rolling 12) Lowest Individual Ward CHPPD Overall (summary table, prev month & prev rolling 12) Compliance to E-Roster Training Completion of e-Roster 6 weeks % of Professional Judgement Reviews Completed SNCT Training sessions No of establishment reviews validated
		Outcome Safer Nursing Care Tool assessment February and July % of Wards that have 1 or more (of the 4) fill rate < 85% CHPPD Registered midwives/nurses (Trust - SPC)

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Workstream Metrics

Quality & Safety	**2.7 Safe staffing**	CHPPD Care Staff (Trust - SPC) CHPPD Overall (Trust - SPC) Unused hrs National Quality Benchmark – Safer Nursing Care Tool
Operations & Performance	**3.1 Urgent Care Improvement**	***Structure*** SDEC - Direct referral provision from GP/111/999 and virtual wards Frailty - Opening of Acute Frailty SDEC Provision 70hrs + per week and activity Frailty - Access and activity of the Frailty service (community-based rehab and enablement response within two days and intermediate care services) - 12 hours a day, 7 days a week. Measure - Older patient with reduced mobility referred by NHS-111, ambulance service or GP Frailty - Community diagnostics (ECGs, x-rays and blood tests) readily and quickly available (with reports if required) - 12 hours a day, 7 days a week. Measure - patient requiring urgent ECG or CXR to possibly avoid hospital referral Frailty - Multi-agency support and care packages available at short notice for appropriate patients - 12 hours a day, 7 days a week. Measure - patient requiring home support for sudden change in ability to self-care
		Process NM Criteria to Reside – <5% G&A beds High Level KPIs - NMC2R - % of G&A Bed (Target <5%) High Level KPIs - Transfer of Care Hub - (Target TBC) New ED metrics - Time to Initial Assessment New ED metrics - Mean Time in Department for non-admitted patients SDEC - Opening 12hrs, 7 days as a minimum, for Surgery and Medicine as a minimum and activity SDEC - SDEC activity (captured with BI support as there are Coding implications) Frailty - referral into urgent community response services/reablement Frailty - onward discharge from urgent community response services No corridor care - % compliance of ambulance HO checklist In Hospital Flow - Dx before noon as a % of all discharges from bed base

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Workstream Metrics

Operations & Performance	**3.1 Urgent Care Improvement**	In Hospital Flow - No. of flow failures (patients not being in the right place for the right care -i.e. outliers etc...) In Hospital Flow - % available capacity (i.e. % units / wards with at least 1 available bed at 7am) In Hospital Flow - Occupancy rate In Hospital Flow - No or % unnecessary bed days (from when patients no longer meet criteria to reside) In Hospital Flow - No. of ED visits / hospital admissions Improving Discharge - NMC2R numbers
		Outcome %>12 hours in ED <1% Zero Corridor Care High Level KPIs - SDEC - % 0 Day LOS (National Minimum 33% local target 40%) High Level KPIs - Frailty - Crisis Response in 2h (National Target TBC) High Level KPIs - NMC2R - 21 Day LOS Mean Value (Seasonal Target TBC) High Level KPIs - NMC2R - 21 Day LOS Mean Value (NHSE Ave 17%) High Level KPIs - Mental Health - 12h Breaches High Level KPIs - Physical Health - 12h Breaches High Level KPIs - No Corridor Care - % of ED attends 12h (Target <1%) High Level KPIs - No Corridor Care - Total Patients in Corridor High Level KPIs - No Corridor Care - Ambulance Handover Time (Target 15 mins) New ED metrics - Hospital handover delays New ED metrics - Percentage of patients spending more than 12 hours in A&E SDEC - 0-3 LoS patients SDEC - SDEC - % 0 day stays NEL admissions SDEC - Qualitative metrics Frailty - Crisis response within 2 hours from any referral source needed for up to 48 hours (required nationally from March'22) Frailty - Reablement care within 2 days from any referral resource apart from hospital ward/ bed needed for up to 6 weeks (required nationally from March'24).

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Workstream Metrics

Operations & Performance	**3.1 Urgent Care Improvement**	Frailty - the care delivered
		Frailty - how care was delivered
		No corridor care - Total patient numbers (per day)
		No corridor care - RCAs for those patients waiting over 60 mins
		No corridor care - Actions arising from complaints
		No corridor care - Picker survey information
		In Hospital Flow - 14 and 7 day LOS
		In Hospital Flow - Readmissions
		In Hospital Flow - Patient Experience (satisfaction associated with waits / delays)
		In Hospital Flow - Clinician / staff satisfaction (relate to work load)
		In Hospital Flow - No. or % of hospital acquired conditions
		In Hospital Flow - Average LOS
		Improving Discharge - 21-day LOS
	3.2 Clinical Operating Model / BaBB and associated workforce Transformation, Outpatients and Theatres	Outpatient - Total Attendances (v 18/19 baseline month on month)
		Structure
		Theatres - Staffing levels meet requirements (by staff group)
		See also metrics in 5.4
		Process
		Theatres - Reduction In late starts
		Theatres - Reduction in early finishes
		Theatres - Touchtime utilisation above 85%
		Theatres - Overnight conversion Rate
		Theatres - % of Elective activity at WGH

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Workstream Metrics

Operations & Performance	**3.2 Clinical Operating Model / BaBB and associated workforce Transformation, Outpatients and Theatres**	Theatres - Day Case Rate Outpatient - Number of internal referrals within specialties Outpatient - E letter roll out (47p per hard copy letter saved) : Target Outpatient - E letter roll out (47p per hard copy letter saved) : Actual Outpatient - eBooking Outpatient - decrease in OP volume Outpatient - increase in Non face to face Outpatient - 5% PIFU Outpatient - 16% Advice & guidance Outpatient - 25% reduction in OP attendances (from 19/20 levels) Outpatient - 25% non face to face OP delivery Theatres - Cancelled on the day rates Improved utilisation of outpatient and theatre capacity Delivery of productive 42 weeks
		Outcome Theatres - Patients within baseline activity Theatres - Bed capacity Theatres - Reduction in mortality Theatres - GIRFT – BADS (British Association of Daye Case Surgery) scheme Theatres - Financial Outcomes – 840k reduction Outpatient - Patients self booked through e-booking Outpatient - Total letters downloaded as e-letters Outpatient - Total video consultations Outpatient - % Attendances undertaken as non face to face Reduction in AAS, locum, agency

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Workstream Metrics

Operations & Performance		Theatres - Free from harm for patients Reduction in follow up appointments Theatres - Patient feedback Theatres - Wait times Improvement to patient and staff experience Improved outcomes – aligned to GIRFT
	3.3 Stroke Improvement Plan and Section 31	***Outcome*** SSNAP Metrics Trust Metrics
Leadership & Culture	**4.1 Cultural Engagement**	***Structure*** Culture Dashboard to Measure Improvement over a 5-year period As the Leadership and Culture Programme is Finalised Project metrics will be defined % of FTSU cases closed within x working days with an appropriate and meaningful outcome % of FTSU cases with a Quality Assurance review conducted
		Process QA Review or Annual Appraisals % of FTSU cases having a Quality Assurance review has been conducted, where coding is determined to be correct People Pulse: % Response Rate People Pulse: % Employees taking part % RTW Discussions Held Link to Clinical Service Reviews & Fundamentals of Care
		Outcome Proportion of FTSU Cases matched against national benchmark People Pulse: supporting my health and wellbeing

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Workstream Metrics

Leadership & Culture	**4.1 Cultural Engagement**	People Pulse: Employee Engagement Score (MH) Attendance % Turnover rate % Introduction of thematic coding across multiple workforce processes and systems
	4.2 Revision and refresh of Organisational Development Strategy	***Structure*** As the Leadership and Culture Programme is Finalised Project metrics will be defined
		Outcome Culture Dashboard to Measure Improvement over a 5-year period
	4.3 Revised Leadership & Management Development Strategy & Plan	***Structure*** As the Leadership and Culture Programme is Finalised Project metrics will be defined
		Process No. through Leadership Development % staff fully compliant with CSF Appraisal Compliance Medical Appraisal Compliance
		Outcome Culture Dashboard to Measure Improvement over a 5-year period

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Workstream Metrics

Sustainable Financial Improvement	5.1 H1/H2 Roadmap	***Process*** Planned Improved run rate Release contingency Reduce funding for cost pressures Recover lost non nhs income CIP - to offset inflation CIP's - Procurement CIP's - Revenue to capital Minimum covid cost reduction Benefits in business cases approved Build a Better Bay Further improvement in runrate Green Agenda Impact of Agile Working ICS Efficiencies Unfunded Developments Additional Savings Required
		Outcome Financial Balance for the Trust this Financial Year Improvement in Underlying financial run rate from 1.4.21 at 31.3.22
	5.2 Financial Control Environment	Total cases reviewed by IPG

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Workstream Metrics

Sustainable Financial Improvement	5.2 Financial Control Environment	No. prior approvals forms approved to business case at IPG
		No. prior approvals not approved
		No. business cases recommended to TMG
		No. business cases IPG waiting for
		No. business cases not approved
		Total Number of business cases approved
		No. case in monitoring
		Structure
		New Business Case and investment planning process – COMPLETE (post implementation review 15.12.21)
		Completion of NHSi Grip and Control Checklist and approval of improvement plan – 31.1.22
		Implementation of recommendations from scheme of delegation review aligned to Improvement Plan accountability framework – 31.3.21
		Process
		High Cost Locums: Number of post out to advert
		High Cost Locums: Number of locums in place for 6 months
		High Cost Locums: Number of locums in place for 12 months
		High Cost Locums: Number of locums in place for 18 months
		High Cost Locums: Number of locums in place for 24 months
		High Cost Locums: Number of locums in place above 24 months
		Scheme of Delegation: Number/% of people trained
		Outcome
		High Cost Locums: Number of Agency to Substantive staff
		Scheme of Delegation: Number of exceptions by severity
		Run rate reduction high cost locum spend 31.3.22

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Workstream Metrics

Sustainable Financial Improvement	**5.3 Financial Skills Development**	***Process*** Total number of people trained % Available Spaces Utilised at Each Training Event All elements of enhanced finance training and skills development programmes rolled out Q4 21/22 – 31.3.22 Per training package: % Compliance - within target deadline (for information only) Per training package: % Compliance overall
		Outcome Develop crib sheet/QA assessment for finance managers to work with departments to asses the development of financial skills in the department. Evidenced improvement in planning and performance vs delegated budgets H2 and 22/23 – 31.3.22 and on-going Per training package: training feedback questionnaire
	5.5 System Reform	***Structure*** Evidenced connection and support for system and organisational improvement plans and the development of the L&SC clinical strategy Maximise benefits of system collaboration, efficient use of resources, and enhanced skills and capacity across the ICS Implementation of a system wide financial risk management framework. Implementation of system integrated working through alignment of resources, skills, capacity and planning processes.
	5.6 Commercial	***Structure*** Increased investment in commercial / business development capability Maximise Assets through disposals, Redevelopments & Commercial use of space.

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Thank you
Any questions?

@UHMBT

"Creating a great place to work and a great place to be cared for"

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Recovery Support Programme Exit Criteria Review March 22

"Creating a great place to work and a great place to be cared for"

Executive Summary

Exit from the RSP and SoF4 will be decided by NHSE and NHSI System Improvement Board

The exit criteria for UHMBFT has been agreed between the NHSEI regional team with the trust supported by the Improvement Director

UHMBFT progress is presented for the SIB consideration and have been informed by discussion with trust colleagues and the intensive support team.

- Exit criteria and intensive support programme funding and support agreed and in place – developing 22/23 priorities.
- Improvement Plan (IP) priorities and programme approach developed and implemented – presented to November SIB and NHSEI Executive (13 Dec) - Highlight reports on progress presented monthly
- Monthly deep dive reviews for all programmes to demonstrate **progress, impact and improvements** - Deep Dive reviews and Exit criteria reviews in SIB workplan through to June/July 22.
- Urology and T&O reports published and reviewed in November 21 Public Board – support session provided by Region and Niche for Trust follow-up of all actions (phase 4)
- Maternity Safety Support Programme (MSSP) diagnostic completed, and priorities agreed – Leadership, Governance, Strategy and Vision – escalation due to Ockenden compliance.
- Details of ICS and PCB support and milestones to be presented in March 22 SIB – in relation to Ward Accreditation, Quality Management System and Clinical Strategy.
- Follow up RSP Review Meeting to be scheduled for June 22

No outstanding actions from historical reviews - Niche, RCS, IBD, Kirkup

Exit criteria position March 22	Q1 June 22	Q4 March 23
Trust has compiled comprehensive action plans from Niche, RCS (T&O) reviews (215 actions inclusive of CQC MD/SD).	Confirmation and alignment of all IBD actions - further information is being requested prior to the final report (planned for April)	Assurance gained and delivered Demonstrable robust systems and processes as described by SIB
Support session provided by Region and Niche for Trust follow-up actions and assurance relating to review recommendations Session undertaken in March 2022 with Executive Chief Nurse, Medical Director and Director of Governance	2 day session planned in March /early April with agreed stakeholder panel (including NHSI) to consider/agreed the 4 key priorities and ongoing arrangement for oversight.	
(82 actions in total across historical reviews Niche, RCS, IBD, Kirkup) 26 trust actions completed	• Panel output to project delivery on recommendations • Niche stage 4 complete - trust wide and Urology specialty specific sessions provided by Niche team • Phase 5 planning for October 2022 • Formal Feedback to RCS (T&O) on progress with 7 recommendations	
Escalation re Maternity and Ockenden compliance. Maternity Trust self assessment completion and submission Dec 21 following recommendations from Independent review of Maternity Services (Shrewsbury and Telford NHS Trust) received at Trust Board March 2022	• Vision and Strategy for Maternity Services: (Patient Eng) April 2022 • Maternity Risk Strategy Approval – April 2022 • Digital Transformation - Badgernet full roll -out April 2022 • Procedural Documents Strategy Approval – April 2022 • Director of Midwifery in Post – May 2022	

No outstanding actions arising from regulatory notices (HEE, GMC, CQC, HSE)

Exit criteria position	Q1 June 22	Q4 March 23
HEE - no regulatory notices	Nil action required	Assurance gained and delivered Demonstrable robust systems and processes in place as described by SIB
GMC – no regulatory notices	Nil action required	
HSE - no regulatory notices	Nil action required	
CQC - 117 actions CQC actions on AMaT with Care group governance in place to manage 15 Complete 102 In Progress Updates to Quality Committee, Trust Board and SIB	Respond to request for other actions (March 22 ICS co-ordinated visit to ED and Medicine) 'Test' of accredited service reviews - 'so what?'	
Stroke - Trust submitting CQC information requests and reports for Stroke and NoP26. Substantive stroke consultant in place FGH & RLI – SNAP Data C	Consideration for the application for step down of S31 for Stroke. RLI therapy new permanent therapy area planned to commence June 2022. Peer Review – Qtr4 Date TBC	
SIQSG for Safeguarding (S42) meetings stepped down to monthly. Final verbal recommendation made to the Quality Assurance Committee and the SIB as to closure of the incident. Approved	Item closed - 6 month report due to QAC August 22 on progress with actions	
N**oP S31 issued for ITU at FGH in December** – no further action to be taken at this stage by CQC.	• All case reviews complete • Peer review and self assessment • Audit programme in place to monitor with oversight from Quality Committee and Critical Care Delivery Group	

Demonstrate robust organisation wide governance structure in place

Exit criteria position March 22	Q1 June 22	Q4 March 23
Completion of GGI report and handover end October 2021 – follow-up priorities for sustainable improvement included in Trust Improvement Plan with support from NHSEI Governance specialist.	Project go-live with new format Patient Safety Procedures – April 2022 Project go-live with new Risk Management Procedures – April 2022 (Roll out of training due to complete End of Dec 2022).	Assurance gained and delivered Demonstrable robust systems and processes in place as described by SIB
Undertake re assessment of position against HM Treasury Risk Maturity Assessment Framework to confirm achievement of Level 3 (good) meaning risk management is implemented in key areas across the organisation.	Develop action plan of focus for next phase of work based in the outcome of the self assessment to continue to improve organisations maturity in respect of risk management.	
New national PSIRF to be published setting out new approach to responding to patient safety incidents	Consider Phase 1 Project Closure Report based on current method of working. Patient Safety Incident Response Plan to be developed to identify areas of focus for system level investigations.	

Demonstrable robust systems and process relating to safety & quality e.g., Safe staffing, Serious Incidents

Exit criteria position March 22	Q1 June 22	Q4 March 23
Reports for S26 NoP include development of SI processes and Risk Management.	See slide 5 for SI processes and risk management	Assurance gained and delivered Demonstrable robust systems and processes
Quality and safety workstream in Improvement Plan includes Fundamentals of Care, Clinical Service Reviews, Productive Ward and Safe Staffing	Completion of Clinical Service reviews April 22 Ward Dashboard Agree final version May 22 - Go Live June 22 Quality Improvement/Engagement with QI Lead to scope a programme for band 5,6, ward managers, matrons - Small cohort/ pilot to commence June 22. Staff Recognition for Improvement.	
'Medicines Measures for success' to be agreed by end March 22.	Medicine Management workstream commence April 22 Antimicrobial Stewardship and Medicines Reconciliation Business Case approved with phasing to full delivery RSP funding request for Medicines Management Support at Ward Level with proof of concept to sustain	

Agreement of a sustainable clinical strategy for Morecambe Bay, that contributes to the system financial plan and sustainable services.

Exit criteria position March 22	Next Steps
Significant work has already been undertaken, or is in progress, in defining future models for some of our clinical services: • Stroke (integrated stroke and neuro delivery network, as stipulated in the NHS Long Term Plan) • Vascular services (now working towards a LSC Vascular Network) • Head and Neck (will be re-starting and working towards a LSC network) • Ophthalmology • Clinical Haematology • Diagnostics – developing a LSC Diagnostics Imaging Network • Community Diagnostic Centres	Further specialties in the Clinical Strategy will be developed through a series of waves within a comprehensive Programme Plan. In each wave, clinical specialties will follow a process that includes wide engagement and is evidence based, to inform a strategy and delivery model for that specialty. Agree Exec Sponsor, SRO, and Clinical Lead for each specialty Agree membership of the workshops and dates for the first workshops to be held (c. 10 weeks from approval) A vital part of these programmes will be led by out of hospital/place, and therefore the joint working through end-to-end pathways is essential to achieve the required transformation.

Evidence of UHMBT priorities in South Cumbria and Lancashire system development plan and alignment of clinical strategy.

Exit criteria position March 22

The LSC Provider Collaborative is developing a clinical vision and strategy for the future of clinical services which encompasses all member trusts and responds to the government's plans (system reform agenda) for clinical commissioning and the regulation of heatlh and social care.
The following programmes of work in the RSP (or aligned to the RSP) demonstrate connectivity with PCB/ICS:

1. **UHMB has commenced the development of our UHMBT clinical strategy**

- Engagement in place with Value Circle with an expected delivery of the UHMB strategy due 2022
- Key Principles Identified with engagement from all care groups and corporate teams
- Clinical Case for Change Established
- 36 week plan to delivery

2. **UHMBT aligned to key elements of work:**

- The use of the resources within the PCB to maximise the infrastructure for our QI approach and Quality Management System. A Regional QI Peer review will take place in April to review and support a sustainable resource for UHMBT (HIVE review)
- Ward accreditation programme - UHMBT will complete an accredited service review programme across all sites by 31st March 22. The service reviews with inform ward-based improvement programmes supported by accelerated QI training for front line staff to own and deliver the required improvements

3. **The UHMBT capital estates strategy on elective recovery input as part of 22/23 plan:**

Bid into the ICS as part of the Elective recovery capital funding as per below:

- Theatres - Expansion & Refurbishment of theatres at WGH to support creation of the green site elective hub at WGH for all specialities with a sum of £7.1m has been secured
- UHMB part of the Community Diagnostic Hubs

Evidence of robust and embedded internal whistleblowing processes, that are utilised by staff, with appropriate and timely outcomes; evidence of sustained improvement in staff engagement.

Exit criteria position March 22	Q1 June 22	Q4 March 23
Staff engagement platform live November 21 and completed Jan 21 Development and sign off of strategies for culture OD and Leadership incorporating psychological safety and FTSU.	Implementation plan for Culture programme (2022-2025) – from April 2022 Implementation plan for OD Programme (2022-2025) – From April 2022 Commence Board Development Programme - April 2022 Commence Design and development of an of an internal programme designed to deliver the following: • Aspirant to Senior Leadership Development of 3 year Programme – Live from to June 2022 • Triumvirate Development Programme – live from end of May / Beginning of June 2022 – (implementation of new operating model) - to May 2023 • Medical Leadership Development Programme – Live from June 2022	12 months into Implementation plan for Culture programme (2022-2025) 12 months into Implementation plan for OD Programme (2022-2025) 9 months into Revised Leadership & Management Development Strategy and Plan Assurance gained and delivered Demonstrable robust systems and processes as described by SIB

Top 3 risks to the trust exiting RSP on schedule

Risk descriptor	Mitigating actions	RAG
1. Leadership team capacity and capability **(Vacancy in key posts).**	Interim MD started 1 November 2021 Substantive MD recruitment underway Substantive Executive Chief Nurse started Jan 2022 Recruitment of substantive Chief Operating Officer end Feb 2022. Director of Midwifery appointed - start April 22 Clinical leadership recruitment underway (Clinical leads /Clinical directors)	
2. Ensuring priorities have robust delivery plans, QI support and clinical leadership.	Priority initiatives identified and programme approach in development and strengthened through recruitment of Programme Director, Clinical Director and allocation of project management support to all priority areas. Revised clinical leadership structure in place with recruitment commenced March 22	
3. U&EC programme – resourcing and development of business case for new models and system flow.	ECIST, regional and ICS support required for U&EC, expedited by region. Key projects identified for priority SDEC implemented 7 Feb 22 with 7/7 service planned for April 22. Frailty Business Case approved – continued focused support required for each area. Initial scoping for Paediatric Assessment Unit underway with clinicians leading the way.	

Thank you
Any questions?

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"Creating a great place to work and a great place to be cared for"

CQC Improvement Plan Dashboard

Recommendations by Oversight Committee/Group (alphabetical order of group/committee)

Oversight Committee/Group	Reference Number	Recommendation
Acutely Ill & Resuscitation Group	MD52/1	The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))
Capital Plan Group	MD102/1	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance
Capital Plan Group	MD96/1	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment
Capital Plan Group	SD24/1	The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily
Care Group Governance & Assurance Group Meeting	MD13/1	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))
Care Group Governance & Assurance Group Meeting	MD16/1	The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (2) (b))

Care Group Governance & Assurance Group Meeting	MD17/1	The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (2) (a) (b) (d))
Care Group Governance & Assurance Group Meeting	MD18/1	The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (2) (a)
Care Group Governance & Assurance Group Meeting	MD48/1	The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))
Care Group Governance & Assurance Group Meeting	MD49/1	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))
Care Group Governance & Assurance Group Meeting	MD53/1	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))
Care Group Governance & Assurance Group Meeting	SD23/1	The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines
Care Group Governance & Assurance Group Meeting	SD28/1	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy
Clinical Audit Standards Group	MD14/1	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))
Clinical Audit Standards Group	MD37/1	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))
Clinical Audit Standards Group	MD47/1	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))
Clinical Audit Standards Group	MD84/1	service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))
Clinical Audit Standards Group	SD44/1	The service should act to improve the assessment of women's pain in light of their clinical condition and ensure all women receive pain relief in a timely manner

Clinical Effectiveness Group	MD19/1	The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (2) (a) (b))
Clinical Effectiveness Group	MD36/1	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))
Cultural Transformation Programme Board	MD5/1	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))
Emergency Planning & Resilience Group	SD41/1	The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security
Emergency Planning & Resilience Group	SD62/1	The trust should ensure that wards are secured to maintain patient safety
ENACT - Executive Nurse Accountable Care Team	SD26/1	The trust should ensure that a more robust system of assessing skin integrity and pressure sores is put in place rather than the "safe and seen" assessment used presently.
Finance and Performance Committee	MD70/1	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))
Finance and Performance Committee	SD56/1	The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.
Finance and Performance Committee	SD80/1	The service should implement effective use of the whiteboard communication system on the birth centre
Fire Safety Group	SD63/1	The trust should ensure that fire doors are maintained and used correctly
Infection Prevention Control Group	MD46/1	The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))
Infection Prevention Control Group	SD22/1	The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary
Information Governance And Data Quality Group	SD103/1	The trust should ensure that all records are securely stored

Information Governance And Data Quality Group	SD65/1	The trust should ensure patient records are stored securely.
Information Governance And Data Quality Group	SD83/1	The Trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information
Joint Medicines Management, Drugs and Therapeutics Group	MD15/1	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))
Joint Medicines Management, Drugs and Therapeutics Group	MD6/1	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))
Joint Medicines Management, Drugs and Therapeutics Group	SD7/1	The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation
Joint Medicines Management, Drugs and Therapeutics Group	SD8/1	The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety
Joint Medicines Management, Drugs and Therapeutics Group	SD9/1	The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors
People & Organisational Development Strategy Group	MD66/1	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))
People & Organisational Development Strategy Group	MD99/1	The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
People Committee	MD92/1	The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))

People Committee	MD98/1	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
People Committee	SD34/1	The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.
People Committee	SD35/1	The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets
People Committee	SD93/1	The service should consider protected time to allow for the completion of mandatory training
Procedural Documents and Information Group	MD86/1	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))
Procedural Documents and Information Group	SD42/1	The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.
Quality Assurance Committee	MD1/1	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))
Quality Assurance Committee	MD10/1	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))
Quality Assurance Committee	MD100/1	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance
Quality Assurance Committee	MD21/1	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))

Quality Assurance Committee	MD38/1	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))
Quality Assurance Committee	MD39/1	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))
Quality Assurance Committee	MD50/1	The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))
Quality Assurance Committee	MD51/1	The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))
Quality Assurance Committee	MD58/1	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))
Quality Assurance Committee	MD59/1	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))
Quality Assurance Committee	MD68/1	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))
Quality Assurance Committee	MD85/1	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))
Quality Assurance Committee	MD88/1	The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) & (e))

Quality Assurance Committee	MD91/1	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) & (b))
Quality Assurance Committee	SD104/1	The service should ensure they complete MUST documentation
Quality Assurance Committee	SD25/1	The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.
Quality Assurance Committee	SD27/1	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident
Quality Assurance Committee	SD43/1	The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place
Quality Assurance Committee	SD64/1	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.
Quality Assurance Committee	SD76/1	The service should act to improve the quality of safety information shared in SBAR handover.
Quality Assurance Committee	SD81/1	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.
Quality, Governance & Patient Safety Management Group	MD3/1	The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (2) (b))
Quality, Governance & Patient Safety Management Group	MD4/1	The trust must improve on the timeliness of responses to complaints. (Regulation 16 (2))
Risk Management Group	MD2/1	The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (2) (b))

Safeguarding Operational Performance Group	MD12/1	The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (2) (a))
Safeguarding Operational Performance Group	MD54/1	The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))
Safeguarding Operational Performance Group	MD67/1	The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))
Safeguarding Operational Performance Group	MD97/1	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment
Safeguarding Operational Performance Group	SD55/1	The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.
Strategy and Transformation Cells	MD33/1	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))
Trust Management Group	MD101/1	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance
Trust Management Group	MD20/1	The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (2) (i); Regulation 17 (2) (a))
Trust Management Group	MD29/1	The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1) & (2) (a) & (b))
Trust Management Group	MD30/1	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))
Trust Management Group	MD31/1	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))
Trust Management Group	SD45/1	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets

Trust Management Group	SD79/1	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.
Trust Management Group	SD95/1	The service should work to engage the workforce and increase visibility of the executive team

Key:

Not Applicable
Unable to Complete
Not Started
In Progress (Behind Schedule)
In Progress (Completion by Oct 2022)
In Progress (Completion after Oct 2022)
Fully Completed (awaiting approval)
Fully Completed / Approved

Inspection	Reference Number	SRO	Committee	Service	Recommendation	Action	Status	Target Due	Comments
CQC Must Do	MD1/1	Mr Richard Sachs	Quality Assurance Committee	TRUSTWIDE	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	The Trust will complete the recommendations from the Good Governance Institute (GGI) to deliver improved governance and assurance structures and processes from ward to board	In Progress	31/03/2022	

CQC Must Do	MD1/2	Mr Stuart Bates	Quality Assurance Committee	TRUSTWIDE	The trust must ensure that governance processes are robust and effective (Regulation 17 (1))	The Trust has completed an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained	Fully complete (Awaiting approval)	31/10/2021	
CQC Must Do	MD2/1	Mrs Anna Smith	Risk Management Group	TRUSTWIDE	The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (2) (b))	The Trust will implement and embed a new Risk Management Strategy, new Trust Wide Risk Management Group to oversee Risk and review, update the associated Risk Management Processes and deliver Risk Management Training, to ensure this is embedded throughout the organisation. The operational elements are in place. The resource with regards to Risk Practitioner in place until December 2021.	Fully complete (Awaiting approval)	31/12/2021	

CQC Must Do	MD3/1	Mrs Nicola Edmondson	Quality, Governance & Patient Safety Management Group	TRUSTWIDE	The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (2) (b))	The Trust will implement a review of the existing Trust Wide Incident Reporting, Investigation and Management Policy, Procedures and Systems, in line with the new National Patient Safety Strategy and Framework, and then deliver and embed the required improvements. The infrastructure, revised Policy and systems in place by end of Q2. The embedding / reviewing by the end of Q3. Review the position by end of Q4.	In Progress	31/03/2022	
CQC Must Do	MD4/1	Mrs Nicola Edmondson	Quality, Governance & Patient Safety Management Group	TRUSTWIDE	The trust must improve on the timeliness of responses to complaints. (Regulation 16 (2))	The Trust will implement an action plan to improve Complaints responses time with a target to meet regulatory standards by end of October 2021, with a stretch target of meeting Trust standards by the end of March 2022.	In Progress	31/03/2022	

CQC Must Do	MD5/1	Ms Claire Alexander	Cultural Transformation Programme Board	TRUSTWIDE	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	The Trust will continue to deliver its ESP Programme within the wider Trust Culture and Transformation Group workstream to make the required improvements in the WACS Care Group to enhance a positive culture and support the delivery of effective care and treatment	In Progress	31/03/2022	
CQC Must Do	MD5/2	Ms Claire Alexander	Cultural Transformation Programme Board	TRUSTWIDE	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	The Trust will continue to deliver its ESP Programme within the wider Trust Culture and Transformation Group workstream to make the required improvements in the T&O Speciality to enhance a positive culture and support the delivery of effective care and treatment	In Progress	31/03/2022	

CQC Must Do	MD5/3	Mr David Wilkinson	Cultural Transformation Programme Board	TRUSTWIDE	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	The Trust has developed and implemented a Trust Wide Cultural Transformation Workstream which is overseen by the Director of People and Organisational Development and is monitored/reported at Workforce Assurance Committee and Trust Management Group, the Work Stream include programmes on: Just and Learning Culture, Magnet 4 Europe, Freedom to Speak Up, Medical engagement/leadership, Talent Management & Leadership Development, Workforce Transformation	In Progress	31/03/2022	

CQC Must Do	MD5/4	Mr Paul Jones	Cultural Transformation Programme Board	TRUSTWIDE	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	Within the Culture and Transformation Work Stream, the Trust has a specific programme of work to develop and implement a Cultural & Leadership Diagnostic & Dashboard, with target outcomes of; Build of UHMB Cultural Dashboard in Model Hospital, Completion of all diagnostic tools across the 6 elements of the programme, Outcomes presented to Cultural Transformation Board, Trust Management Group and Board of Directors	In Progress	31/03/2022	
CQC Must Do	MD5/5	Mr David Wilkinson	Cultural Transformation Programme Board	TRUSTWIDE	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	The Trust (Led by People and Organisational Development) will work with NHSE/I to implement a cultural engagement tool to help improve staff engagement.	In Progress	31/03/2022	

CQC Must Do	MD5/6	Mr David Wilkinson	Cultural Transformation Programme Board	TRUSTWIDE	The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (2) (a))	Trust to implement an online conversation platform to enable staff to provide anonymous feedback on: - The Trust's; Vision, Values, Culture and Leadership - What changes are needed? - Our Fundamental purpose as an NHS Trust? - Acceptable behaviours to colleagues, patients, partners and the public - What is required to make these changes? The Trust will then publish the results form the conversation , then develop and implement an action plan to address the issues raised.	In Progress	31/03/2022	
CQC Must Do	MD6/1	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	TRUSTWIDE	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	The Pharmacy Service will develop and submit a Business Case for the recruitment of substantive pharmacy staff to undertake medicines reconciliation in the Trust. Once approved this will be implemented and the additional capacity deployed to ensure this recommendation is met and sustained through regular monitoring.	In Progress	01/04/2023	

CQC Must Do	MD6/2	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	TRUSTWIDE	The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))	The Pharmacy Service will develop and submit a Business Case for the recruitment of substantive pharmacy staff to undertake antimicrobial stewardship in the Trust. Once approved this will be implemented and the additional capacity deployed to ensure this recommendation is met and sustained through regular monitoring.	In Progress	01/04/2023	
CQC Must Do	MD10/1	Mrs Melanie Woolfall	Quality Assurance Committee	Accident and Emergency	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	The Trust has developed and implemented a detailed improvement plan to address the issues identified in the Section 31 Notice, the plan includes; To meet the immediate safety concerns by 20.5.21, To deliver the agreed improvement plan against the 8 domains by the 8 week deadline (July 2021) and To ensure improvements are sustained September 2021	In Progress	31/03/2022	
CQC Must Do	MD10/2	Mrs Melanie Woolfall	Trust Management Group	Accident and Emergency	The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (2) (i))	The Medicine Care Group will work with partner organisations to deliver and submit the ICS business case for stroke services. This will ensure sufficient capacity and resources to meet best practice	In Progress	31/03/2022	

						guidance.			
CQC Must Do	MD12/1	Mrs Melanie Woolfall	Safeguarding Operational Performance Group	Accident and Emergency	The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (2) (a))	Trust Safeguarding Policy already includes MCA Risk Assessments. The Care Group will work with Safeguarding Team to ensure that assessments are carried out as part of everyday practice in line with Trust Policy and all staff understand their role and responsibilities. This will be monitored through Spot Checks and Audit, with Best Practice and learning to be shared from these. Maintain high quality risk / MCA assessments in line with Trust policy.	In progress (behind schedule)	31/12/2021	The risk assessments and mental capacity assessments are carried out as part of everyday practice and reviewed through individual incident management and matron assurance checks. The Care Group work closely with corporate safeguarding to ensure best practice and learning identified from any incidents. Safeguarding Lead undertaking thematic review reporting to SIRI. ~~Action appears complete – to confirm with leads and request evidence of completion and regular monitoring process.~~
CQC Must Do	MD13/1	Mr Neil Smith	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This includes meeting national guidance for staffing requirements,	In Progress	31/03/2022	

					paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))	including paediatrics.			
CQC Must Do	MD13/2	Mrs Melanie Woolfall	People Committee	Accident and Emergency	The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))	The Medicine Care Group has confirmed that existing arrangements for the RLI Paediatric Ward to provide overnight Paediatric Nursing Cover/Support to RLI ED on an 'as required' basis remain in place.	In Progress	31/03/2022	

CQC Must Do	MD14/1	Mr Neil Smith	Clinical Audit Standards Group	Accident and Emergency	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	The Medicine Care Group will strengthen and assure the local Audit processes and leadership to ensure audits are completed and submitted as required in line with RCEM requirements and any remedial actions are implemented.	In Progress	31/03/2022	
CQC Must Do	MD14/2	Mrs Heather Pratt	Clinical Audit Standards Group	Accident and Emergency	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	The Medicine Care Group ensure compliance with Audit including; RCEM and Safer Care for Nursing Tool (SNCT). Audit will be a standing agenda item at MGAG from January 2022 for regular monitoring.	In Progress	31/03/2022	

CQC Must Do	MD14/3	Mrs Heather Pratt	Quality Assurance Committee	Accident and Emergency	The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (2) (a))	The Trust Clinical Audit team will review and update Trust Wide Clinical Audit processes, to include; Implement and Embed new Clinical Audit Governance structure as required from the Trust Wide GGI Governance Review, to ensure consistent Ward To Board processes and escalation and to appoint a National Audit Co-ordinator within the Trust Clinical Audit Team.	Fully complete (Awaiting approval)	31/12/2021	
CQC Must Do	MD15/1	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	Accident and Emergency	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))	The Medicine Care Group will increase vigilance/oversight of remedial actions following Controlled Drug and Enhanced control safe and secure storage audit actions as captured on the new AMaT System. Any findings or recommendations from these audits will be implemented and monitored through future regular audits.	In progress (behind schedule)	31/01/2022	Quarter 3 Controlled Drug and Enhanced Control Medicines Audits complete. Themes: • Improvement requirements on storage and access to Medicines Cupboard/Controlled Drug and Enhanced Control cupboard keys. • Challenges with storage of medicines as in some area's insufficient suitable storage for the current required storage of medicines including those that are Controlled Drugs and under Enhanced Control. Some area's have challenge with storage of TTO's and of Registers. • Improvement requirements with daily stock checks • Improvement with full completion of records on EPMA and in the respective registers. The report for Quarter Three audits is to be produced, the above are early findings. This report will be compared with Quarter 1 findings.

CQC Must Do	MD15/2	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	Accident and Emergency	The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (2) (g))	The Pharmacy Service will strengthen Patient Group Direction oversight. To include refresh of the policy, implementation of audit, increasing staff awareness and delivery of any required staff training.	In Progress	31/03/2022	
CQC Must Do	MD16/1	Miss Leanne Cooper	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (2) (b))	Plans have been developed as part of the BHACP UEC Programme, it has been signed off by A&E Delivery Board and now has additional PMO support to help its delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan.	Fully complete (Awaiting approval)	31/03/2022	

CQC Must Do	MD17/1	Mrs Melanie Woolfall	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (2) (a) (b) (d))	The Medicine care Group ensure that the RLI ED corridor escalation plan is adhered to by staff and that incidents are recorded and escalated to the Patient Flow Team. Investigate scope for automated monitoring/recording of corridor waits.	In Progress	31/03/2022	
CQC Must Do	MD18/1	Mrs Melanie Woolfall	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (2) (a)	The Medicine Care Group will review Processes for maintaining the privacy and dignity of (non-Cubicle) patients in RLI ED, to identify and implement improvements, to include; Staff Awareness, Matron Review/Spot Checks, Seen and Safe Process/documentation, collaborative projects with NHSE/I and NWAS colleagues	In Progress	31/12/2022	
CQC Must Do	MD19/1	Mr Neil Smith	Clinical Effectiveness Group	Accident and Emergency	The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (2) (a) (b))	To be managed through the fundamentals work on managing a deteriorating patient and medicines management. To be reviewed as part of RCEM audit to determine required actions Pain scores to be monitored as part of safety checks	In Progress	31/03/2022	

CQC Must Do	MD20/1	Mrs Diane Smith	Trust Management Group	Accident and Emergency	The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (2) (i); Regulation 17 (2) (a))	The Medicine Care Group will review current MDT working arrangements in the RLI ED to identify and implement improvements, including the design and development of a new priority admissions unit (PAU).	In Progress	31/03/2022	
CQC Must Do	MD21/1	Mrs Diane Smith	Quality Assurance Committee	Accident and Emergency	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	The Medicine Care Group will review all risks in line with the business plan to ensure risk have been identified and properly captured on the risk registers with appropriate mitigation in place	Fully complete (Approved)	31/08/2021	
CQC Must Do	MD21/2	Mrs Diane Smith	Quality Assurance Committee	Accident and Emergency	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where	The Medicine Care Group will ensure a regular review of risk registers is built in with the Health and Safety & Risk team to provide review and challenge, ensure a process with the Clinical Governance Team for identifying and agreeing new risks.	Fully complete (Approved)	30/11/2021	

					progress cannot be achieved. (Regulation 17 (2) (b))				
CQC Must Do	MD21/3	Mrs Diane Smith	Quality Assurance Committee	Accident and Emergency	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	The Medicine Care Group will explore possibility of risk register workshops with the Good Governance Institute (GGI) to improve the medicine risk register and associated management	Fully complete (Approved)	30/11/2021	

CQC Must Do	MD21/4	Mr Stuart Bates	Risk Management Group	Accident and Emergency	The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (2) (b))	The Trust will implement and embed new Trust Wide Risk Management Strategy, New Risk Management Group and associated Risk Management Process, to ensure this is embedded throughout the organisation.	Fully complete (Approved)	31/12/2021	
CQC Must Do	MD29/1	Mrs Melanie Woolfall	Trust Management Group	Medicine	The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1) & (2) (a) & (b))	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group and Partner Organisations.	In Progress	31/03/2022	

CQC Must Do	MD30/1	Mrs Melanie Woolfall	Trust Management Group	Medicine	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group and Partner Organisations	In Progress	31/03/2022	
CQC Must Do	MD31/1	Mrs Melanie Woolfall	Trust Management Group	Medicine	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group.	In Progress	31/03/2022	
CQC Must Do	MD32/2	Mrs Carol Park	Strategy and Transformation Cells	TRUSTWIDE	The trust must continue to monitor and take appropriate actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation 12 (1))	The Trust has established a number of Work streams in the Accelerator/ Restore and Recovery Programme to help improve (reduce) the average length of stay of patients (including T&O Patients), the Work Streams are; Cancer services, Outpatients,	In progress (behind schedule)	31/12/2021	There has been a neck of femur steering group set up and the length of stay is monitored through this. No improvement is being seen at the current time, however, as a trust we continue to have over 120 patients not meeting the criteria to reside and this will be a prominent factor in this patient group To be reviewed as possibly completed as the ask is to monitor and take actions where required/appropriate. Rationale for being behind schedule appears to be because 100% compliance

						Diagnostics and Elective Inpatients			has not yet been achieved.
CQC Must Do	MD33/1	Ms Kate Maynard	Strategy and Transformation Cells	TRUSTWIDE	The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))	The Trust has established a number of workstreams within the Accelerator / Restore and Recovery Programme which will help improve RTT performance, these include; Cancer services , Outpatients , Diagnostics and Elective Inpatients	In Progress	31/03/2022	
CQC Must Do	MD36/1	Mrs Carol Carlile	Clinical Effectiveness Group	Maternity Service	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	The Maternity Service will work with the Trust Policy Co-ordinator to Implement and deliver a review and update of the service's Procedural Documents to ensure all guidelines are up to date (outcome measures: to achieve 95% target)	In Progress	31/03/2022	
CQC Must Do	MD36/3	Mrs Carol Carlile	Procedural Documents and Information Group	Maternity Service	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	The Maternity Service will work with Trust NICE Lead to Implement and deliver a review and update of the service's Procedural Documents to ensure they are aligned with prevailing NICE Guidance Documents	In Progress	31/03/2022	
CQC Must Do	MD36/4	Mrs Carol Carlile	Procedural Documents and Information Group	Maternity Service	The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))	To review and update any out of date, high-risk, emergency guidelines.	In progress (behind schedule)	31/01/2022	Work ongoing and is being monitored through maternity governance meeting. Director of Governance now chairs a governance meeting in WACS, each service has prioritised 5 documents for updating and approval. Operational pressures have hampered progress.

CQC Must Do	MD37/1	Mrs Carol Carlile	Clinical Audit Standards Group	Maternity Service	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))	The Maternity Service will work with the Trust Acute Care Team and the Trust Clinical Audit Team to undertake a Re-audit of the sepsis management of all expectant mothers against national standards, a post audit action plan will be developed and implemented to address any performance issues.	In Progress	31/03/2022	
CQC Must Do	MD37/3	Mrs Carol Carlile	Procedural Documents and Information Group	Women and Children's Services	The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))	The Service appointed Consultant Obstetrician will work with the Trust NICE Lead to review the sepsis guidance to ensure it is aligned with national NICE guidance.	In Progress	31/03/2022	
CQC Must Do	MD38/1	Mrs Tamsin Cripps	Quality Assurance Committee	Maternity Service	The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))	The Maternity Service will work with patients, staff and partner organisations to undertake a sustainability focussed review and update of the 'Better Births Strategy'	In Progress	31/03/2022	
CQC Must Do	MD39/1	Mrs Carol Carlile	Quality Assurance Committee	Maternity Service	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and	The Maternity Service will work with the Corporate Governance Team and Good Governance institute (GGI) to deliver and embed the new Trust Wide governance processes and systems within the Care Group	In Progress	31/03/2022	

					families using the service. (Regulation 17 (1) (2) (a) (b))				
CQC Must Do	MD39/3	Mrs Carol Carlile	Care Group Procedural Document Meeting	Maternity Service	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))	To develop and implement a governance Maternity Risk Strategy which aligns to the wider Trust Risk Strategy	In Progress	31/03/2022	
CQC Must Do	MD46/1	Mrs Amy Mbuli	Infection Prevention Control Group	Accident and Emergency	The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))	Prevailing and COVID specific IPC/PPE Policies already in place, monitoring through Spot Checks and Audits already in place. The service will re-communicate requirements to increase staff awareness and to encourage staff to actively challenge and/or report non-compliance, reported or identified incidents of non-compliance to be investigated and resolved.	Fully complete (Awaiting approval)	28/02/2022	

CQC Must Do	MD47/1	Mr Neil Smith	Clinical Audit Standards Group	Accident and Emergency	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))	The Care Group will participate in Clinical Audit as required and the Medicine Care Group will ensure that Clinical audit is tracked through the Care Group MGAG Meeting to ensure participation, timely data submission and implementation of post Audit Action Plans. Audit Progress will also be shared with and/or reported at Trust Clinical Audit Meeting. In particular; RCEM, SSNAP and TARN Audits	In Progress	31/03/2022	
CQC Must Do	MD47/2	Mrs Heather Pratt	Quality Assurance Committee	Accident and Emergency	The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))	The Trust Clinical Audit Team will review and update Trust Wide Clinical Audit processes, to include; Implement and Embed new Clinical Audit Governance structure as required from the Trust Wide GGI Governance Review, to ensure consistent Ward To Board processes and escalation and to appoint a National Audit Co-ordinator within the Trust Clinical Audit Team.	Fully complete (Awaiting approval)	31/12/2021	

CQC Must Do	MD48/1	Miss Leanne Cooper	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))	Plans has been developed as part of the BHACP UEC Programme, it has been signed off by A&E Delivery Board and now has additional PMO support to help its delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan. (See MD16/1 also)	In Progress	31/03/2022	
CQC Must Do	MD49/1	Miss Leanne Cooper	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))	The Service Mental Health improvement projects are being managed within the Bay Health and Care Partners (BHACP) Urgent and Emergency Care (UEC) Improvement Programme under the Pre Hospital/A&E avoidance programme. The BHACP UEC Improvement Plan includes input from local MH Trust (Lancashire and South Cumbria Trust) and local Police Forces.	In Progress	31/03/2022	

CQC Must Do	MD49/2	Mr Mark Lippett	Safeguarding Operational Performance Group	Accident and Emergency	The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))	The BHACP UEC Improvement Programme includes implementation of MHUAC services, actions specific to FGH ED include: Implementation of an additional mental health post at FGH ED to support frequent attender service, introduction of Street triage service with Cumbria police in October 2021. This service will run Tues to Fri (twilight) as this is when the majority of 136s occur. This service will hopefully have a positive impact on the number of patients with mental health problems presenting at ED.	In Progress	31/03/2022	
CQC Must Do	MD50/1	Mrs Melanie Woolfall	Quality Assurance Committee	Accident and Emergency	The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management. To be reviewed as part of RCEM audit to determine required actions Pain scores to be monitored as part of safety checks	In Progress	31/03/2022	

CQC Must Do	MD51/1	Mrs Melanie Woolfall	Quality Assurance Committee	Accident and Emergency	The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management	Fully complete (Awaiting approval)	30/11/2021	
CQC Must Do	MD52/1	Mrs Melanie Woolfall	Acutely Ill & Resuscitation Group	Accident and Emergency	The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))	The Medicine Care Group will review resuscitation training requirements / standards in relation to paediatric training and develop a plan for compliance where necessary	In Progress	31/03/2022	
CQC Must Do	MD53/1	Mr Neil Smith	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to MGAG. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for Medical Staffing Levels.	In Progress	31/03/2022	

CQC Must Do	MD53/2	Mrs Melanie Woolfall	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to MGAG. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for Nursing Staffing Levels.	In Progress	31/03/2022	
CQC Must Do	MD53/3	Mrs Diane Smith	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This will include Medical and Nursing staffing levels and paediatric environment at FGH ED. This Action is for paediatric environment.	In Progress	31/03/2022	
CQC Must Do	MD54/1	Mrs Diane Smith	Safeguarding Operational Performance Group	Accident and Emergency	The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))	The Medicine Care Group will review Safeguarding guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team	In Progress	31/03/2022	

CQC Must Do	MD58/1	Mrs Diane Smith	Quality Assurance Committee	Medicine	The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) & (2) (a) & (b))	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan overseen by the Chief Operation Officer and its progress is monitored at / reported to Trust Management Group.	In progress (behind schedule)	31/12/2021	All stroke pathway recommendations are monitored directly through monthly reporting to CQC. Action to be complete when CQC have confirmed they are happy with progress and sustainability. Date to be reviewed in light of this.
CQC Must Do	MD59/1	Mrs Diane Smith	Quality Assurance Committee	Medicine	The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2) (a))	All recommendations related to the stroke treatment pathway are being managed under the Action Plan that Trust has developed to address the section 31 improvement work, this action plan is overseen by the Chief Operations Officer and its progress is monitored at / reported to Trust Management Group.	In progress (behind schedule)	31/12/2021	All stroke pathway recommendations are monitored directly through monthly reporting to CQC. Action to be complete when CQC have confirmed they are happy with progress and sustainability. Date to be reviewed in light of this.
CQC Must Do	MD66/1	Mrs Tamsin Cripps	People & Organisational Development Strategy Group	Maternity Service	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))	To complete a robust workforce plan agreed by Trust Board based on the outcomes of the Birth Rate Plus Review.	Fully complete (Awaiting approval)	28/02/2022	

CQC Must Do	MD66/2	Mrs Carol Carlile		Maternity Service	The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))	Review and complete a maternity training plan to include Core Skills Framework, job essential training and core competency training	Fully complete (Awaiting approval)	14/01/2022	
CQC Must Do	MD67/1	Dr Julia Alcide	Safeguarding Operational Performance Group	Maternity Service	The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))	The Maternity Service will ensure medical staff complete safeguarding level 3 training in a timely manner and in line with Trust targets	Fully complete (Awaiting approval)	28/02/2022	
CQC Must Do	MD68/1	Mrs Tamsin Cripps	Quality Assurance Committee	Maternity Service	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))	The Maternity Service will complete its existing work programme to move all risk assessments into the Local ICS 'BadgerNet' Maternity System and to establish; an auditing process for the Risk assessments held in BadgerNet and to review and update existing escalation processes in light of the introduction of BadgerNet	In Progress	31/07/2022	
CQC Must Do	MD68/2	Mrs Carol Carlile		Maternity Service	The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))	To develop a process to ensure appropriate risk assessments are carried out throughout the pregnancy journey	In Progress	31/07/2022	

CQC Must Do	MD70/1	Mrs Tamsin Cripps	Finance and Performance Committee	Maternity Service	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))	The Maternity Service will implement the Local ICS 'BadgerNet' Maternity System	Fully complete (Awaiting approval)	31/07/2022	
CQC Must Do	MD70/2	Mrs Tamsin Cripps	Quality Assurance Committee	Maternity Service	The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(2)(c))	The Maternity Service will further strengthen existing processes for record keeping, undertake appropriate audit and external checks of these processes.	In Progress	31/03/2022	
CQC Must Do	MD84/1	Mrs Linda Womack	Clinical Audit Standards Group	Maternity Service	service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))	The Maternity Service will undertake an Audit of MOEWS at HHCMU to confirm compliance levels with this recommendation and, if required, will then review and the relevant guidance documents for HCMU and undertake staff awareness and training that is required.	In Progress	31/03/2022	
CQC Must Do	MD85/1	Mrs Linda Womack	Quality Assurance Committee	Maternity Service	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))	Recommendation relates to the Helme Chase Maternity Unit (HCMU), which is ~~is~~ a Mid Wife Led Unit. WACs Care Group will review the service provision at HCMU and confirm whether it is concordant with the prevailing national standards/requirements for a Mid Wife Led Maternity Unit.	Fully complete (Awaiting approval)	31/08/2021	

CQC Must Do	MD85/2	Mrs Linda Womack	People & Organisational Development Strategy Group	Maternity Service	The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))	The Maternity Service will look at recruitment and retention strategy for Helme Chase Maternity Unit and deliver an improved trajectory for education and training for Helme Chase Maternity Unit, as part of wider Maternity Service strategy	In Progress	31/03/2022	
CQC Must Do	MD86/1	Mrs Linda Womack	Procedural Documents and Information Group	Maternity Service	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))	The Maternity Service will review and update the Operational Policy Document(s) for the Helme Chase Maternity Unit and ensure the documents are aligned with relevant standards.	In progress (behind schedule)	31/01/2022	New policy to be developed for births at WGH or home. Discussed at Procedural Documents on 10/12/21 - more work needed. Discussed at Procedural Documents Group in January 2022. Currently document is still in draft, awaiting update as to when it will be finalised.
CQC Must Do	MD86/2	Mrs Linda Womack	People Committee	Maternity Service	The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))	The Maternity Service will meet with North West Ambulance Service (NWAS) to discuss and agree dates for skills drills/training to take place.	In Progress	31/03/2022	

CQC Must Do	MD88/1	Mrs Linda Womack	Quality Assurance Committee	Maternity Service	The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) & (e))	The Maternity Service have confirmed that; the domestic bath has not been used since 2014, it has been very clearly identified as being 'out of order' and will now be de-commissioned, an SOP for the evacuation of the Birthing Pool is in place, staff awareness and training took place in August 2021 - Action Completed	Fully complete (Awaiting approval)	31/01/2022	
CQC Must Do	MD91/1	Mrs Carol Carlile	Quality Assurance Committee	Maternity Service	The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) & (b))	The Maternity Service will further strengthen local governance and assurance processes in line with the Trust's internal Governance Review and established Maternity best practice and work with the national maternity and safety improvement team to review and develop any additional improvements identified	In progress (behind schedule)	31/01/2022	Through the WACS improvement plan (HIVE) a governance workstream has been established and is reviewing policies and governance processes. This was established and in place at the time of the CQC visit with a clear programme of work which is reported to the WACS Programme Board, chaired by the COO. This is then reported through performance reviews on a monthly basis. Ongoing as per previous action re governance and risk process and GGI model. Due date needs a review / extending. Director of Governance has now commenced chairing a weekly Maternity Governance Meeting.

CQC Must Do	MD92/1	Mrs Carol Carlile	People Committee	Maternity Service	The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))	The Maternity Service will implement a training plan to ensure that staff at the Helme Chase Maternity Unit have the appropriate skills and competency to provide care and treatment to the low risk births / expectant mothers treated at the Helme Chase Maternity Unit.	In Progress	31/03/2022	
CQC Must Do	MD96/1	Mrs Diane Smith	Capital Plan Group	Medicine	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment	The Service will investigate moving one ward from Medical Unit 2 to a new purpose built frailty unit in Medical Unit 1 (action under review in reference to the recommendation)	In Progress	31/08/2022	Action under review to ensure more specific to recommendation. Need to clarify status as linked action at MD102/1 is complete.
CQC Must Do	MD96/2	Mrs Emily Henry-Farncombe	Capital Plan Group	Medicine	The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. Regulation 12 (1)(2)(a) and (b): Safe care and treatment	The Service will undertake additional building work on the existing wards in Medical Unit 2 to enhance the accommodation	In Progress	31/03/2022	
CQC Must Do	MD97/1	Mrs Melanie Woolfall	Safeguarding Operational Performance Group	Medicine	The service must ensure people are kept free from harm. Regulation 13(5) Safeguarding service users from abuse and improper treatment	The Medicine Care Group will review Safeguarding guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team to ensure service users are kept free from harm	In progress (behind schedule)	31/01/2022	Monitored through MGAG. Fortnightly check and challenges, SOPG. Audit has been completed – results awaited.

CQC Must Do	MD98/1	Mrs Melanie Woolfall	People Committee	Medicine	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.	The Service will recruit a new Advanced Nurse Practitioner to improve the care offered to patients. This will form part of a wider staffing review to ensure there is adequate nursing staffing within the service.	Fully complete (Awaiting approval)	28/02/2022	
CQC Must Do	MD98/2	Mr Tony Crick	People Committee	Medicine	The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.	Improving the care offered to patients by employing two new physiotherapists, to support Medical Wards in Medical Unit 2	Fully complete (Awaiting approval)	31/03/2022	
CQC Must Do	MD99/1	Mr Scott Bremner	People & Organisational Development Strategy Group	Medicine	The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing	To service will undertake a medical staffing review to ensure staffing levels are meeting RCP minimum standards. Findings to be reported via MGAG with actions put in place to recruit to roles where necessary.	Fully complete (Awaiting approval)	31/03/2022	
CQC Must Do	MD100/1	Mr Richard Sachs	Quality Assurance Committee	Medicine	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance	The Trust will complete an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained.	In Progress	31/03/2022	

CQC Must Do	MD100/2	Mr Stuart Bates	Quality Assurance Committee	Medicine	The trust must ensure there is full oversight of services offered by the care group through robust governance processes. Regulation 17(2)(a): Good Governance	The Trust has completed an Initial Section 26 / Notice of Proposal evidence submission detailing the actions taken to address governance processes and ensure they are robust and will be sustained	Fully complete (Awaiting approval)	02/11/2021	
CQC Must Do	MD101/1	Mrs Dee Houghton	Trust Management Group	Medicine	The service must ensure effective systems are in place to monitor discharges to prevent patients from becoming deconditioned. Regulation 17 (1)(2)(b): Good governance	The service will review current systems in place for patient discharges and seek to improve the monitoring and escalation processes to help prevent patients from becoming deconditioned.	In progress (behind schedule)	31/12/2021	There are several patient flow meetings a day to manage the discharge process.
CQC Must Do	MD102/1	Mrs Diane Smith	Capital Plan Group	Medicine	The service must ensure there are effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance	The Service will investigate moving one ward from Medical Unit 2 to a new purpose built frailty unit in Medical Unit 1	Fully complete (Awaiting approval)	31/03/2022	
CQC Should Do	SD7/1	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	TRUSTWIDE	The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation	Chief Pharmacist, Trust Procedural Document Team and Chair of Drugs, Therapeutics and Medicines Management Group to continue and complete existing programme of work to review and improve the processes for the review, approval and implementation of	In progress (behind schedule)	31/12/2021	Revised, strengthened Policy approved and in place. Audit of PGD management /implementation and review - Is included on the Pharmacy Forward Audit Plan 2022/2023 - Scheduled for June 22 to July 23. Discussion with lead required to confirm if action is now complete.

						Patient Group Directives (PGDs)			
CQC Should Do	SD8/1	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	TRUSTWIDE	The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety	The Pharmacy Service will implement proactive scrutiny of medicines management e-learning compliance via the Medication Safety Group and plan improvements with the Care Groups	In progress (behind schedule)	31/01/2022	• Medication Safety Group and Educational Governance Group - collaborating to scope the option of making this mandatory. Care Groups feeding back that teams struggling to keep up with Core Skills • Clinical Care Groups will be feeding back monthly on compliance with Medicines Management E- Learning compliance. Prior to this the reporting was quarterly. • The Lead Pharmacist for Education and Training is reviewing the content of the current Medicines Management E-learning to enable a refresh/capture of all recent changes
CQC Should Do	SD9/1	Mrs Kam Mom	Joint Medicines Management, Drugs and Therapeutics Group	TRUSTWIDE	The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors	As part of GGI Governance review, confirm that Electronic Prescribing and Medicines Administration (EPMA) auditing will be part of remit of EPMA Steering Group and complete review of EPMA Steering Group Terms of Reference to including	In Progress	31/03/2022	

						Auditing of EPMA. Chair of EPMA Steering Group to work with Trust Clinical Audit Team to establish programme of Audits with results reported back to EPMA Steering Group for post audit action plans to be developed in conjunction with Care Groups.			
CQC Should Do	SD22/1	Mrs Melanie Woolfall	Infection Prevention Control Group	Accident and Emergency	The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary	Prevailing and COVID specific IPC/PPE Policies already in place, monitoring through Spot Checks and Audits already in place. The service will re-communicate requirements to increase staff awareness and to encourage staff to actively challenge and/or report non-compliance, reported or identified incidents of non-compliance to be investigated and resolved.	Fully complete (awaiting approval)	30/11/2021	Marked complete from discussion with IP Matron.

CQC Should Do	SD23/1	Mrs Linda Womack	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines	The Trust has a programme of work for reviewing compliance with the 'Facing The Future' requirements and to deliver improvements, which is reported through to the A&E delivery Board. This will include a review provision of paediatric services at RLI ED to determine most appropriate service design	In progress (behind schedule)	30/12/2021	Paediatric waiting area completed August 2021 2 cubicles designated to treatment of paediatric patients – one in majors and 1 in minors completed August 2021
CQC Should Do	SD24/1	Mr Richard Vallely	Capital Plan Group	Accident and Emergency	The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily	The Medicine Care Group will, in conjunction with the RLI Estates Team, undertake a review of the RLI ED triage area and develop improvement plan	In progress (behind schedule)	31/01/2022	Outline costings and plan now received from Capital colleagues. Cost in excess of £100k. Full Business Case for Capital Spend to be developed and submitted (aiming for 04/03/22 to submit case - hopefully approved by 31/03/22). If successful, funding and subsequent build expected to be completed in 1st halve of 2022/23. Due date to be extended to 31/03/22.

CQC Should Do	SD25/1	Mr Richard Vallely	Quality Assurance Committee	Accident and Emergency	The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.	The Medicine Care Group will review records of Medical attendance at Safety huddles and consider the feasibility of requiring Medical attendance at all safety huddles at RLI ED. The Service will then undertake a review of the safety huddle process and will review and update the Safety Huddle SOP if required.	In progress (behind schedule)	28/02/2022	Huddles implemented with regular attendance of Ops Management, Site Management, Flow, Nursing and Medical. SOP to be drafted for submission through March 2022 Medicine Care Group Governance process. Expected completion by 31/03/22 due to operational pressures.
CQC Should Do	SD26/1	Miss Joanne Mcguire	ENACT - Executive Nurse Accountable Care Team	Accident and Emergency	The trust should ensure that a more robust system of assessing skin integrity and pressure sores is put in place rather than the “safe and seen” assessment used presently.	The Medicine Care Group will undertake comparative Audits of the 'Waterlow' risk assessments against the 'Seen & Safe' risk assessments to identify the most appropriate documentation method. The more robust method for assessing Tissue Viability will then be implemented, with procedural documents to updated accordingly	In progress (behind schedule)	31/12/2021	Action still in progress. Pressure ulcers are a focus of the Harm Free Care Panel chaired by ECN commencing 04/02/22. Completion date to be reviewed and clarified.

CQC Should Do	SD27/1	Mrs Melanie Woolfall	Quality Assurance Committee	Accident and Emergency	The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident	Incident Management Policy already in place which contains detailed guidance on the grading of the harm level of incidents. Review of Incident Management System has confirmed that; ED managers already have access rights to all incidents in the ED, have access rights to re-grade the harm level of these incidents and have access rights to flag these incidents as a 'Serious Incident'. ED Managers have been offered further training in the Incident Management System and grading the harm level of incidents. All Incidents graded with a Harm level of Moderate or above are also independently reviewed at the Trust Wide Weekly Patient Safety Summit.	Fully complete (Approved)	30/11/2021	

CQC Should Do	SD28/1	Miss Leanne Cooper	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy	Plans have been developed as part of the BHACP UEC Programme and signed off by A&E Delivery Board. Additional PMO support allocated to help delivery. A robust improvement programme that facilitates patient flow corporately is in place and delivered in line with the Urgent Care action plan.	In Progress	31/03/2022	
CQC Should Do	SD28/2	Mrs Diane Smith	Care Group Governance & Assurance Group Meeting	Accident and Emergency	The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy	Bay/Trust Wide elements being managed through Action SD28/1 by Leanne Cooper Medicine Care group are responsible for implementing two elements of the Urgent and emergency care plans; 'Front Door' and 'ED'.	In Progress	31/03/2022	
CQC Should Do	SD34/1	Mrs Carol Park	People Committee	Surgery and Critical Care Services	The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.	The Surgery Care Group has improved Mandatory training compliance and is currently meeting Trust targets, the Surgery Care Group will review compliance again in 3 months time and if compliance remains high, action can be closed.	Fully complete (Awaiting approval)	31/01/2022	

CQC Should Do	SD35/1	Mrs Carol Park	People Committee	Surgery and Critical Care Services	The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets	The Surgery Care Group has improved Staff Appraisal compliance and is currently meeting Trust targets, the Surgery Care Group will review compliance again in 3 months time and if compliance remains high, action can be closed.	In progress (behind schedule)	31/01/2022	Appraisal rates monitored weekly at SMG, Red flagging of compliance hot spots. Discussed in 1:1s. Compliance reported via monthly Governance meetings. Appraisal rates continue to improve (currently around 85%) - but unlikely to meet 95% target by due date.
CQC Should Do	SD41/1	Mrs Linda Womack	Emergency Planning & Resilience Group	Maternity Service	The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security	The Maternity Service at RLI will work with the Estates Team and the Security to undertake a review of the security systems, to establish the practical feasibility and implementation of Swipe Card Access, or the continuation of Key Pad Access, if Key Pad access continues a schedule of code changes will then be established and implemented.	Fully complete (Awaiting approval)	31/12/2021	
CQC Should Do	SD42/1	Mrs Linda Womack	Procedural Documents and Information Group	Maternity Service	The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.	The Maternity Service will review and update the organisational policy for the cleaning of the birthing pools and ensure the document complies with relevant standards	Fully complete (Awaiting approval)	28/02/2022	

CQC Should Do	SD43/1	Mrs Carol Carlile	Quality Assurance Committee	Maternity Service	The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place	The WACS Care Group Triumvirate will review recommendations from external incident investigations (including the Ockenden Report) and will then ensure that remedial action plans are robust, are monitored at Triumvirate meetings and that evidence is provided against each action.	In Progress	31/03/2022	
CQC Should Do	SD44/1	Mrs Claire Bowman	Clinical Audit Standards Group	Maternity Service	The service should act to improve the assessment of women's pain in light of their clinical condition and ensure all women receive pain relief in a timely manner	The Maternity Service will carry out a Pain Management Audit and will develop an improvement plan once audit results are available	In Progress	30/09/2022	
CQC Should Do	SD45/1	Mrs Ruth Deery	Trust Management Group	Maternity Service	The service should continue to act to ensure women received continuity of care in line with national recommendations and targets	The Maternity Service will develop a continuity of care model by locality, the care model will be aligned with national recommendations and targets.	In Progress	31/03/2023	
CQC Should Do	SD55/1	Mrs Diane Smith	Safeguarding Operational Performance Group	Accident and Emergency	The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.	The Medicine Care Group will review guidance / training requirements against current compliance and ensure robust plan in place in conjunction with the Safeguarding Team (action links to MD54)	In Progress	31/03/2022	

CQC Should Do	SD56/1	Mr Neil Smith	Finance and Performance Committee	Accident and Emergency	The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.	The Medicine Care Group will work with the Business Intelligence Team to include data on the ED paediatric activity within the Trusts command and control centre platform, and will undertake a review of the ED Safety Huddle SOP to ensure that includes ED paediatric activity.	In Progress	31/03/2022	
CQC Should Do	SD62/1	Ms Sarah Maguire	Emergency Planning & Resilience Group	Surgery and Critical Care Services	The trust should ensure that wards are secured to maintain patient safety	The Surgery Care Group will obtain quote(s) to improve security on Surgery Wards at FGH. Quote obtained on day of Inspection, funding in place, need to confirm progress of Works.	In progress (behind schedule)	28/02/2022	Finance approved, just awaiting programme of works to start (date TBC). Existing procedures for patient security remain in place in the interim.
CQC Should Do	SD63/1	Mrs Carol Park	Fire Safety Group	Surgery and Critical Care Services	The trust should ensure that fire doors are maintained and used correctly	Met with staff and ward managers. Responsibilities and accountabilities made clear and staff will be held to account re standards for their ward/ department. Daily matron checks in place Action completed	Fully complete (Awaiting approval)	31/01/2022	

CQC Should Do	SD64/1	Ms Sarah Maguire	Quality Assurance Committee	Surgery and Critical Care Services	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.	The Surgery Care Group has existing processes to ensure that Resuscitation equipment is checked daily and monitored via the AMaT system. Action complete	Fully complete (Awaiting approval)	31/08/2021	
CQC Should Do	SD64/2	Ms Sarah Maguire	Joint Medicines Management, Drugs and Therapeutics Group	Surgery and Critical Care Services	The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.	Trust Wide Safe and secure storage of medicine (SSSM) policies and procedures already in place, annual SSSM audit undertaken by Pharmacy and reported to Medication Safety Group. Spot checks on SSSM undertaken by Matrons and Ward Managers. SSSM data collection/audit to be moved to AMAT system to enable more rigorous monitoring by Matrons and Ward Managers. The Service will communicate to staff to reiterate the importance of the SSSM and will continue with monitoring and escalation.	Fully complete (Awaiting approval)	31/12/2021	

CQC Should Do	SD65/1	Ms Sarah Maguire	Information Governance And Data Quality Group	Surgery and Critical Care Services	The trust should ensure patient records are stored securely.	Briefings held with staff to staff to reinforce IG and privacy requirements Daily matron checks in place, Information Governance included in Service Reviews. The majority of patient records are now electronic, Minimal paper notes remaining within locked trollies for security.	Fully complete (Awaiting approval)	30/12/2021	
CQC Should Do	SD76/1	Mrs Holly Parkinson	Quality Assurance Committee	Maternity Service	The service should act to improve the quality of safety information shared in SBAR handover.	The Maternity Service will undertake a review and update of the SOP / Guideline for SBAR Handover and ensure it is aligned with National Standards.	Fully complete (Awaiting approval)	31/03/2022	
CQC Should Do	SD76/2	Mrs Linda Womack	Quality Assurance Committee	Maternity Service	The service should act to improve the quality of safety information shared in SBAR handover.	The Maternity Service will undertake a review practice of current SBAR Handover processes and identify if/how these can be re-implemented / re-energised	In progress (behind schedule)	31/01/2022	Consultant has completed SBAR improvement project and SBAR forming part of Hive communication project.
CQC Should Do	SD76/3	Mrs Linda Womack	Clinical Audit Standards Group	Maternity Service	The service should act to improve the quality of safety information shared in SBAR handover.	The Maternity Service will work with the Trust Clinical Audit team to undertake an annual Audit to measure compliance with SBAR guideline/ SOP and will develop remedial action plans if required undertake a yearly audit to provide assurance	In Progress	31/03/2022	

CQC Should Do	SD79/1	Mrs Linda Womack	Trust Management Group	Maternity Service	The service should progress actions to enable improved access within the birth centre, in context of the physical environment.	There are two lifts for access to the South Lakes Birth Centre; one for emergency access for trolley patients, one for ambulatory patient/family access. The Maternity Service will ensure the induction training of all new staff includes information on how to enable access the delivery suites in an emergency.	In Progress	31/03/2022	
CQC Should Do	SD80/1	Mrs Tamsin Cripps	Finance and Performance Committee	Maternity Service	The service should implement effective use of the whiteboard communication system on the birth centre	The Maternity Service, in conjunction with I3 Service, will undertake a post Badger Net implementation review of the whiteboards at the South Lakes Birth Centre	In Progress	31/03/2022	
CQC Should Do	SD81/1	Mrs Diane Smith	Quality Assurance Committee	Accident and Emergency	The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.	The Medicine Care Group will develop and implement posters/signage so patients attending the Kendal Urgent Treatment Centre are made aware that they can request a chaperone to be present during their treatment	Fully complete (Awaiting approval)	31/01/2022	

CQC Should Do	SD83/1	Mrs Melanie Woolfall	Information Governance And Data Quality Group	Accident and Emergency	The Trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information	The Medicine Care Group will brief staff at the Kendal Urgent Treatment Centre to re-iterate the importance of maintaining patient confidentiality and will then undertake a review as part of the regular matron audit to confirm compliance with patient privacy / confidentiality requirements, ensure staff are up to date with IG training. Regular monitoring at MCGAG to be established.	In progress (behind schedule)	31/01/2022	Matron Spot Checks to be implemented. Included on Chaperone Policy audit and will be presented to QAC.
CQC Should Do	SD93/1	Mrs Linda Womack	People Committee	Maternity Service	The service should consider protected time to allow for the completion of mandatory training	The Maternity Service already schedule 4 compulsory mandatory training days per annum for all staff in Maternity Services, to help ensure ongoing compliance with mandatory training. Additional protected time for the completion of mandatory training is available to staff at the discretion of Department/Unit/Ward Managers.	Fully complete (Awaiting approval)	31/01/2022	
CQC Should Do	SD95/1	Mr Paul Jones	Trust Management Group	Maternity Service	The service should work to engage the workforce and increase visibility of the executive team	The Trust will maintain and enhance Executive Directors presence on all sites, through a schedule of planned Executive visits/presence.	Fully complete (Awaiting approval)	31/03/2022	

CQC Should Do	SD103/1	Mrs Melanie Woolfall	Information Governance And Data Quality Group	Medicine	The trust should ensure that all records are securely stored	The Medicine Care Group will brief staff at RLI Medical Unit 2 to re-iterate the importance of maintaining patient confidentiality and will then undertake a review as part of the regular matron audit to confirm compliance with patient privacy / confidentiality requirements. Also check compliance with IG core skills training on Medical Unit 2 Wards	In progress (behind schedule)	31/12/2021	Matron Spot Checks in progress re compliance with policy. Review of medical storage on MU2 to take place in February.
CQC Should Do	SD104/1	Mrs Melanie Woolfall	Quality Assurance Committee	Medicine	The service should ensure they complete MUST documentation	The Medicine Care Group will manage this recommendation through the fundamentals work on managing a deteriorating patient and medicines management. Matrons will maintain regular oversight through assurance checks.	In progress (behind schedule)	31/01/2022	Part of a Trust Wide review of fundamental care standards. Forms part of Chief Exec Nurse focus areas. MUST, nutrition and hydration compliance to be a focus of harm free care through February. Compliance data to be requested.

1. NICHE Improvement Plan Dashboard

Inspection	Ref. No.	SRO	Committee	Theme	Service	Recommendation	UHMBT Action	Status	Target Date	Tolerance Testing Target Date	Risks
NICHE Report	MD1/1	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 1 - Oversight of Urology through Trust governance structures: Reporting lines need to be clearly articulated in the terms of reference for each of the groups and committees which have been established for oversight of the Urology service and depicted in an organogram. Links to the Urology department, care group, committee and Board governance structure should also be confirmed	Urology TFG, Chaired by Aaron Exec and Non Exec Stood down, Urology Oversight Group evolved into System Improvement Board Urology meetings in place: Urology Business Meeting (Full MDT), Clinical Business Unit (Triumverate) Urology Audit Meeting - feed into SGAG and SMB, then on SCC Triuniverate - Performance reviews and TMG Urology Action plan presented monthly at QAC. GGI Work completed for Care Group, Committee and Board Structure - update from CQC Plan/Paul Jones	Completed (awaiting approval)	31/03/2022	May 22	
NICHE Report	MD2/1	TBC	Trust Management Group	Performance Monitoring & Reporting	UROLOGY	Recommendation 2 - Quality and safety data in the Integrated Performance Report: The quality and safety data in the Integrated Quality and Performance Report (IQPR) should be expanded to include trend and thematic analysis. Key quality and safety metrics should be included in a new upfront performance dashboard and hotspot reporting should include more detailed analysis on key risks	Review of IQPR quality and Safety data to include; trend and thematic analysis, headline Dashboard, hotspot reporting To be completed in time for start of 2022/23 Financial year	Completed (awaiting approval)	31/01/2022	Jun 22	
NICHE Report	MD3/1	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)	In place fro Urology, Monthly Safe today with 'At a Glance' scorecard with Quality and safety, workforce and finance metrics - mini IPR Safe today provide triangulaton of Incident, Patient Relations in terms of Care Hours Monthly Exec to Service Review with Clinical Lead and CSM - still in place ? - also undertaken for other ESP Specialities: T&O, Paeds, Maternity	Completed (awaiting approval)	31/03/2022	May 22	
NICHE Report	MD3/2	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 3 - Performance framework for Urology: Introduce a performance and accountability framework which clearly sets out the approach to corporate and care group scrutiny of Urology and, where necessary, support from the Enhanced Support Programme (ESP)	As per response to MD1 & MD2 Completed for urology ?Wider Applicability	Completed (awaiting approval)	31/03/2022	May 22	
NICHE Report	MD4/1	TBC	Clinical Audit Standards Group	Clinical Governance	UROLOGY	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	Trust Clinical Audit Team to work with Audit Lead for Urology (Mr Saqib), Service Manager for Urology (Rebecca Cullen) and Care Group Governance Business Partner (Gregg Peers) to ensure appropriate support is in place for Urology Audit Meeting.	Completed (awaiting approval)	31/03/2022	Mar 22	

NICHE Report	MD4/2	TBC	Care Group Governance & Assurance Group Meeting	Clinical Governance	UROLOGY	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	Place Holder for Governance Meeting Action	Completed (awaiting approval)	31/03/2022	Mar 22	
NICHE Report	MD4/3	TBC	Clinical Audit Standards Group	Clinical Governance	UROLOGY	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	Trust Clinical Audit Team to review ToR of Urology Audit Meeting against prevailing best practice ToR in the Trust (as per GGI Governance Review) and to consider best practice from other Urology Services.	Completed (awaiting approval)	31/12/2021	Mar 22	
NICHE Report	MD4/4	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 4 - Urology audit: The newly appointed Urology Audit Lead should have dedicated and experienced support to provide best practice guidance on conducting audit and governance meetings. The terms of reference and agendas for the audit meeting should be drawn from best practice in other Urology services	MD and ESP provided support and Best Practice Guidance to Mr Saqib - See update from Claire regarding Audit, inc RCS guidance Link to RSP Workstream 2 Quality and Safety (Clinical Effectiveness)	Completed (awaiting approval)	31/03/2022	Mar 22	
NICHE Report	MD5/1	TBC	TBC	Performance Monitoring & Reporting	UROLOGY	Recommendation 5 - Safe Today Report: The Safe Today Report should be received at department and care group level before presentation to UT&FG and UQOC33. It should also be developed further to provide more appropriate measures of assurance with: • inclusion of an overarching scorecard to enable the reader to understand performance 'at a glance'; • a reduction in the narrative analysis throughout the report; • greater emphasis on prospective performance through the use of early warning indicators and forecasting in order to allow timely identification of deteriorating performance; • more same causal factor analysis of complaints, litigation, incidents and Patient Advice and Liaison Service (PALS) feedback; • an expansion of the quantitative and qualitative data relating to patient and staff experience, including patient feedback in the form of real time and retrospective data collection, staff pulse surveys and a wider range of workforce metrics (e.g. turnover, appraisals, training, use of agency staff, staff sickness, as well as concerns raised by staff)	UQOC - Urology Quality Oversight Committee As per Recommendation 2 - Inclusion of SPC for trajectories - Safe Today App, Completed for Urology Completed for other ESP Specialities Wider Trust Applicability to be confirmed - Safe today produced monthly, transferred from QAC to PSQG as monthly Agenda Item	Completed (awaiting approval)	31/03/2022	Jun 22	

NICHE Report	MD6/1	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 6 - Meeting administration: Meeting administration must be improved. This should include: • a review of the ToR for all meetings at departmental and care group level to ensure they are in date, aligned to the objectives required of the meeting, and also other key meetings, with agendas planned to reflect these; • the introduction of standardised templates for agendas, minutes, and action logs; and • the provision of training for individuals with minute-writing responsibilities and all minutes should be reviewed by the relevant Chair before distribution	Completed under GGI work - Urology confirmed Need wider confirmation for Trust Sustainability over time for Trust? Links to NOP 26 - check with Stuart	Completed (awaiting approval)	31/03/2022	May 22	
NICHE Report	MD7/1	TBC	Risk Management Group	Corporate Governance	UROLOGY	Recommendation 7 - Risk registers at service, care group and Trust level: The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly	Review Urology risk register with ADOP and Gov BP to confirm all risks identified and assigned to appropriate level of the Risk Register or to add any further risks. Provide assurance to Risk Management Group 27th January 2022 for acceptance. Identify whether risks are discussed at Urology meetings as standing agenda item and that risk profile is considered quarterly at GAG.	Completed (awaiting approval)	29/04/2022	May 22	
NICHE Report	MD7/2	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 7 - Risk registers at service, care group and Trust level: The challenges currently being faced by the Urology service should be reviewed to determine whether the risks are sufficient to warrant inclusion on the service, care group or Corporate Risk Register (CRR) or the Board Assurance Framework (BAF); this includes the difficulties with on call cover at Furness General Hospital (FGH) and continuing fractured relationships as a patient safety risk. Departmental and care group meetings should include risk as a standing agenda item and the risk profile of the service should be reviewed at least quarterly	Completed for Urology - confirm with Anna Consolidated risks - RTT etc Wider Trust applicability	Completed (awaiting approval)	31/03/2022	May 22	

NICHE Report	MD8/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 8 - Quality of investigations in Urology services: All reported incidents and complaints received in relation to Urology services should, for a period of at least 12 months, be investigated by a dedicated independent team outside the department which has access to independent Urology advice. This would remove pressure on the existing team to investigate each other and provide room to work on relationship development. It would also help to set a standard for future high-quality investigations. [This recommendation related to incidents and complaints requiring investigation not all cases]	Development of Independent Investigation Team (IIT), all Urology incidents/RCA's were managed by IIT for a period of 8 months - see update from Claire (Andrea, Stuart, Sue Smith etc) Nov 2020 to Aug 2021 Check with Nicky Edmondson for details/dates etc Completed for Urology Query Wider Applicability? Principles, not Actions - RCA Training, RSP Work stream 1, outcome measures	Completed (awaiting approval)	31/03/2022	Mar 22	
NICHE Report	MD9/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 9 - Thematic review: Quality performance reporting should include thematic and same causal factor analysis of complaints, litigation, incidents, and PALS information to ensure that lessons can be learned, and actions taken to prevent recurrence of the same. Themes should be discussed at departmental, care group, and committee level with a clear focus on actioning improvement	Recommendations 2 & 4 - Safe Today Completed fro Urology Completed for other ESP Specialties Query Wide Trust?	Completed (awaiting approval)	31/03/2022	Mar 22	
NICHE Report	MD10/1	TBC	TBC	Mortality & Morbidity	UROLOGY	Recommendation 10 - Mortality review (Link to R15 and R26) Every inpatient Urology death must have a case review conducted by Consultant Urologists with external support in using structured judgement review (SJR) methodology (Royal College of Physicians) or other recognised case note review methodology and be subject to Trust level scrutiny (as per Trust Policy). Every death must then be presented without exception to a Urology mortality meeting. These should be separate from audit and multidisciplinary team (MDT) meetings until such time that mortality review becomes an accepted and business as usual activity	Completd - see Email from Claire Check with Helen Irving that all Urology Deaths reviewed - 12 cases? 4 outstanding, check for evidence of review On agenda at Mortality Meeting and Clinical Effectiveness. Trust Wide - Check with Helen, applicability to chronic conditions etc. SJR review Links to ME triage, new process Learning from Deaths RSP Workstream 2 - Mortality	Completed (awaiting approval)	31/03/2022	Oct 22	
NICHE Report	MD11/1	TBC	TBC	Culture and Leadership	UROLOGY	Recommendation 11 - Professional relationships: Intelligence from the InterBe meeting in August 2020 should be used to assess the severity of concerns associated with relationships between senior clinical staff to determine whether issues can be resolved or if other remedial action needs to be taken	Urology Only Completed, presented to CEO on 26/04/21 Video session available as evidence of completion	Completed (awaiting approval)	31/03/2022	Apr 22	

NICHE Report	MD12/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 12 - Pooled model of patient care • There is an urgent need to review the pooling of patient referrals and the way in which patients are allocated to, and reviewed by, clinicians in Urology to ensure that continuity of care is optimised. • There should be clear procedures for allocating patients against specific pathways (including in line with Cancer MDT guidance). Any subsequent changes to management plans should be agreed with the named Consultant/an appropriate clinician especially if there are clinic cancellations or delays to treatment.	Named clincian process in place from Jan 21 for Urology Six monthly Audit - check detais - latest results Require more evidence on clear procedures, action number 6 on teh T&O RCS Action Plan Wider applicability?	Completed (awaiting approval)	31/03/2022	Jun 22	
NICHE Report	MD13/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 13 - Monitoring of additional activity sessions (AASs) Introduce a robust policy and controls to retrospectively and prospectively review AAS activity in the Urology department, including a quarterly analysis of the number, value, and justification for AASs undertaken on a clinician-by-clinician basis.	Urology Only Review of AAS included in Safe Today (Recommendation 2&4) to include rational for additional activity and agency - confirmed Query? Policy in Finance to monitor/review SCC oversight of AAS, still in place?, check with Carol Park	Completed (awaiting approval)	31/03/2022	Jun 22	
NICHE Report	MD14/1	TBC	TBC	Fundamental Care Standards	UROLOGY	Recommendation 14 - Fluid balance monitoring Fluid balance practice should be audited and a programme of high-quality recording put in place for Urology patients.	Current Case Review Action Evidence taken from QAAS assessment of Wards/Departments RSP Workstream 2 - Quality and Safety (Fundamentals of Care) Completed for Urology Query sustainability across wider trust	Completed (awaiting approval)	31/03/2022	Aug 22	
NICHE Report	MD15/1	TBC	TBC	Mortality & Morbidity	UROLOGY	Recommendation 15 - Mortality review (Link to R10 and R26) • Following on from our recommendation on mortality review in our Draft Current Controls Assessment Report, the Trust must develop a robust mechanism for identifying deaths by speciality using both admission and treatment function codes and other identifiers. This should include deaths up to 30 days post-discharge. • The HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring arising from mortality reviews must be subject to audit and further scrutiny within the Trust. • All NCEPOD or HOGAN scores of 2 or above should give rise to further review by the Trust, investigation where appropriate and the potential need for Duty of Candour processes.	See response to Recommendation 10 RSP Workstream 2 - Quality & Safety - Mortality Query ME process in Trust	Completed (awaiting approval)	31/03/2022	Oct 22	

NICHE Report	MD16/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 15 - Named Consultants • Named Consultants, for complex patients, should be introduced in Urology. This should include non-cancer patients. Complex cases without a diagnosis should be discussed at MDT or Radiology meetings. • Clinicians should be allocated clinical responsibility for the oversight of pathways including by cancer type to develop greater ownership and to drive improvements in services. (See R54(E)).	As per Recommendation 12 Completed for Urology	Completed (awaiting approval)	31/03/2022	Jun 22	
NICHE Report	MD17/1	TBC	TBC	Mental Capacity/Mental Health	UROLOGY	Recommendation 17 - Capacity and best interests: applying the Mental Capacity Act 2005 • Capacity assessment and best interest decision-making should be improved through audit, training, and best practice examples. • An enhanced focus should be given to people presenting with dementia or confusion and those with a learning disability. • A thematic review examining the pathway, management and replacement of suprapubic catheters should be undertaken.	Urology - Ongoing - Capacity Assessment/BIA - In progress CA to check/confirm progress on third bullet point on suprapubic catheters Review completed by Jane Kenny and Sarah Maguire - obtain details Performance improvements in SCC - evidence	In progress	31/03/2022	Sept 22	
NICHE Report	MD18/1	TBC	TBC	Consent	UROLOGY	Recommendation 18 - Consent Consent for operations must be completed on every occasion. Any consent not completed correctly must be reported and investigated to improve practice. Consenting practice should be subject to audit and should include whether the patient dated the consent and the practice of confirmation of consent where the operating surgeon is different from the consenting surgeon. Theatre staff should be alerted to our concerns regarding consenting practice and be authorised to report all incidents where consent is not compliant with expected practice.	Action ahead of Trust Wide Electronic Consent Project CA - to check/confirm Evidence for Improvements in Urology Trust Wide process still not gone live - check dates	Completed (awaiting approval)	31/03/2022	Aug 22	
NICHE Report	MD19/1	TBC	TBC	Consent	UROLOGY	Recommendation 19 - Lorenzo All scan and clinical results should be acknowledged by the requester. Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity. It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. A record of stent register status should be clearly marked and visible.	All scan and clinical results should be acknowledged by the requester - in place Clinicians should be trained on the use of Lorenzo to ensure that they are aware of how to complete this activity - in place It should be made clear to all staff in which part of Lorenzo key documentation should be filed to reduce the amount of time spent finding key clinical information. - in progress see Mel Waszkiel part of Documentation TFG A record of stent register status should be clearly marked and visible. - Completed Complete for Urology ? Trust Wide applicability	Completed (awaiting approval)	31/03/2022	Aug 22	

NICHE Report	MD20/1	TBC	TBC	EPR/Patient Records	UROLOGY	Recommendation 20 - Recording of ethnicity • The sample provided does not include information on ethnicity other than White or Unknown/Mixed. The Trust should examine whether it is recording ethnicity in its records in line with expected practice.	Ongoing - Urology Ongoing - Trust	In progress	31/03/2022	Aug 22	
NICHE Report	MD21/1	TBC	Clinical Audit Standards Group	Clinical Governance	UROLOGY	Recommendation 21 - Case note review • There should be a repeat case note review (100 cases) in 12 months (Autumn 2022) to assess if improvements have been sustained and embedded.	Trust Clinical Audit Team to work with Urology Audit Lead (Mr Saqib) to ensure that Repeat Audit of 100 Case Notes is added to the Trust Forward Audit Plan for 2022-23. Audit will take place in Quarter 2/3 of 2022/23, with completion in Quarter 3 of 2022/23.	In progress	31/12/2022	Mar 22	
NICHE Report	MD21/2	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 21 - Case note review • There should be a repeat case note review (100 cases) in 12 months (Autumn 2022) to assess if improvements have been sustained and embedded.	Action for NICHE, not UHMBT - not started/completed Query - Any Audit recorded on Forward Plan?	In progress	31/03/2022	Mar 22	
NICHE Report	MD22/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 22 (Cancer Alliance) - Improving the pathway for bladder cancer diagnosis • Where appropriate, conducting a flexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service. • Patients meeting the two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram prior to attending clinic to streamline the service. • Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust, on completing their therapy, who is then responsible for co-ordinating on-going care (e.g. in this case, being clear about the rationale for examination under anaesthetic (EUA), biopsy, cystoscopy and stenting). The MDT will need to ensure there is a clear management plan and processes put in place to ensure Urology actions are implemented. This will also allow time to plan dates for surgery to meet required timescales. • Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed. • All patients should be listed on the stent register. If they are transferred to another Trust with the expectation that the stent is removed, this should be explicitly stated; if patients are transferred into the Trust with a stent in situ, they should be added to the Trust's stent register.	Urology Completed lexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service - In Place two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram - completed Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust All patients should be listed on the stent register Need to review for Trust lexible cystoscopy on the day of attending the One Stop Clinic would make this a truly one-stop service - In Place two-week wait criteria with visible haematuria and normal estimated glomerular filtration rate (eGFR) should be triaged to have a CT Urogram - completed Patients requiring ongoing monitoring following chemotherapy/radiotherapy should be referred back via the MDT to a named Consultant at the Trust All patients should be listed on the stent register Lancashire and South Cumbria Cancer Alliance - update require, raise with Trust Cancer Lead Lancashire and South Cumbria Cancer Alliance follow up protocols should be agreed and followed.	Completed (awaiting approval)	31/03/2022	Jun 22	

NICHE Report	MD2 3/1	TBC	TBC	Fundamental Care Standards	UROLOGY	Recommendation 23 - Clinical monitoring The Trust should continue to embed good practice and use of: • Venous thromboembolism (VTE) assessment. • Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. Use of the Malnutrition Universal Screening Tool (MUST) should be audited at specified intervals to ensure scoring and onward actions are appropriate. Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored to ensure that this option is considered early for all patients who are at risk of malnutrition. • The Trust should monitor the recent implementation of the electronic NEWS2 charts to ensure that the new system is successful in identifying and responding to deteriorating patients. • Access to formal on call microbiology advice out-of-hours should be provided.	Urology Ongoing - Venous thromboembolism (VTE) assessment - update from VTE Steering Group - Nutrition, hydration and associated food/fluid balance monitoring must be enforced as fundamental standards. Use of the Malnutrition Universal Screening Tool (MUST) - QAAS Monitoring - Total Parenteral Nutrition (TPN) guidelines should be reviewed and monitored - Updated and re-issued (Check TPDL) - Monitor the recent implementation of the electronic NEWS2 charts - RSP Workstream 2 Quality & Safety - Fundamentals of Care (Lynne Wyre and DMD- TBC) - Access to formal on call microbiology advice out-of-hours - Completed - resolved in March 2015, 24-7 cover consultant on-alll Trust Ongoing As above	In progress	31/03/2022	Aug 22	
NICHE Report	MD2 4/1	TBC	Procedural Documents and Information Group	Clinical Governance	UROLOGY	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Trust Procedural Documents Team to work with Surgery and Critical Care Care Group to review the following documents and ensure they contain a requirement for regular Audit • the identification and management of Urosepsis and obstructed kidneys; • the management and registration of stents; • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	In progress	31/03/2022	Mar 22	

NICHE Report	MD24/2	TBC	Procedural Documents and Information Group	Clinical Governance	UROLOGY	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Trust Procedural Documents Team to work with Patient Safety Matron to review the following documents and ensure they contain a requirement for regular Audit • the identification and management of sepsis and the deteriorating patient;	In progress	31/03/2022	Mar 22	
NICHE Report	MD24/3	TBC	Procedural Documents and Information Group	Clinical Governance	UROLOGY	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Trust Procedural Documents Team to work with Medical Director to review the following documents and ensure they contain a requirement for regular Audit • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes;	In progress	31/03/2022	Mar 22	

NICHE Report	MD2 4/4	TBC	Clinical Audit Standards Group	Clinical Governance	UROLOGY	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Trust Clinical Audit Team to work with Trust Procedural Documents Team to ensure Audits from the following documents are placed on the 2022/23 Audit Forward Plan: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	In progress	31/03/2022	Mar 22	
NICHE Report	MD2 4/5	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 24 - Standard operating policies and procedures The Trust must ensure the following are up-to-date and subject to regular audit: • the identification and management of Urosepsis and obstructed kidneys; • the identification and management of sepsis and the deteriorating patient; • the management and registration of stents; • handover of patients between on call Consultants; • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; • interspecialty referral processes; and • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full.	Urology - Partially complete - the identification and management of Urosepsis and obstructed kidneys - completed (on Audit Plan?) • the identification and management of sepsis and the deteriorating patient - completed (on Audit Plan?) • the management and registration of stents; - completed (on Audit Plan?) • handover of patients between on call Consultants - completed (on Audit Plan?) • consenting guidelines, including actions to be taken when patients cannot consent and when emergency surgery is required; - in progress Electronic consent project • interspecialty referral processes; and - I3 project lead by Sarah Hart • recording decisions made when a patient is referred to Intensive Treatment Unit (ITU), the escalation of capacity issues and a clear protocol regarding options when ITU is full - In Progress, check with Mark Wilkinson Trust - Partially complete	In progress	31/03/2022	Mar 22	
NICHE Report	MD2 5/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 25 (ICS &CCG) - Nephrostomy service • The Trust and Clinical Commissioning Groups (CCGs) should review arrangements for out-of-hours nephrostomy provision, including over bank holidays and emergency cover. • The arrangements that have been put in place should be assessed to ensure that standards for accessing nephrostomy provision out of hours and for returning patients to the Trust are appropriate, agreed, and form part of a standard operating procedure that is audited to confirm compliance.	Urology only? Completed? Procedure approved at TPDIG - August 21 Agreed SLA - Neil Swindlehurst ICS SOP in place Has this been signed off by the ICS?	Completed (awaiting approval)	31/03/2022	Jun 22	

NICHE Report	MD26/1	TBC	TBC	Mortality & Morbidity	UROLOGY	Recommendation 26 (National) - Mortality review (Link to R10 and R15) • Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level. This would also help support accurate reports to the Coroner if required to be written some months post death. • Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy. • Every inpatient death within the Surgical and Critical Care Group (S&CCG) should be reported and subject to case review, this review should be shared within the department and at Trust level. • Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings. • Every inquest involving the Trust must include consideration of whether an incident might have occurred that requires investigation and to prepare statements and reports in an adequate timeframe. • Statements to Coroners written in relation to whole episodes of care involving a team or a Trust service should be subject to validation by legal or corporate services to ensure that all parties have a right of reply (where needed) and that statements made are accurate. This is distinct from an individual health care professional providing a witness statement solely in relation to their own input. • Failures in care identified as a result of producing a Coroner's statement must be reported as an incident and any named individuals given a right of reply. • The Trust's Providing Statements to the Coroner Standard Operating Procedure should be revised to include the above. • The Trust must assure themselves that the Providing Statements to the Coroner Standard Operating Procedure is being complied with. Statements should differentiate between fact and opinion. In addition, there should be a clear indication of how the statement has been compiled. • The Trust should ensure that records are retained post-death and copies made for the purposes of review and investigation to mitigate the risk of retrospective entry. [The Medical Examiner role was introduced in the Trust in April 2020; this function should be assessed against the above recommendations].	As per Recommendations R10 and R15 Urology - Partially complete Trust - ongoing Any post-operative death should be subject to rigorous and contemporaneous case review and monitored at Trust level - ongoing Death summaries and sudden death reports to the Coroner should be audited for quality and accuracy - No national best practice in place for 'Death Summary' - Helen Irving developed pro forma - obtain confirmation from Helen Update from Car Every inpatient death in Urology services and other surgical specialties should be discussed in departmental meetings - ongoing Review remaining bullet points with Ranu - does not follow current procedure with HM Coroner	In progress	31/03/2022	Oct 22	

NICHE Report	MD27/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 27 - Managing complaints and compound family questions • The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious. • Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. • Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. • Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. • Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. • When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that the Trust has a full record of searches available to them.	Urology partially completed The Trust's Management Procedure for the Investigation and Resolution of Complaints should be reviewed to ensure advice is clear on the handling of persistent/compound complaints that are not vexatious - Completed, confirm with Stuart Bates • Repeated approaches/compound questions from a family in relation to concerns in care, including the death of a loved one, should be formally logged as a complaint. Completed, confirm with Stuart Bates These cases should be allocated an appropriate single point of contact or family liaison officer to manage the process and support the family. These cases should also be flagged and carefully monitored as they have potential for extended resolution timescales. - Completed, confirm with Stuart Bates • Any case involving an inquest or complaint from a family should also be reviewed to determine whether it should be recorded as an incident(s). Any subsequent investigation and complaints processes should be managed in a coordinated fashion. - Completed, confirm with Stuart Bates • Compound complaints often arise once medical records are provided as these may be incomplete (due to archiving and multiple patient record systems). The Trust should ensure that full sets of medical records are provided at the outset of the request in line with existing Freedom of Information Act (FOIA), Subject Access Requests (SAR) and Access to Health Records Policies. - Complete records from EPR and Paper issued? • Clear guidance on sharing the medical records of deceased patients with families should be set out to ensure that relatives are provided with requested information promptly and in line with the appropriate legislation. • When FOIA or SAR include requests for email-based information, all searches should be formally logged and centrally managed so that the Trust has a full record of searches available to them. Trust ongoing	In progress	31/03/2022	Mar 22	

NICHE Report	MD28/1	TBC	TBC	Culture and Leadership	UROLOGY	Recommendation 28 - Consultant relationships (Link to R65(E)) • The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer. Prompt and diligent investigations should be undertaken to ensure that the basis of concerns is fully understood and properly actioned to resolve peer-to-peer difficulties and concerns in a transparent and effective manner. • The Board should be made aware at an early stage of any specialty where relationships may be failing as this is a key patient safety marker. The Board should monitor actions to achieve improvement. This should be undertaken via the Employee Relations Report. • The Medical Director should be informed of any concerns about Consultant relationships (as Responsible Officer).	Urology Completed/processes in place - Ongoing Monitoring RSP Workstream 4: Culture & Leadership - The Trust should pay particular attention to any grievance raised by a Consultant or senior medical member of staff about another peer - The Board should be made aware at an early stage of any specialty where relationships may be failing - EDG Hotspot reporting MD is on EDG - The Medical Director should be informed of any concerns about Consultant relationships - Medical Director is now RO - completed Trust Wide - Ongoing RSP Workstream 4: Culture & Leadership	Completed (awaiting approval)	31/03/2022	Apr 22	
NICHE Report	MD29/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 29 - Triggers for external investigations • Terms of reference for all externally commissioned investigations should be scoped individually and quality assured to ensure that patient/family questions are included and that specific Trust concerns are addressed. (This principle should be followed for all root cause analysis (RCA) and serious incident (SI) reports undertaken internally in line with good practice). The Trust should develop a set of triggers for external investigations to be undertaken including when departmental dysfunction is apparent. • The Trust should revisit its tolerance for requesting external support in investigations.	Urology Ongoing Trust Wide Ongoing Action for Medical Director - get update Query processes established by ESP	In progress	31/03/2022	Mar 22	

NICHE Report	MD30/1	TBC	TBC	EPR/Patient Records	UROLOGY	Recommendation 30 (ICS/CCG) - Clinical records in the form of emails (Link to R34(E)) • The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended. • The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. This should include: - clarification of what is an acceptable use of email in sharing patient specific clinical information, both internally and externally, to the Trust (including in clinical networks); - ensuring that where patient specific clinical information is shared by email (if appropriate) that these communications are retained as part of the clinical record; - revisiting the Trust email archiving policy, in light of the above, to ensure that emails can be retrieved where necessary (for example for SAR purposes); and - that all professionals should record the fact that an onward communication has been made within the clinical record.	Urology - Partially completed The Trust should add all Consultant staff email accounts to their Very Important Persons (VIP) list for a period of seven years once employment is ended - completed by IG • The Trust should revisit its record-keeping policy as regards the use of email communications between clinicians containing clinical information. - underway, need update from IG/Russell Norman Trust Wide Response - ongoing	In progress	31/03/2022	Aug 22	
NICHE Report	MD31/1	TBC	TBC	Culture and Leadership	UROLOGY	Recommendation 31 - Clinical dispute resolution • The Trust should introduce a mechanism of escalation, separate to the existing grievance and Freedom to Speak Up processes, whereby clinical disputes (in MDTs, between individuals or within departments) are formally mediated and resolved. The responsibilities for professionals involved in the event to engage in this mechanism of escalation should be made clear. This should be supported by a formal policy and should detail timescales for reporting, arbitration, resolution, and the trigger for the involvement of independent clinical adjudicators. Processes to report into other forums (such as Clinical Governance, mortality review, Ethics Committee and Revalidation) should be made clear within this policy.	Urology - Ongoing RSP Workstream 4: Culture and Leadership Trust Wide - Ongoing RSP Workstream 4: Culture and Leadership	In progress	31/03/2022	Apr 22	
NICHE Report	SD35/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 35 - Review Niche patient case studies The Trust should review all Niche case studies in priority order to contact patients in respect of Duty of Candour or ensure appropriate investigations have been completed to a high standard and actions have been implemented.	Urology - completed? Confirm evidence DoC Review of all NICHR Review Patients Update from Stuart/Nicky	In progress	31/03/2022	Mar 22	

NICHE Report	SD36/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 36 - Urology pathway priority management • There is a need to redesign follow-up pathways for Urology patients to match capacity and demand to prevent backlogs and balance this with the faster response for new referrals. Clear protocols for long-term active surveillance which ensures cases are appropriately seen at the right intervals are required. • Advance booking for long-term surveillance procedures should be introduced (including stent replacement and cystoscopy) and audited to ensure delays are minimised.	Urology - Partially completed COM review of Follow Up Pathways - ongoing Long Term Surveillance in Place	In progress	31/03/2022	Jun 22	
NICHE Report	SD37/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 37 - Capacity and demand modelling in Urology The Trust should undertake a capacity and demand modelling exercise (including the use of PLICS information) to provide an up to date baseline for the service and to support job planning. This should include: • Medical staffing levels • Junior staffing resources • Administrative resource • Nursing skills and a clinical nurse specialist role review	Urology Completed capacity and demand modelling exercise - completed by COM	Completed (awaiting approval)	31/03/2022	Jun 22	
NICHE Report	SD38/1	TBC	Procedural Documents and Information Group	Clinical Governance	UROLOGY	Recommendation 38 - Revisit and align all reporting policies The Trust should revisit and recommunicate the following policies to ensure that the purpose is clear, that they are aligned to each other and that they are workable for staff to readily follow and apply when escalation is required. This should include a flow diagram so staff can see which policy to follow in which situation. • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up	Trust Procedural Document Team to work with Patient Safety Team and People & Organisational Development to review, update and recommunicate the following policies: • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up	In progress	31/03/2022	Mar 22	
NICHE Report	SD38/2	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 38 - Revisit and align all reporting policies The Trust should revisit and recommunicate the following policies to ensure that the purpose is clear, that they are aligned to each other and that they are workable for staff to readily follow and apply when escalation is required. This should include a flow diagram so staff can see which policy to follow in which situation. • Incident reporting • Raising Concerns • Grievance management • Whistleblowing • Freedom to Speak Up	Trust Wide Only Need to confirm with Stuart Bates and/or Workforce RSP Workstream 1 & 4	In progress	31/03/2022	Mar 22	

NICHE Report	SD39/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 39 (ICS/CCG) - A specialty focus The Trust should identify key specialty metrics that enable focus on harms to be triangulated in subspecialties of the Surgical and Critical Care Group (S&CCG). This should include: • A single monthly report on claims, incidents, Parliamentary Health Service Ombudsman (PHSO), Never Events and complaints with a cumulative analysis of themes arising. • At least biannual thematic reviews (regardless of whether complaints or claims are upheld) to understand any concerns being raised at the earliest possible opportunity. • An annual reconciliation of claims and complaints and their conversion to incident reports should be undertaken to ensure all patient safety concerns are logged through the incident reporting process for learning. • Learning and sharing relevant patient safety issues arising from MHPS investigations (which should be logged as incidents where appropriate). • Use of the annual GMC National Trainee Survey results to ensure information on junior doctors' experience is considered as part of these metrics.	Some progress in SCC - check with Greg Trust Quality standards with CCG - check with Stuart Bates	In progress	31/03/2022	Mar 22	
NICHE Report	SD40/1	TBC	Clinical Audit Standards Group	Clinical Governance	UROLOGY	Recommendation 40 - Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47) A standard should be set for each of the following against which a clinical audit programme should be implemented: • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance	Trust Clinical Audit Team to work with Clinical Audit Leads to ensure that the below Audits are included in the Trust Forward Audit Plan for 2022-23. Audit will take place 2022/23, with completion across 2022/23. Progress to be reported to Clinical Audit Standards Group Meeting. • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance	In progress	31/03/2023	Mar 22	

NICHE Report	SD40/2	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 40 - Implement clinical audit programme (Link to R4, R9, R14, R18, R25, R41, R47) A standard should be set for each of the following against which a clinical audit programme should be implemented: • Handover quality • Emergency surgery including access to and use of theatres out of hours • Emergency transfers from FGH to RLI • Stent register compliance • Results review and acknowledgement • MDT referrals, implementation of actions, attendance and quality of behaviours • Out-of-hours support from junior doctors • Ward round management • Consenting practice • Continuity of care • Harms as a result of delayed follow ups and IRDs • Application of National Institute for Clinical Excellence (NICE) guidance	Urology - In progress Check forward Audit Plan Trust - In Progress Will Require Audits of Safe Today, confirm what is not included in Safe Today and what needs to be added	In progress	31/03/2022	Mar 22	
NICHE Report	SD41/1	TBC	TBC	Service Design and Delivery	UROLOGY	Recommendation 41 (Cancer Alliance) - Cancer MDT management The Trust, with the Cancer Alliance, should: • Agree and implement new Standards of Care (SoC) in line with the advice of the Streamlining MDT Meetings guidance. • Clarify the expectations of core members at both local and network MDTs and the expectation for named Consultant Urologists to present their cases. A deputy role for the chair of the local MDT should be put in place. • Ensure that all core members attend the MDT as agreed above. • Audit the new processes to ensure alignment with the introduction of the named Consultant. • Ensure responsibility for actioning decisions made at the local MDT is maintained within the Trust. • Ensure there is clarity for responsibility for actioning decisions made at the network MDT. • Ensure that professional behaviours are demonstrated at both local and network MDTs and confirmed through observation and transparent feedback on a regular basis for all attendees.	Urology - Partially complete Trust Wide Only - Partially complete Need to review with Sarah Hauxwell and update	In progress	31/03/2022	Jun 22	

NICHE Report	SD42/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 42 - 104 day cancer breach root cause analysis • Ensure all 104 day cancer waiting time breaches are subject to a root cause analysis (RCA) and thematic reviews are acted upon to ensure pathway problems are properly identified and improved. • The Trust should follow the newly released (October 2021) North West Guideline: Managing Long Waiting Cancer Patients	Trust Wide Only - Completed Revised 104 process in place Update from Sarah Hauxwell	Completed (awaiting approval)	31/03/2022	Mar 22	
NICHE Report	SD43/1	TBC	TBC	Performance Monitoring & Reporting	UROLOGY	Recommendation 43 - Emergency theatre access • The Trust should monitor the use of emergency theatres out of hours in Urology (building on the analysis provided in this report) to establish whether the existing Standard Operating Procedure (Theatre Access) is effective in changing the pattern of practice highlighted by this report. • This should be examined in the context of whether some emergency theatre demand could be reduced through the provision of ward based facilities.	Trust Wide Only - Partially complete SOP in Place - Consultants do not always follow policy - needs to be embedded	In progress	31/03/2022	Jun 22	
NICHE Report	SD44/1	TBC	TBC	Fundamental Care Standards	UROLOGY	Recommendation 44 - Patient handover Handover of patients between Consultants should include: • a formal handover arrangement between Consultants for out of hours cover. • a handover for patients who are transferred between Consultants.	Urology Completed Trust Ongoing	Completed (awaiting approval)	31/03/2022	Aug 22	
NICHE Report	SD45/1	TBC	TBC	Culture and Leadership	UROLOGY	Recommendation 45 - Managing team dysfunction A uniform approach should be applied to team dysfunction. This should include: • Clear communication from the Trust re the service strategy, goals and objectives - particularly around behavioural standards • Holding to account against professional standards in Good Medical Practice • Sustained visible leadership and "sponsorship" from the Board • Intelligent review of patient outcomes and harms • Follow-up, monitoring and review to ensure that behavioural improvements are sustained.	Urology - Completed Trust - Ongoing RSP Workstream 4	Completed (awaiting approval)	31/03/2022	Apr 22	
NICHE Report	SD46/1	TBC	TBC	Staffing: Health and Wellbeing	UROLOGY	Recommendation 46 - Duty to monitor staff wellbeing The Trust has a duty to monitor staff stress levels and wellbeing and to intervene to support and understand the underlying issues before burn out affects patient care. The Trust should develop a cultural dashboard to identify key metrics that can provide early warning of team stress e.g. Occupational Health referral, employee relations concerns, engagement scores.	Urology - Ongoing RSP Workstream 4 Culture Dashboard - ongoing	In progress	31/03/2022	Apr 22	

NICHE Report	SD47/1	TBC	TBC	Staffing: Appraisal and CSF Training	UROLOGY	Recommendation 47 - Appraisals for medical staff (Link to R40) • Appraisals may identify colleagues who are having difficulties and a protocol should be put in place to safeguard staff when concerns are apparent. • The Responsible Officer should explicitly monitor appraisals which may demonstrate team dysfunction as a means of early warning and to instigate remedial interventions. • Specialty interests with key outcome measures at unit level should be agreed. Individual Consultants should be given lead responsibility for specialist areas with outcomes linked to the clinical audit programme and fixed into appraisal processes.	Medical Appraisal Only Need update from Jane McNicholas and check with Re-validation Team Medical Appraisal records are not 'Open' for review	In progress	31/03/2022	Apr 22	
NICHE Report	SD48/1	TBC	TBC	Culture and Leadership	UROLOGY	Recommendation 48 - Engagement with Consultant body • Engagement by executive and non-executive members of the Board with the Consultant body should be examined and options provided to facilitate increased opportunities for interaction. • This should include a clear programme of engagement at sub-specialty level over a rolling programme. This should be in addition to existing Medical Advisory Committee meetings.	Urology partially completed/ Exec involvement , Board Sponsorship Trust Wide Appointment of Clinical Director to RSP Development of Clinical Reference Group Check with Jane McNicholas Non-Exec check with Paul Jones	In progress	31/03/2022	Apr 22	
NICHE Report	SD49/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 49 - Trust Management of Royal College reports • The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee.	The Trust should inform regulators (CQC and NHS England and NHS Improvement) and commissioners of any plans for external reviews for quality and safety concerns, including Royal College Invited Service Reviews as soon as they are confirmed. This will ensure that regulators and commissioners can take this into account in their assurance activity in real time. • Advisory reports from the Royal Colleges should be shared, in full or in summary where appropriate, by the Trust with the Trust Board. • The Trust should formally inform the regional or local NHS England and NHS Improvement team, the Care Quality Commission and relevant fitness to practice investigations conducted by the GMC and commissioners of relevant Royal College reports and share these where appropriate. • Transparent action plans arising from all Royal College reports should be developed by the Trust, shared with the Trust Board and formally monitored through the Trust Quality Committee. - Check QAC ToR	In progress	31/03/2022	Mar 22	

NICHE Report	SD50/1	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 50 - Clarify role of governors and escalation mechanisms • Governor training and induction programmes should be revisited to confirm that methods for escalating concerns are clearly set out and understood. • Procedures for escalation should include processes for resolution where governors remain dissatisfied with responses to issues raised.	Need to Review Paul Jones	In progress	31/03/2022	May 22	
NICHE Report	SD51/1	TBC	Audit Committee	Corporate Governance	UROLOGY	Recommendation 51 - Institutional memory Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.	Executive handover procedure to be developed and implemented by March 2022.	In progress	31/03/2022	May 22	
NICHE Report	SD51/2	TBC	Procedural Documents and Information Group	Corporate Governance	UROLOGY	Recommendation 51 - Institutional memory Formal handover procedures should be in place for all incoming and outgoing Board members (including postholders with committee chair roles). These handovers should include employee relations issues and sub-specialty summaries.	Trust Procedural Document Team to review Procedural Documents to identify documents relevant Work with Company Secretary to Agree Standard 'Role Names' for Executive Directors and other Senior Directors (e.g. Deputies to Executives) Use agreed Standard 'Role Names' to initiate and complete a 'find and replace' review of all procedural documents to ensure correct role names are used. Develop process for identifying, collating and reporting all responsibilities allocated to a Standard 'Role Names'	In progress	31/03/2022	May 22	
NICHE Report	SD52/1	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 52 - Media articles Revise advice and guidance on dealing with media articles that name individuals and provide support to ensure an appropriate right of reply is sought (also in line with GMC guidance on responding to criticism in the media).	Review with Phil Woodford	In progress	31/03/2022	May 22	

NICHE Report	SD63/1	TBC	TBC	Clinical Strategy	UROLOGY	Recommendation 63 - Development of safe services and specialist interests A Urology strategy should be developed involving all key Urology medical staff and other relevant healthcare professionals to set the context for the following actions: • The Trust should undertake an equipment stocktake for Urology and plan into the capital replacement programme the need for cystoscopes, bipolar diathermy and suction equipment both in the short term and over the medium term or consider lease options. • Examine, with the Trust and CCG, the development of Urology sub-specialisms building on Andrology and stone services, the management of superficial bladder cancer, local anaesthetic transperineal biopsy work and paediatrics. • Examine, through the provider collaborative network, the viability of Urology provision across two sites and its associated support services in the long term should be examined in respect of future provision at Furness General Hospital. Formal consideration of centralising inpatient and emergency Urology services on one site should be revisited. This should include options for dedicated ward based facilities.	The Trust should undertake an equipment stocktake for Urology and plan into the capital replacement programme the need for cystoscopes, bipolar diathermy and suction equipment both in the short term and over the medium term or consider lease options. - Completed • Examine, with the Trust and CCG, the development of Urology sub-specialisms building on Andrology and stone services, the management of superficial bladder cancer, local anaesthetic transperineal biopsy work and paediatrics. - Ongoing • Examine, through the provider collaborative network, the viability of Urology provision across two sites and its associated support services in the long term should be examined in respect of future provision at Furness General Hospital. Formal consideration of centralising inpatient and emergency Urology services on one site should be revisited. This should include options for dedicated ward based facilities. - Ongoing	In progress	31/03/2022	May 22	

NICHE Report	SD65/1	TBC	TBC	Corporate Governance	UROLOGY	Recommendation 65 (National) - Guidance and support to Responsible Officers from NHS England and NHS Improvement Regional Medical Directors • NHS England and NHS Improvement should ensure that guidance to ROs is up to date and a final version is in force to include the 2013 RO regulation amendments and learning since the role was introduced. Regional Medical Directors should use this investigation as a case study to reinforce escalation processes for Responsible Officers who may be facing conduct difficulties within their medical workforce. • The North West Regional Medical Director should share this case study with other Regional Medical Directors to reinforce the importance of the RO role, appointment processes and the lessons learned from this investigation. • Good practice should be shared between Trusts to provide clarity on the best approaches for dealing with and escalating behavioural and conduct issues that are impacting on patient safety in line with Good Medical Practice. • The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.	Only one action for Trust The Trust Board should revisit its understanding of the role of the RO and assure itself that there is clarity of duties between the Medical Director (now as RO) and the wider team in exercising duties to meet the RO regulations.	In progress	31/03/2022	May 22	
NICHE Report	SD72/1	TBC	TBC	Clinical Governance	UROLOGY	Recommendation 72 (National) - Testicular Implant Recall NHS England and NHS Improvement should share the findings from the testicular implant recall exercise with relevant bodies and agree the next steps at a local or national level.	Partially complete External Urology Consultant Report expected by end of Jan 2022	In progress	31/01/2022	Mar 22	

2. RCS Improvement Plan Dashboard

Inspection	Ref. No.	SRO	Committee	Theme	Service	Recommendation	UHMBT Action	Status	Target Date	Tolerance Testing Target Date	Risks
RCS Report	MD1	TBC	TBC	Staffing: Non-CSF Training	Trauma and Orthopaedics	Actions the Trust Must take to ensure patient safety is protected: A review of redacted clinical activity in performing unicompartmental knee replacements is required given the review may indicate an insufficient number of these procedures being undertaken to maintain the appropriate skill set required for the techniques involved.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Apr 22	
RCS Report	MD2	TBC	TBC	Staffing: Appraisal and CSF Training	Trauma and Orthopaedics	Actions the Trust Must take to ensure patient safety is protected: Assure evidence of redacted training in anterior approach surgery before further anterior approach hip replacements are performed.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Apr 22	
RCS Report	MD3	TBC	TBC	Service Design and Delivery	Trauma and Orthopaedics	Actions the Trust Must take to ensure patient safety is protected: In respect of more complex cases, more effective utilisation of MDT to: (i) Improve governance in respect of clear decision making, transfer/handover of care documentation. (ii) Ensure appropriate consultant surgeon involvement.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Jun 22	
RCS Report	MD4	TBC	TBC	Consent	Trauma and Orthopaedics	Actions the Trust Must take to ensure patient safety is protected: The consent pro-forma should ensure that the potential risks of the planned surgery are clearly documented for the patient to assimilate and space to record that these have been explained to the patient.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Aug 22	
RCS Report	MD5	TBC	TBC	Clinical Governance	Trauma and Orthopaedics	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: redacted may benefit as part of learning to reflect upon and discuss with colleagues case AXX in particular, possible reasons for the femoral notch (which was not documented in the operation note) occurring.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Mar 22	
RCS Report	MD6	TBC	TBC	Service Design and Delivery	Trauma and Orthopaedics	Actions the Trust Must take to ensure the Trauma and Orthopaedic Service is improved: The Trust should take steps to improve the continuity of care for patients through their pre-operative, intra-operative and post-operative care pathway. This may include, but is not limited to, listing patients, wherever possible, on the operating surgeon clinic list.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Jun 22	

RCS Report	SD7	TBC	TBC	Clinical Governance	Trauma and Orthopaedics	Actions the Trust Should consider as part of its development of the Trauma and Orthopaedic service: If the Trust identifies primary concerns about an individual surgeon, then a formal review of their clinical practice is recommended. If the Trust identifies concerns associated with the surgical service then a review of the service is recommended.	TBC – action detail forthcoming from Medical Director in April following submission of update to the Royal College of Surgeons.	TBC		Mar 22	

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Minutes of the Audit Committee held on Thursday 21 October 2021

Due to preventative measures taken to prevent the spread of COVID-19, the meeting was held virtually via Microsoft Teams.

Present:	Liz Sedgley	Non-Executive Director (Chair)
	Bruce Jassi	Non-Executive Director
	Stephen Ward	Non-Executive Director
In Attendance:	Richard Anderson	Engagement Manager Grant Thornton
	Nicola Barnes	Trust Board Administrator
	Jackie Bird	Interim Chief Nurse
	Paul Bell	Senior Anti-Fraud Manager Mersey Internal Audit Agency
	Sandra Cudlip	Assistant Director – Assurance Mersey Internal Audit Agency
	Janet Higgs	Deputy Director of Finance
	Paul Jones	Company Secretary
	Gareth Kelly	Engagement Lead Grant Thornton
	Jane Stanley	Head of Financial Services
	Lisa Warner	Internal Audit Manager Mersey Internal Audit Agency

21/61 Welcome and Introductions

Liz Sedgley (LS-NED) welcomed Paul Bell to the Committee.

Apologies

Apologies were received from Chris Adcock, Adrian Leather, Sarah Rees, Hugh Reeve and Jill Stannard.

Declarations of Conflicts of Interest

None.

21/62 Minutes of the Audit Committee held on 15 July 2021

Decision: That the Minutes of the meeting held on 15 July 2021 be agreed as an accurate record.

21/63 Action Sheet and Matters Arising from the Minutes of the Audit Committee held on 15 July 2021

Non-Compliance with Policy and Procedure:
Paul Jones (PJ) advised that following discussions at the last meeting of the Committee, he had sought an update on actions taken for non-compliance of policies and procedures. PJ explained he would provide a further update at the

next meeting of the Committee.

Action 10: Process Adopted by the Trust for Payment of Course if colleagues left the Trust
It was agreed an update would be sought from the People Committee.

Action 50: Anti-Fraud:
Paul Jones advised the anti-fraud, bribery and corruption policy would be presented to the Audit Committee for consideration and approval.

Action 60: Recruitment Controls for Medical Consultants
It was agreed an update would be sought from the People Committee.

Decision: The Committee considered the action sheet and noted the actions taken.

21/64 Audit Committee Terms of Reference

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:
1. PJ advised that as part of Good Governance Institute (GGI) review, the Committee's Terms of Reference had been revised taking into consideration views from the auditors.
2. PJ recommended that in the interim period, the Committee adopted the revised Terms of Reference. A review of the Terms of Reference would take place at the end of the financial year to ensure they remained fit for purpose.

During deliberation of this item the following points were considered:
3. Bruce Jassi (BMJ-NED) advised that the revised Terms of Reference referred to the Workforce Committee not People Committee. BMJ-NED sought assurance on the rationale for a quorum of 3 Non-Executive Directors.
4. PJ advised that this had been reviewed in line with current guidance and best practice. PJ suggested that rather than named Non-Executive Directors, Non-Executive Director attendance was rotated through the financial year to ensure all Non-Executive Directors had an opportunity to meet with the auditors at the Audit Committee.
5. Liz Sedley (LS-NED) noted her concern regarding the breadth of discussions if Non-Executive Director attendance was not rotated and would like to ensure a rotation of Non-Executive Directors was in place. Nicola Barnes agreed to share the rota of Non-Executive Director attendance at future meetings of the Audit Committee with LS-NED.

Decision:
1. That the Committee approved the Terms of Reference; and
2. That the Trust Board Administrator would share the rota of Non-Executive Director attendance at future meetings of the Audit Committee with the Chair of the Committee.

21/65 Receivables and Payables Outstanding to 30 September 2021

Consideration was given to a report presented by Jane Stanley (JS).

The following points were made in discussion:

1. JS advised that the report included details of overpayments of salary as this was a concern raised at the last meeting of the Committee.
2. JS provided an update on receivables and payables outstanding at 30 September 2021 in excess of £5000 and those over six months old.

During deliberation of this item the following points were considered:

3. Sandra Cudlip (SC) advised that in relation to overpayment of salaries, the auditors reviewed this 12 months and one of the reflections was that SBS (former payroll provided) had contributed to this. SC sought assurance that since moving to a different payroll provider had this improved. JS advised that SBS did make a lot of errors. Since moving to a new payroll provider, most of the overpayment of salaries was due to late management action. Overpayment of salaries was slowly reducing. ELFS (new payroll provider) were efficient at processing invoices. SC advised that a routine payroll audit was planned, and salary overpayments could be included part of that review to provide assurance to the Committee.
4. Liz Sedgley (LS-NED) commented that with the systems Chris Adcock was adopting regarding financial accountability, managers would become accountable for their financial targets as well as performance targets. As new systems and processes came in place, it was envisaged this would improve.

Decision: That the report be noted.

21/66 Losses and Special Payments

Consideration was given to a report presented by Jane Stanley (JS).

The following points were made in discussion:

1. JS advised this report detailed the losses and special payments made/incurred by the Trust for the period 1 July 2021 to 30 September 2021.
2. JS provided an explanation of the stores losses which related to pharmacy drugs.

Decision: That the report be noted.

21/67 Waivers of Standing Financial Instructions

Consideration was given to a report presented by Jane Stanley (JS).

The following points were made in discussion:

1. JS advised the report detailed the instances where the Trust's Standing Financial Instructions had been waived.

Decision: That the report be noted.

21/68 Company Secretary Update

Consideration was given to a report presented by Paul Jones (PJ).

<u>Fit and Proper Person Policy</u>

The following points were made in discussion:

1. PJ advised that the policy had been reviewed to reflect the recommendations of the MIAA review of the application of the Fit and Proper Persons requirements.
2. MIAA had provided a rating of Moderate Assurance following their review which was in line with the CQC's assessment of the Trust's Fit and Proper Person test.
3. MIAA made recommendations which would enhance the fit and proper person checks. These had been implemented.
4. PJ advised that he had sought assurance on the application of the Fit and Proper Person test across the North West. When the Fit and Proper Person test was established the Trust applied the test to all voting members of the Board. MIAA had recommended that the Fit and Proper Person test be extended to include PJ as Company Secretary, the Director of Governance and Director of Corporate Affairs as these roles provided professional advice to the Board.

During deliberation of this item the following points were considered:

5. Bruce Jassi (BMJ-NED) queried the inclusion of Geoff Jolliffe as Advisor to the Board. PJ advised the Fit and Proper Person test would be applied to this role; the policy had been revised to include this. BMJ-NED sought assurance on the process for countersigning the Fit and Proper Person self-declaration forms Board members were required to complete. PJ advised of the process.
6. Liz Sedgley (LS-NED) sought assurance on the process for applying the Fit and Proper Person test to interim directors and challenged why deputies had not been included. PJ advised there was not a clear view regarding the application of the Fit and Proper Person test to deputy roles. PJ agreed to seek advice from the national team in terms of those roles that might from time to time step up in an acting capacity. Regarding interim directors, the process was very clear as the Trust was required to undertake the Fit and Proper Person test for these roles. PJ would ensure this was made explicit in the policy.

<u>Anti-Fraud, Bribery and Corruption Policy</u>

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:

7. PJ advised that at the last meeting of the Committee, the Committee approved a zero-tolerance statement. The policy had been revised to ensure it was compliant with best practice and reflected the work of the Freedom to Speak Up Guardian.

<u>Good Governance Institute (GGI</u>

Consideration was given to an update presented by Paul Jones (PJ).

8. PJ advised that as part of the handover from GGI, a handbook and supporting material would be catalogued in the library and held by the Company Secretary's office to ensure all colleagues had access to this material
9. Sandra Cudlip (SC) sought assurance how polices had been kept updated during pandemic, as this had impacted other Trusts. PJ advised that a corporate policy group led by colleagues in the clinical governance team had continued to meet during the pandemic. In the first instance any alerts would

be escalated to the Executive Chief Nurse as the lead executive who would alert the Committee. The Committee agreed to PJ suggestion to present a report on the current status of the Trust's policies and procedures at the next meeting of the Committee. PJ advised there was a process in place to remind colleagues when policies were due for review. At a future meeting the Committee would welcome a report on the changes made following the GGI review and how this had made a difference to Care Groups. PJ advised that it had been agreed to provide an update on risk management and Care Group structures as part of the audit programme. PJ suggested that when this report was presented to the Committee, an update from the Care Groups was included to demonstrate how the changes implemented by GGI had been sustained. It was agreed this report would be presented to the next meeting. Colleagues from a Care Group would be invited to provide an update on how the changes implemented by the GGI team had made a difference.

During deliberation of this item the following points were considered:

Decision:

1. That the Committee approved the Fit and Proper Person and Anti-Fraud, Bribery and Corruption policies;
2. That the Company Secretary would review the application of the Fit and Proper Person test to deputy roles;
3. That the Company Secretary would ensure the application of the Fit and Proper Person test to interim roles was explicit in the Fit and Proper Person Policy;
4. It was agreed a report on the current status of the Trust's policies and procedures would be presented to the Committee at their meeting on 20 January 2022; and
5. It was agreed a report on risk management and Care Group structures following the GGI review would be presented to the Committee at their meeting on 20 January 2022. Care Group colleagues would be invited to attend to provide an update on how the changes implemented by the GGI team had made a difference.

21/69 Annual Report and Accounts 2020/21: Auditor's Annual Report on University Hospitals of Morecambe Bay NHS Foundation Trust

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:

1. PJ advised that, as previously noted by the Committee, an enhanced audit had been carried out by the external auditors. The outcome of this audit was presented in the report. The management response had been overseen by PJ, Janet Higgs, Jane Stanley and Tim Povall supported by Chris Adcock who had approved the response.
2. PJ explained that following the Committee's approval of the report, the Trust's Annual Report and Accounts for 2020/21 would be submitted to the Parliamentary Clerk for laying in order to hold the Trust's Annual Members' Meeting in November 2021.
3. Gareth Kelly (GK) outlined the key messages of the report and the new requirements of the value for money assessment.
4. The report presented the auditor's key recommendations and provided a high-level summary of the auditor's findings.

5. One of the key recommendations was in relation to financial sustainability; the report included detail of the progress that had been made in bringing the Trust into financial balance in the medium to long term future.
6. A key recommendation in relation to clinical governance had been made. This had been driven by the outcome of the CQC inspection, the Good Governance Institute review and also as a result of the some of the matters raised. Grant Thornton engaged the support of a healthcare advisory specialist to complete their report. This included meetings with the Medical Director, Executive Chief Nurse and Director of Governance to inform the overall view on clinical governance. The report outlined the findings of this review. The key recommendation in relation to clinical governance was driven by the significant weakness identified which related to the quality and clinical governance challenges. These had been reflected in the Trust's composite action plan. In relation to stroke care, the report acknowledged the impact of the pandemic but noted that some of the indicators around stroke performance were starting to materialise pre-COVID-19 which had also been identified by the CQC. The report noted that the Trust was working hard to address this.
7. The report included the Trust's contribution to the work of the Integrated Care System. The report reflected that some of the challenges facing the Trust, particularly in relation to finance, would require a system wide solution to address them.
8. The report contained the proposed opinion which would be finalised following approval of the report. Following approve, the auditor would issue their opinion and close the 2020/21 audit.
9. The report included commentary around the use of statutory recommendations. For 2020/21, the auditors gave serious consideration as to whether some of the challenges should be escalated higher. GK outlined the implications of this for the Trust. For 2020/21 it had been agreed not to exercise any statutory powers. The report reflected the work the Trust was doing to address the challenges and return the Trust to financial balance in the medium and long term as well as the progress made towards the composite action plan. Progress would be reviewed in February 2022. The auditors noted that the outcome of the independent reviews regarding trauma and orthopaedics and urology were awaited.
10. Richard Anderson (RA) explained the report included commentary on areas where the auditors did not identify any weaknesses and had a much broader scope. Regarding financial sustainability, the report reflected the work of the Trust to address the challenges; a key part of this was the financial improvement programme, which formed part of the Trust's recovery plan, and implementation of this would inform the value for money assessment for 2021/22. The report recommended that bids for capital PDC were realistic and built on the accounts audit work. The report included the work of the New Hospital Programme and the opportunities for the Trust. The report Included commentary on risk management, budget setting and monitoring and decision making. The report included a section on economy, efficiency and effectiveness. The report included commentary on working with partnerships and key stakeholders, but did not raise any specific recommendations in this regard. The auditors reviewed the Trust's arrangements for dealing with the pandemic through the themed areas of economy, efficiency and effectiveness and no concerns had been raised in relation to those arrangements.

During deliberation of this item the following points were considered:

11. Jackie Bird (JB) acknowledged that in relation to clinical governance, the

auditor's assessment was taken at a particular point in time. JB provided an update in relation to the role of the Director of Midwifery which GK agreed to reflect in the final report. JB confirmed that since receipt of the CQC inspection report, the Trust was part of the maternity safety support programme. GK agreed to consider including this detail whilst balancing this with the timing of the report as the report reflected the period 2020/21.

12. Steve Ward (SW-NED) acknowledged the auditor's decision not to use its statutory powers and their commentary on the challenges faced by the Trust. The report reflected that slow escalation had been an issue for the Trust which had contributed to a number of issues the Trust was addressing. SW-NED encouraged the auditors not to delay escalating issues. GK acknowledged this point.
13. Tim Povall (TP) acknowledged the recommendations regarding capital bid and noted that feedback received from the national teams had demonstrated that it was likely the Trust would be in the same position for 2021/22 as 2020/21. GK advised that Grant Thornton had raised this issue nationally which had been recognised.
14. In response to Liz Sedgley (LS-NED) question regarding raising this issue nationally, PJ advised he had prepared a letter, on behalf of the Committee, and would share with LS-NED out of the meeting.
15. LS-NED commended the report and sought assurance on how this report was shared across the organisation and publically. PJ advised the report was a public record and would be included in the final version of the Annual Report and Accounts 2020/21 which would be shared with the Parliamentary Clerk for laying in Parliament. This report also formed part of Grant Thornton's presentation at the Trust's Annual Members' Meeting. PJ advised tracking the management responses through the Audit Committee and agreed to discuss this further with Chris Adcock, as executive lead for the Committee. PJ agreed to share the report with members of the Trust Management Group. LS-NED suggested sharing this report as part of the Board of Directors' Reference Pack. PJ agreed to include in a future Board pack and suggested placing this report on the Trust website alongside other statements such as the Modern Slavery Statement and NHS Improvement Submission of Annual Self Declaration.
16. Jane Stanley (JS) advised that the Parliamentary Clerk had contacted JS as UHMB was the only Foundation Trust not to have submitted the annual report. It was agreed that GK would issue the auditor's opinion following the Committee's approval to enable this to be included in the final version of the Annual Report and Accounts 2020/21, which would be sent to the Parliamentary Clerk by close of play.

Decision:

1. That the Committee endorsed the report;
2. That the Company Secretary would discuss with Chris Adcock regarding the tracking of management responses in relation to the auditor's report, through the Audit Committee; and
3. The auditor's report would be included in a future Board of Directors' Reference Pack for Board members' information.

21/70 Risk Management Update

Consideration was given to a report presented by Paul Jones (PJ).

The following points were made in discussion:

1. PJ advised this was a follow up report to the substantive report relating to the new risk management structure which was presented to the Committee at the last meeting.
2. This report provided an update on the Trust's latest assessment which had demonstrated an improving picture when looking at application of the risk management.
3. The team had escalated efforts to recruit a suitably qualified substantive risk practitioner, but had retained the current interim (Kevin Street) to maintain the progress made.
4. Jackie Bird (JB) advised the Committee that a new Director of Governance had been appointed and would review this, when in post, as the Trust had not been able to recruit a substantive risk practitioner. Regarding risk management, there were a number of pending risks and an extra-ordinary meeting had been arranged to address these.
5. PJ advised that a review of risk descriptors was ongoing and through the recovery support programme, a list of actions and assurances that required Board oversight would be included and the Board Assurance Framework (BAF) would be aligned to that. This would feature as part of the quarterly 2 report which would be presented at the Board of Directors' meeting on 27 October 2021.
6. PJ advised a further report would be presented to the Committee at their meeting on 20 January 2022 which would include the outcome of the MIAA review of the BAF.

During deliberation of this item the following points were considered:

7. Steve Ward (SW-NED) acknowledged the ongoing work on the definition of the risks and offered his support with this. PJ welcomed this support and agreed to share the current risk descriptors.

Decision:

1. That the report be noted; and
2. That the Committee noted a further report would be presented at the next meeting on 20 January 2022.

21/71 External Audit Update

Consideration was given to a report presented by Gareth Kelly (GK).

The following points were made in discussion:

1. GK advised there was nothing further to add following presentation of the auditor's report.
2. Jane Stanley (JS) sought assurance on the preparations of the interim audit for 2021/22. GK advised he would discuss this outside the meeting with JS.

Decision: That the report be noted.

21/72 Internal Audit Update

Internal Audit Update Report

Consideration was given to a report presented by Lisa Warner (LW).

The following points were made in discussion:

1. LW advised that three final reports had been included in the progress report.
2. Data Quality – the assurance rating had been split for this review with Substantial Assurance awarded for control design and Limited Assurance for control operation. LW advised that the key findings had demonstrated a lack of Care Group engagement in the Data Quality Group. The Data Quality Issues Log (DQIL), which were used to track known data quality issues and was monitored by the Data Quality Group, had not had any new issues added to the log since April 2020 and existing issues had not been subject to update in respect of progress of actions.
3. Attendance Management – the assurance rating had been split for this review with Substantial Assurance awarded for control design and Limited Assurance for control operation. MIAA review had demonstrated that whilst the Trust had an overall well designed process in place for attendance management, testing showed that the controls were not operating as intended. The Return to work interviews were not always being completed or if they were completed, they were not always completed within the 48 hour timescale set out in the policy. Evidence of fit notes being obtained and retained could also not be evidenced for the sample tested. A request for evidence of extended return to work interviews being undertaken where the triggers in the policy had been breached could not be obtained and therefore, MIAA were unable to provide assurance that this control was operating effectively
4. Fit and Proper Person – this review had awarded Moderate Assurance. A number of recommendations had been made and it was pleasing to note the positive direction as the last review had awarded a rating of Limited Assurance. LW acknowledged that the recommendations were being addressed.
5. The report provided an update on follow up reports. There were a few outstanding recommendations that were slow to being closed down. LW emphasised the importance of ensuring recommendations were actioned and embedded and advised that this was an area of focus for the Trust.
6. LW advised there were three proposed changes to the audit plan:
    a. At the last meeting it was reported that the planned review of Incident Reporting and Lessons Learnt had been requested to be deferred until quarter 1 2022/23. Following discussions with the Interim Chief Nurse this review would be undertaken in quarter 4. The review would focus on whether the improvements made have been fully implemented and sustained.
    b. It was proposed that the planned review of Post-COVID-19 Lessons Learnt be stood down. The rationale for this was that the scope of this review was potentially so wide that a single piece of work would not be feasible. It was therefore suggested that a post-COVID-19 review be built into each individual audit where this was appropriate.
    c. The timing of the key financial systems review was moved from quarter 4 to quarter 3 which would enable MIAA to complete their work before external audit commence their interim work.
7. LW advised that since publication of this report, LW had received an urgent request to review the Trust membership database following the concerns raised at the recent governor elections. A review of data quality was due to take place in quarter 4; as a result of the request to review the membership database, a review of the data quality would be deferred to 2022/23.
8. LW welcomed the Committee's view on the internal audit plan to ensure it reflected the key risks of the Trust and the areas to be reviewed provided the

best value for the Trust.

During deliberation of this item the following points were considered:

9. Jackie Bird (JB) advised she had met with SC and LW and had requested a copy of the internal audit reports she was accountable for to ensure the recommendations were addressed. JB sought assurance on the process for raising issues on where recommendations had not been implemented. PJ advised that each report was sponsored by an executive lead and it was their responsibility to ensure the recommendations had been implemented. PJ explained that there were two escalation points; PJ meeting with the internal auditors and more formally through meetings with Chris Adcock as executive lead with any exceptions reported to this Committee.
10. LS-NED noted her disappointment regarding the number of outstanding actions that had not been addressed. This report reflected that a number of the reviewed undertaken by MIAA showed *Significant Assurance* for procedures and policies being in place but *Limited Assurance* as to those being implemented. LS-NED encouraged sharing this message across the Trust via the Non-Executive Directors and executive leads to emphasise the importance of implementing the recommendations in a timely manner.
11. SC advised that in the context of the Head of Internal Audit Opinion, implementation of recommendations formed a key part of this opinion. PJ agreed to meet with Chris Adcock to ensure implementation of MIAA recommendations in a timely manner was addressed.

<u>Anti-Fraud Update Report</u>

Consideration was given to a report presented by Paul Bell (PB).

The following points were made in discussion:

12. As the Committee had noted, the anti-fraud, bribery and corruption policy had been updated which had been updated to reflect best practice. The Committee would undertake bribery training at the conclusion of the meeting.
13. A fraud risk assessment exercise would be undertaken during quarter 3; the outcome of which would be reported to the Committee.
14. In relation to fraud awareness, work was ongoing to ensure updated material was shared with staff.
15. PB advised it was international fraud awareness week commencing 14 November 2021 and preparation was ongoing for this.
16. Six fraud prevention notices had been issued since the last report to the Committee and two referral queries had been received during the last reporting period.

During deliberation of this item the following points were considered:

17. Jane Stanley (JS) and PB agreed to discuss fraud risks outside the meeting.
18. LS-NED welcomed the work on fraud prevention, particularly cyber security.

Decision:

1. That the report be noted;
2. That the Committee approved the changes to the audit plan; and
3. The Company Secretary and Director of Finance would meet to ensure implementation of MIAA recommendations in a timely manner was addressed.

21/73 Items to be recommended for decision or discussion by the Board or other

Committees

Decision:

1. Auditor's Report – auditor's decision to not use their statutory powers for 2020/21 but the risk of implementing statutory recommendations for 2021/22; and;
2. The impact of the Head of Internal Audit Opinion if the Trust did not address the number of outstanding recommendations that had not been implemented. The Director of Finance would lead the response to this potential risk.

21/74 Schedule of Business

Noted.

21/75 Attendance Monitoring Register

Noted.

21/76 Urgent business

MIAA Masterclasses
Lisa Warner agreed to share the details of these sessions.

21/77 Date and time of next meeting:

It was noted that the next meeting of the Audit Committee would be held on Thursday 20 January 2022 at 9am in the Board Room, Westmorland General Hospital, Burton Road, Kendal LA9 7RG

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Minutes of the People Committee Meeting held on Monday 21 February 2022 via M/S Teams

PRESENT:

Adrian Leather	Chair, Non-Executive Director
David Wilkinson	Director of People & OD
Lyn Hadwin	Deputy Director of People & OD
Ray Olive	Assistant Director of People & OD
Matt France	Assistant Director of Organisational Development & Learning
Clare Hill	OH & Wellbeing Matron / Clinical Lead
Arthur Jones	Public Governor
Mike Wilson	Public Governor
Ben Maden	USS Chair
Lynne Wyre	Deputy Chief Nurse
Caroline Chubb	Minute Taker

108. WELCOME & APOLOGIES FOR ABSENCE

Apologies were noted from Richard Sachs, Stuart Bates, Bridget Lees, Jane McNicholas, Kate Maynard, Leanne Cooper, Paul Jones and Karmini McCann. The Committee noted the large number of apologies were due to this Committee clashing with the Quality Committee on this occasion due to today's Committee being an extraordinary meeting following the amount of business deferred at the January 2022 meeting in response to the organisational pressures at that time. It was agreed that the Committee was quorate and to proceed with the meeting.

The Committee noted that Mike Wilson was in attendance as an observer in his role as one of the new Public Governors, as part of his general induction into the organisation. The Committee noted that Paul Jones, Company Secretary is currently reviewing the attendance of Governors at Committees.

109. DECLARATIONS OF INTEREST

No conflicts of interest were noted.

110. MINUTES OF THE MEETING HELD MONDAY 17 JANUARY 2022

Ben Maden raised a query on item 94 where it is recorded that he accepted the position regarding Union Staff Side attendance at the People Committee and stated this is not accurate. Ben advised that he is awaiting a written resolution proposal following a meeting with Susy Cook, and wished for the minutes to be amended to reflect that he did not accept the position at that time. The Chair agreed to pick this up and Ben agreed with this.

Ben raised a query on item 100 where recommendations would be brought to the next meeting regarding Richard Sachs' points relating to the People & OD Strategy Group and questioned why this was not on the agenda for today's Committee.

111. MATTERS ARISING AND ACTION LOG

The Committee considered the action sheet and noted the actions taken.

Item 100 – the Chair confirmed that a discussion had been held with Ben Maden regarding the Terms of Reference for the Committee and the membership. A further piece of work will take place overseen by Susy Cook and Colette O'Kane, external expert. Ben outlined that he is awaiting a clear written proposal of what this piece of work will entail and the scope of people involved.

Item 100 – Ben raised that Richard Sachs had outlined concern that the People & OD Strategy Group meeting held on 13 December 2021 was only attended by People & OD, Occupational Health & Union Representation with no Care Group representation. Ray Olive clarified that the POD Strategy Group was scheduled to be held today (21 February 2022), where a discussion on this matter was due to take place to feedback to the People Committee, however because today's People Committee is an extraordinary meeting and has replaced the POD Strategy Group, these discussions have not taken place. The Committee noted that this subject will be discussed at the next POD Strategy Group and feedback will be given to the People Committee following this.

The Chair noted that there are a number of actions in the Action Tracker where the original due date is last calendar year due to the pandemic and there is a need to bring the actions back on track as soon as possible given the pressures on services. The Chair noted that the dates will be reviewed as part of the Cycle of Business to ensure the actions can be delivered over the next cycle of the Committee.

ACTION:

- Chair to pick up regarding the Terms of Reference and membership of the Committee

112. RISK REPORT TO PEOPLE COMMITTEE

Consideration was given to the report presented by Ray Olive.

Ray outlined that due to the national change in rules around Vaccination as a Condition of Employment (VCOD) it was suggested that the risk level be reduced from 20 to 8. Ray highlighted there is a new risk as a consequence of the changes concerning unvaccinated colleagues posing a risk patients and other colleagues. This has been raised as a concern by a number of Clinically Extremely Vulnerable (CEV) colleagues around their wellbeing. As such, there is a proposal to raise a new risk at a score of 12 because if some of the individuals are absent, it would have a significant impact on the organisation's ability to deliver services.

Ray confirmed that discussions have been held with Infection Prevention regarding the rule changes concerning isolation which commence this week, around the impact on CEV colleagues and that the Occupational Health Consultant had concerns, hence the reason for the scoring. Lynne Wyre outlined that the organisation cannot make any changes until the Chief Medical Officer and Chief Nursing Officer provide guidance and highlighted it is likely that there will be some changes to hospitals but they may not be the same as for the public.

Ray confirmed that the BAF risk remains at 16 and outlined that although absence has decreased to 6.9%, there are still areas of concern where mitigations are in place.

Lyn Hadwin proposed that risk number 2862 could be closed as it has been confirmed by the unions that industrial action regarding the pay award will not be taken. A new risk maybe required at a later date pending negotiations around the 2022/23 pay award.

Ray outlined that all the Care Groups have been asked to review their risks due to a number being overdue and an update will be provided in the report to the March Committee. At the request of the Chair, Ray highlighted the measures taken to elevate the risks within the Care Groups which includes contacting the Governance Business Partners and the Associate Director of Operations for each Care Group for discussion at their Monthly Governance Meeting. This works well but there have been delays in updating Ulysses recently due to the pressures faced by the organisation.

At the request of the Chair, Ray confirmed that BAF risk number 2873 has been flat over the last 6 months but it is anticipated with the continued reduction in absence and the increase in recruitment in Hospital Home Care, there will be scope to request a reduced risk score at the March Committee. As matters are improving, the risks will become individual Care Group risks rather than an overall BAF risk.

Ray gave assurance that the actions in place for risk 2413 (Pharmacy) and 2872 (WAC) are undergoing significant work with a view to reducing the scores and highlighted that there had been score fluctuations in line with the third and fourth Covid waves. They are being reviewed on a monthly basis and it is anticipated that the scores will decline in the coming months.

AGREED: The Committee:

- Risk No 2873 (BAF) to remain at 16, due to absence increasing and the requirement to successfully recruit a number of colleagues to the Hospital Home Care and CSW roles.
- Risk No 2949 to be downgraded to a score of 8 due to the Government announcement.
- New Risk to be created with a score of 12 (Possible – 3 x Major – 4) to reflect the impact of non-vaccinated colleagues upon services. To be reviewed at the next Committee.
- Risk No 2862 to be closed.

RISK EXPOSURE/LOCUM CONSULTANTS

Consideration was given to the report presented by David Wilkinson.

David set out how the report highlights the number of locums employed by the organisation, how long they have been in post and the vacancies they are filling. David confirmed that the next exercise is to develop detailed plans around the solutions and report back to the next Committee with more details including the particular risks around the vacancies which are clinical, quality and financial.

David confirmed that a plan is required for each locum and direct conversations have commenced, including working with Clinical Directors. The Chair highlighted that this issue has been raised as a major financial pressure and as such the Board will be interested to see progress.

AGREED: The Committee:

- Accepted the contents of the paper and discussed the approach outlined in the report, acknowledging the challenges

ACTION: Updated report to be presented at the next Committee.

113. VACCINATIONS AS A CONDITION OF EMPLOYMENT (VCOD)

Consideration was given to the report presented by Ray Olive.

Ray confirmed that following instructions from the Secretary of State for Health & Social Care, the organisation has paused all planned activities relating to VCOD pending further details. All colleagues who were potentially going to be affected, have been contacted to advise that the regulations are paused. Ray confirmed that the organisation is working with counterparts across the ICS to ensure consistency.

Ray confirmed that the legislation has not been removed, only paused. As such the organisation must keep the VCOD vaccination status as a mandatory requirement for all new starters in line with this becoming law from 01 April 2022. Recruitment adverts already feature this requirement otherwise the organisation would be open to discrimination cases. Details around the legislation have been circulated via the Trust Communications.

Ray confirmed that the organisation is in the top third of Trusts both locally and nationally in terms of the numbers of unvaccinated colleagues with national uptake being approx. 91%. The organisation's substantive uptake figure of 96% is considerably higher than most Trusts.

AGREED: The Committee:

- Noted the contents of the report
- Is reassured that the organisation is in a good position regardless of how the legislation and the pandemic moves

ACTION:

- Ray to provide a copy of the final version of the letter sent to unvaccinated colleagues, to Ben Maden, Karen Thompson and Union Reps from the Task & Finish Group
- Ben to provide Ray with the names of those unvaccinated colleagues who have not received a letter

114. CQC IMPROVEMENT PLAN

Consideration was given to the report submitted by Stuart Bates.

The Chair outlined that the BAF Actions and Improvements were not joined up with the Improvement Plan from the Recovery Support Programme but was assured to see that work will be carried out to cross-reference and bring them together. It was noted that the report is 80 pages which is too much to be meaningful at the Committee.

The Chair noted the following questions which he will direct to Stuart:

- Clarity on the longevity of the RSP - some of the actions extend beyond the end of October 2022 as continuous support will be required to maintain the momentum
- The deep dive around who will undertake the actions and how they will be structured and how the Committee can support
- How will the stress testing on the actions can be maintained and checking on reliability – who will undertake the stress testing and what will the parameters be?

ACTION: The Committee:

- Chair to raise issues with Stuart Bates to revert to the Committee with clear details
- Ray to discuss with Stuart Bates to clarify the People Committee elements of the report to ensure oversight going forward.

115. CULTURE & LEADERSHIP PROGRAMME UPATE

Consideration was given to the presentation by David Wilkinson.

The Committee noted that the organisation is committed to making lasting, transformational and embedded change with support from the external team including Susy Cook and that additional support and funding has been made available due the Trust being in the Strategic Oversight Framework (SOF4).

David outlined that the Trust wishes to adopt the National Cultural Dashboard created by NHSEI based on all the best evidence and the organisational approach will be shared with the Committee.

AGREED: The Committee:

- Noted that the programme is well co-designed and demonstrates clear plans on recruitment, career development and staff resources
- Recognised that further development is required around the measurement for improvement to be overseen by the Committee

116. MOVING FORWARD FEEDBACK & ACTION PLAN

Consideration was given to the presentation by David Wilkinson.

The Committee noted the contributions made by colleagues on the Moving Forward platform and the co-development of the responses.

Ben Maden wished the Committee to note that the USS did not feel assured by the actions outlined in the presentation but highlighted that it was good to see inclusion and diversity being included. The Committee also noted Ben's comments that the recently agreed Exit Interview Policy and Blended Location Working Policy had not been well publicised and suggested this is increased.

A discussion took place around concerns outlined on the platform about culture and nepotism in HR. The Chair highlighted there is recognition that some improvements are needed across the services. David outlined that the National Staff Survey 2021 results were broadly positive in respect of the People & OD Team but it is recognised that there are some areas where improvements are required and these are reflected in the Action Plan. Matt France pointed out that the Moving Forward platform was very different to the

format of the National Staff Survey, which asked specific questions with a range of answer options.

The Chair noted that the Committee will be reassured when it is understood how the actions it will be implemented and the feedback from colleagues shows a significant level of improvement. Further updates will be provided to the Committee by David.

ACTION:

- Lyn Hadwin and Ben Maden to discuss working in partnership to deliver training across the organisation concerning policies, specifically the Exit Interview Policy and the Blended Location Working Policy, to ensure clear interpretation and to work on the development of FAQ's for colleagues.

AGREED: The Committee

- Noted that action plans with clear delivery and outcomes will be developed by the Cultural Transformation Programme Board
- Noted the positive comments on the Moving Forward platform from a large number of colleagues across the organisation

117. PEOPLE & OD INTEGRATED PERFORMANCE REPORT

Consideration was given to the report and slides presented by Ray Olive.

Vaccination as a Condition of Employment (VCOD) – On 31 January 2022, the Secretary of State for Health & Social Care announced the government's intention to revoke the regulations making vaccination a condition of deployment (VCOD) in all health and social care settings. (This is subject to consultation and Parliamentary process). Work continues to promote vaccination with colleagues and OH support continues to be offered to all affected.

Recruit & Retain – Consultant Recruitment remains a priority for the Trust and the vacancy rate increased slightly to 13.0% (from 10.1%). Reduction in long term locum usage (>6 months) for medical staff with the longest serving now being 24 months instead of the previous longest serving 4.2 years.

Grow & Develop – The average completion rates for all Core Skills Framework courses remains above the 95% target despite a dip in performance during the recent L3 critical incident. Departmental Fire Training continues to be an issue – action required to contact nominated fire officers to ensure all colleagues have training within their department. Appraisal compliance for bands 1-7 is low (no Care Group has met the target of 85%) and has remained static once again. This has been escalated to Care Group triumvirates and will be monitored through monthly performance reviews and People Committee.

Discussion took place around the low level of Appraisal compliance for bands 1-7 which is discussed at the Performance Meetings and has been reported to TMG. The Chair will escalate this to the Board.

Engage & Involve – Moving Forward: Making Changes Together themes from the original consultation and suggested action plan were shared (03.02.22) on the Moving Forward platform. Comments and suggestions have already posted by colleagues. Final date for comments in 11 February 2022. The Friends & Family tests, including recommendation of the Trust as a place to work have shown deterioration since October/November's staff survey.

Health & Wellbeing – Absence remained just over 9% throughout January 2022, up until 28 January 2022 when there was a marginal reduction. As of today (21 February 2022), this figure had been reduced to 6.9%. Workforce Cell is in place to monitor and review; providing support across the Trust to Care Groups. The joint COVID/influenza vaccination programme has seen 63% of colleagues receive their COVID Booster and 58% of colleagues receive their influenza vaccines. Reduced the waiting times for OH physio across the whole Trust to 2 weeks and under, this from a wait time of 9 weeks in October 2021.

Clare Hill reported that a rapid review has taken place for psychological support and MSK and triage and access for both is now in place with self-referrals and management referrals being triaged and assessed within 14 days. David outlined that sadly the organisation has lost 3 colleagues to suicide in the last 12 months which has prompted a review around supporting colleagues and raising management awareness. Clare outlined the actions which have taken place around this: (a) 8 clinicians are attending STORM training (self-harm mitigation training), (b) established a direct route into the Crisis Team, (c) whole OH team will complete Every Life Matters e-learning, (d) EMDR training has been introduced for Trauma Cases, (e) work continues with the ICS Trauma Network, (f) continuing with face to face engagement with wards and departments.

Discussion took place around the support for colleagues of the staff who have been lost to suicide due to the trauma and grief this brings. The OH team support all affected colleagues including TRIM Practitioners. Across the BHCP, dedicated work is taking place around suicide including sharing information, resources and practices across all partners, including BAE systems, Lancashire County Council, fire and police. The Committee was assured that the organisation is acting accordingly and acknowledged that there is a need to promote the support available.

ACTION:

- Chair to escalate the low level of Appraisal compliance for bands 1-7 to the Board
- Include the increased level of OH support in the 3A's report to the Board, given the concerns around the Trust losing 3 colleagues to suicide

118. NHS STAFF SURVEY 2021 - FEEDBACK

Consideration was given to the report presented by Matt France.

Matt confirmed that the overall results mask areas where there are potential issues and that the Trust is average in comparison to peer organisations. It was noted that the Care Groups received an individual highlight report outlining results of their top 5 best/worst questions and their 5 best/worst departments and their report on relationships.

The Committee noted the contents of the report and was assured that action will be taken to understand and support the areas who are outliers in terms of the results with focus on positive learning and improvement work.

ACTION:

- Matt to share the slides with the Committee and noted that they are not for wider sharing

119. EMPLOYEE RELATIONS

Consideration was given to the report presented by Lyn Hadwin.

The Committee noted the reduction in month of formal and facilitated conversations and it remains to be seen if this is due to the work taking place around the Just & Learning Programme. The Committee noted that the number of MHPS cases has reduced to one and this may have a significant impact on culture in a number of departments.

Ben Maden raised that he had been informed that the number of grievances had been reduced for confidentiality reasons and therefore the figure listed in the report was incorrect. Discussion took place and the Chair requested that Lyn and Ben discuss outside of this meeting to review how the information is recorded and reported going forward.

The Committee noted that hot-spot areas continue to progress and where there is formal action underway this is closely overseen by the Director and Deputy Director of People & OD to ensure that cases are progressing as timely as possible.

ACTION:

- Lyn & Ben to discuss information recording of grievance cases

120. PEOPLE & OD STRATEGY GROUP

Meeting was not held in January 2022 so no 3As report presented.

121. CULTURAL TRANSFORMATION PROGRAMME BOARD

3As key issues report and minutes received and noted.

122. JOINT LOCAL NEGOCIATING COMMITTEE (JLNC)

Meeting was not held in January 2022. Minutes and 3As in relation to meeting in November 2021 received and noted.

123. PARTNERSHIP NEGOTIATING CONSULTATIVE COMMITTEE

Minutes of meeting held on 14 January 2022 received and noted.

124. INCLUSION AND DIVERSITY STEERING GROUP

3As key issues report received and noted.

125. CYCLE OF BUSINESS

Cycle of Business was noted.

126. ATTENDANCE MONITORING REGISTER

The Committee noted that the meeting was well attended with core members of the Committee.

ACTION:

- The Chair to discuss with Richard Sachs concerning the attendance of his team to ensure a good level of support going forward.

127. ANY OTHER BUSINESS

- **3A'S REPORT** – The Chair to discuss with Caroline Chubb.

AGREED: The Committee agreed that the level of Assurance at today's Committee was Moderate.

DATE AND TIME OF NEXT MEETING:

People Committee Meeting
Monday 21 March 2022, 09:30–11.30 via M/S Teams

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Minutes of the Quality Assurance Committee Meeting held on Monday 21st February 2022

Present:	Jill Stannard (JS) Bridget Lees (BL) Jane McNicholas (JM) Richard Sachs (RS)	Chair & Non-Executive Director Executive Chief Nurse Interim Medical Director Director of Governance
In attendance:	Stuart Bates (SB) Diane Smith (DS) Claire Alexander (CA) Mike Bone (MB) Jane Jones (JJ) Ameeta Joshi (AJ) Kate Maynard (KM) Emma Fitton (EF) Emily Henry (EH) Lorna Pritt (LP) Andrew Higham (AH) Mark Lippett (LP) Alison Mayor (AM) Linda Womack (LW)	Deputy Director of Clinical Governance Associate Director of Operations Associate Director of Operations CCG Layperson Lead Nurse Quality & Head of Safeguarding, CCG Associate Medical Director Chief Operating Officer Associate Chief Nurse Deputy Associate Director of Nursing for Medicine Associate Chief Nurse Consultant Physician, Medicine Head of Safeguarding Matron, Maternity Inpatients ADOP, WACS

22/218	**Welcome and Introductions** Jill Stannard opened the meeting at 13.00 and performed welcome and introductions. **Apologies for Absence** Apologies were noted from Janet Pitman, Lorraine Crossley-Close and Hugh Reeve. **Declarations of Conflicts of Interest** None.
22/219	**Minutes of the Quality Assurance Committee Meeting held on 17.01.2022** The minutes of the January meeting were accepted as a true and accurate reflection. **Decision:** 1. That the Minutes of the meetings held on 17.01.2022 be adopted.
22/220	**Action Sheet and Matters Arising from the Minutes of the Quality Assurance Committee on 17.01.2022** The Committee reviewed the action tracker and noted the updates. JMc provided a verbal update on action 21/147 GIRFT, explaining that work continued to look at the best ways to include GIRFT into clinical effectiveness but a conclusion had not yet been reached. JMc would continue to progress and assured that the work would report through the RSP and had been discussed regionally. JS confirmed assurance and the item would be closed on the tracker. **Decision:**

	1. The QAC considered the action sheet and noted the actions taken. 2. Item 21/147 was completed and closed.
22/221	**Integrated Performance Report Dashboard** The Committee considered an update on the IPR dashboard, which was presented by Richard Sachs. The report provided an update and assurance on issues related to the Quality and Safety IPR. The following points were made in discussion: - A new format for the IPR had been designed and would be in use for the start of the new financial year - Attention was drawn to page 24 and the graphs which showed data related to patient safety incidents. The significant rise towards the end of the calendar year was highlighted and the increase was attributed to Omicron - RS reflected that not all the improvements to the report discussed in the January meeting and noted on the action tracker had been completed and that they would now be finalised BL provided a further update as follows: - Assurance was offered around the time to notify StEIS incidents; BL explained that a more robust process was being implemented to ensure the right things were reported at the right time - Deep dives were being undertaken by the Care Groups and, based on these, targets could now be set - Comparative data from other Trust's was requested for the Friends & Family updates as initial findings suggested that UHMBT was performing well in comparison to peer Trust's JMc updated that, in relation to Breast Cancer, the teams continued to work through the required actions both nationally and within the Trust. During deliberation of the item the following points were considered: - JS (NED) queried the patient safety data and asked for a more detailed explanation which RS would provide in the next report, this should include themes related to slips, trips and falls and links to length of stay. BL noted that SI's had decreased and an increase had been seen in moderate and above incidents which included pressure ulcers, falls and IPC. Issues related to operating above capacity and staffing levels were discussed. BL confirmed that covid numbers had decreased along with the number of outbreaks but that further work was still required in terms of reporting PU & falls; assurance was offered to the Chair that BL viewed all incidents that were reported and additionally sat on the Serious Incident Panel - JJ welcomed information related to validation of harms from falls along with the actions being taken to mitigate - JS (NED) discussed the de-conditioning of patients whilst waiting for discharge into a suitable community setting. JS highlighted that the CQC had raised similar concerns and she would highlight this to the Board through the 3A report for a multi-agency response. BL advised that a staffing review was currently being undertaken and that this would help to identify what care was needed to serve the local community including alternative roles which would be focused on the prevention of de-

	conditioning. - AJ questioned a change of wording in the Friends and Family update and asked for clarification of the word citizens. SB/RS would look into this and update at the next meeting. Decision: 1. The Committee received and were assured by the report. 2. The Committee approved the report for submission to the Board of Directors.
22/222	**Trust Regulatory Update** The Committee considered the update which was provided by Richard Sachs. The report provided an update on the current position, the progress of cross cutting themes of the CQC along with Must and Should Do actions. The following points were made in discussion: - The report was presented for the second month in the new format which now included cross cutting CQC must and should do actions along with Niche and RCS recommendations - The report was confirmed to also be submitted to the Trust Board and then the System Improvement Board following approval at QAC - Work continued to populate AmaT with evidence to allow tolerance testing - Proposed dates for deep dives in identified cross cutting themes had been found - There were a number of recommendations in progress that were beyond their original agreed completion date. These actions would be chased to ensure they did not go unnecessarily overdue. The gearing of completion dates around the end of the financial year was discussed. During deliberation of the item the following points were considered: - JS (NED) discussed a recent NED meeting with the Chair of the Trust where information related to cross cutting themes had been requested. This information would stay with the QAC to prevent further work so JS noted that any additional information on this would be welcomed, including updates on deep dives, and this would in turn be alerted to the Board via the 3A report - BL discussed sustainability and how the deep dives would ensure that the correct processes were in place to allow work to be integrated into business as usual - AJ asked for further information on the SRO with RS advising that this hadn't yet been finalised but that he would confirm as soon as possible - CA discussed Niche and matrix working to ensure there was not unnecessary duplication of work. It was confirmed that a series of events was planned over the coming two weeks and elements would be shared with the wider triumvirates to ensure clarity around measuring against exit criteria and long term sustainability **Trauma & Orthopaedic Task & Finish Group 3A Report** The report was accepted by the Committee. - JS (NED) asked for further information around the Alert on inconsistencies in use of Trust policies. JMC explained this was around Trust policies not being well known around autonomous practise for non-consultants. Orthopaedics had picked the issue up and were working hard to address it - JJ discussed the wider findings of the RCS report and felt that aspects, for example, quality of MDT's, could be included in the assurance section going forwards

	Decision: 1. The Committee received and were assured by the report.
22/223	**Trusts CQC Stroke Progress Plan Update** The Committee considered an update on the CQC stroke plan which was provided by Diane Smith. The report updated progress made in the improvements against a range of SSNAP standards. The report was accepted as read. The following points were made in discussion: - 10 submissions had now been made - Two main areas of focus remained which were Time to Scan and Time to Ward. The Trust were confirmed to be meeting the national target of 50% for time to scan but had seen high variance in achieving this. Similar variabilities were confirmed in achieving time to wards with delays being attributed to increased attendances at ED's and high bed acuity and both impacting on the Trust's ability to get stroke patients into stroke beds in a timely manner. It was also highlighted that patients not meeting the criteria to reside was also impacting on stroke patients - The weekly Task & Finish group continued to meet - The FGH therapy area was due to open at the end of February with a business case for one at the RLI due at the Finance Committee in March with a tentative April start date for work to commence - There had been some recent recruitment - SNNAP comparison date was discussed with quarter 2 showing RLI as D and FGH as a B with Preston at D, Chorley at C, East Lancs at A and Blackpool at B. Quarter 3 data was expected in March - Overall an improving trend was being seen but there were areas of variance that still needed further work During deliberation of the item the following points were considered: - JS (NED) noted the good progress but confirmed concern related to the impact of delayed discharges. As with item 222, the issue would be highlighted to the Board via the 3A report **Decision:** 1. The Committee received and noted progress detailed within the report. 2. The Committee were concerned about the effect of delayed discharges on stroke patients and JS would highlight them to the Board via the 3A report
22/224	**Deep Dive by Medicine Care Group** The Committee considered the update which was presented by Diane Smith and Emily Henry. It was noted that the medicine care group trialled the new deep dive template. The template was shared with a number of areas highlighted. The following points were made in discussion: - 12 hour trolley waits had increased and a review of the 12 hour breach process would be undertaken - An error in the Insight information on SNNAP was highlighted with the actual rating a D not E - An error in the Insight information on RTT was highlighted with the actual rate at 50%

	not 25% - SDEC and FIT had both been implemented in February - Ward moves for further improvements had been undertaken with more planned for April - Development of the Hyper Acute Stroke Bay at FGH had been undertaken - The respiratory wards had been moved to an area with a higher footprint over winter to allow for increased admissions due to Covid - Huge improvements in the Lancaster Suite were highlighted with the ward manager praised for making a big difference, embedding good leadership - Well Being Ambassadors had been trained and were working with 25 individual members of staff in learning sets or one to one coaching. Close links with Occupational Health were noted and learning was being triangulated for sharing wider across the Trust - Corridor care was noted to still be an issue; a weekly meeting to ensure safe corridors along with an increase in nursing and a cap of 8 patients only had been implemented to help mitigate. A No Corridor workstream had been set up to look at a whole system approach - Nosocomial infections had/continued to be an issue. This was attributed in part to the multiple patient movements that had been required along with staff absence. The care group were working closely with IPC and carried out weekly IP audits and peer reviews. IP colleagues were considering an IP audit to check for adherence - There had been a reduction in core skills compliance but it was now improving and practise educators had been assigned to specific wards - Open incidents remained high. Good reporting was celebrated but work was ongoing to close where possible with the right actions in place and feedback provided - Some issues around tissue viability were highlighted with a possible over reporting of PU's; the group continued to work closely with corporate colleagues to understand and address - Staff absences had been high; fortnightly check and challenge was in place and the team worked with the wellbeing ambassadors to help get staff back into work with reasonable adjustments and re-deployment - Multiple staff moves – Matrons carried out a morning call daily to ensure a fair spread of staff - The group continued to aim for no mixed sex breaches - Work continued on ward rounds to reduce patients who did not meet the criteria to reside - Support was being provided to international recruits During deliberation of the item the following points were considered: JS (NED) thanked the care group for a very informative and positive update. The use of the new template was noted. Decision: 1. The Committee received and were assured by the report.
22/225	**Quarterly Mortality Report** The Committee considered the deferred update on Mortality which was presented by Jane McNicholas. The report provided information of the Trust's mortality data for July – September 2021 along with ongoing actions for Learning for Deaths.

	The following points were made in discussion: - JMc offered thanks to Robin Proctor and team for the report improvement - Care Group representation at the monthly Mortality Steering Group was problematic - Work to improve coding was continuing with issues being worked through - Red alerts for mortality related to fractured neck of femur, pneumonia and obstetrics were highlighted and a task and finish group had been put in place; differences across the sites were being reviewed. Analysis had indicated that there could be data issues with obstetrics and work would be undertaken to understand the issues related to pneumonia - An NHSEI data dashboard was discussed and would be updated weekly for wider sharing and identification of focus areas and improvements required During deliberation of the item the following points were considered: The alert pertaining to care group attendance was queried by the Chair with JMc acknowledging that attendance was not at the right level but that work was being undertaken and the risk did not need to be flagged to the Trust Board. Decision: 1. The Committee received and were assured by the report.
22/226	**IPCC Report** The Committee considered the IPCC report which was presented by Bridget Lees. The report provided an update in IPCC issues across the Trust. The following points were made in discussion: - An external peer review had been carried out in September with a follow up planned in March. The results of this would be brought to the Committee - Improvements were noted in the report but could also be seen in other reports coming to the Committee - Investment in the IP team and domestic services had been finalised and signed off - Covid and C-Diff infections were detailed within the report and it was highlighted that a reduction in them was starting to be seen. Isolation was noted to be difficult and work was ongoing with the national team to look at different ways of working During deliberation of the item the following points were considered: The high number of hospital acquired infections, PU's and falls was highlighted by the Chair as concerning and it was acknowledged pressures related to NMC2R, high covid numbers and staffing issues had all contributed. JS noted the reduction now being seen and the assurance this offered that the situation was improving. Decision: 1. The Committee received and were assured by the report. 2. Concerns related to higher than usual numbers of falls, pressure ulcers and hospital acquired infections would be raised to the Board via the 3A report.
22/227	**Confidential Assurance Report following SIQSG surveillance into Safeguarding Incidents in Care of the Elderly** The Committee considered the SIQSG update which was presented by Mark Lippett and Emma Fitton. The report provided an update on the SIQSG related to the alleged physical and sexual

	assault of nine patients in the Trust's care within older people services. The following points were made in discussion: - The background to the Section 42 was briefly recapped - It was confirmed that the cluster of incidents had been reported to the Local Authority and Police - The possible outcomes for the S42 were detailed - It was confirmed that all patients had been discharged with ongoing support for themselves and their families where required - BL detailed some of the immediate actions that were put in place which had included the chaperone policy along with 24 hour security. It was ensured that all staff were made aware of the policy and that it was is use across all the elderly wards - Sustainability of the work was highlighted with key learning around communication, audits, documentation, and appropriate escalation were discussed - Ongoing audits had been planned for summer along with any required additional actions During deliberation of the item the following points were considered: JJ confirmed the CCG had reviewed the full action plan including issues that were wider than just safeguarding; the plan had been reported through to NHSE/I by Jackie Bird. NHSE/I Improvement Director and had been signed off. JJ confirmed that a number of actions were still ongoing and ongoing audits would be required but that she was satisfied that each 'had a home'. JS (NED) voiced assurance that the required actions were in place and that she felt the item could be closed from the Committee but asked that an update be brought to the Committee in six months to ensure that actions had become embedded in business as usual work. Decision: 1. The report received and were assured by the report. 2. A follow up report was requested in six months' time for assurance of embedment of actions
22/228	**Monthly Maternity and Neonatal Surveillance Update** The Committee considered the monthly update which was presented by Linda Womack. The report would be submitted to the Board of Directors meeting on Wednesday 23rd February. The following points were made in discussion: - CNST had been suspended for three months - A review against Ockenden had been requested and the team would have this ready for submission by the deadline of close of play on Monday 28th February 2022 - Service User engagement had been received and consideration was being given on how this should be included in the vision and strategy of the service - The results of the 2021 CQC Service User Report had been received which showed the service was a positive outlier for the experience of service users; consideration was being given on how to use the findings to influence future vision and strategy of the service - Ongoing issues with staffing was discussed

	- The first cohort of Apprentice Midwives was confirmed to be starting in 2022 with recruitment being underway - Concerns around the homebirth boxes were discussed. It was informed that Baby Lifeline could supply a homebirth bag which would be easier to transport and had a standard layout, which would help in locating equipment in an emergency. The request to purchase these was being considered **Gynaecology FFT Review** The report provided the requested update on poor F& S results for ward 16 at RLI. The following points were made in discussion: - The findings had been reviewed and cross refenced with PALS and complaints and this had identified the positive feedback over the period September 2021 to January 2022 at 86.6% - The limited feedback currently available meant individual patients could not be identified but there had been regular discussions with staff on the ward about the feedback provided and the Care Group would continue to work with the business analysist and clinical service manager to triangulate the data - It was recognised that there were a significant number of outliers in general on ward 16 During deliberation of the item the following points were considered: JS (NED) confirmed that the update had fulfilled the ask of the Committee and that the action could now be closed but asked if any further issues were to be seen then this be flagged to the Committees attention. LW and BL discussed the new posts in the care group including the Director of Midwifery and Head of Midwifery, both of whom were due to start in their new posts imminently. **MSSP Update** The report provided an update on MSSP work and actions underway. The following points were made in discussion: - The diagnostic report had been completed on the 5th of November, identifying 6 main areas of concern - Leadership issues were noted to be one of the top 3 risks and in response the structure had been reviewed and updated. A Director of Midwifery had been appointed and would be in post imminently and a Head of Midwifery had also been successfully recruited to - Options for a Consultant Midwife were being considered and the JD was going through the banding process - Governance, another top 3 risk, had been addressed with a review of the governance processes undertaken - A single action tracker had been developed - The service had undertaken the NHSE/I Improvement Self-Assessment. Further work was required - Maternity Vision and Strategy was the final of the 3 top risks; a workshop had been held to review and discuss the needs of the women, their families and staff - Further work would be undertaken in February 2022 - Maternity attended the Board of Directors monthly to ensure that maternity information was highlighted

	Decision: 1. The Committee received and were assured by the update provided. 2. The action was confirmed to be closed.
22/229	**Testicular Implant Recall Update** The Committee considered the update report which was presented by Claire Alexander. The following points were made in discussion: - An update paper had been written and would be disseminated with the minutes - Appointments had been offered to 27 of the 36 patients identified. The remaining 9 were offered appointment on Sunday 20th February, the offer had been followed up with a telephone call but four had failed to arrive; this had been the second appointment the 4 patients had been offered and a letter would now be sent to them acknowledging that they had chosen not to participate in the process but that were welcome to contact the Trust as at any if wished - The 4 patients seen underwent ultrasound and had positive outcomes, with no needle guards in situ. - All 36 patients identified had received an appointment offer, of those who had attended all had undergone full diagnosis. Two patients had required further investigation and had been placed on two week wait lists - A closure report would be brought back to the Committee which would details lessons learned and assurance of embedment into ongoing practise During deliberation of the item the following points were considered: JS (NED) thanked CA for the update and requested that the follow up/closure paper included evidence of sustainability and auditing to assurance of best practise. Decision: 1. The Committee received and were assured by the update provided. 2. A final closure report was requested which should demonstrate assurance of embedment into ongoing practise. CA to confirm timings.
22/230	**NEIAA Update** The Committee considered the update which was presented by Jane McNicholas. The following points were made in discussion: - The Trust was not yet fully consistently able to comply with all the standards but improvements had been seen in the key measures and the Trust was beginning to be more in line with national averages - Recruitment had been an issue but an external locum had gone into post at FGH since the last update. Recruitment for a substantive colleague had continued without success During deliberation of the item the following points were considered: JS (NED) noted the Trust's compliance against peer Trust's , noting that they too had not achieved, and highlighted that it felt perhaps this was a regional issue. The good data and planning evidenced in the report was recognised as having provided some assurance but it was felt that further was still required and another update in six months was requested. Decision: 1. The Committee received the update which provided some assurance 2. A further update was requested in six months' time

	3. The continued lack of full compliance with the standards would be raised to the Board via the 3A report.
22/231	**Never Event Theatre Update** The Committee considered the update which was presented by Carol Park. The following points were made in discussion: - The service was currently over established with a full summary within the report - Utilisation time was above the national average - Bespoke training had been put in place across all areas - The Theatre productivity and Governance group had been reinstated - The Stop Moment was explained and took place before the implant was handed to the surgeon - The area Locsip had been updated - 12 patient complaints referred to theatre at FGH but it was confirmed that none were as a direct impact of theatres themselves - A theatre compliance dashboard has been incorporated in to the update - Department managers were aware of and managing BLS compliance - Civility and Behaviours work had commenced - Governance were launching excellence reporting to capture and report what went well and to provide a needed morale boost to the theatre teams - A 'Secret Shopper' approach had been implanted to ensure the WHO checklist was being adhered to During deliberation of the item the following points were considered: It was queried by JS (NED) when the human factors training would be picked up with CP confirming this had not been progressed due to winter pressures but would now be picked up and moved forwards. JS (NED) discussed how assurance would be provided and asked that a follow up report be brought back to Committee in six months. Decision: 1. The Committee received and were assured by the report. 2. A follow up report was requested in six month. 3. A lack of human factor training would be raised to the Board via the 3A report.
22/232	**Serious Incident Report** The Committee received and noted the update. **Decision:** 1. That the report be noted.
22/233	**Quality Assurance Cycle of Business** Noted
22/234	**Attendance Monitoring Register** Noted.
22/235	**Any Other Business** n/a
22/236	**3A Report for Board** JS would draft outside of the meeting and share with BL and RS before submission to the Board.

	RS suggested that the Committee advise the Board that they were provisionally encouraged by the use of the new care group template that the Medicine Care Group had trialled at the meeting.
22/237	**Date, Time, and Venue of Next Meeting** It was noted that the next meeting of the Quality Assurance Committee would be held on 21st March 2022, 13.00 – 15.00 via Teams.

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Minutes of the Finance Committee held on Monday 21 February 2022 via Microsoft Teams

Present:	Steve Ward Bruce Jassi Liz Sedgley Chris Adcock Kate Maynard Bridget Lees	Non-Executive Director (Chair) Non-Executive Director Non-Executive Director Director of Finance Chief Operating Officer Executive Chief Nurse
In attendance:	Richard Sachs Tim Povall Janet Higgs Ian Lacey Suzanne Hargreaves Sarah Nicholls Paul Cain-Renshaw Daniel Bakey Nicola Crossman	Director of Governance Operational Director of Finance Deputy Director of Finance Head of Financial Management Associate Director of Strategy and Transformation Finance Manager Consultant (Item 170) Theatre Transformation Lead (Item 175) Minutes
Observer:		

21/163	**Welcome and Introductions** The Chair welcomed everyone to the meeting. **Apologies for Absence** Apologies were noted from Arthur Jones, Rhiannon Tinson and Jim Collins. **Declarations of Conflicts of Interest** None.
21/164	**Minutes of the Finance Committee held on 24 January 2022** **Decision:** The Minutes of the meeting held on 24 January 2022 be agreed as an accurate record.
21/165	**Action Sheet and Matters Arising from the Finance Committee held on 24 January 2022** **Action:** Follow up with the Company Secretary's office to confirm a date present the Financial Improvement Strategy to the Council of Governors, taking into consideration the Board Workshop on Financial Strategy in March. **Lead: NC** **Decision:** The Committee noted the progress against the actions.
21/166	**Director of Finance Report** CA provided an overview of the Director of Finance report included in the pack. The key points brought to the attention of the Committee included:

	• Significant movement in financial position between Month 9 and Month 10, largely due to:
	  o The uncertainty of the forecast produced at the end of December relating to Omicron and period of Level 4 escalation.
	  o Spent less than anticipated on elective recovery and winter pressure surges.
	  o Pushing hard on CIPS and savings delivery targets across the organisation.
	  o Additional income arriving in the system that wasn't anticipated.
	• Still expecting to work with the system to ensure an overall breakeven position but cautious in interpreting forecast recognising work still to do.
	• Further information provided in the Month 10 report on the agenda.
	
	The following points were raised in consideration of the report:
	
	1. SW queried the report that the Trust had spent less than expected but still achieved the targeted activity levels. CA advised that the complexity of the operation of the elective recovery fund at a system level meant that recovery of income is dependent on system performance not specifically that of an individual Trust. Income in the report was at the level notified by the ICS. JH advised that at an ICS level, sufficient income had been generated in Q3 22/23 to cover M10 income assumptions as well despite January activity levels being low. SW advised that he would highlight this within his 3As report to the Board.
	
	2. In reference to paragraph 4b. of the report, LS sought reassurance regarding unknown sources of income and any potential conditions attached.
	
	CA clarified that the comment was specific to income received from Health Education England (HEE) and IL confirmed follow-up with HEE gave confidence that the £500k was not repayable and therefore included in the position and forecast.
	
	3. In reference to paragraph 5d. of the report, BJ requested clarification on what would happen once the CCG is devolved.
	
	It was noted that initially there remained a requirement for MBCCG to fulfil commissioning responsibilities from April – July 2022 and the draft letter was the start of that process. Subsequent guidance from the ICS to simplify contractual arrangements for the coming financial year were expected to supersede this. Once the details of the ICS guidance had been determined, it would be reported back to the Committee.
	
	Decision: The Committee noted the content of the Director of Finance report.

21/167	**22/23 Operational Plan Update** SH provided an update on the development of the 22/23 operational plan, noting the complex guidance being continually received and considered with colleagues across the ICS. Key points raised for the attention of the Committee were:

	• ICS commissioned KPMG to support the assessment of plans at an ICS level but are meeting with providers individually. • ICS financial principles detailed in the paper. • National delivery plan to tackle elective care backlog providing further clarity on guidance. • Integration white paper was released on 9 February 2022 and it was important to understand what that means going forward. The need for an extraordinary Finance and Performance Committee in March was signalled at the last meeting, however, there was a proposal to allocate additional time at the Committee on 28 March 2022 to consider the plans in detail following the first ICS submission on 16 March before final submission at the end of April. The Committee agreed the proposal of a formal review of the plans in detail on 28 March, accepting that the draft submission on 4 March will be subject to further change and noting the risk management framework with executive oversight in place. However, it was agreed that 3As style update of the position would be shared with the Committee in the interim. **Action:** SH to share 3As style update of the position with the Committee. **Decision:** The Committee noted the content of the report and agreed the proposal of a formal review and approval of plans in detail on 28 March 2022.
21/168	**Revision of the Capital Programme Policy** TP outlined the refresh of the Capital Programme Policy linking into procurement, SFIs and accounting policy, aligning with current practice and the Investment Priority Group terms of reference. The refresh aims to enhance governance processes for the management of the capital programme. A fundamental part of programme is how to prioritise resources available and provide flexibility in the Capital Programme. It was noted that the proposed scoring matrix had been considered by the Trust Management Group. The following points were raised in consideration of the report: 1. The benefits of the policy were noted in the event of unexpected or short-term capital being made available. 2. In terms of the capital policy strategic framework, BJ suggested the process should recognise the role of the ICS in determining the capital plan in the future as well as revenue programmes. It was confirmed that the Trust were in consultation with other ICS DoFs and priorities for capital spend align with the top priorities for health & safety risk, CQC must dos and regulatory changes, etc. Work to prioritise schemes submitted for 2022/23 was in progress across the ICS against available capital resources as it was noted this was currently oversubscribed. 3. TP provided further clarity on how scores were assigned to the major programme prioritisation process. It was noted that there was a benefit to showing more of an objective link between capital investment and priorities

	and it was hoped this approach would become consistent across the ICS. 4. LS queried the deadline to balance capital spend allocations across the ICS. TP confirmed UHMBT schemes were prioritised in readiness for when new funding opportunities arise and also confirmed links with the ICS priority matrix. **Decision:** The Committee noted and approved the Capital Programme Policy.
21/169	**2022/23 Capital Programme** KM outlined the draft capital plan development for next year, which was included in the pack for information, and confirmed the final version of the capital programme would be presented to the Committee next month. **Decision:** The Committee noted the content and recommendations of the report.
21/170	**Financial Recovery Plan Update** CA introduced Paul Cain-Renshaw, an external consultant who has been working with the Trust to develop the Sustainable Financial Improvement Programme and is central to ensuring the analysis and output of the work presented becomes embedded into the planning process and a central component of the refreshed performance and accountability framework. The presentation included in the pack provided a detailed update from the January Committee resulting from further work to refine and validate the first draft of information. Further refinement would be required on receipt of the final 22/23 allocations and to provide clarity around the underlying financial deficit prior to presenting the final draft as the Trust's financial strategy and improvement trajectories at the Board workshop on 30 March 2022. In consideration of this item the following points were raised: 1. SW commented that making the most effective use of clinical resources is key and has been on the Trust's agenda for several years. He therefore sought further clarity on how this would be achieved. CA noted that this would be part of the challenge of operating in a flat cash environment and would go into further detail as he progressed through the presentation about how to build granularity of where effectiveness and productivity would be gained. 2. LS requested further information on the role and responsibilities of the proposed Clinical Director of Finance. In a clinically led organisation, this role is central to provide a more representative leadership structure and approach with direct clinical leadership into the Finance agenda, helping the Finance function to understand messaging and assisting with the coordination of narrative and leadership into clinical teams, particularly in quality and safety indicators. It

	would also play a leading role in investment decision making processes and in a wider financial advisory panel. 3. BJ requested clarity on the underlying deficit figure. It was noted that the underlying deficit was £75m 4. BJ queried the priority in tackling drivers of the underlying deficit. CA confirmed that the focus would be on the drivers of the deficit detailed on the chart on page 91 of the pack. There would be defined plans and financial statements for each driver to enable clear articulation of what benefit should be delivered. 5. From a clinical perspective, BL confirmed support for the clinical leadership approach. In addition, commented that where money is spent must be aligned to strategic objectives and focused business planning. It's important to ensure the Trust improves from a quality and safety perspective alongside financial sustainability and the clinically led design would be key to ensuring financial decisions are made without detriment. 6. BJ noted that as well as corporate service efficiencies, equal focus would be required in terms of value for money and productivity in clinical services. 7. Aim to develop a timetable in the first half of the next financial year to ensure each service has a clear understanding of their financial forecast and position over the next 3-5 years, what the drivers and issues are and plans for delivery. **Decision:** The Committee noted the content of the paper
21/171	**IPR Update** It was noted that this presentation would be considered in detail by the Trust Board on 23 February 2022. **Decision:** The Committee noted the content of the paper
21/172	**Month 10 Financial Performance Report** **Decision:** The Committee noted the content of the financial performance report which was accepted as read.
21/173	**Month 10 Operational Performance Report** KM drew the Committee's attention to cancer 2 week wait performance for breast care in December. Performance had fallen to 3.6% following breast awareness month in October, coupled with a shortfall in capacity due to sickness absence in November. It was noted that additional agency staff had been secured and robust workforce plan was being developed. **Decision:** The Committee noted the remainder of the operational performance report which was accepted as read.

21/174	**Investment & Priorities Group 3As Report** **Decision:** The Committee noted the Investment and Priorities report.
21/175	**Theatres Business Case** DB presented the drivers, options, plans, risk analysis and recommendations of the capital business case for a WGH Theatres Elective Green Hub. It was noted that the business case had been subject to consideration by the Trust Management Group and Quality Impact Assessments had been done with no issues escalated to the Committee. The Chair requested that dates of these assessments be added to the cover sheet. **Decision:** The Committee confirmed support for the business case and approved progression to the next stage of the process.
21/176	**New Hospitals Programme** **Decision:** The Committee noted the New Hospitals Programme report.
21/177	**Attendance Monitoring Register** In recognition of Bruce Jassi's final meeting, following 7 years' service as Non-Executive Director, the Chair commended his long and valued contribution to the Finance and Performance Committee and on behalf of the members, wished him well for the future. **Decision:** The Committee noted the Attendance Monitoring Register.
21/178	**3As Report and Meeting Effectiveness**
21/179	**Any Urgent Business** None.
	Date, Time and Venue of Next Meeting It was noted that the next meeting of the Finance Committee would be held on Monday, 28 March 2022 at 10:00 via Microsoft Teams.

University Hospitals of Morecambe Bay
NHS Foundation Trust

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Scope: Board of Directors Governors All staff	**Classification:** Organisational
Author / Title: Company Secretary	**Responsibility:** Chief Executive as Accountable Officer for the Trust
Replaces: Scheme of Reservation and Delegation of Powers	**Head of Department:** Company Secretary
Validated By: Audit Committee and Finance Committee	**Date:**
Ratified By: Board of Directors	**Date:**
Review dates may alter if any significant changes are made	**Review Date:** July 2023

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** All	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** All

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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

Introduce yourself with #hello my name is. . .	Value the contribution of everyone	Share learning with others
Be friendly and welcoming	Team working across all areas	Recognise diversity and celebrate this
Respect shown to everyone	Seek out and act on feedback	Ensure all our actions contribute to safe care and a safe working environment
Put patients at the centre of all we do	Be open and honest	For those who supervise / manage teams: ensure consistency and fairness in your approach
Show support to both staff and patients	Communicate effectively: listen to others and seek clarity when needed	Be proud of the role you do and how this contributes to patient care

INTERPRETATION AND DEFINITIONS FOR STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF RESERVATION AND DELEGATION OF POWERS

a) Unless otherwise stated, words or expressions contained in this Scheme of Reservation and Delegation of Powers shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

b) Further details on the definitions of terms used may be found in both the Standing Financial Instructions and the Scheme of Reservation and Delegation of Powers may be found at page 6 of the Trust's *Standing Financial Instructions*.

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1. SUMMARY

This Scheme details which powers have been retained solely for use by the Board of Directors and which have been delegated to Board Committees or officers of the Trust. The Scheme also describes the powers and duties of the Council of Governors.

1.1 Background

1.1.1 This Scheme of Reservation and Delegation of Powers details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the University Hospitals of Morecambe Bay NHS Foundation Trust (referred to as the "Trust"). They should be used in conjunction with the Constitution and the Standing Financial Instructions which have been adopted by the Trust. The Trust's Constitution and the Foundation Trust Code of Governance from NHS Improvement requires such a formal document recording the exercise of delegated powers.

1.1.2 The Trust is a Public Benefit Corporation following approval by the Independent Regulator of NHS Foundation Trusts Monitor now known as NHS Improvement pursuant to the National Health Service Act 2006 (the "2006 Act"). The Trust is governed by the 2006 Act, as amended by the Health and Social Care Act 2012 (and subsequent statute) its Constitution and the NHS Provider Licence granted by NHS improvement. The functions of the Trust are conferred by the Regulatory Framework and the Trust is required to comply with the guidance issued by NHS Improvement. This Scheme of Reservation and Delegation of Powers and their content and approval are the sole responsibility of the Board of Directors and are not required to be submitted for approval to any group or organisation including NHS Improvement or the Council of Governors.

1.2 Role of the Chief Executive

1.2.1 All powers of the Trust which have not been retained as reserved by the Board of Directors, Council of Governors or delegated to a committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive has prepared this *Scheme of Reservation and Delegation of Powers* identifying which functions shall be performed personally and which functions have been delegated for operational responsibility to other Executive Directors and officers.

1.2.2 All powers delegated by the Chief Executive can be re-assumed by them should the need arise. As Accountable Officer the Chief Executive is accountable to the Department of Health and Social Care for the funds devolved to the Trust (NHS Foundation Trust Accounting Officer Memorandum).

1.3 Caution over the Use of Delegated Powers

1.3.1 Powers are delegated to directors and officers on the understanding that they will not exercise delegated powers in a manner that is likely to be a cause for regulatory or public concern.

1.3.2 Any delegation must be exercised:

- Within the approved budget and strategic and operational framework approved by the Board (or separate approval must be sought from either the relevant Executive Director, Trust Management Group or the Board of Directors)
- In compliance with all Trust Policies and procedures including Standing Financial Instructions
- In accordance with the decision-making requirements set out in the Constitution including requirements for decision-records and record keeping for audit purposes.
- Having identified, controlled or mitigated appropriate strategic and operational risks within the officer's area of responsibility
- Having regard to relevant legislative, regulatory, consultative or procedural requirements that may be required.

1.3.3 Whenever legislation is amended or replaced by new provisions, then the relevant delegated authority in this scheme applies to those new provisions. Whenever new legislation relevant or related to the functions exercised by the Executive is introduced, that Officer will have the delegated authority to exercise powers or otherwise take action under that legislation until such time as the Board decides to whom to allocate responsibility for the new legislation.

1.4 Absence of directors or officer to whom powers have been delegated

1.4.1 In the absence of an Executive Director or officer to whom powers have been delegated those powers shall be exercised by that Director or officer's superior unless alternative arrangements have been approved by the Board of Directors.

1.4.2 If there is any dispute or lack of clarity as to which Chief Officer has power to make decisions on specific areas of service, the Chief Executive shall have power to determine where the delegation should be exercised.

1.4.3 If the Chief Executive is absent, their delegated powers may be exercised by the Deputy Chief Executive. If both the Chief Executive and the Deputy Chief Executive are absent, the Chairman will nominate an alternate Executive Director to exercise the Chief Executive's delegated powers.

2. PURPOSE

2.1.1 The purpose of this document is to detail how the powers that are reserved to the Board of Directors, for which it is held accountable to NHS Improvement, are discharged and also sets out the delegated authorities to to the appropriate level. The Board of Directors remains accountable for all of its functions, even those delegated to individual directors or officers and through the Audit Committee receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.1.2 This document also describes the powers and duties of Governors.

3. SCOPE

Board of Directors, Governor, all staff, contractors and agents.

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4. PROTOCOL

4.1 Reservation of Powers to the Board of Directors

4.1.1 Accountability

4.1.1.1 Pursuant to the NHS Foundation Trust Code of Governance and the Code of Accountability for NHS Boards and the requirement for effective systems of internal control the Board of Directors has determined those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 4.1.2 to 4.1.9 below:

4.1.2 General Enabling Provision

4.1.2.1 The Board of Directors may determine any matter it wishes in full session within its statutory powers and taking account of the Trust's Constitution and any guidance issued by NHS Improvement.

4.1.2.2 The Board has six key functions for which it is held accountable by the Independent Regulator

- to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- to appoint, appraise and remunerate senior executives;
- 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;
- to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; and
- 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.

4.1.3 Regulation and Control

4.1.3.1 The powers reserved to the Board of Directors generally represent matters for which it is held accountable to NHS Improvement under the Trust's NHS Provider Licence, Terms of Authorisation and the Regulatory Framework, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, even those delegated to individual committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. The Board of Directors exercises this delegation of regulation and control by the:

a) approval of *Standing Orders for the Board of Directors* which form part of the Trust's Constitution;

b) approval of a schedule of matters reserved to the Board of Directors and

Standing Financial Instructions (SFIs) for the regulation of its proceedings and business;

c) approval of a *Scheme of Reservation and Delegation of Powers* (SoRD) of powers from the Board of Directors to managers and committees;

d) requirement to receive the declaration of Board members and directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration;

e) disciplining of Directors who are in breach of Statutory Requirements or the Trust's Constitution and governance documents;

f) approval of the disciplinary procedure for Executive Directors;

g) To approve arrangements for dealing with complaints;

h) adoption of senior management structures and the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to;

i) requirement to receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon;

j) requirement to approve the recommendations of the Trust's committees;

k) requirement to establish terms of reference and reporting arrangements of all committees;

l) ratification of any urgent decisions through use of emergency powers in accordance with (Emergency Powers) of the *Standing Orders for the Board of Directors* as described in Annex 6 of the Trust's *Constitution*;

m) Approval of the arrangements for the use of the Seal.

n) Ratify or otherwise instances of failure to comply with Standing Orders.

o) with the Council of Governors, and in accorda*nce with the* Trust's *Constitution,* approving changes to the Trust's *Constitution*.

p) to vary or amend and suspend Standing Order

q) receive and approve the Trust's Annual Financial Accounts and accompanying report prior to being laid before Parliament

r) 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.

s) Establish performance and quality measure that ensure effective use of resources and value for money.

t) Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the board can fully undertake its responsibilities.

4.1.4 Appointments and Dismissals

4.1.4.1 The Board of Directors exercises this delegation of appointments by:

a) the appointment and dismissal of committees;

b) Establishing an nominations committee who's responsibility includes the appointment, appraisal, disciplining and dismissal of Executive Directors;

c) the appointment of members of any committee of the Trust or the appointment of representatives of o*utside bodies.*

4.1.4.2 In accordance with the Trust's Constitution, the Council of Governors will appoint the Chairman, the Non-Executive Directors approve the appointment of the Chief Executive.

4.1.4.3 The appointment of the Deputy Chair of the Board and the Senior Independent Director are reserved to Board as set out in the standing orders for the Board.

4.1.4.4 The appointment and dismissal the Company Secretary in consultation with the Council of Governors is also reserved to Board.

4.1.5 Policy Determination

4.1.5.1 The Board of Directors exercises this delegation of policy determination by:

a) the approval of Trust management policies where not specifically delegated to Committee(s) or the Executive to approve. The policies reserved for Board will typically be those which have wide ranging strategic or financial implications for the Trust or are fundamental to the Trust business.

b) The list of Management Policies reserved for Board will be kept under review by the Chief Executive in consultation with the Chairman and Company Secretary

4.1.6 Strategy and Business Plans and Budgets

The Board of Directors exercises this delegation of strategy, business plans and budgets by:

c) the definition of the strategic aims and objectives of the Trust and the approval of the Trust's overarching Strategy;

d) Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Independent Regulator.

e) the approval of the following plans and strategies;

- Annual Operational Plan and approval of the overall budget for the Trust including the control total (and associated plans and submissions)
- Workforce Plan and Organisational Development Strategy
- Behavioural Standards Framework (Code of Conduct)
- Patient Experience Strategy
- Clinical Services Strategy
- Quality Improvement Strategy
- Research and Development strategy
- Digital Strategy
- Estates Strategy and Capital Investment Programme
- Financial Sustainability Plan
- Membership Strategy
- Risk Management Strategy
- Major Incident Plan
- Any other plans or strategies reserved for Board by NHSE/I

f) The list of plans and strategies reserved for Board will be kept under review.. All other Plans and Strategies will be approved by either Assurance Committees or the Executive. Arrangements for approval of plans and strategies will be kept under review by the Chief Executive in consultation with the Chairman and Company Secretary

4.1.6.1 The Board of Directors shall, in accordance with the Trust's Constitution, take account of the need to present forward plans to the Council of Governors.

4.1.7 General Matters

4.1.7.1 The Board of Directors exercises this delegation of general matters by:

a) Ratify proposals for accession disposal or change of use of land and other buildings in excess of £1m or which have a material impact on the Trust's estate.
b) The introduction or discontinuance of any significant activity or operation. The significance should be determined by the Executive Director with delegated authority for the function using a risk management approach;
c) Approval of applications for external Financial Resources which may have a material impact on the financial position of the Trust.
d) Approval of draft and final Business Cases in excess of £2m or which may have a material impact on the financial position of the Trust.
e) Approval of formal partnership agreements prior to them being entered into by the Trust.
f) Approval of regulatory and other returns reserved to the Board and receipt and approval of Annual Reports that are reserved to the Board.

g) Oversight for all monitoring returns required by NHSE, CQC and other regulators shall be reported, at least in summary, to the relevant assurance Committees and Board as appropriate.
h) Agreeing action on litigation against, or on behalf of, the Trust where the estimated value was in excess of £150,000.
i) All other matters required by statute. The Company Secretary will keep these requirements under review.

4.1.8 Financial and Performance Reporting Arrangements

4.1.8.1 The Board of Directors exercises this delegation of financial and performance reporting arrangements by:

a) the continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Executive Directors, committees and associate directors of the Trust;

b) the approval of the annual budget and capital plans

c) The approval of opening or closing of any bank or investment accounts;

d) the receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive;

e) Approval of PFI proposals

f) Approval of contracts (other than NHS Framework or Capital contracts) with a revenue value likely to amount to £5,000,000 over a 3 year period.

g) Review the use of NHS Resolution

h) the consideration and approval of the Trust's Annual Report including the annual accounts;

i) the receipt and approval of the Annual Report(s) for funds held on Trust.

j) To approve proposals for the disposal of, or relinquishing of control over, any relevant significant or material asset (subject to compliance with the Trust's licence).

k) To approve proposals for the acquisition, disposal or change of use of land and/or buildings In line with guidance issued by NHS Improvement ; and where the disposal involves disposal of a relevant asset, subject to compliance with the Trust's licence.

l) To approve losses and compensations at the levels set out in the Scheme of Delegation.

m) To approve all loans including the working capital facility, and major finance

leases at the limits set out in the Scheme of Delegation.

n) To approve the use of assets that are not "relevant assets" as security for a loan. To approve income and expenditure in excess of the financial limits set out in the Scheme of Delegation

4.1.8.2 The Board of Directors shall, in accordance with the Trust's Constitution, present performance information and the annual accounts and report to the Council of Governors.

4.1.8.3 The Trust will maintain a Performance and Accountability Framework.

4.1.9 Audit Arrangements

4.1.9.1 The Board of Directors exercises this delegation of audit arrangements by:

a) Appointing an Audit Committee to approve the Trusts Audit arrangements including (including appointment and dismissal of internal auditors, for the separate audit of funds held on Trust) and to receive reports of the Audit Committee meetings and take appropriate action;

b) the receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee;

c) the receipt of the Annual Internal Audit Report from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit Committee.

4.1.9.2 The Board of Directors note, in accordance with the Trust's *Constitution*, that the Council of Governors is responsible for the appointment, re-appointment and removal of the External Auditor, advised by the Board of Directors' Audit Committee.

4.1.10 Monitoring

4.1.11 The Board of Directors exercises this delegation of audit arrangements by:

a) Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. This includes and Annual Report from each of the Committees.

b) Continuous appraisal of the affairs of the Trust by means of the provision of reports to the Board as the Board may require from directors, committees, and officers of the Trust

4.1.12 **Roles and Responsibilities of the Chair**

4.1.13 It is the Chair's role to:

- provide leadership to the Board;
- enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team;
- ensure that key and appropriate issues are discussed by the Board in a timely manner,
- ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;
- lead Non-Executive Board members through a formally-appointed Board of Directors Nominations Committee of the main Board on the appointment and remuneration of the Chief Executive and (with the latter) other Executive Board members;
- appoint Non-Executive Board members to Board Committees and the Audit Committee of the main Board;
- advise the Council of Governors on the performance of Non-Executive Board members.
- Discharge the duties and responsibilities of the chair as set out in Standing Orders.

4.1.14 Risk:

- It is the responsibility of the Board of Directors to provide active leadership over the Trust within and framework of prudent and effective controls which enable risk to be assessed and managed.
- In accordance with the Risk Management Strategy and the supporting standing operating procedures, the roles and responsibilities of both the Board and employees of the Trust are clearly defined.
- The Executive Team and all employees of the Trust are empowered to execute the Trust's risk management arrangements in accordance with the strategy and the supporting operating procedures. This includes assuring that risks are effectively identified considered and appropriate action taken to mitigate and control risks or escalated as required.
- It is the responsibility of the Audit Committee and the Executive Chief Nurse to ensure that the Trust programme of Risk Management operates effectively and monitored on behalf of the Board of Directors.

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4.2 Delegation of Powers

4.2.1 Delegation to Committees

4.2.1.1 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees, having regard to the Trust Constitution, NHS guidance and the NHS Foundation Trust Code of Governance. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board shall determine the reporting requirements in respect of these committees.

4.2.1.2 The purpose and duties of the committees will be agreed annually by the Board of Directors and set out in their terms of reference.

4.2.1.3 In addition, each committee will approve the following on behalf of the Board.

Committee	Decisions Duties delegated	SFI reference if applicable
Finance And Performance Assurance Committee	a) Review Plans for the delivery of the financial and operational strategies; b) Examine exceptions to the achievement of those plans and actions to correct exceptions; c) Determine those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions; and d) Assess the management of risks relating to the finance and operational strategies.	
Quality Committee	The Quality Assurance Committee is a Non-Executive Committee (accountable to the Board) with no executive powers other than those specifically delegated to it in these Terms of Reference. The primary purpose of the Committee is to: 1. provide a focus for improving the quality of patient-centred healthcare in accordance with the Trust objectives; 2. provide a focus on quality in clinical governance, with a particular emphasis on patient safety, effectiveness and patient experience issues; 3. provide detailed scrutiny of clinical and operational performance in order to provide assurance and raise	

	concerns to the Board, or other committees where appropriate; 4. make recommendations on quality in clinical governance and clinical and operational performance matters to the Board, as appropriate; 5. ensure the Trust responds effectively to the clinical issues raised in national and local reports, patient surveys and service-user feedback, and demonstrates learning from serious untoward incidents, complaints and claims; 6. assess and identify risks to achieving objectives within the quality portfolio, escalating matters, as appropriate; 7. determine those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions.	
Workforce Committee	The Workforce Committee is a formal committee, established by the Board of Directors to which it is accountable. The primary purpose of the Committee is to: a) 1. provide strategic direction and assurance to the Board in relation to all workforce matters; b) 2. make recommendations, as appropriate, on workforce matters to the Board; c) 3. determine those matters delegated to the Committee in accordance with the Trust's Scheme of Delegation and Standing Financial Instructions; d) 4. assess and identify risk within the People and Organisational Development portfolio, escalating matters to the Board, as appropriate; e) 5. monitor and influence the development of the OD Strategy, Creating Better Care Together; and f) 6. oversee delivery against the following core organisational values: g) People – our staff and volunteers are the ones who make a difference. They understand and share our values and this is reflected in their work; h) Progress – our progress will be improved through	

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	innovation, education, research and technology to meet the challenges of the future The Committee will also act as the strategic partner, including performance management of operational teams, to oversee delivery of Staff Pledges within the NHS Constitution to ensure that strategies and plans protect and enhance the wellbeing and experience of the Trust workforce	
Audit Committee	To monitor the integrity of the Trust's financial statements and to review the Trust's financial and non-financial controls and management systems. The Committee shall take a risk-based approach to the overarching scrutiny of the Trust's assurance, risk and governance structures and processes so that the Board may be provided with assurance that the corporate objectives shall be met. In particular, the Committee shall commission and scrutinise assurances that the Trust has operated, and shall continue to operate, in accordance with its Terms of Authorisation and that compliance requirements of NHS Improvement and the Care Quality Commission shall be met, thereby ensuring that the Trust's licence to operate is maintained.	
Remuneration Committee	The Remuneration Committee (known as 'the Committee') in these terms of reference) is a formal committee, established by the Board of Directors to which it is accountable. The primary purpose of the Committee is to oversee: a) the nomination of the Chief Executive and other Executive Directors for the University of Morecambe Bay Hospitals NHS Foundation Trust; and b) the determination of the remuneration, terms of service and allowances of the Chief Executive and other Executive	
Corporate Charity Trustee Committee	The Corporate Charity Trustees' Committee is a Non-Executive Committee (accountable to the Board) with no executive powers other than those specifically delegated to it in these Terms of Reference. The primary purpose of the Committee is to:	

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	a) apply the Trust's charitable funds in accordance with their respective governing b) documents, and to ensure that funds are used in accordance with the Charity's c) objectives; d) ensure that the Trust policies and procedures for charitable funds investments are followed; e) make decisions involving the sound investment of charitable funds in a way that f) both preserves their capital value and produces a proper return consistent with g) prudent investment and statutory compliance; h) receive reports from the Director of Finance, at least twice per annum, on investment decisions and actions in accordance with delegated powers and upon the advice of the Trust's investment adviser; i) formulate and advise Trustees on the strategy of fundraising and to monitor the progress of any charitable appeal funds; j) approve all individual charitable funds expenditure in excess of £25,001 prior to Board approval.	

4.3 Scheme of Reservations and Delegations to Officers

4.3.1.1 Introduction

4.3.1.2 The Trust's *Constitution*, *Standing Financial Instructions* and this Scheme of Delegation set out in detail the responsibilities of the Chief Executive, the Director of Finance and other Executive Directors and Officers.

4.3.1.3 The Chief Executive as the accountable officer for the Trust, has a number of statutory duties that are set out in the NHS Foundation Trust Accounting Officer Memorandum. The table below summarises the responsibilities for the discharge of these functions.

4.3.1.4 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive as the Accountable Officer.

Function	Discharged by
there is a high standard of financial management in the NHS foundation trust as a whole	Executive Team
the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation	Executive Team
financial considerations are fully taken into account in decisions by the NHS foundation trust.	Executive Team
the propriety and regularity of the public finances for which he or she is answerable	Director of Finance
the keeping of proper accounts	Director of Finance
prudent and economical administration in line with the principles set out in *Managing public money*[1]	Director of Finance
the avoidance of waste and extravagance	Executive Team
the efficient and effective use of all the resources in their charge.	Executive Team
Ensure the accounts of the Trust are prepared under principles and in a format directed by the Independent Regulator. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.	Director of Finance
Sign a statement in the accounts outlining responsibilities as the Accounting Officer.	Chief Executive

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Sign a statement in the accounts outlining responsibilities in respect of Internal Control including the Annual Governance Statement Sign the accounts on behalf of the Board.	
Ensure effective management systems that safeguard public funds and assist the Trust Chair 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."	Chief Executive

4.3.1.5 The Chief Executive will maintain a list the statutory roles for which there must be an Accountable Officer within an foundation trust, together with the Nominated or Designated Officer were appropriate. The List will be kept under review by the Chief Executive in consultation with the Company Secretary. Nominated Officers are authorised to carry out all necessary tasks in performance of their roles having regard to the requirements of this Scheme of Delegation and Reservation and Standing Financial Instructions of the Trust. A Schedule of roles assigned to Non-Executive Directors is maintained by the Chair of the Trust

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AREA	Officer	ROLE	REFERENCE
Overall Responsibility for the Trust	Chairman Aaron Cummins – Chief Executive	Chairman Accountable Officer	NHS Act 2006 NHS Act 2006
Emergency Preparedness	Chief Operating Officer	Accountable Officer for Emergency Preparedness	Emergency Preparedness Resilience and Response (EPRR), NHS England 2009
Medicines Management	Chief Pharmacist	Accountable Officer for the Destruction of Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
	Chief Pharmacist	Accountable Officer for Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
	Chief Pharmacist	Medicines Safety Officer	Patient Safety Alert NHS/PSA/D/2014/005
	Chief Pharmacist	Non-Medical Prescribing Lead	NMC Code of Conduct/Standards
Finance	Chief Executive	Accounting Officer	NHS Act 2006
	Director of Finance	Counter Fraud Lead (Executive)	Directions to NHS Bodies on Counter Fraud 2004
	Fraud Champion	Company Secretary	NCFCA Requirement
	Local Counter Fraud Specialist	Counter Fraud Specialist	Directions to NHS Bodies on Counter Fraud 2004
	Chief Operating Officer	Security Management Director	Secretary of State Directions March 2005
	Chair of Finance Committee	Security Management Non-Executive Director	Secretary of State Directions March 2005
	Local Security Management Specialist	Local Security Management Specialist	Secretary of State Directions March 2005
	Director of Finance	Senior Compliance Officer	Bribery Act 2010
	Medical Director	Hospital Pharmacy and Medicines Optimisation Executive Lead	NHSI, Carter Project
	Chief Pharmacist	Hospital Pharmacy and Medicines Optimisation Lead	NHSI, Carter Project
Information Management/Governance	Medical Director	Caldicott Guardian	HSC1999/012
	Director of Finance	Senior Information Risk Officer (SIRO)	Information Governance Toolkit

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	Director of Finance	Information Governance Lead	NHS Standard Contract
	Appointed Clinical Lead	Chief Clinical Information Officer	NHS Information Strategy
	Chief Information Officer	Data Protection Officer	Data Protection Act and General Data Protection Regulations
	Director of Finance	Executive Board member for data and cyber security	Data Protection Act and General Data Protection Regulations
Health & Safety	Executive Chief Nurse	Lead Executive for Health & Safety	Health & Safety at Work Act 1974
	Chief Operating Officer	Fire Safety Lead	Fire code; Fire Safety in the NHS
	Head of Health, Safety and Risk	Advisor for RIDDOR/COSHH	Health & Safety at Work Act 1974
	Radiation Protection Supervisors	Ionising Radiation (Medical Exposure) Lead (where organisations provide radiotherapy services)	Ionising Radiation (Medical Exposure) Regulations 2000
	Radiation Protection Supervisors	Radiation Protection Advisor	Ionising Radiation Regulations 1999
Infection Control	Executive Chief Nurse	Director of Infection Prevention & Control (DIPC)	Health & Social Care Act 2008 Code of Practice on Control of Infection
	Executive Chief Nurse	Decontamination Lead	Health & Social Care Act 2008 Code of Practice on Control of Infection
Safeguarding	Executive Chief Nurse	Safeguarding Executive Lead	Safeguarding Accountability Assurance Framework NHS Standard Contract
	Head of Safeguarding & Professional Lead	Lead Professional for Safeguarding	Safeguarding Accountability Assurance Framework
	Details of Appointed Leads are held by Head of Safeguarding & Professional Lead	Designated Doctor for Child Protection	Safeguarding Accountability Assurance Framework
		Designated Doctor for Safeguarding Adults	Safeguarding Accountability Assurance Framework
		Named Nurse for Safeguarding Adults	Safeguarding Accountability Assurance Framework
		Designated Midwife for Safeguarding	Safeguarding Accountability Assurance Framework
		Deprivation of Liberty & Safeguarding (DoLS) Lead	Mental Capacity Act 2005

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		Mental Health Act Administrator	Mental Capacity Act 2005
	Head of Resilience & Patient Flow	Prevent Lead	Counter-Terrorism and Security Act 2015 NHS Standard Contract
Freedom of Information Act	Associate Director of Corporate Affairs	Freedom of Information Act Lead	Freedom of Information Act
	Associate Director of Corporate Affairs	Qualified Person for FOIA	Freedom of Information Act
Freedom to Speak Up	Executive Chief Nurse Freedom to Speak Up Guardian	Freedom to Speak Up Guardian Executive Lead	NHSE Requirement & requirement of NHS Standard Contract
	Senior Independent Director	NED for Freedom to Speak Up/Raising Concerns	HSC 1999/198 Freedom to Speak Up Review
Quality/Patient Safety	Executive Chief Nurse	Quality Executive Lead	Francis Inquiry
	Executive Chief Nurse	Executive Lead for End of Life Care	More Care, Less Care Report 2013
	Director of Governance	Responsible Person for Compliance with Complaints Regulations	NHS Complaints Regulations
	Patient Relations Manager	Complaints Manager	NHS Complaints Regulations
	Appointed NED	Maternity Champion	Ockenden Review
	Medical Director	Guardian of Safe Working Hours	NHS Employers
	Head of Medical Engineering	Medicines Devices Safety Officer	Patient Safety Alert NHS/PSA/D/2014/006
	Director of Governance	Central Alerting System (CAS) Liaison Officer	NHS England – Introduction to the National Patient Safety Alerting System
	Medical Director	Responsible Officer for Revalidation	General Medical Council
	Executive Chief Nurse	Quality Review Service Lead	NHS England
People	Chair of People and OD Committee	NED responsible for Doctors Disciplinary MPHS/ Doctors Disciplinary Champion	General Medical Council
	Chair of People and OD Committee	Staff and Wellbeing Champion	Health Education England Pearson Report
Human Tissue Authority	Clinical Director Core Clinical Services	Designated Individual	Human Tissue Act
Human Fertility	Appointed Lead	Responsible Person	Human Fertility &

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& Embryology			Embryology Act
Care Quality Commission	Executive Chief Nurse	CQC Registered Manager	Health & Social Care Act 2014
Sustainability	Chief Operating Officer	Trust Board Lead (Executive)	NHS Carbon Reduction Strategy 2009
Equality & Diversity	Director of People and Organisational Development	Board Executive Lead	Equality Act 2010

4.3.1.6 The delegation shown below is the lowest level to which authority is delegated.

a) **Table A – Delegated Authority**:

The Board of Directors delegated authority to Committees, Executive Directors and other officers of the Trust as set out in Table A.

b) **Table B – Delegated Financial Limits**:

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

c) **Table C – Mental Health**

Although not a mental health provider Table C sets out a general delegation in respect of the care of mental health patients.

d) Table D Community Services

UHMBT holds a Community services contract. Table D sets out a general delegation in respect of Community Services.

e) Table E Partnerships

The Constitution describes principle purpose of the Trust is the provision of goods and services for the purposes of the Health service in England and more specifically the provision of goods and services to the population of Morecambe Bay that compliment and integrate with local authorities and health service commissioners. Table E sets out a general delegation in respect of partnerships.

f) Table F Powers and duties of the Council of Governors

The Council of Governors has statutory roles and these are listed in Table F.

g) Table G – Risk

In accordance with Standing Financial Instructions the Chief Executive shall ensure that the Trust has a programme of Risk Management. The Programme will be in accordance with current directions and guidance in relation to Assurance Framework requirements from NHS Improvement, which must be approved and monitored by the Board of Directors.

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4.3.2 Table A – Delegated Matters

Delegated Matter	Ref	Delegated Matter	Ref
Audit Arrangements	A1	Hospitality, Gifts and Individual Commercial Sponsorship	A24
Authorisation of Clinical Trials	A2	Legal Proceedings	A25
Authorisation of New Drugs	A3	Losses, Write-Offs and Compensation	A26
Authorisation of Product Trials	A4	Medicines Inspectorate Regulations	A27
Authorisation of Research Projects	A5	Meetings	A28
Bank Accounts (Excluding Charitable Fund Accounts)	A6	Non Pay Expenditure	A29
Capital Investment	A7	Patients and Relatives Complaints	A30
Carbon Reduction Commitment/Green Plan	A8	Patients Services Agreements	A31
Clinical Audit	A9	Patients' Money and Property	A32
Commercial Sponsorship	A10	Personnel and Pay	A33
Confidential Information	A11	Professional Leadership	A34
Data Protection Act	A12	Quotations, Tendering and Contract Procedures	A35
Declaration of Interests	A13	Records	A36
Disposal and Condemnations	A14	Reporting Incidents to the Police	A37
Environmental Regulations	A15	Review of Fire Precautions	A38
External Borrowing	A16	Risk Management	A39
Financial Planning / Budgetary Responsibility	A17	Safeguarding - Adults	A40
Financial Procedures	A18	Safeguarding - Children	A41
Fixed Assets	A19	Seal	A42
Fraud	A20	Security Management	A43
Freedom of Information Act	A21	Setting of Fees and Charges	A44
Funds Held on Trust	A22	Stores and Receipt of Goods	A45

4.3.3 Table B – Delegated Financial Limits

Delegation Limit	Ref No
Quotation and Tenders	B1
Non Pay Expenditure	B2
Petty Cash Disbursements	B3
Contracted Services	B4
Removal Expenses	B5
Charitable Funds	B6
Losses and Special Payments	B7
Short Term Borrowing	B8

Use of Seal	B9
Setting Fees and Charges	B10
Agreements and Licences	B11
Condemning and Disposal	B12
Engagement of Staff not on the Establishment	B13
Business Planning	B14
Virement	B15

4.3.4 Table C – Mental Health

General Provisions Relating to Mental Health	C1
Although the Trust is not licenced as a mental health provider, delegation is given to UHMBT staff to exercise and discharge mental health legislation and provisions (including those in the Mental Health Act 1983 as amended and other relevant legislation) as they relate to patients in the care of the Trust. This includes DoLS (Deprivation of Liberty safeguards) The Medical Director and the Executive Chief Nurse have responsibility for issues relating to mental health within the Trust. They have the primary responsibility for ensuring that mental health rules and regulations are followed and that their treatment and care of patients accord fully with national rules and provisions and that patients are fully informed of and supported when excising their statutory rights.	
The Medical Director and the Executive Chief Nurse are empowered to introduce Trust-wide policies and procedures to support the delivery of care to Mental Health patients	

4.3.5 Table D – Community Services

General Provisions relating to Community Services	D1
UHMBT holds a Community services contract local Commissioners. Delegation is given to UHMBT staff to exercise all necessary functions and activities under NHS legislation and provisions to enable the discharge of community services as set out in the Community Services Contract Operational day to day management is delegated to Deputy Chief Operating Officer Community. Executive Lead is Chief Operating Officer	

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4.3.6 Table E – Partnerships

General Provisions Relating to Partnerships	E1
The principle purpose of the Trust is the provision of goods and services for the purposes of the Health service in England and more specifically the provision of goods and services to the population of Morecambe Bay that compliment and integrate with local authorities and health service commissioners. In pursuit of this objective the board authorises the executive team to fulfil leadership roles within the Lancashire and South Cumbria ICS and Morecambe Bay Place Based Partnership In doing so executives will rely upon their delegated decision-making authority from the Trust when fulfilling system wide roles. Until such time as the ICS and PBP become formal NHS entity's the executive team will operate within the framework on the UHMB Constitution, Scheme of Delegation and Standing Financial Instructions	•

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4.3.7 Table F - General Provisions Relating to Governors

General Provisions Relating to Governors	F1
The Council of Governors is responsible for representing the interests of NHS Foundation Trust members and the public and staff in the governance of the Trust. It remains the responsibility of the Board to design and then implement agreed priorities, objectives and the overall strategy of the Trust. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The statutory roles and responsibilities of the Council of Governors are: a) To appoint and, if appropriate, remove the Chair b) To appoint and, if appropriate, remove the other Non-Executive Directors c) To decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors d) To approve any new appointment of a Chief Executive e) To appoint and, if appropriate, remove the Trust's external auditor f) To receive the annual report, annual accounts and any report of the auditor on them at a general meeting g) To hold the Non-Executive Director individually and collectively to account for the performance of the Board of Directors h) To represent the interests of the members of the Foundation Trust as a whole and the interests of the public To approve "significant transactions" as defined within the Constitution i) To approve an application by the Trust to enter into a merger, acquisition, separation or dissolution j) To approve any proposal to increase the proportion of the Trust's income from non-NHS work by 5% of total income a year or more k) To decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions	

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4.3.8 Table G – Risk

General Provisions Relating to Risk	
Accountability for risk management sits with the Chief Executive Officer CEO), as accountable officer the CEO delegates all risk performance duties to the Executive Directors. It is the responsibility of the Board of Directors to provide active leadership over the Trust within and framework of prudent and effective direction and controls which enable risk to be assessed and managed. In the Risk Management Strategy/ Policy and the supporting standing operating procedures, the roles and responsibilities of both the Board and employees of the Trust are clearly defined. The Executive Team and all employees of the Trust are empowered to execute the Trust's risk management arrangements in accordance with the strategy/policy and the supporting operating procedures. This includes assuring that risks are effectively identified considered and appropriate action taken to mitigate and control risks or escalated as required. It is the function and form of the Audit Committee to ensure Risk Management is planned and operates effectively The Executive Chief Nurse and Deputy Chief Executive is responsible for monitoring risk outcomes and performance on behalf of the Board of Directors.	

5 POWER TO IMPLEMENT DECISIONS OF THE BOARD AND MANAGEMENT ARRANGEMENTS AND PRINCIPLES UNDERPINNING THE SCHEME OF DELEGATION

5.1 When the Board or one of its Committees makes a decision the Chief Executive and the Executive Directors have, in accordance with this scheme of delegation, the power to take all necessary actions (including the letting of contracts and incurring expenditure) to implement those decisions, without further reference to the Board, to ensure that all matters of day to day management and administration of the Trust's affairs are carried out effectively and efficiently.

5.2 In implementing Board or one of its Committees decisions the Chief Executive and the Executive Directors are empowered to undertake statutory processes and carry out, consider and act upon the outcome of statutory and non-statutory consultations on service provision providing that this is consistent with the overall policy and objectives of the Trust Council.

5.3 The general delegation and the delegations above include the power to do anything ancillary or incidental to, arising from, or necessary or desirable to give effect to or facilitate the exercise of the powers and functions delegated to Executive Directors including, where not specifically prohibited or available within the Trust, the engagement or retention of any external source of expertise to advise, represent or act for or on behalf of the Trust.

5.4 In exercising their power and duties, all leaders must seek to achieve value for money and strive for improved efficiency and productivity. Leaders are expected to manage efficiently and effectively, the resources at their disposal. All leaders will support and deliver a positive material change to the financial position of the organisation and be held accountable for contributing to the reduction of the deficit. As such, leaders must not authorise any expenditure which is not provided for in the budgets for which they are responsible. Authorise expenditure which is not budgeted for is a breech of these rules and SFIs and may lead to disciplinary action.

MANAGEMENT ARRANGEMENTS

5.5 The day to day management arrangements for the Trust is overseen by the Trust Management Group, comprising the Chief Executive, the Executive Team and Clinical Leadership. Those functions which have not been retained by Board or delegated to a Committee or an Executive Director shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will retain and then nominate Officers for the remaining functions (Standing order 6.4.1)

5.6 Each member of the Group is accountable to the Chief Executive for leading the Services within their area of responsibility and ensuring that the Divisions are managed in accordance with the objectives, plans, policies, programmes, budgets and processes of the Trust. This includes responsibility for the proper exercise of any delegated powers.

5.7 Divisional Management Teams are accountable to the Chief Executive and the appropriate Executive Director for effectively and efficiently managing the Services for which he or she is responsible, in accordance with the objectives, plans, policies, programmes, budgets and processes of the Trust. This includes responsibility for the proper exercise of any delegated powers, the responsible use of resources including capital, people and revenue expenditure.

5.8 From time to time, the Chief Executive and the Director of Finance will issue separate guidance and procedures in support of management arrangements. Examples include cost control measures and business case development and approval.

5.9 Within this scheme powers are delegated to members of the Trust Management Group who with the consent of the Chief Executive may establish, operate and keep under review schemes of internal delegation to cascade powers and responsibilities to members of Divisional Management Teams Heads of Service and other colleagues. Every such sub-delegation shall be recorded in writing within an internal divisional scheme of delegation. The sub-delegation of functions shall not in any way diminish the overall responsibility and accountability of the delegation.

PRINCIPLES UNDERPINNING THE SCHEME OF DELEGATION

5.10 The Trust will shall devolve responsibility for service delivery and management to the nearest practicable point to the service user.

5.11 In some circumstances, a delegate (whether officer or committee/sub-committee) may consider a matter to be of such importance that their delegated authority should not be exercised. In these circumstances the delegate may refer the matter back to the delegator for determination.

5.12 The fact that a function is delegated under these arrangements does not preclude the delegator (the manager) from exercising the function directly themselves.

5.13 Any power delegated under this scheme may in emergency be exercised be exercised by the Chief Executive or in their absence the Director of Finance personally.

5.14 Each colleague with power to act under this section is authorised to do so only in relation to the budgets, resources and policies within their areas of responsibility.

5.15 Before taking decisions, colleagues are under a duty to satisfy themselves that they have the duly delegated power to do so and that they have undertaken any appropriate consultation. Appropriate advice must be taken where the matter in question involves financial, professional or clinical considerations that are not within their sphere of competence.

5.16. Colleagues are under a duty to ensure that they take decisions in accordance with:-

- Principles of natural justice.
- Professional standards.
- Statutory powers and requirements, guidance and Codes of Practice.
- The Trusts Constitution and Schemes of Finical Standing Instruction and Tendering Procedures.
- The strategies, plans and budget approved by the Board.
- Any other approved policies, procedures and practices.

5.17 UHMB Staff and are accountable for delivery and will be held to account in accordance with the Performance and Accountabilities Framework of the Trust

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Table A - Delegated Authority

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
Standing Orders for the Board of Directors / Standing Financial Instructions / Scheme of Reservation and Delegation			
a)	Approval of the Trust's Standing Orders for the Board of Directors, Standing Financial Instructions and Scheme of Reservation and Delegation of Powers (including variations and amendments)	Board of Directors	Board of Directors (supported by the Company Secretary)
b)	Final authority in interpretation of Standing Orders	Chairman	Chairman (supported by Chief Executive / Company Secretary)
c)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive and Director of Finance	Executive Directors / Associate Medical Directors (Clinical Divisions) / Chief Operating Officers (Clinical Divisions) / Deputy Director of Finance / Heads of Department
d)	Responsibility for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Trust's Constitution, Standing Orders for the Board of Directors, Financial instructions and financial procedures	Director of Finance	All Employees

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
e) Ensuring Standing Orders for the Board of Directors / Standing Financial Instructions are compatible with Department of Health requirements re building and engineering contracts	Chief Executive	Director of Finance (supported by Company Secretary)
f) Suspension of Standing Orders for the Board of Directors / Standing Financial Instructions	Board of Directors	Board of Directors
g) Suspension of Standing Orders for the Board of Directors / Standing Financial Instructions / Scheme of Reservation and Delegation of Powers	Board of Directors	Board of Directors
h) Review suspension of Standing Orders for the Board of Directors / Standing Financial Instructions / Scheme of Reservation and Delegation of Powers	Audit Committee	Audit Committee
i) Use of emergency powers relating to the authorities retained by the Board of Directors	Chairman and Chief Executive with two Non Executive Directors	Chairman and Chief Executive with two Non Executive Directors

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
j) Advice on the interpretation or application of the Standing Financial Instructions	Director of Finance	Deputy Director of Finance / Company Secretary
k) Approval of Financial Procedures	Director of Finance	Deputy Director of Finance / Company Secretary
l) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented	Director of Finance and Deputy Director of Finance	Director of Finance and Deputy Director of Finance
m) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position	Director of Finance and Deputy Director of Finance	Director of Finance and Deputy Director of Finance
n) Providing financial advice to members of Board and staff	Director of Finance and Deputy Director of Finance	Director of Finance and Deputy Director of Finance
o) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.	Director of Finance and Deputy Director of Finance	Director of Finance and Deputy Director of Finance
p) Advice on the interpretation or application of the Scheme of Reservation and Delegation of Powers	Chief Executive	Company Secretary

Table A – Delegated Authority

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
q) Disclosure of non-compliance with Standing Orders (as per the Constitution) to the Chief Executive (report to the Audit Committee)	Chief Executive and Company Secretary	All Employees
r) Disclosure of non-compliance with Standing Financial Instructions to the Director of Finance (report to the Audit Committee)	Director of Finance	All Employees
s) Disclosure of non-compliance with the Scheme of Reservation and Delegation of Powers to the Chief Executive (report to the Audit Committee)	Chief Executive and Company Secretary	All Employees

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A1.	**Audit Arrangements**		
a)	Advise the Board of Directors on internal audit services.	Audit Committee	Director of Finance
b)	Advise the Council of Governors on external audit services (the appointment of the External Auditors by the Council of Governors)	Audit Committee	Director of Finance
c)	Review, appraise and report in accordance with NHS internal audit manual and best practice.	Audit Committee	Director of Finance
d)	Provide an independent and objective view on internal control and probity.	Audit Committee	Chief Executive Officer and Director of Finance
e)	Advising the Council of Governors to ensure cost-effective external audit.	Audit Committee	Director of Finance
f)	Implement recommendations from internal and external audit Reviews	Chief Executive	Relevant Executive Directors / Executive Team members Relevant Officers

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A2.	**Authorisation of Clinical Trials**		
a)	Develop a policy / procedure for the authorisation of clinical trials, including the appropriate ethical approval, intellectual property and patient confidentiality measures	Medical Director	Research and Development Lead
b)	Authorisation of clinical trials in accordance with the policy / procedure for the authorisation of clinical trials	Medical Director (with advice from the Research and Development Group)	Research and Development Lead
A3.	**Authorisation of New Drugs**		
a)	Develop a policy / procedure for the authorisation of new drugs with advice from Research and Development Group	Medical Director	Chief Pharmacist
b)	Approval of expenditure on new drugs in accordance with the policy / procedure for the authorisation of new drugs (with advice from the Joint Medicines Management, Drugs and Therapeutics Sub-Committee (MMDTSC)	Refer to paragraph B2(c) in Table B – Delegated Limits	Refer to paragraph B2(c) in Table B – Delegated Limits

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A4.	**Authorisation of Product Trials**		
a)	Develop a policy / procedure for the authorisation of product trials including the appropriate ethical approval, intellectual property and patient confidentiality measures (with advice from Research and Development Group)	Medical Director	Research and Development Lead
b)	Authorisation of product trials in accordance with the policy / procedure for the authorisation of product trials (with advice from the Research and Development Group)	Medical Director	Research and Development Lead
A5.	**Authorisation of Research Projects**		
a)	Discharge the duties of Lead Director of Research Governance	Medical Director	Research and Development Lead
b)	Develop a policy / procedure for the authorisation of research projects including the appropriate ethical approval, intellectual property and patient confidentiality measures (with advice from the Centre for Perfect Care Clinical Research and Development Group)	Medical Director	Research and Development Lead

	DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
	Authorisation of research projects trials in accordance with the policy / procedure for the authorisation of research projects (with advice from the Clinical Research and Development Group)	Medical Director	Research and Development Lead
c)	Ensure compliance with statutory requirements and procedures under research governance	Medical Director	Research and Development Lead
d)	Comply with statutory requirements and procedures under research governance	Medical Director	All Employees
A6.	**Bank Accounts (Excluding Charitable Fund Accounts)**		
a)	**Operation:**		
	• Managing banking arrangements and operation of bank accounts	Director of Finance	Operational Director of Finance/Deputy Director of Finance/ Head of Financial Services
	• Opening bank accounts	Director of Finance	Operational Director of Finance/Deputy Director of Finance/ Head of Financial Services

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Authorisation of transfers between Trust bank accounts	Director of Finance	Operational Director of Finance/Deputy Director of Finance/ Head of Financial Services
• Authorisation of: BACS schedules; Automated cheque schedules; Manual cheques	Director of Finance	Operational Director of Finance/Deputy Director of Finance/ Head of Financial Services
b) **Investments:** • Investment of surplus funds in accordance with the Trust's investment policy	Director of Finance	Operational Director of Finance/Deputy Director of Finance/ Head of Financial Services
A7. Capital Investment		
a) **Capital Programme**:	Director of Finance	
• Ensure that there is an adequate appraisal and approval process for determining capital expenditure priorities and the effect that has on each business plan	Director of Finance	Capital Programme Group supported by Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager in accordance with the Capital Programme Policy

Table A – Delegated Authority

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Preparation of Capital Investment Programme	Director of Finance	Capital Programme Group supported by Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager in accordance with the Capital Programme Policy
• Preparation of a business case	Director of Finance	Members of the Trust management Group, triumvirate leaders with support from Investment and Priorities Group in accordance with Business Case Governance Process
• Authorisation of capital requisitions	Refer to Table B – Authorisation Limits	Refer to Table B – Authorisation Limits
• Responsibility for the management of capital schemes and for ensuring that they are delivered on time and within cost	Director of Finance	Scheme SRO, Capital Programme Group supported by Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager in accordance with the Capital Programme Policy
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Director of Finance	Capital Programme Group supported by Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager in accordance with the Capital Programme Policy

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Additions, variations and amendments to the Capital Investment Programme (within limits stipulated in Table B)	Director of Finance and Chief Operating Officer	Capital Programme Group supported by Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager in accordance with the Capital Programme Policy
• Issue procedures governing capital investment projects, including variation to contract, covering ○ Financial management ○ Staged payments	Director of Finance and Chief Operating Officer	Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager
b) **Contracting**: • Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations and Trust tender procedures	Director of Finance and Chief Operating Officer	Associate Director of Estates and Facilities/ Capital Services Manager
c) **Private Finance**: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector	Director of Finance and Chief Operating Officer	Capital Programme Group supported by Operational Director of Finance/Associate Director of Estates and Facilities/ Capital Services Manager in accordance with the Capital Programme Policy

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A8.	**Carbon Reduction Commitment/Green Plan** (see also A15 – Environmental Regulations)		
a)	Develop and approve a Sustainable Development Management Plan which sets out clear and measurable milestones to measure, monitor and reduce direct carbon emissions in support of delivering a "Net Zero" National Health Service (Green Plan)	Chief Operating Officer	Head of Procurement Associate Director of Estates and Facilities /
b)	Implement and monitor the Trust's Sustainable Development Management Plan	Chief Operating Officer	Associate Director of Estates and Facilities
A9.	**Clinical Audit**		
a)	Development of a strategy and policy for clinical audit	Medical Director/ Chief Nurse	Director of Governance
b)	Implementing and monitoring the clinical audit programme(s)	Medical Director/ Chief Nurse	Director of Governance
c)	Adhering and contributing to the clinical audit policy and programme(s)	Medical Director/ Chief Nurse	All Employees
A10.	**Commercial Sponsorship** (see also A22 – Hospitality, Gifts and Individual Commercial Sponsorship)		
a)	Develop a policy for the acceptance of commercial sponsorship	Director of Finance	Operational Director of Finance
b)	Agreement to proposal	Director of Finance	Operational Director of Finance

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Up to £50,000 • Over £50,000	Director of Finance Director of Finance	Operational Director of Finance Director of Finance
c) Maintain a register for the receipt of commercial sponsorship	Director of Finance	Operational Director of Finance
A11. Confidential Information		
a) Discharge the duties of the Trust's Senior Information Risk Owner and Information Asset Owner	Director of Finance	Chief Information Officer
b) Develop, maintain and implement the Trust's Information Risk Policy	Director of Finance	Chief Information Officer
c) Ensure Trust's Information Risk Policy is adhered to	Director of Finance	All Employees
d) Review of the Trust's compliance with the code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" requirements	Medical Director (Caldicott Guardian)	Information Governance Manager
e) Develop robust systems and policies to ensure confidentiality and confidentiality of person identifiable data	Medical Director (Caldicott Guardian)	Information Governance Manager

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
f) Ensure Trust's policies for protecting patients / person identifiable data are adhered to	Medical Director (Caldicott Guardian)	All Employees
g) Developing Information Sharing Protocols (as appropriate) with partner agencies	Medical Director and the Trust's Senior Information Risk Owner Associate Director of Communications	Information Governance Manager
A12. Data Protection Act		
a) Review of Trust's compliance and ensure appropriate policies and procedures are in place	Chief Executive and Medical Director (Caldicott Guardian) and Trust's Senior Information Risk Owner (Director of Finance)	Information Governance Manager
b) Ensure Trust's policies for data protection are adhered to	Chief Executive and Medical Director (Caldicott Guardian) and Trust's Senior Information Risk Owner(Director of Finance)	Information Governance Manager All employees
c) Complying with the Trust's policies for data protection are adhered to	Chief Executive and Medical Director (Caldicott Guardian) and Trust's Senior Information Risk Owner(Director of Finance)	All Employees

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A13. Declaration of Interest		
a) Maintaining a register of Conflicts of interests encompassing the Council of Governors, Board of Directors, all employees	Chief Executive	Company Secretary
A14. Disposal and Condemnations		
a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (to be recorded in the appropriate Losses Register)	Director of Finance	Head of User Department in conjunction with Head of Medical Devices
b) Develop arrangements for the sale of assets	Director of Finance	Deputy Director of Finance
A15. Environmental Regulations (see also A8 – Carbon Reduction Commitment/Green Plan)		
c) Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Operating Officer	Associate Director of Estates and Facilities
A16. External Borrowing		
a) Advise the Board of Directors of the requirements to repay / draw down Public Dividend Capital.	Director of Finance	Head of Financial Services

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
b) Application for draw down of Public Dividend Capital and overdrafts, Loan or PDC Utilisation Request	Director of Finance	In accordance with relevant mandate (Head of Financial Services with approvals from the Chair)
c) Preparation of procedural instructions	Director of Finance	Head of Financial Services
A17. Financial Planning / Budgetary Responsibility –		
a) **Setting**: • Submit business plan to the Board of Directors	Chief Operating Officer and Director of Finance	Associate Director of Strategy & Transformation
• Submit budgets to the Board of Directors • Submit to the Board of Directors financial estimates and forecasts	Director of Finance Director of Finance	Operational Director of Finance/Deputy Director of Finance Operational Director of Finance/Deputy Director of Finance
b) **Monitoring**: • Devise and maintain systems of budgetary control • Monitor performance against budget	Director of Finance Director of Finance	Operational Director of Finance/Deputy Director of Financial Services/ Head of Financial Services Operational Director of Finance/Deputy Director of Financial Services/ Head of Financial Services

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Submit quarterly financial monitoring returns	Director of Finance	Operational Director of Finance/Deputy Director of Financial Services/ Head of Financial Services
• Delegate budgets to budget holders (where appropriate)	Director of Finance	Operational Director of Finance/Deputy Director of Financial Services/ Head of Financial Services
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget	Director of Finance	Operational Director of Finance/Deputy Director of Financial Services/ Head of Financial Services
c) **Preparation of**:		
• Annual accounts	Director of Finance	Head of Financial Services
• Annual report	Chief Executive	Company Secretary
d) **Budget responsibilities**		
• Ensure that no overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Board of Directors	Director of Finance	Budget Holders
•		

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Ensure that approved budget is not used for any other than the specified purpose subject to rule of virement	Director of Finance	Budget Holders
• Ensure that no permanent employees are appointed without the approval of the relevant Executive Director, the Director of People and OD and the Director of Finance other than those provided for within available resources and manpower establishment	Chief Executive	Executive Director in consultation with Director of People and OD and the Director of Finance
e) **Authorisation of Virement**: • The facility of virement is available to Care Group Leadership Teams • Virement can involve the following different types of transfers: Transfers between non-pay budgets; Transfers between staff budgets; and • Transfers from staff to non-pay budgets. NB: Transfers from non-pay to staff budgets	Director of Finance	Care Group Leadership Teams, Budget Holders with explicit permission from Deputy Director of Finance. There is no financial ceiling limiting the amount of any one virement transfer. In all cases, the Divisional Accountant shall be consulted. It is paramount that virement changes do not undermine the integrity of the budgets. Final Approval is required from Deputy Director of Finance

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
is not allowable. • . Virement between different budget holders requires the agreement of both parties and Director of Finance.		
A18. Financial Procedures		
a) Maintenance & Updating of Trust Financial Procedures	Director of Finance	Deputy Director of Finance and Head of Financial Services
b) **Responsibilities** • Implement the Trust's financial policies and coordinate corrective action • Ensure that adequate records are maintained to explain the Trust's transactions and financial position • Providing financial advice to the Board of Directors and employees • Ensure that appropriate statutory records are maintained across the organisation • Designing and monitoring compliance with all financial systems	Director of Finance	Deputy Director of Finance and Head of Financial Services

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
c) **Responsibilities** • Adherence to the Trust's financial policies • Assist with ensuring that appropriate statutory records are maintained • Seeking financial advice from the Director of Finance • Providing advice on compliance with all financial systems	Director of Finance	Operational Director of Finance and Deputy Director of Finance Head of Financial Services and All Employees
A19. Fixed Assets		
a) Maintenance of asset register	Director of Finance	Operational Director of Finance and Deputy Director of Finance
b) Approval of fixed asset control procedures.	Director of Finance	Operational Director of Finance and Deputy Director of Finance
b) Calculate and pay capital charges in accordance with NHS England and Improvement guidance	Director of Finance	Operational Director of Finance and Deputy Director of Finance
c) Responsibility for security of Trust assets including notifying discrepancies to the Director of Finance and accordance reporting losses in with Trust procedures	Chief Executive and Director of Finance	All Employees

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A20.	**Fraud**		
a)	Monitor and ensure compliance with statute and Secretary of State Directions on fraud and corruption	Director of Finance	Anti Fraud Specialist
b)	Appoint a Anti Fraud Specialist	Director of Finance and Audit Committee	Head of Financial Services
c)	Prepare an Anti Fraud, Corruption and Bribery Policy and response Plan (F06)	Director of Finance	Head of Financial Services / Anti Fraud Specialist
d)	Inform Counter Fraud and Security Management, the police, the Audit Committee and External Auditors of frauds that have taken place in the Trust	Director of Finance	Anti Fraud Specialist
A21.	**Freedom of Information Act**		
a)	Development of Freedom of Information Act policies and the Trust's Publication Scheme in accordance with statute and guidance	Associate Director of Corporate Affairs	Associate Director of Corporate Affairs
b)	Ensure Freedom of Information Act policies are adhered in respect of requests received under the Freedom of Information Act within the correct timescales	Associate Director of Corporate Affairs	Associate Director of Corporate Affairs

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A22. Funds Held on Trust (charitable)		
a) **Management**:		
• Funds held on Trust are managed appropriately	Director of Finance	Head of Financial Services
• Maintenance of authorised signatory list of nominated fund holder	Director of Finance	Head of Financial Services
• Expenditure Limits	Refer to Table B Delegated Limits	Refer to Table B Delegated Limits
• Dealing with Legacies	Director of Finance	Head of Financial Services
b) **Fundraising Appeals**:		
• Fundraising appeal proposals	Associate Director of Corporate Affairs	Head of Charities
• Preparation and monitoring of budget	Associate Director of Corporate Affairs	Head of Financial Services
• Reporting progress and performance against budget	Associate Director of Corporate Affairs	Head of Financial Services
c) **Operation of Bank Accounts**:		
• Managing banking arrangements and operation of bank accounts	Director of Finance in conjunction with Trustees	Head of Financial Services
• Opening bank account	Director of Finance	Director of Finance

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
d) **Investments**: • Nominating deposit taker • Placing transactions	Charitable Trustees Committee Director of Finance	Director of Finance Head of Financial Services
e) **Charities Commission**: • Registration of fund(s) with the Charity Commission	Director of Finance	Head of Financial Services
A23. Health and Safety		
a) Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Executive Chief Nurse	Associate Deputy Director - Health and Safety
b) Develop policies and procedures to comply with statutory requirements, including control of Substances Hazardous to Health Regulations	Executive Chief Nurse	Associate Deputy Director - Health and Safety
c) Ensure compliance with statutory requirements and Trust policies and procedures	Executive Chief Nurse	Associate Deputy Director - Health and Safety
d) Comply with statutory requirements and Trust policies and procedures	Executive Chief Nurse	All Employees

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A24.	**Hospitality, Gifts and Individual Commercial Sponsorship** (see also A10 – Commercial Sponsorship)		
a)	Keeping of hospitality / gifts / individual sponsorship register in line with the Trust's Standards of Business Conduct Policy	Chief Executive	Company Secretary
b)	Declaring the receipt of gifts and hospitality and / or individual sponsorship in the hospitality, gifts and individual sponsorship register (Applies to both individual and collective hospitality / gifts / sponsorship received in excess of £50.00 received)	Company Secretary	All staff must make declarations as required in the *Standards of Business Conduct Policy*
c)	**Approving the retention of gifts and the receipt of hospitability / sponsorship**	Refer to *Conflicts of Interest Policy*	Refer to *Conflicts of Interest Policy* Refer to *Standards of Business Conduct Policy*
	• For Non-Executive Directors and Chief Executive	Chairman	Company Secretary
	• For Executive Directors	Chief Executive	Company Secretary
	• For all other employees	Company Secretary	Line Manager
d)	Monitoring compliance with these arrangements (Refer to *Standards of Business Conduct Policy*)	Audit Committee	Company Secretary

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A25. Legal Proceedings		
a) Engagement of Trust's Solicitors	Chief Executive	Company Secretary/Head of Legal Services and others duly authorised by CEO (In excess of £150,000 estimated legal fees requires Board consent)
b) Approve and sign all documents which will be necessary in legal proceedings, i.e., executed as a deed	Chief Executive and Board of Directors	Company Secretary/Head of Legal Services and others duly authorised by CEO
c) Sign on behalf of the Trust any agreement or document not requested to be executed as a deed	Chief Executive	Chief Executive, Executive Directors and Company Secretary
A26. Losses, Write-off & Compensation		
a) **Losses & Special Payments**:		
• Prepare procedures for recording and accounting for losses and special payments	Director of Finance	Head of Financial Services
• Approving payments - Financial Limits (NB – all payments are subject to formally being reported to, and ratified by the Trust's Audit Committee)	For Financial Limits refer to Table B	For Financial Limits refer to Table B

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
b) **Compensation Payments**: • Expedite compensation payments by Court Order (also refer to Table B - Financial Limits) • Notify the Board of Directors and the Audit Committee	Chief Executive Chief Executive	Director of Finance Director of Finance
c) **Ex-Gratia Payments**: • to patients / staff for loss of personal effects • For clinical negligence after legal advice • For personal injury after legal advice • Other clinical negligence and personal injury • Other ex-gratia payments	For Financial Limits refer to Table B	For Financial Limits refer to Table B
d) **Write Offs**: • Write off of Non NHS Debtors	Director of Finance	Head of Financial Services reported to Audit Committee for information
e) Review the appropriateness of insurance arrangements to meet these various losses, write offs and other claims	Director of Finance	Head of Financial Services

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
f) Collate and maintain a register of all of the payments made across the Trust which should be available for inspection	Director of Finance	Head of Financial Services
A27. Medicines Inspectorate Regulations		
a) Review Regulations and ensure Trust policies and procedures adhere to these statutory requirements	Medical Director	Chief Pharmacist
b) Discharge the duties of Accountable Officer for Controlled Drugs for the Trust	Medical Director	Chief Pharmacist
c) Officers designated by the Accountable Officer for Controlled Drugs for the Trust to act as an Authorised Witness for the disposal of Controlled Drugs	Medical Director	Chief Pharmacist / Deputy Chief Pharmacist
d) Ensure Trust staff dispose of Controlled Drugs in accordance with statute and Trust Policy	Medical Director	Chief Pharmacist / Deputy Chief Pharmacist
e) Dispose of Controlled Drugs, as used by the Trust, in the manner laid out by statute and Trust policy	Medical Director	Chief Pharmacist / Deputy Chief Pharmacist
f) Responsibility for controls of all pharmaceutical stock as used by	Medical Director	All Employees

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
the Trust		
A28. Meetings		
a) Calling meetings of the Trust and the Board of Directors	Chairman	Company Secretary
b) Chair all Board meetings and associated responsibilities	Chairman	Chairman supported by Company Secretary
A29. Non Pay Expenditure		
a) Maintenance of a list of managers authorised to place requisitions / orders and accept goods	Director of Finance	Head of Procurement
b) Obtain the best value for money when requisitioning goods/services	Director of Finance	All staff / Head of Procurement
c) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in A17(e) of Table A)	Chief Executive	Director of Finance
d) Develop and maintain systems for the prompt payment of accounts in accordance with national guidance	Director of Finance	Head of Financial Services

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
e)	For the approval of the Board of Directors, develop a schedule of Delegated Financial Limits (see table B)	Director of Finance	Head of Financial Services
f)	Financial Limits	Refer To Table B Delegated Limits	Refer To Table B Delegated Limits
g)	Develop and maintain systems to comply with NHS England and Improvement's consultancy spending guidance controls	Director of Finance	Head of Financial Services
A30.	**Patients & Relatives Complaints**		
a)	Overall responsibility for ensuring that all complaints are dealt with effectively	Executive Director of Nursing	Director of Governance and Patient Relations Manager
b)	Responsibility for ensuring complaints relating to a Divisional Directorate / Hosted Service are investigated thoroughly.	Executive Director of Nursing	Director of Governance and Patient Relations Manager
c)	Medico - Legal Complaints Coordination and management	Executive Director of Nursing	Head of Legal Services

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A31.	**Patient and Non Patient Services Agreements**		
a)	Negotiation of Service Level Agreements, Contracts and Non Commercial Contracts	Director of Finance	Deputy Director of Finance and Contracts Manager
b)	Quantifying and monitoring out of area treatments	Director of Finance	Deputy Director of Finance and Contracts Manager
c)	Reporting actual and forecast income	Director of Finance	Deputy Director of Finance and Contracts Manager
d)	Costing all SLA's, Contracts and Non Commercial Contracts	Director of Finance	Deputy Director of Finance and Contracts Manager
A32.	**Patients' Money and Property**		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Executive Chief Nurse	General Managers / Department Heads / Matrons and Ward Managers
b)	Prepare detailed written instructions for the administration of patients' property and money,	Director of Finance	Head of Financial Services and Local Security Management Specialist
e)	Informing staff of their duties in respect of patients' property and money.	Director of Finance	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
f)	For deceased patients, issuing property valued >£5,000 only on production of a probate letter of administration	Director of Finance	Head of Financial Services

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A33. Personnel & Pay		
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Department Heads /Matrons and Ward Managers
b) Authority to fill funded post on the establishment with permanent staff.	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Department Heads /Matrons and Ward Managers
c) The granting of additional increments to staff within budget	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers in consultation with HR Business Partners
d) All requests for upgrading / regarding / major skill mix changes shall be dealt with in accordance with Trust Procedure	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers in consultation with HR Business Partners
e) **Establishments** • Additional staff to the agreed establishment with specifically allocated finance. (Note: Additional staff cannot be agreed to the establishment without specifically allocated finance or explicit approval by the Director of Finance)	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers in consultation with HR Business Partners and Divisional Finance Manager

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
f) **Pay** • Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
• Authority to authorise overtime (subject to resources being available)	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
• Authority to authorise travel & subsistence expenses	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
g) **Leave** All approvals must be taken in accordance with the UHMB Leave Policy • Approval of annual leave • Annual leave - approval of carry forward (up to maximum of 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service). • Adverse weather conditions • Carer Leave • Bereavement/Compassionate Leave • Unpaid Leave including time off for public duties	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Manager, Line/Departmental Manager

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
h) Family Leave All approvals must be taken in accordance with the UHMB Family Leave Policy Approval of :- • Maternity leave • Adoption leave • Paternity leave • Parental leave • Shared Parental leave • Surrogacy	Director of People and OD	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Manager, Line/Departmental Manager
i) **Sick Leave** All approvals must be taken in accordance with the Attendance at Work Policy • Extension of sick leave on pay • Return to work part-time on full pay to assist recovery	Director of People and OD Director of People and OD	Line/Departmental Manager Line/Departmental Manager

Table A – Delegated Authority

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
i) **Study Leave** All approvals must be taken in accordance with the Study Leave Policy • Study leave outside the UK • Medical staff study • All other study leave	Director of People and OD and Medical Director	Line Manager/ Deputy Medical Director/Tutor
j) **Removal Expenses, Excess Rent and House Purchases** • Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was agreed at interview)	Director of People and OD Refer to Table B Delegated	Line Manager in conjunction with HR Business Partners
k) **Grievance Procedure** • All grievances cases must be dealt with strictly in accordance with the Grievance Procedure.	Director of People and OD	Deputy Director of People and OD Assistant Director of People & Organisational Development, in consultation with Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers supported by HR Business Partners
n) **Renewal of Fixed Term Contract**	Director of People and OD	Budget Holder on advice from HR Business Partner

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
o) **Staff Retirement Policy** • Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Director of People and OD	Deputy Director of People and OD Assistant Director of People & Organisational Development, in consultation with Line Managers
p) **Redundancy** (Note: The relevant policies of the Trust must be followed).	Chief Executive	Executive Director of the Service supported by Deputy Director of People and OD Assistant Director of People & Organisational Development, in consultation with Line Managers
q) **Ill Health Retirement** (Note: The relevant policies of the Trust must be followed).	Executive Director of Workforce	Executive Director of the Service supported by Deputy Director of People and OD Assistant Director of People & Organisational Development, in consultation with Line Managers
r) **Disciplinary Procedure** (excluding Executive Director and some very senior managers) (Note: The relevant policies of the Trust must be followed).	Executive Director of Workforce	Deputy Director of People and OD Assistant Director of People & Organisational Development, in consultation with Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers supported by HR Business Partners
s) **Salary Sacrifice Schemes** (i.e. Bikes and Cars) (Note: The relevant policies of the Trust must be followed).	Director of Finance	Deputy Director of Finance, Head of Financial Services, Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A34. Professional Leadership		
a) **Medical Professionals**		
• Provide professional leadership in respect of professional standards, education and training for all of the Trust's medical employees	Medical Director	Deputy Medical Director
• Ensuring compliance with statutory and regulatory arrangements relating to medical professionals	Medical Director	Deputy Medical Directors
• Quality assurance of medical professionals processes	Medical Director	Deputy Medical Directors
b) **Nursing Professionals**		
• Provide professional leadership in respect of professional standards, education and training for all of the Trust's nursing professionals	Executive Chief Nurse	Deputy and Associate Directors of Nursing and Senior Nursing Leadership Team, Nursing Leads for Care Groups and Matrons
• Ensuring compliance with statutory and regulatory arrangements relating to nursing professionals	Executive Chief Nurse	Deputy and Associate Directors of Nursing and Senior Nursing Leadership Team, Nursing Leads for Care Groups and Matrons

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• Quality assurance of nursing professionals processes	Executive Chief Nurse	Deputy and Associate Directors of Nursing and Senior Nursing Leadership Team, Nursing Leads for Care Groups and Matrons
c) **Allied Health Professionals**	Executive Chief Nurse	Deputy and Associate Directors of Nursing and Senior Nursing Leadership Team, Nursing Leads for Care Groups and Matrons and Allied ~health Professional Leads
• Provide professional leadership in respect of professional standards, education and training for all of the Trust's allied health professionals		
• Ensuring compliance with statutory and regulatory arrangements relating to allied health professionals	Executive Chief Nurse	Deputy and Associate Directors of Nursing and Senior Nursing Leadership Team, Nursing Leads for Care Groups and Matrons and Allied ~health Professional Leads
• Quality assurance of allied health professionals processes	Executive Chief Nurse	Deputy and Associate Directors of Nursing and Senior Nursing Leadership Team, Nursing Leads for Care Groups and Matrons and Allied ~health Professional Leads

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
d) **Financial Employees** • Provide professional leadership in respect of professional standards, education and training for all of the Trust's financial employees	Director of Finance	Deputy Director of Finance and Head of Financial Services
A35. Quotation, Tendering & Contract Procedures		
a) **Services**: • Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Executive Directors and their deputies, Care Group Leadership Teams, Department Heads / Head of Procurement
• Nominate officers to oversee and manage the contract on behalf of the Trust.	Director of Finance	Head of Procurement/ Director of Finance / Associate Director of Estates and Facilities Contract Lead
b) **Competitive Tenders**: • Authorisation Limits	Chief Executive	Refer To Table B Delegated Limits
• Receipt and custody of tenders prior to opening (where the Trust's designated	Chief Executive or their nominated representative	Lead Buyer

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
e-tendering portal is being used)		
• Opening Tenders (using the Trust's designated e-portal system)	Chief Executive or their nominated representative	Head of Procurement/Lead Buyer
• Maintain a list of approved firms for tenders	Director of Finance	Head of Procurement/Lead Buyer
• Maintain an organisational wide register to show the tenders received for each competitive tendering exercise	Director of Finance	Head of Procurement
• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote	Director of Finance	Head of Procurement/Contract Lead and Lead Buyer
c) Waive the requirement to request		
• Tenders - refer to Contract Procedure Rules and Standing Financial Instructions subject to the	Chief Executive	Executive Directors/Head of Procurement and Head of Financial Services (reported to the Audit Committee)

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
completion of an Application to Waiver Competitive Tenders Procedure form		
• Quotes – refer to Contract Procedure Rules and Standing Financial Instructions subject to the completion of an Application to Waiver Competitive Tenders Procedure form	Director of Finance	Executive Directors/Head of Procurement and Head of Financial Services (reported to the Audit Committee)
A36. Records		
a) Review Trust's compliance with the Public Records Act 1958, the Data Protection Act 1998 and the Freedom of Information Act 2000 (together with any other statutory requirement and any subsequent amendments / additions)	Director of Finance	Medical Director / Information Governance Manager / Records Manager
b) Ensure records are retained in accordance with the Department of Health's *Records Management: NHS Code of Practice* and subsequent / relevant guidance:		
• For Clinical Records	Medical Director	Heads of Department / Records Manager

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
• For Non-Financial Corporate records	Director of Finance	Heads of Department / Records Manager / Information Governance Manager
• For Financial Corporate records	Director of Finance	Deputy Director of Finance / Records Manager / information Governance Manager
c) Ensure record, retain and dispose of records in accordance with Trust records management policies and procedures	Chief Executive	All Employees
A37. Reporting of Incidents to the Police		
a) Where a criminal offence has occurred or is suspected to have occurred, such as • criminal offence of a violent nature • arson or theft	Chief Executive	Executive Directors/Director On-call / Clinical Site Manager / Department Heads supported by Head of Legal Services
b) Where a fraud is involved (reporting to the NHS CFA)	Director of Finance	Director of Finance / Local Anti- Fraud Officer

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
A38.	**Review of Fire Precautions**		
a)	Review and ensure that the Trust's fire safety precautions and prevention policies and procedures are adequate and that the fire safety and integrity of the estate is intact	Chief Executive	Associate Director of Estates and Facilities / Fire Safety Officer
b)	Develop fire precautions and prevention policies and procedures that comply with statute and guidance	Chief Operating Officer	Fire Safety Officer
c)	Ensure compliance with the fire precautions and prevention policies and procedures within the premises for which you have responsibility	Chief Operating Officer	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
d)	Comply with the fire precautions and prevention policies and procedures	Chief Operating Officer	All Employees
A39.	**Risk Management**		
a)	Ensure the Trust has robust risk management processes in place	Chief Executive	Executive Chief Nurse
b)	Review and maintain the Trust's Risk Management Strategy, for approval by the Board of Directors	Executive Chief Nurse	Director of Governance / Head of Risk and Company Secretary

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
c) Review and maintain / develop the Trust's systems for the management of risk	Executive Chief Nurse	Director of Governance / Head of Risk and Company Secretary
d) Review and maintain / develop the Trust's systems for incident / accident reporting	Executive Chief Nurse	Director of Governance / Head of Risk and Company Secretary
e) Ensure compliance with the Trust's systems for the management of risk and incident / accident reporting	Executive Chief Nurse	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
e) Approval of self insured risks outside of the Risk Pooling Scheme, Administered by NHS Resolution	Director Of Finance	Head of Financial Services in consultation with Head of Legal Services
A40. Safeguarding – Adults		
a) Discharge the duties of the Board of Directors Level Lead for Safeguarding Vulnerable Adults	Executive Chief Nurse	Head of Safeguarding & Professional Lead
b) Review and maintain the Trust's *Policy for Safeguarding Vulnerable Adults from Abuse*	Executive Chief Nurse	Head of Safeguarding & Professional Lead
c) Contribute to the development of	Executive Chief Nurse	Head of Safeguarding & Professional Lead

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
	multi-agency strategies, policies and procedures to safeguarding vulnerable adults in conjunction with: • Cumbria County Council • Lancashire County Council		
d)	Ensure compliance with statutory requirements and policies and procedures for safeguarding vulnerable adults	Executive Chief Nurse	Head of Safeguarding & Professional Lead
e)	Comply with statutory requirements and policies and procedures for safeguarding vulnerable adults	Chief Executive	All Employees
A41.	**Safeguarding – Children**		
a)	Discharge the duties of the Board of Directors Level Lead for Safeguarding Children	Executive Chief Nurse	Head of Safeguarding & Professional Lead
b)	Review and maintain the Trust's *Policy and Procedure for the Safeguarding and Protection of Children*	Executive Chief Nurse	Head of Safeguarding & Professional Lead
c)	Contribute to the development of multi-agency strategies, policies and procedures to safeguarding children through membership of	Executive Chief Nurse	Head of Safeguarding & Professional Lead

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
	the following Local Safeguarding Children's Boards • Cumbria • Lancashire		
d)	Ensure compliance with statutory requirements and policies and procedures for safeguarding children	Executive Chief Nurse	Head of Safeguarding & Professional Lead
e)	Comply with statutory requirements and policies and procedures for safeguarding children	Chief Executive	All Employees
A42.	**Seal**		
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Company Secretary
b)	Attestation of seal in accordance with Standing Orders for the Board of Directors	Chief Executive	Two Executive Directors and/or Company Secretary
A43.	**Security Management**		
a)	Discharge the Lead Executive Director Responsibility for Security Management, including complying with statute and guidance issued by NHS Protect	Chief Operating Officer	Local Security Management Specialist

DELEGATED MATTER		DELEGATED AUTHORITY	OPERATIONAL DELIVERY
b)	Review, maintain and develop Trust policies and procedures for security management	Chief Operating Officer	Local Security Management Specialist
c)	Ensure compliance with statutory requirements and Trust policies and procedures for security management	Chief Operating Officer	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers
d)	Comply with statutory requirements and Trust policies and procedures for security management	Chief Operating Officer	All Employees
A44.	**Setting of Fees and Charges**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Director of Finance	Head of Financial Services
b)	Non patient care income	Director of Finance	Head of Financial Services
c)	Informing the Director of Finance of monies due to the Trust	Director of Finance	All Employees
d)	Recovery of debt	Director of Finance	Head of Financial Services
e)	Security of cash and other negotiable instruments	Director of Finance	Head of Financial Services
A45.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of	Director of Finance	Deputy Medical Directors, Clinical Directors/ General

DELEGATED MATTER	DELEGATED AUTHORITY	OPERATIONAL DELIVERY
control over stores and receipt of goods, issues and returns		Managers / Senior Nurses / Department Heads /Matrons and Ward Managers Department Heads
b) Stocktaking arrangements	Director of Finance	Deputy Medical Directors, Clinical Directors/ General Managers / Senior Nurses / Department Heads /Matrons and Ward Managers

Table B – Delegated Limits

Delegated Authority - the delegation shown below is the lowest level to which authority is delegated. Delegated authority to a named position cannot be further delegated to another officer or Board member.

Absence of the Chief Executive - if the Chief Executive is absent, powers delegated to him / her may be exercised by the Director of Finance (as the nominated Deputy Chief Executive) or, if both are absent, by a nominated Executive Director.

Absence of a director or officer other than the Chief Executive - in the absence of a director or officer to whom powers have been delegated, that director's or officer's superior shall exercise those powers unless alternative arrangements have been approved in writing by the Board of Directors.

Financial limits – financial limits are subject to funding available within relevant budget(s) and are exclusive of VAT.

Failure to comply with the delegated limits - ***the failure to comply with delegated limits below could be regarded as a disciplinary matter that could result in dismissal.***

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B1. Quotations / Tenders		
a) **Quotations**: **Quotations must be sought in accordance with the Quotation SOP – SUP 207**		
• Obtain a minimum of x1written competitive quote for goods / service following appropriate market research to obtain best value	Up to £4999 inc VAT	• Budget Holder, or Head of Procurement
• Obtain a minimum of x2 competitive quotes for goods/ services	£5000 to £9999 inc VAT	Budget Holder, Project Manager and Head of Procurement
• Obtain a minimum of three competitive quotations for goods / services	£10000 up to £14999 inc VAT	Project Manager and Head of Procurement
b) **Competitive Tenders**: • Obtaining a minimum of 3 written competitive tenders for goods or services (following the official Trust Procedure)	Above £15,000	• Executive Director of Finance, Support Services & People

***Note* - Authorisation of requisitions via the E-Procurement System (which are required without exception) should be adequately supported and evidenced by the Trust Officers identified for each delegated limit.**

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B2. Non Pay Expenditure		
a) **Revenue expenditure**.	£100	Bands 2,3 & 4
• Requisitioning, Ordering, payment of goods and services.	£500	Bands 5 & 6
Except ordering and paying for pharmacy, building works and computer equipment (see below)	£1,000	Band 7
	£2,500	Band 8s
	£25,000	ADOPs or Equivalent
	£25,000+	Executive Directors
b) **Engagement of Consultants** Consults will only be engaged in accordance with rules set out by NHS Improvement	As set out in NHSI guidance/and or the delegated levels above	Executive Directors or their nominated Deputies

***Note* - Authorisation of requisitions via the E-Procurement System (which are required without exception) should be adequately supported and evidenced by the Trust Officers identified for each delegated limit**

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
c) **Pharmacy**	Up to £25,000 (excl. VAT)	Chief Pharmacist or their authorised deputies
	Above £25,000 plus VAT	Chief Pharmacist Associate Medical Director/Deputy Chief Operating Officer
***Note* - Authorisation of requisitions via the E-Procurement System (which are required without exception) should be adequately supported and evidenced by the Trust Officers identified for each delegated limit.**		
d) **IT and Medical Equipment**		Purchases can only be made which have been included in the approved annual programme and/or within approved budget).
IT	Requisitions upto £1000	IT Operations Manager/ Deputy IT Operations Manager
	Requisitions from £1000 upto £50k	Chief Information Officer
	Above £50K	Director of Finance
Medical Devices	Requisitions upto £25k	Head of Medical Engineering

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
Medical Devices	Requisitions from £25k to £50k	Associate Director of Operations
	Requisitions above £50k	Chief Operating Officer
***Note* - Authorisation of requisitions via the E-Procurement System (which are required without exception) should be adequately supported and evidenced by the Trust Officers identified for each delegated limit.**		
e) **Capital construction and annual building maintenance.**	**Capital Expenditure only where included in the approved annual programme (as approved by the Board of Directors) and within budget and in accordance with Capital Policy**	
• Award of Contracts	Within Value of Scheme	Capital Services Manager
• Additions, amendments and variations to Schemes	Within Value of Scheme Beyond value of Scheme	Capital Services Manager Capital Plan Group

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
• Additions, amendments and variations to Programme	Within Value of Programme Beyond value of Scheme	Capital Plan Group (with variations reported to Finance Committee) Capital Plan Group (with variations approved by Finance Committee)
• Capital building works and stage payments for the Capital Programme	As per the schedule of payments	Capital Services Manager
• building works – repairs and maintenance	As per the procurement framework approved by the Head of P	Divisional Manager - Estates Maintenance estates & facilities
***Note* - Authorisation of requisitions via the E-Procurement System (which are required without exception) should be adequately supported and evidenced by the Trust Officers identified for each delegated limit**		
B3. Petty Cash Disbursements		
a) Individual items (only on authorised, approved purposes of Trust business where the use of the normal ordering system would be too slow or inappropriate)	Up to £50	• Budget Holder or Petty Cash Holder
	£50 to £250	• Head of Financial Services

DELEGATED MATTER		DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B4.	**Contracted Services**		
a)	Services covered by Contract, Service Level Agreement *(including negotiation and contract variations)*	Any Amount with approved budget	Relevant Executive Director in consultation with the Director of Finance
b)	Intra NHS invoices	Any Amount with approved budget	Budget Holder or Head of Financial Services
B5.	**Removal Expenses**		
a)	Removal expenses, excess rent and home purchase incurred by officers taking up new appointments (providing consideration was agreed at interview)	Up to £8000	• Appointing Manager in consultation with Director of People and OD
		Over £8000	• Chief Executive/ relevant Executive Director in consultation with Director of People and OD or • in the case of the appointment of a Chief Executive, the Chair in consultation Director of People and OD

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B6. Charitable Funds *(Please Note – at present the Trust does not hold any Charitable funds, but retains the right to hold funds if appropriate)*		
a) Expenditure authorisation	Up to £500	• Fund Manager
	From £500 Up to £24,999 (overseas conferences must also be authorized by the CE)	• Head of Financial Services
	£25,000 and above per request	• Corporate Trustee Committee`
B7. Losses and Special Payments ***Note - All payments made under losses and special payments are subject to formally being reported to, and ratified by the Trust's Audit Committee.***		
a) **Losses** • Losses of cash due to theft, fraud, & others.	Up to £50,000	Chief Executive and Director of Finance
• Fruitless payments (including abandoned Capital Schemes)	Up to £250,000	Chief Executive and Director of Finance

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
• Bad debts and claims abandoned.	Up to £5000	Deputy Director of Finance
	£5001 - £10000	Operational Director of Finance
	Over £10000	Director of Finance
• Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson).	Up to £25000	Director of Finance
	From £25,000 to £50,000	Director of Finance ***and*** Chief Executive
b) **Special Payments** • Compensation payments by Court Order	Any amount	Director of Finance and Director of People and OD
c) **Ex gratia Payments**:- • To patients and staff for loss of personal effects	Up to £1000	Budget Holder
	Between £1,000 and £50,000	Operational Director of Finance

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
• For clinical negligence claims after legal advice funded by UHMB	Up to £10,000 (including plaintiff's costs) Above £10,000 (including plaintiff's costs)	Head of Legal Services Director of Finance
• For personal injury after legal advice funded by UHMB	Up to £10,000 (including plaintiff's costs) Above £10,000 (including plaintiff's costs)	Head of Legal Services Director of Finance
• Other cases of maladministration where legal advice has been obtained and guidance applied	Up to £10,000 (including plaintiff's costs) Above £10,000 (including plaintiff's costs)	Head of Legal Services Director of Finance
• Other ex gratia payments	Up to £10,000	Director of Finance

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DELEGATED MATTER		DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B8.	**Short Term Borrowing**		
a)	Short term borrowings	Any amount	Any two from the: • Director of Finance • Operational Director of Finance • Deputy Director of Finance. • Head of Financial Services
B9.	**Use of Seal and Signing Capital Contracts**		
a) b) c)	All contracts for the purchase or lease of land or buildings Any lease agreement Capital Contracts as required	Any amount	Two Executive Directors and/or Company Secretary
B10.	**Setting Fees and charges**		
a)	Private Patient, Overseas Visitors,Trading Services,Income Generation and other patient related services.	Any amount	Director of Finance
b)	Non patient care income	Any amount	Director of Finance
B11.	**Agreements and licences**		
a)	Signature of tenancy agreements and licences for all staff subject to Trust Policy on accommodation for staff.	Any amount	• OperationalDirector of Finance in consultation with the Associate Director of Estates and Facilities

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
b) Extensions to existing leases.	Any amount	Either the • Director of Finance or • Associate Director of Finance together with the Associate Director of Estates and Facilities
c) Letting of premises to outside organisations.	Any amount	Chief Executive and Director of Finance
d) Approval of rent based on professional assessment.	Any amount	Director of Finance
B12. Condemning and Disposal		
a) Items obsolete, obsolescent, redundant, and irreparable or cannot be repaired cost effectively.	Up to £5000	Budget Holder in conjunction with a representative of the Director of Finance
b) Disposal of mechanical and engineering plant	Up to £25k	Head of User Department in conjunction with Head of Medical Devices and a representative of the Director of Finance

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B13. Engagement of staff not on the establishment		
a) Non medical consultancy staff Note - any expenditure relating to consultancy costs Consults will only be engaged in accordance with rules set out by NHS Improvement Please notify the Head of Procurement prior to entering / varying / spending more money on consultancy contracts.	As set out in NHSI guidance/and or the delegated levels for Non Pay Expenditure	Chief Executive, Executive Directors,
b) Original Engagement of Solicitors	Upto £150,000 Beyond £100,00	Chief Executive, Executive Director, Company Secretary and Head of Legal Services Board of Directors
c) Engagement of Bank staff, Agency Staff, Medical Locums, Nursing or Clerical staff As per High Agency Policy	As per High Agency Policy	As per High Agency Policy

DELEGATED MATTER	DELEGATED LIMIT	OPERATIONAL RESPONSIBILITY
B14. Business Cases		
Business Cases are needed for the establishment of new services or development of existing services, to support external funding opportunities and to identify revenue costs arising from capital projects. The Business Case process is overseen by the investment and priories group. The group is empowered to establish the framework for the development of business cases and where business cases are fully funded to give the necessary approvals required. Where business cases are unfunded, the investment and priorities group is authorized to refuse such business cases or recommend to the Trust Management Group their approval together with the rational. Requests under £500k: - Delegated to Investment Priorities Group £500k - £1m Delegated to Trust Management Group approval £1-2m - Delegated to Finance Committee Above £2m - Trust Board approval		
B15. Virement		
Virement is available to Care Group Leadership Teams, Budget Holders with explicit permission from Deputy Director of Finance. There is no financial ceiling limiting the amount of any one virement transfer. In all cases, the Divisional Accountant shall be consulted. It is paramount that virement changes do not undermine the integrity of the budgets. Final Approval is required from Deputy Director of Finance		

4 ATTACHMENTS	
Number	**Title**

5 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**

6 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	
2	
3	
Bibliography	

7 DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**

8 CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**

9 DISTRIBUTION PLAN	
Dissemination lead:	Enter the lead of the development group
Previous document already being used?	Yes / No (Please delete as appropriate)
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Please detail how staff will be informed of document contents and changes.

	Include in the UHMB Friday Corporate Communications Roundup or Weekly News. New documents uploaded to the Document Library.

10 TRAINING		
Is training required to be given due to the introduction of this procedural document? *Yes / No (Please delete as required)		
Action by	**Action required**	**Implementation Date**

11 AMENDMENT HISTORY – Please complete if version 2 or higher				
Version No.	**Date of Issue**	**Section/Page Changed**	**Description of Change**	**Review Date**

University Hospitals of Morecambe Bay
NHS Foundation Trust

Equality Impact Assessment Form

Department/Function				
Lead Assessor				
What is being assessed?				
Date of assessment				
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☒	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Select	
Disability (Including physical and mental impairments)	Select	
Sex	Select	
Gender reassignment	Select	
Religion or Belief	Select	
Sexual orientation	Select	
Age	Select	
Marriage and Civil Partnership	Select	
Pregnancy and maternity	Select	
Other (e.g. caring, human rights)	Select	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

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3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.** ➢ This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups ➢ This should be reviewed annually.		
Action Plan Summary		
Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.

University Hospitals of Morecambe Bay
NHS Foundation Trust

Document Type: **Policy**	**Unique Identifier:** SF1
Document Title: **Standing Financial Instructions**	**Version Number:** 0.1 6 February 2022 **Status:** Draft
Scope: Board of Directors, Governors and All staff	**Classification:** Organisational
Author / Title: Director of Finance and Company Secretary	**Responsibility:** Chief Executive as Accountable Officer for the Trust
Replaces: **Standing Financial Instructions**	**Head of Department:**
Validated By: Audit Committee and Finance Committee	**Date:** DD/MM/YYYY
Ratified By: Board of Directors	**Date:** DD/MM/YYYY
Review dates may alter if any significant changes are made	**Review Date:** April 2023
Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** All	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** All
Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? ***Yes** * **Please delete as required**	
Document for Public Display: *Yes * Please delete as required	
Evidence Search Completed by……..Date……. **To be completed by Library and Knowledge Services Staff** **Model Stanfing Financial Instriction 2006**	

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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

For those who supervise / manage teams: ensure consistency and fairness in your approach

Show support to both staff and patients

Communicate effectively: listen to others and seek clarity when needed

Be proud of the role you do and how this contributes to patient care

INTERPRETATION AND DEFINITIONS FOR STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF RESERVATION AND DELEGATION OF POWERS

a) Unless otherwise stated, words or expressions contained in these Standing Financial Instructions and the Scheme of Reservation and Delegation of Powers shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

b) Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

c) In the Standing Financial Instruction and the Scheme of Reservation and Delegation of Powers the following definition apply:

- **the 2006 Act** is the National Health Service Act 2006.
- **the 2012 Act** is the Health and Social Care Act 2012.
- **the Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act and shall be the officer responsible and accountable for funds entrusted to the Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The 2006 Act designates the Chief Executive as the Accounting Officer. The definition of duties and responsibilities of the Accounting Officer are set out within the NHS Foundation Trust Accounting Officer Memorandum.
- **Annual Members' Meeting** is defined in Paragraph 12 of the Constitution.
- **Auditor** means the ***external auditor*** appointed by the Council of Governors in accordance with the Constitution. This role is distinct from the ***internal auditor*** as described in paragraph 2.4 of these Standing Financial Instructions,
- **the Board of Directors** means the Board of Directors as constituted in accordance with the Constitution.
- **the Board** means the Board of Directors.
- **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.
- **Budget holder** means the Executive Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisations' budget.
- **The Chair** means the Chairman of the Trust appointed in accordance with the Constitution to lead the Board if Directors and the Council of Governors to ensure they successfully discharge their overall responsibilities for the Trust as a whole or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution, the person chairing the meeting. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable. **Chief Executive** means the chief officer (and accounting officer) of the Trust.

- **Commissioning** means the process for determining the need for and for obtaining the supply of healthcare and related services for the Trust within available resources.
- **Committee** means a committee or sub-committee created and appointed by the Board of Directors.
- **Committee members** means persons formally appointed by the Board of Directors or the Council of Governors to sit on or to chair specific committees.
- **the Constitution** means the Constitution of the Trust as approved by the Board of Directors and the Council of Governors (it describes the governance and membership arrangements for the Trust and includes the Standing Orders for the Board of Directors, the Council of Governors and 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.
- **the Council of Governors** means the Council of Governors as constituted in accordance with the Constitution.
- **Director of Finance** means the Chief Financial Officer of the Trust.
- **Director** means a person appointed to the Board of Directors in accordance with the Constitution and includes the Chairman.
- **E-Procurement Systems or E-Tendering Systems** means those electronic purchasing, tendering or procurement portals or systems designated by the Director of Finance for use within the Trust by nominated officers.
- **Executive Director** means an executive director of the Trust who is a voting member of the Board of Directors in accordance with the Constitution.
- **The Foundation Trust** means University Hospitals of Morecambe Bay NHS Foundation Trust.
- **Financial Limits** means the delegated financial limits set out in Table B of the Scheme of Reservation and Delegation of Powers.
- **Funds held on Trust** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable.
- **Governor** means a governor elected by the members or appointed by the Trust in accordance with the Constitution.
- **Head Governor** means the governor appointed by the Council of Governors in accordance with the Constitution.
- **Member** means a member of the Trust as defined in the Constitution.
- the **MHA** means the Mental Health Act 1983.
- **NHS England** is the corporate body established as provided by Section 61 of the 2012 Act (formerly know as Monitor).
- **NHS Commissioning Board** is the body corporate established pursuant to Section 1H of the 2006 Act, known as NHS England.
- **NHS England/Improvement** is the NHS Commissioning Board.
- **NHS Provider Licence** means the licence which contains the conditions placed on the Trust as a provider of NHS services in respect of its authorisation as Foundation Trust by the regulator (NHS England/Improvement).

- **Nominated Officer** means an officer charged with responsibility for discharging specific tasks in accordance with the Constitution (Standing Orders), the Standing Financial Instructions or the Scheme of Reservation and Delegation of Powers.
- **Non-Executive Director** means a member of the Board of Directors appointed in accordance with the Constitution who is not an officer of the Trust.
- **Officer** means an employee of the Trust.
- **SFI's** means *Standing Financial Instructions*.
- **SO's** means *Standing Orders* (which are available in the Constitution for both the Council of Governors and the Board of Directors).
- **SoRDP (or SoRD)** means *Scheme of Reservation and Delegation of Powers*.
- **Vice-Chair** means the Non-Executive Director appointed in accordance with the Constitution to take on the Chair's duties if the Chair is absent for any reason.
- **System Oversight Framework** means the guidance of the same name published by NHS England/Improvement to oversee and assess delivery of care.
- **The Trust** means University Hospitals of Morecambe Bay NHS Foundation Trust.
- **Trust Secretary** means the Company secretary of the Trust or any other person appointed to perform the duties of the secretary including a secretarial assistant.

1 INTRODUCTION

1.1. General

1.1.1. These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the University Hospitals of Morecmabe Bay NHS Foundation Trust (referred to as the "Trust"). They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law, with Government policy and with other good practice in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Constitution and the Scheme of Reservation and Delegation and Powers which have been adopted by the Trust.

1.1.2. The Trust is a Public Benefit Corporation following approval by the Independent Regulator of NHS Foundation Trusts (known as NHS England/Improvement) pursuant to the National Health Service Act 2006 (the "2006 Act"). The Trust is governed by the 2006 Act, as amended by the Health and Social Care Act 2012 (or subsequent statute, its Constitution and the NHS Provider Licence granted by NHS England/Improvement. The functions of the Trust are conferred by the Regulatory Framework and the Trust is required to comply with the guidance issued by NHS England/Improvement . These Standing Financial Instructions, their content and approval are the sole responsibility of the Board of Directors and are not required to be submitted for approval to any group or organisation including NHS England/ Improvement or the Council of Governors.

1.1.3. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance or their delegated officers must approve all departmental financial procedures. A Register of these is maintained by the Director of Finance.

1.1.4. For ease of reference separate policies, rules and procedures exist (or will be approved) for:-

Budget Setting Policy
Business Case Process
High Cost Agency, Agency Break Glass approval Policy and Process
Capital Programme Policy
Contract and Procurement Rules

1.1.5. The Director of Finance also has delegated authority to introduce new polcies that are required to maintain a strong financial control environment.

1.1.6. The Director of Finance has delegated authority to keep under review and agree revisons to all financial policies with the exception of the Budget Setting Policy and Management of Capital Policy which will be approved by the Finance Committee on behalf of the Board

1.1.7. Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions must be familiar with and comply with the provisions of the Trust's Constitution/standing orders and Scheme of Delegation.

1.1.8. A failure by an employee or officer of the Trust to comply with these Standing Financial Instructions, the Constitution, the Standing Orders and the Scheme of Reservation and Delegation of Powers is a failure of their accountability to ensure there is a strong control environment in the Trust. In the most serious cases this could be regarded as a disciplinary matter that may result in dismissal.

1.1.9. In exercising their power and duties, all leaders must seek to achieve value for money and improve efficiency and productivity. Leaders will manage efficiently and effectively, the resources at their disposal. All leaders will support and deliver a positive material change to the financial position of the organisation and be held accountable for contributing to the reduction of the deficit. As such, leaders must not authorise any expenditure which is not provided for in the budgets for which they are responsible. Incurring expenditure which is unfunded is not permitted. Leaders must seek the advice of the the Director of Finance before acting if there is uncertainty regarding the avaiblity of funding.

1.1.10. 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 of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.1.11. Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of fraud reported to the Local Counter Fraud Specialist. Where failure to comply with this document constitutes a criminal offence it may result in a criminal investigation and criminal sanctions being applied.

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

1.2. Responsibilities and delegation

1.2.1. The Board of Directors

The Board of Directors exercises financial supervision and control by:

(a) Formulating the Financial Strategy and ensuring it is consistent with, and an integral part of the business plan requiring the submission and approval of budgets within approved allocations/overall income;

(b) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); Independent monitoring of the financial viability of the Trust;

(c) defining specific responsibilities placed on Members of the Board of Directors and employees as indicated in the Scheme of Reservation and Delegation of Powers document; and

(d) The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. All other powers have been delegated to such other committees or members of staff. The details of this are set out in the Constitution, Scheme of Reservation and Delegation of Powers and these Standing Financial Instructions.

1.2.2. The Chief Executive and Director of Finance

(a) The Chief Executive and Director of Finance will, as far as possible, delegate their detailed financial authority, but they remain responsible and accountable for financial control being exercised appropriately.

(b) Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and, as Accountable Officer, to the Secretary of State, for ensuring that the Board of Directors 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 of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

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

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

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

1.2.3. The Director of Finance

The Director of Finance is responsible for:

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

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

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

(d) without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(e) the provision of financial advice to other Members of the Board of Directors and employees;

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

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

1.2.4. Board of Directors Members and employees –

All Members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

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

(d) conforming with the requirements of the Constitution, the Standing Orders, the Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation of Powers.

1.2.5. Contractors and their employees

(a) 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.

(b) For all Members of the Board of Directors 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 of Directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2 AUDIT

2.1. Audit Committee

2.1.1. In accordance with the Constitution, the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the Audit Committee Handbook and the Audit Code for NHS Foundation Trusts issued by NHS England/Improvement , any other relevant directions and guidance issued by NHS England/Improvement or any other relevant body, which will provide an independent and objective view of internal control. This shall be achieved by monitoring the degree to which organisational risk management, control and governance processes support the achievement of the Trust's agreed objectives.

2.2. The powers and duties of the Committee are as follows:

2.2.1. Authority

(a) The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference, and will utilise this authorisation rigorously should the need arise;

(b) it is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee;

(c) The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure external expertise if it considers this necessary.

2.2.2. Duties: The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

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

(b) Monitor compliance with Standing Orders and Standing Financial Instructions and ensure appropriate action is taken;

(c) Review schedules of losses and special payments and making recommendations to the Board when appropriate;

(d) Oversee Internal and External Audit services;

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

(f) Review the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;

(g) Review schedules of debtors/creditors balances over 6 months old and £5,000 and explanations/action plans with reference to the Trust's working capital management arrangements. (Note: The working capital arrangements are kept under review by the Finance Committee in consultation with the Audit Committee)

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

2.2.3. Internal Audit

(a) The Audit Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors.

2.2.4. External Audit

(a) The Audit Committee shall consider and make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor, following the criteria for such matters agreed with the Council for Governors Audit Appointment Committee . The Foundation Trust will undertake a market-testing exercise for the appointment of the external auditor at least once every five years.

(b) the Audit Committee shall review the work and findings of the External Auditor, in line with what has been agreed with the Council of Governor's Auditor Appointment Committee, and consider the implications and management's responses to their work and when necessary escalate matters of significant risk or significant adverse findings to the Board.

(c) The Audit Committee must assess the fees of external audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable. The Commoittee will also consider any additional charges that may arise.

2.2.5. Other Assurance Functions

(a) the Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

(b) these will include, but will not be limited to, any reviews by NHS England/Improvement or Department of Health and Social Care, arms length bodies or regulators / inspectors (e.g., Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)..

(c) in addition, the Committee will review the work of other Board of Directors committees, whose work can provide relevant assurance to the Audit Committee's own scope of work. The committee will satisfy itself that its work and that of other committees is co-ordinated to avoid duplication or omission. In reviewing issues around clinical risk management, the Audit Committee will wish to satisfy itself of the assurance that can be gained from the clinical audit function.

2.2.6. Management

(a) the Audit Committee shall request and review reports and seek positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

(b) the Committee may also request specific reports from individual functions within the organisation as may be appropriate to the overall assurance requirements.

(c) the Audit Committee will develop an annual workplan to cover the four standard Committee meetings per year.

2.2.7. Financial Reporting

(a) the Audit Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors and the Council of Governors

(b) the Audit Committee should also ensure that the systems for financial reporting to the Board of Directors and Council of Governors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors and Council of Governors.

2.2.8. Reporting

(a) The minutes of Audit Committee meetings shall be formally recorded by the Company Secretary and submitted to the Board of Directors. The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board of Directors, or require executive action.

(b) The Committee will report to the Board of Directors annually on its work in support of the Annual Governance Statement

(c) Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should, in the first instance, raise the matter with the Director of Finance and, if not satisfied, then raise the matter with the Accountable Officer for the Trust and the Chair and the Senior Independent Director. The Audit Committee Chair can also raise matters at a full meeting of the Board of Directors.

(d) Exceptionally, after the matter has been formally reported to the Board the matter may need to be referred to NHS England/Improvement.

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

(f) The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.3. **Director of Finance**

2.3.1. The Director of Finance is responsible for:

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

(b) ensuring that the purpose, authority and responsibility of Internal Audit is formally defined by the Foundation Trust in the Terms of Reference with regard to professional best practice;

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

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

(e) a clear statement and opinion on the effectiveness of internal control in accordance with the System Oversight Framework guidance issued by NHS England/Improvement (or relevant advisory body) including for example compliance with control criteria and standards;

(f) major internal financial control weaknesses discovered;

(g) progress on the implementation of internal audit recommendations;

(h) progress against plan over the previous year;

(i) strategic audit plan covering the coming years;

(j) a detailed plan for the coming year.

(k) ensuring that effective links with the Anti Fraud Specialist are maintained.

(l) The Director of Finance or designated auditors are entitled without necessarily giving prior notice, whilst bearing in mind the efficient running of the Trust, to require and receive:

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

(n) access at all reasonable times to any land, premises or Members of the Board of Directors, employee of the Trust or contractor;

(o) the evidencing of any cash, stores or other property of the Trust under a member of the Board of Directors, an employee's or a contractors control; and

(p) explanations concerning any matter under investigation.

2.4. **Role of Internal Audit**

2.4.1. Internal Audit will, in accordance with regulatory and recognised professional best practice, review, appraise and report upon:

(a) the extent to which the achievement of the Trust's objectives are monitored;

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

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

(d) the suitability of financial and other related management data;

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

(a) fraud and other offences;

(b) waste, extravagance, inefficient administration;

(c) poor value for money or other causes.

2.4.3. Internal Audit shall also independently verify any Assurance Statements in accordance with guidance/and or from Department of Healh, NHS England/Improvement or relevant advisory body)

2.4.4. The Head of Internal Audit will produce an annual audit opinion on the effectiveness of the system of internal control.

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

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

2.4.7. The Head of Internal Audit shall be accountable to the Director of Finance.The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit in the form of an Internal Audit Charter. The Charter will comply with guidance on reporting contained in the Public Sector Internal Audit Standards. The Charter will be reviewed at least every three years

2.4.8. The Senior Internal Audit Manager shall co-ordinate internal audit plans and activities with line managers, external audit and other review agencies to ensure the most effective audit coverage is achieved and duplication of effort is minimised.

2.4.9. A final report will be issued to the appropriate manager(s) and Directors and to the Director of Finance. All final reports will be available to the Chief Executive and the Audit Committee members. The Audit Committee will also receive a report from the Senior Internal Audit Manager at each of its meetings, summarising the final reports issued and the adequacy of the management response.

2.4.10. The Trust will provide the Senior Internal Audit Manager with every facility and all information which they may reasonably require for the purposes of thier functions under the Terms of Reference.

2.4.11. Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within agreed timescales specified in the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported to the Audit Committee.

2.5. **External Audit**

2.5.1. The External Auditor is appointed in accordance with the Constitution, subject to approval by the Council of Governors, and paid for by the Trust. The Audit Committee must ensure a cost-efficient service and ensure compliance with guidance by NHS England/Improvement (or other relevant advisory body).

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

2.5.3. External audit responsibilities (in compliance with the requirements of the Independent Regulator) are:

(a) to be satisfied that the accounts comply with the directions provided, i.e. that the accounts comply with the Annual Reporting Manual for NHS Foundation Trusts.

(b) to be satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts;

(c) to be satisfied that proper practices have been observed in compiling the accounts;

(d) to be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources;

(e) to comply with any directions given by the Independent Regulator as to the standards, procedures and techniques to be adopted, i.e. to comply with the Audit Code for Foundation Trusts;

(f) to consider the issue of a public interest report;

(g) to certify the completion of the audit;

(h) to express an opinion on the accounts; and

(i) to refer the matter to the Independent Regulator if the Foundation Trust, or an officer or Director of the Foundation Trust, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

2.5.4. External auditors will ensure that there is a minimum of duplication of effort between themselves and the Independent Regulator. The auditors will discharge this responsibility by:

2.5.5. reviewing the statement made by the Chief Executive as part of the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the Trust;

2.5.6. reviewing the results of the work of relevant assurers, for example the Care Quality Commission, to determine if the results of the work have an impact on their responsibilities;

2.5.7. undertaking any other work that they feel necessary to discharge their responsibilities.

2.5.8. The Trust will provide the external auditor with every facility and all information which he may reasonably require for the purposes of his functions under Part 1 of the 2003 Act.

2.5.9. The Trust shall forward a report to the Independent Regulator within 30 days (or such shorter period as the Independent Regulator may specify) of the external auditor issuing a public interest report in terms of Schedule 5 paragraph 3 of the Act. The report shall include details of the Foundation Trust's response to the issues raised within the public interest report.

2.6. **Fraud and Corruption**

2.6.1. Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements. In line with their responsibilities, the Trust Chief Executive and Chief Finance Officer shall monitor and ensure compliance on fraud, corruption and bribery as set out in the Bribery Act 2010, NHS Counter Fraud Authority Standards for providers and the Trust's Standards of Business Conduct Policy .

2.6.2. The Trust shall nominate a suitable person to carry out the duties of the Anti Fraud Specialist as specified by the NHS Protect Fraud and Corruption Manual and guidance.

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

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

2.6.5. The Director of Finance is responsible for providing detailed procedures to enable the Trust to minimise and where possible to eliminate fraud and corruption. These procedures set out action to be taken by persons detecting a suspected fraud and persons responsible for investigating it.

2.6.6. The measures that are put in place shall be sufficient to satisfy all external bodies to whom the Foundation Trust is accountable to, through;

(a) encouraging prevention;

(b) promoting detection and

(c) ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively.

2.6.7. Proven instances of fraud and corruption should be considered as gross misconduct.

2.6.8. It is expected that all officers shall act with the utmost integrity, ensuring adherence to all relevant regulations and procedures. It is the responsibility of the Director of Finance to produce and issue these to the appropriate Directors and Managers who should ensure that all staff have access to these. The Director of Finance will be supported by the Trusts' Fraud Champion.

2.7. **Prevention**

2.7.1. The Director of People & Organisational Development is responsible for ensuring that steps are taken at recruitment stage to establish as far as possible the previous record of potential officers in terms of their propriety and integrity.

2.7.2. Staff are expected to act in accordance with the Trust's Standing Orders, "Code of Business Conduct" following the guidance on the receipt of gifts and hospitality.

2.7.3. Non-Executive Directors are subject to the same high standards of accountability and are required to submit a Fit and Proper Person declaretion and declare and register any interests which might potentially conflict with those of the Trust.

2.7.4. The Anti-Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls, and evaluate the implication of fraud for their opinion on the system of risk management, control and governance.

2.8. **Detection and Resulting Action**

2.8.1. Staff are encouraged to raise any concerns they may have regarding suspected fraud and/or corruption. They can do this through:

(a) the Trust's Anti- Fraud Specialist,

(b) the NHS National Fraud Hotline Internal Audit, or

(c) the Director of Finance,

(d) the Freedom to Speak Up Guardian

2.8.2. The Director of Finance is responsible for ensuring that action is taken to investigate any allegations of fraud or corruption through the Anti- Fraud Specialist. The steps to be taken are incorporated in the Trust's Fraud Policy and Response Plan.

2.8.3. Senior Managers are expected to deal firmly and promptly and in accordance with the Trust's disciplinary procedure with anyone who attempts to defraud the Trust or who acts in a corrupt manner.

2.8.4. Any abuse of the procedures, such as unfounded or malicious allegations, is itself subject to full investigation and appropriate disciplinary action.

2.9. Security Management

2.9.1. Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.9.2. The Trust shall nominate a suitable person(s) to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.9.3. The Trust shall nominate a Non-Executive Director (Chair of Audit Committee) to be responsible to the Board of Directors for NHS security management. (Note this is a retained role – Enham=ncing Board Oversight of Important Issues 29 November 2021)

2.9.4. The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Chief Operating Officer (executive lead for Security) and the appointed Local Security Management Specialist (LSMS).

3 ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING AND INDEPENDENT REGULATION

3.1. Budget Setting Policy - Preparation and Approval of Plans and Budgets

3.1.1. In accordance with the requirements of the Independent Regulator the Chief Executive will ensure the compilation and submission to the Board of Directors of a Strategic Direction Document that encompasses an annual Financial and Operatioal Plan and takes into account financial targets and forecast limits of available resources. The Financial and Operatioal Plan plan will contain:

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

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

3.1.2. The Foundation Trust will provide information as to its forward planning in respect of each financial year to the Independent Regulator. This information will be prepared by the Directors, who must have regard to the views of the Council of Governors.

3.1.3. The Delegated Officer will, on behalf of the Chief Executive, compile and submit to the Board of Directors an annual business plan. The preparation and approval of operational plans and budgets will be in accordance with the Budget Setting Policy of the Trust approved by the Board.

3.1.4. Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive and in accordance with the Budget Setting Policy approved by the Finance Committee, prepare and submit budgets for approval by the Board of Directors. Such budgets will be in accordance with the aims and objectives set out in the Financial and Operational Plan;

(a) accord with workload and manpower plans and activity plans and capital requirements;

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the limits of available funds;

(d) identify potential risks;

(e) enable the Trust to meet its statutory financial duties.

3.1.5. The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board of Directors. Detailed financial reporting will be via the Finance Committee which shall undertake detailed scrutiny on behalf of the Board of Directors. The Chief Operating Officer will monitor activity and other performance targets. Performance reports shall be presented by the relevant Directors not less frequently than quarterly. The Trust shall submit information in respect of its financial plans to NHS England/Improvement, once approved by the Board of Directors.

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

3.1.7. All budget holders are responsible and accountable for setting their financial plan in line with the process set out by the Director of Finance, operating within their allocated budgets at the commencement of each financial year, and will sign to accept their allocated budgets prior to the commencement of the financial year.

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

3.1.9. All budget holders have a duty to monitor their allocated budgets and to manage them effectively. It is the duty of individual budget holders to seek further advise training, to assist in managing their allocated budgets, if required.

3.1.10. The Director of Finance will keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, inflation and other events and trends affecting the financial position of the Foundation Trust.

3.1.11. The Director of Finance with the Executive Team is responsible for ensuring that the development of plans and strategies are consistent with achieving our financial plans and responsibilities but the identification and implementation of savings programmes is a shared responsibility with all the budget holders through the Trust's scheme of delegation.

3.2. **Budgetary Delegation**

3.2.1. The Chief Executive and all delegated budget holders must not exceed the budgetary totals or virement limits set by the Board of Directors in the Annual Plan. Variance in financial performance from permitted levels will be reported to the Finance Committee and to the Board as required.

3.2.2. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under section 25 of the National Health Service Act 2006. 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 responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

3.2.3. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive. A facility of virement is available details of which are set out in Table B of the Scheome of Reservation and Delegation.

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

3.3. **Budgetary Control and Reporting**

3.3.1. The Director of Finance will devise and maintain systems of budgetary control. Including monthly financial reports to the Board of Directors in a form approved by the Board of Directors containing:

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

(b) movements in working capital;

(c) movements in cash and capital;

(d) financial performance against delegated budgets;

(e) financial performance against contracts by exception

(f) summary cashflow

(g) summary balance sheet;

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

(i) explanations of any material variances that explain any movement from the planned retained surplus/deficit at the end of the current month position;;

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

(k) key performance indicators;

(l) financial risk and mitigating actions.

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

(a) investigation and reporting of variances from financial, workload and manpower budgets;

(b) monitoring of management action to correct variances; and

(c) arrangements for the authorisation of budget transfers.

3.4. **Each Budget Holder is responsible for ensuring that:**

(a) Income and expenditure is maintained within budgeted limits and that a recovery or mitigation plan is submitted to address and adverse variance to plan during the financial year. Any overspending or reduction in income against annual planned levels requires prior consent of the Finance Committee on behalf of the Board of Directors;

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

(c) No permanent employees are appointed without the approval of the Chief Executive or Director of Finance other than those provided for within the available recurrent resources and the manpower establishment as approved by the Board of Directors (see Standing Financial Instructions paragraph 9.2 – Funded Establishment).

(d) the systems of budgetary control established by the Director of Finance are complied with fully

3.5. **Capital Expenditure**

3.5.1. The Trust has adopted a Capital Programme Policy. The Capital Programme Policy sets clear expectations of what will be done and by whom and how capital schemes are managed and how delivery will be monitored and by whom. See also Standing Financial Instructions paragraph 4 (Business Cases) and 13 (Capital investment, depreciation, private financing, fixed asset registers and security of assets).

3.5.2. The Board shall approve the capital programme for the Trust, consistent with the approved Annual Plan.

3.5.3. The Director of Finance shall ensure that regular reports to the Capital Plan Group, Finance Committee and the Board are prepared, containing:

(a) progress reports on the programme

(b) explanations and approvals of any changes to the programme

3.6.4 The Director of Finance shall ensure that the appropriate monitoring returns are submitted to NHS England/Improvement in line with the System Oversight Framework

3.6. **Financial Performance and Monitoring Monitoring Returns**

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

3.6.2. The Chief Executive is responsible for ensuring that:

(a) financial performance measures have been defined and are monitored;

(b) reasonable targets have been identified for these measures;

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

(d) reporting lines are in place to ensure overall performance is managed;

(e) arrangements are in place to manage/respond to adverse performance.

3.7.3 The Chief Executive or in their absence the Director of Finance is authorised to approve unbudgeted revenue and capital expenditiure of upto £250,000. Applications for such an approvalmust be submitted to the Operational Director of Finance who will then forward to the Director of Finance for final submission to the Chief Executive Officer. This SFI should be used in conjunction with the emergency powers contained in the Constitution.

3.7. **Business Cases**

3.8.1 The Procedures to be followed in relation to business cases is set out in the Business Case Policy.

3.8.2 A business case is needed for the following:

a) Establishment of new service or development of existing services with cost attached

b) To support external funding opportunities available to the trust

c) Capital projects – including lease of buildings, construction of new buildings, major refurbishments or improvements works, purchase of capital equipment

3.8.3 All Business cases must be prepared using the Guidance on how to complete a Business Case.

3.8.4 The thresholds and authority for approval of Business Cases is set out in the Scheme of Delegation.

3.9 High Cost Agency and Locums, Agency Break Glass Approval Policy and Process and Temporary Operational Staffing Rules (Bank/ Agency)

3.9.1 The Procedures in relation to High Cost Agency and Locums, Agency Break Glass etc. are set out in separate rules and must be followed by all staff. (Agency Break Glass appointments must only be used for emergency short term assignments)

4 ANNUAL ACCOUNTS AND REPORTS

4.8.1 The Director of Finance, on behalf of the Trust, will:

4.8.2 keep accounts, and in respect of each financial year

4.8.3 prepare financial returns in accordance with the accounting policies and guidance given by NHS England/Improvement , the Department of Health, HM Treasury, the Trust's accounting policies, and generally accepted accounting practice;

4.8.4 submit financial returns to the NHS England/Improvement or Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

4.8.5 Ensure that, in preparing annual accounts, the Trust complies with any directions given by and Department of Health and Social Care NHS England/Improvement with the approval of the Treasury as to:

4.8.5.1 the methods and principles according to which the accounts are to be prepared; and

4.8.5.2 the information to be given in the accounts.

4.8.6 In accordance with the Constitution, the Trust's annual accounts will be prepared by the Director of Finance and must be audited by an auditor appointed by the Council of Governors and presented to a meeting of the Council of Governors (as defined in the Constitution. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.8.7 In accordance with the Constitution, guidelines on local accountability and / NHS England/Improvement 's NHS Foundation Trust Annual Reporting Manual, the Trust will publish at a public meeting its annual report and send it to / NHS England/Improvement and Parliament.

5 BANK ACCOUNTS

5.8 General

5.8.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance issued from time to time by the Department of Health. In line with '*Cash Management in the NHS*', Trusts should minimise the use of commercial bank accounts and use Government Banking Services for all banking requirements.

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

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

5.8.4 The Board of Directors shall approve the banking arrangements on the recomendation of the Audit Committee.

5.9 Bank

5.9.1 The Director of Finance is responsible for:

5.9.1.1 all bank accounts;

5.9.1.2 establishing separate bank accounts as required including for the Foundation Trust's charitable funds;

5.9.1.3 reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.9.1.4 monitoring compliance with HM Treasury guidance and any guidance issue by NHS England/Improvement or any other relevant guidance on the level of cleared funds.

5.9.1.5 no employee/officer other than the Director of Finance, or in his/her absence his/her authorised deputy, shall open a bank account in the name of the Foundation Trust.

5.9.1.6 all funds will be held in accounts in the name of the Foundation Trust.

5.10 Banking Procedures

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

5.10.1.1 the conditions under which each bank account is to be operated, the limit to be applied at any overdraft;

5.10.1.2 those authorised to sign cheques or other orders drawn on the Trust's accounts; and

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

5.11 Tendering and Review

5.11.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals not exceeding five years to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.11.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Audit Committee and the Board for approval.

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

6.8 Income Systems

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

6.8.2 All such systems shall incorporate in full the principles of internal check and separation of duties.

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

6.8.4 The Director of Finance will ensure that any restrictions on income imposed by the Independent Regulator will be complied with.

6.9 Fees and Charges

6.9.1 The Trust shall have regard to the latest guidance issued by NHS Improvment in setting prices for NHS service agreements and any later version of such guidance that may be published by NHS Improvment from time to time.

6.9.2 Subject to *Standing Financial Instructions* paragraph 8.1.4 below, the Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's *Commercial Sponsorship – Ethical standards in the NHS* shall be followed.

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

6.9.4 Employees must obtain the approval to income generation schemes prior to implementation in line with the Scheme of Delegation (Scheme of Delegation from SFI's and Detailed Scheme of Delegation).

6.10 Debt Recovery

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

6.10.2 Income not received, following robust credit control activity, should be dealt with in accordance with the losses procedures.

6.10.3 Overpayments should be detected (or preferably prevented) whenever possible. However, recovery should be initiated immediately once an overpayment has been detected.

6.11 Security of Cash, Cheques and other Negotiable Instruments

6.11.1 The Director of Finance is responsible for:

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

6.11.1.2 ordering and securely controlling any such stationery;

6.11.1.3 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;

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

6.11.2 Official money shall not under any circumstances be used for the encashment of private cheques, bank to bank transfers or temporary loans or IOUs.

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

6.11.4 Trust credit cards must not be used for personal expenditure, Trust credit cards should not be used to pay employee expenses without prior approval, as these should be reimbursed via Payroll.

6.11.5 All cheques, postal orders, cash and other monetary items, shall be banked promptly and intact. Disbursements shall not be made from cash received, except under arrangements approved in advance by the Director of Finance.

6.11.6 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.11.7 Where cash collection is undertaken by an external organisation, this shall be subject to such security and other conditions as required by the Director of Finance.

6.11.8 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately to the Director of Finance. Where there is prima facie evidence of fraud or corruption this should follow the form of the Trust's Anti Fraud, Corruption & Bribery Policy & Response Plan and the guidance provided by the Anti Fraud Specialist. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Special Payments Procedures.

6.11.9 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS) and drawn in accordance with these instructions, except with the agreement of the Director of Finance, as appropriate, who shall be satisfied about security arrangements.

6.11.10 Where appropriate, arrangements shall be made for the use of secure electronic payment methods to support e-commercial activities. This may include the use of procurement cards, direct debit cards and in limited circumstances, eBay trading accounts.

6.11.11 The Money Laundering Regulations 2007[1] require that the Trust does not, under any circumstances, accept exchequer cash payments in excess of £10,000 in respect of any single transaction or several transactions which appear to be linked. Any attempts by an individual to effect payment above this amount should be notified immediately to the

[1] Statutory Instrument 2007 No. 2157

Director of Finance. Furthermore, any patient or service user depositing in excess of £500 for safekeeping with the Trust will be notified to the Director of Finance or his nominated Deputy in his capacity as Corporate Appointee and Bailee. Reconciliation of payments are kept and cash is banked for safe keeping.

7 CONTRACTS AND PROCUREMENT

7.1 General

7.1.1 The contract, tendering and procedure rules will be approved by the Director of Finance. Details of the contract, tendering and procedure rules can be found on the intranet or by contacting the Procurement Team

7.1.2 There are three core aims of the rules:

a) To provide an overview of how UHMB will conduct itself and the principles that will be applied to all procurement activity while ensuring compliance with statutory guidelines.

b) To provide advice and guidance for all staff working within the Trust who procure any goods or services by setting out the procurement principles, rules and methods that the Trust will operate within.

c) To provide an overview of key considerations for staff when commissioning and procuring

7.1.3 This rules sets out the existing legal framework for procurement by public bodies in the UK, and moving forward the procurement policy will be updated in line with any changes to UK and EU legislation.

7.2 Duty to comply contracts and procedure rules

7.2.1 All employees an officers of the Trust must follow procurement processes and follow advice from the Procurment Service and must always obtain the best value for money for the Trust. Failure to follow procurement rules is a breach of these Standing Financial Instructions which in certain cases may result in disciplinary action.

8 CONTRACTS FOR PROVISION OF HEALTHCARE SERVICES

8.1 Commissioner Related Contracts

8.1.1 Supported by the Director of Finance the Board of Directors shall regularly review and shall at all times maintain and ensure the capacity of the Trust to provide the *Commissioner Requested Services* referred to in the Trust's *NHS Provider Licenc*e and other *Terms of Authorisation* and related schedules

8.1.2 Subject to *Standing Financial Instructions* paragraph 8.1.5, the Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable contracts and considering the extent to which mandatory NHS Standard Contract Conditions are applicable. 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;
- that contracts build, where appropriate, on existing investment plans.

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

a) costing and pricing of services;

b) payment terms and conditions; and

c) amendments to contracts and extra-contractual arrangements.

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

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

8.1.6 .Any costing relating to the involvement of the Trust in a tender process or bid for additional external income must be undertaken by the Director of Finance' staff.

8.1.7 In exceptional circumstances, for example where the Trust is seeking to retain existing business and / or to win new business, the Trust may decide that it is appropriate for it to enter into a loss-making contract. The decision to enter into any such contract (and as to the terms of such a contract) shall be taken jointly on behalf of the Trust by:

- the Chief Executive; and
- a Non-Executive Director of the Trust

8.2 Non commissioner-related contracts

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

a) For corporate SLAs, the Lead Executive (or nominated deputy) in consultation with the Direcotr of Finance

b) For divisional SLAs, the Clincal Directors in consultation with the Direcotr of Finance

8.2.2 This contract should incorporate:

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

b) the term of the agreement including termination arrangements;

c) the value of the agreement;

d) the operational lead;

e) performance and dispute resolution procedures; and

f) risk management and clinical governance arrangements.

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

8.2.4 Involving Partners and jointly managing risk

8.2.5 The Chief Executive should ensure that the Trust works with all partner agencies/bodies involved in both the delivery and the commissioning of the service required.

8.2.6 Where partner agencies/bodies are involved the contract should 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. Such contracts should be signed by all parties, meet best practice and be annually reviewed.

8.3 Reports to the Board of Directors and its Committees on Contracts

8.3.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board of Directors or its appropriate committee on contracts detailing actual and forecast income and liability from the contracts.

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

9.1 Remuneration and Terms of Service

9.1.1 In accordance with the Constitution, the Board of Directors shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Remuneration Committee will:

a) On behalf of the Board of Directors determine appropriate remuneration and terms of service for the Chief Executive and Executive Directors (and other very senior officers) employed by the Trust:

9.1.2.a.1 all aspects of salary (including any performance-related elements/bonuses);

9.1.2.a.2 provisions for other benefits, including pensions and cars;

9.1.2.a.3 arrangements for termination of employment and other contractual terms;

b) The Committee when considering the remunuration and terms of service of Executive Directors of the Board of Directors (and other senior employees) ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's

circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

c) monitor and evaluate the performance of individual Executive Directors or other very senior officers;

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

9.1.3 The Board of Directors, or where delegated its Committees, will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

9.1.4 The Trust will pay allowances to the Chairman and non-Executive Directors of the Board of Directors in accordance with instructions issued by the Council of Governors in accordance with the Constitution.

9.2 Funded Establishment

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

9.2.2 The funded establishment of any department may not be varied without approval of the Chief Executive unless in accordance with an establishment control procedure approved by the Board.All budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

9.3 Staff Appointments

9.3.1 No Member of the Board of Directors 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 as defined in the *Scheme of Reservation and Delegation of Powers*.

9.3.2 The Board of Directors, or where delegated to its Committees, will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

9.4 Processing Payroll

9.4.1 The Director of Finance and the Director of People and Organisational Development, on behalf of the Board of Directors, is responsible for:

a) Monitoring any external payroll contracts

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

c) the final determination of pay and allowances;

d) making payment on agreed dates;

e) agreeing the method of payment.

9.4.2 The Director of Director of People and Organisational Development 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, to regulatory bodies, under the provisions of the Data Protection Act and GDPR requirements

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

h) procedures for payment 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 in preparing records to safeguard financial transactions;

m) the process for the recovery of overpayments of salary;

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

9.4.3 Appropriately nominated managers have delegated responsibility for:

a) Ensuring employment processes are correctly undertakne through TRAC including processing a signed copy of the contract or appointment form and other such documentation as may be required immediately upon an employee commencing duty;

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

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

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

e) regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review

procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

f) The above paragraphs relate to the payment of staff employed within the Trust. In the event of the Trust providing a Payroll service to any other organisation it will be necessary for the Director of Finance to have prepared a contract to cover the operation of the service provided.

9.5 Contracts of Employment

9.5.1 The Director of People and Organsiational Development has responsibility for:

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

b) dealing with variations to, or termination of, contracts of employment and establishing the required policies, rules and procedures to suppor this.

c) All emplyees will follow the policies, rules and processes established by Director of People and Organsiational Development

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board of Directors 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 prior to the start of the financial year to which the budget relates.

10.1.2 The Chief Executive will set out (See scheme of delegation):

a) the list of managers who are authorised to place requisitions for the supply of goods and services. This to be reviewed on an on-going basis and at least annually by the Finance Department;

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

10.1.3 The Director of Finance will set out the rules for procurement, requisitions, (Refer to Procurment, Contract and Tendering Rules.)

10.2 System of Payment and Payment Verification

10.2.1 The Trust's Chief Executive shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims in accordance with the Better Payments Practice Code. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance;

10.2.3 Additionally, the Director of Finance shall also be responsible for ensuring compliance with the Government's Prompt Payment Code. All invoices for small and medium sized businesses and individuals should be paid within 10 days where possible.

10.2.4 The Chief Executive in consultation with the Director of Finance will advise the Board of Directors, or where delegated to its Committees, 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 the Trust's *Scheme of Reservation and Delegation of Powers* and regularly reviewed;

10.2.5 When applied to leases or recurring service contracts the limits above will be applied to the total costs over the term of the lease or contract.

10.2.6 The Director of Finance will prepare procedural instructions or guidance in accordance with Standing Financial Instructions paragraph 7 on the obtaining of goods, works and services; and be be responsible for the prompt payment of all properly authorised accounts and claims;

10.2.7 Subject always to Government directives, competitive tendering or quotation procedures shall not apply to the disposal of:

i. 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 their nominated officer.

ii. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust.

iii. items to be disposed of with an estimated sale value of less than £1,000 , this figure to be reviewed annually.

iv. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

v. land or buildings concerning which guidance has been issued by Independent Regulator and subject to compliance with such guidance.

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

(i) a list of employees (including specimens of their signatures and allocated UHMB emaill accounts) 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

(iii) the account is arithmetically correct the account is in order for payment,

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

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

(vi) be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

(vii) be responsible for ensuring that value added tax (VAT) is correctly accounted for.

10.2.9 Prepayments are only permitted with the approval of the Director of Finance or his/her authorised Deputy and where exceptional circumstances apply. In such instances:

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

(ii) instructions to employees regarding the handling and payment of accounts within the Finance Department;

10,2,10 The Director of Finance is responsible for ensuring that payment for goods and services is only made once the goods and services are received. The Director of Finance must agree any exceptions to this rule other than those set out in *Standing Financial Instructions* paragraph 10.2.4 (Prepayments);

10.2.11 The Director of Finance is responsible be responsible for undertaking regular reviews of the employees who are authorised to make requisitions for goods and / or services, including specimens of their signatures.

10.3 Prepayments

10.3.1 With the exception of 'fully comprehensive maintenance contracts', prepayments are only permitted where exceptional circumstances apply. In such instances:

- prepayments are only permitted where the financial advantages outweigh the disadvantages,
- 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 their commitments,
- the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the requirements of Standing Financial Instructions paragraph 7),
- the budget holder is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate

Executive Director or Divisional Director or Chief Executive if problems are encountered.

10.4 Official orders

10.4.1 The Trust e-procurement system must be used for all orders;

10.4.2 The e-procurement system will issue orders in consecutive numerical order and in a form approved by the Director of Finance;.

10.4.3 The e-procurement orders will state the Trusts terms and conditions of trade;

10.4.4 Only those members of staff or agents of the Trust approved by their line manager may requisition or authorise Trust orders and at all times they must comply with the procedures and value levels set out in the Scheme of Reservation and Delegation of Powers for this purpose;

10.4.5 Requisitions must be approved before orders for goods and services can be placed. (Failure to observe this requirement may result in disciplinary action).

10.5 Duties of Managers and Officers

10.5.1 Subject to *Standing Financial Instructions paragraph* 8.1.4, managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

- all contracts (except as otherwise provided for in the *Scheme of Reservation and Delegation of Powers*), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made,
- contracts are advertised where required by *Standing Financial Instructions* paragraph 7,
- where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and / NHS England/Improvement ,
- 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:isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;conventional hospitality, such as lunches in the course of working visits.(This provision above needs to be read in conjunction with the followingthe Trust's *Standards of Business Conduct*, and the principles outlined in the national guidance contained in NHS England's "*Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*",)
- no requisition / order is placed for any item or items for which there is no budget provision unless authorised in advance by the Director of Finance on behalf of the Chief Executive,
- all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash,
- word of mouth 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",

- orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds,
- goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase,
- changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance, and the Head of Fincial Services will undertaken this task on an annual bais
- purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance,
- petty cash records are maintained in a form as determined by the Director of Finance;

10.5.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the current regulations issued by Department of Health and NHS Property and Estates. Any technical audit of these contracts shall be the responsibility of the relevant Executive Director or other senior manager.

10.5.3 Under no circumstances should goods or services be ordered through the Trust for personal or private use (other than approved lease car or similar schemes).

10.5.4 The technical audit of building and engineering contracts shall be the responsibility of the relevant Director.

10.5.5 The Director of Finance will ensure capital charges are paid in accordance with Department of Health requirements.

10.5.6 The Director of Finance shall ensure that systems and processes are in place to identify and discharge all relevant tax liabilities.

10.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

10.6.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

11 EXTERNAL BORROWING AND INVESTMENTS

11.1 External borrowing

11.1.1 The Director of Finance will advise the Board of Directors, or where delegated to its Committee(s), concerning the Trust's ability to pay dividends on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by NHS England/Improvement in the Trust's NHS Provider Licence. The Director of Finance is also responsible for reporting periodically to the Board of Directors concerning the PDC debt and all loans and overdrafts.

11.1.2 The Board of Directors, or where delegated to its Committee(s), will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

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

11.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the NHS England/Improvement .

11.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board of Directors, or where delegated to its Committee(s), must be made aware of all short term borrowings at the next meeting.

11.1.6 All long-term borrowing must be consistent with the plans outlined in the current plans and be approved by the Board of Directors, or where delegated to its Committee(s).

11.2 Investments

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by NHS England/Improvement and / or the Secretary of State and authorised by the Board of Directors.

11.2.2 The Director of Finance is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held and providing assurance that the Trust acts in accordance with the latest Best Practice Guidance in Making Investments for NHS Foundation Trusts or other guidance issued by Monitor / NHS England/Improvement .

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

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

12.1 Capital Investment

12.1.1 The Chief Executive:

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

12.1.2 For every capital expenditure proposal the Chief Executive shall in accordance witht he Capital Policy ensure:

- that a business case (in line with the appropriate guidance issued by NHS England/Improvement) is produced setting out:
- an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
- the involvement of appropriate Trust personnel and external agencies;
- appropriate project management and control arrangements;
- that the Director of Finance has certified to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating any recommendations within the current regulations issued by Department of Health and NHS Property and Estates

12.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

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

12.1.6 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:

- specific authority to commit expenditure;
- authority to proceed to tender
- approval to accept a successful tender .

12.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the protection of “the Chief Executive will issue procedures for their management, incorporating any recommendations within the current regulations issued by Department of Health and NHS Property and Estates and the Trust’s Standing Orders for the Board of Directors (Annex 9 of the Constitution).

12.1.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account:

- the delegated limits for capital schemes included in Annex C of HSC (1999) 246 (as amended);
- Supporting NHS Providers: Guidance on Transactions for NHS Foundation Trusts, the Foundation Trust Annual Reporting Manual and other relevant guidance from NHS England/Improvement ;
- the Trust’s investment policy and capital prioritisation list

12.2 Private Finance Initiative (PFI)

12.2.1 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:

12.2.2 The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

- where the sum involved exceeds delegated limits, the business case must be prepared by the Trust in line with any best practice / current guidelines from NHS England/Improvement .
- the proposal must be specifically agreed by the Board of Directors.

12.3 Asset Registers

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted, at least, once a year.

12.3.2 The Chief Executive is responsible for the maintenance of a publicly available property register recording property used in the delivery of Commissioner Requested Services, in accordance with the guidance issued by the Independent Regulator.

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

12.3.4 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour including appropriate overheads;
- lease agreements in respect of assets held under a finance lease and capitalised.

12.3.5 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).

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

12.3.7 The value of land and buildings shall be indexed to current values in accordance with indices agreed with the Trust’s Valuer. The values of each asset shall be depreciated using methods specified in the Foundation Trust Annual Reporting Manual from NHS England/Improvement .

12.3.8 The Director of Finance shall calculate and PDC Dividend as specified in the Foundation Trust Annual Reporting Manual from NHS England/Improvement .

12.3.9 The Director of Finance is responsible for reviewing the Depreciation Policies and ensuring that they meet the needs of the Trust. Any proposed amendments must be discussed with the External Auditors and agreed by the Audit Committee.

12.3.10 Unless the Independent Regulator otherwise directs only assets not used for the delivery of Commissioner Requested Services may be used as collateral to raise funds.

Security of Assets

12.3.11 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Director of Finance for the accounting aspects and the Chief Operating Officer for the physical management and control..

12.3.12 Asset control procedures (including non current assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance and the Chief Operating Officer and take account of guidance issued by NHS England/Improvement . This procedure shall make provision for:

- recording managerial responsibility for each asset;
- identification of additions and disposals;
- identification of all repairs and maintenance expenses;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset;
- reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

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

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

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

12.3.16 Where practical, assets should be marked as Trust property.

13 STORES AND RECEIPT OF GOODS

13.1 General position

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

- kept to a minimum;
- subjected to annual stock take;
- valued at the lower of cost and net realisable value.

13.2 Control of Stores, Stocktaking, condemnations and disposal

13.2.1 The Chief Operating Officer in conjunction with the Director of Finance shall set out procedures and systems to regulate stores (defined as controlled and accountable) including:

- records for receipt of goods, issues, and returns to stores;
- stocktaking arrangements;
- the review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.

13.2.2 Responsibility for the control of stores is set out in the Scheme of Delegation and Guidance issued by the Director of Finance.

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

13.2.4 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores has been delegated to the Head of Procurement by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental employees and stores managers / keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

13.2.5 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.

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

13.2.7 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

13.2.9 The designated Manager / Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with Standing Financial Instructions paragraph 15 - 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.

13.3 Goods supplied by NHS Supply Chain

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

the Director of Finance who shall need to be satisfied that the goods have been received before accepting the recharge.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations - Procedures

14.1.1 The Director of Finance in conjunction with the Chief Operating Officer must prepare detailed procedures for the disposal of assets in accordance with the Regulatory Framework and guidance issued by NHS England/Improvement including condemnations, scrap materials and items surplus to requirements, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the appropriate Head of Department or authorised deputy will notify the Director of Finance to determine the assets current valuation and the impact the disposal may have on the Trusts finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate (refer Table A of the Trust's Scheme of Reservation and Delegation of Powers paragraph A14 - Disposal and Condemnations)

14.1.3 The Trust may not dispose of any property used in the delivery of Commissioner Requested Services. Property must first be deemed surplus to requirements with the approval of the Board of Directors and the Foundation Trust's Commissioners and in line with the guidance issued by the Independent Regulator.

14.1.4 All unserviceable articles shall be:

- condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;
- recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.
- Reports will be made to the Director of Fiajnce to action to maintain the Asset Register

14.1.5 The Condemning Officer shall need to be satisfied as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

14.1.6 Under no circumstances should goods or assets be gifted to a third party without the express permission of the Director of Finance.

14.2 Losses and Special Payments – Procedures

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

14.2.2 Any employee or officer discovering or suspecting a material loss of any kind must either immediately inform their head of department, the Head of Internal Audit, the Local Counter Fraud Specialist an officer charged with responsibility for responding to concerns involving

loss. This officer will then appropriately inform the Director of Finance and / or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant Local Counter Fraud Team (in accordance with Secretary of State for Health's Directions and NHS Counter Fraud Authroity.

14.2.3 The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

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

- the Board of Directors,
- the External Auditor.

14.2.5 In the case of a significant loss the Director of Finance shall arrange for Internal Audit to investigate the circumstances surrounding the loss and ensure that procedures are enhanced to mitigate the risk of a re-occurrence.

14.2.6 Within limits Within limits established by the Foundation Trust and delegated to it by the NHS England/Improvement , the Board of Directors shall approve the writing-off of losses.

14.2.7 The Chief Executive should consult the Treasury on any losses or special payments, irrespective of any delegated authorities passed to the Foundation Trust or the amount of money concerned if they:-

- involve important questions of principle
- raise doubts about the effectiveness of existing systems
- contain lessons which might be of wider interest
- are novel or contentious
- might create a precedent for other departments in similar circumstances
- arise because of obscure or ambiguous instructions issued centrally
- in line HM Treasury manual Managing Public Money.

14.2.8 The Director of Finance shall approve all special payments made to staff where legal advice has been taken and a compensation payment is deemed appropriate.

14.2.9 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

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

14.2.11 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.12 No special payments exceeding delegated limits shall be made without the prior approval of HM Treasury and NHS England/Improvement .

14.2.13 All losses and special payments incurred will be reported to the Audit Committee as detailed in that Committee's workplan (no less than three times per year).

15 INFORMATION TECHNOLOGY

15.1 Responsibilities and duties of the Director of Finance

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

- 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 and General Data Protection Regulations;
- 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;
- ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
- 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.

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

15.1.3 The Chief Executive shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

15.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

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

- details of the outline design of the system;
- in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.3 Contracts for Computer Services with other health bodies or outside agencies

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

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

15.4 Risk Assessment

15.4.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.5 Requirements for Computer Systems which have an impact on corporate financial systems

15.5.1 Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies such as a Digital Strategy;
- data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- the Director of Finance staff have access to such data;
- such computer audit reviews as are considered necessary are being carried out;
- regular backups and contingency strategies are in place.

16 PATIENTS PROPERTY

16.1.1 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 ,mentally ill patients or unconscious or confused patients, patients severely incapacitated for any reason or found in the possession of patients dying in hospital or dead on arrival..

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' money and 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. Examples of how this can be achieved are:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions.

16.1.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including

instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.1.4 The property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Director of Finance, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Director of Finance. Such authority shall include details of the lawful next of kin or other person entitled to the cash and valuables in question.

16.1.5 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

16.1.6 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Trust may be appropriated towards funeral expenses, upon the authorisation of the Director of Finance.

17 STANDARDS OF BUSINESS CONDUCT

17.1 The Company Secretary willl ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. Guidance is made available through the Trust's Standards of Business Conduct policy. This policy follows the guidance contained in NHS England's "Managing Conflicts of Interest in the NHS: Guidance for staff and organisations" and is also deemed to be an integral part of these Standing Financial Instructions

18 CHARITABLE FUNDS (FUNDS HELD ON TRUST)

18.1 Corporate Trustee

18.1.1 The discharge of the Foundation Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance will ensure that each fund is managed appropriately with regard to its purpose and to its requirements. The Director of Finance will monitor compliance with legislation and Charity Commission requirements.

18.2 Accountability to Charity Commission and the Independent Regulator

18.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Independent Regulator for all funds held on trust.

18.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action

18.3 Applicability of Standing Financial Instructions to funds held on Trust

18.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

18.3.2 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.

18.4 Morecambe Bay Hospitals Charity Corporate Governance Manual

18.4.1 Morecambe Bay Hospitals Charity has a separate Corporate Governance Manual in place.

18.4.2 Any changes made to the University Hospitals of Morecambe Bay Hospitals NHS Foundation Trust Corporate Governance manual will automatically update the Morecambe Bay Hospitals Charity Corporate Governance manual where relevant.

19 RETENTION OF RECORDS

19.1.1 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.

19.1.2 The records held in archives shall be capable of retrieval by authorised persons.

19.1.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail including date of destruction shall be maintained of records so destroyed.

20 RISK MANAGEMENT AND INSURANCE

20.1 Programme of Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current directions and guidance in relation to assurance framework requirements from NHS England/Improvement , which must be approved and monitored by the Board of Directors.

20.1.2 The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- 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;
- contingency plans to offset the impact of adverse events;
- audit arrangements including; Internal Audit, clinical audit, health and safety review;
- a clear indication of which risks shall be insured;

- arrangements to review the Risk Management programme.

20.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to complete the Annual Governance Statement within the Annual Report and Accounts as required by Foundation Trust Annual Reporting Manual from Department of Health and Social Care Group Accounting Manual and guidance from NHS England/Improvement .

20.1.4 The Chief Executive in consultation with his/her designated officer(s) shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board of Directors.

20.1.5 Each officer shall promptly notify the designated officer of all new risks or property under his control, which require to be insured, and of any alterations affecting existing risks or insurances.

20.1.6 The designated officer shall ascertain the amount of cover required and shall affect such insurances as are necessary to protect the interests of the Foundation Trust.

20.1.7 The Chief Executive or his/her designated officer shall make all claims arising out of policies of insurance and each officer shall furnish the Director of Finance immediately with full particulars of any occurrence involving actual or potential loss to the Trust and shall furnish an estimate of the probable cost involved.

20.1.8 The Chief Operating Officer shall ensure that all engineering plant under his/her control is inspected by the relevant Insurance Companies within the periods prescribed by legislation.

20.1.9 The value of all assets and risks insured shall be reviewed or index-linked on an annual basis by the designated officer.

20.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

20.2.1 The Board of Directors shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers / third party liability) covered by the scheme this decision shall be reviewed annually.

20.3 Insurance arrangements with commercial insurers

20.3.1 The Director of Finance should secure appropriate specialised advice and ensure value for money by procuring any insurance cover as required

20.4 Arrangements to be followed by the Board of Directors in agreeing insurance cover

20.4.1 Where the Board of Directors decides to use the risk pooling schemes administered by the NHS Resolution, the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

20.4.2 Where the Board of Directors decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board of Directors is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up

formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

20.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20.5 Indemnity for Board of Directors Members, Associate Directors and the Trust Secretary

20.5.1 Members of the Board of Directors (i.e., the Chair, Non-Executive Directors and Executive Directors), Associate Directors and the Trust Secretary who act honestly and in good faith will not have to meet out of their own personal resources the costs associated with any personal civil liability which accrues to them in the execution or purported execution of their functions, save where they have acted recklessly. Any cost arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Board of Directors, Associate Directors and of the Trust Secretary.

21 INTELECTUAL PROPERTY

21.1.1 Intellectual Property can be defined as products of innovation and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images. IP can be given legal recognition of ownership through intellectual property rights (IPR) such as patents, copyright, design rights, trademarks or "know how."

21.1.2 Examples of IP that may be developed in the NHS include: training manuals, clinical guidelines, books and journal articles, PowerPoint presentations, inventions, new or improved designs, devices, equipment, new uses for existing drugs, diagnostics tests, and new treatments.

21.1.3 Ownership of IP will, in most cases, rest with the Trust. This applies to all IP produced by Trust employees in the course of their employment, specifically when undertaken on Trust premises, using Trust equipment and in contact with Trust patients. IP developed by an employee outside the course of their employment, not utilising Trust assets or Trust patients will usually belong to the employee, subject to agreement.

21.1.4 This is in accordance with the Patent Act 1977, and the Copyright, Designs and Patent Act 1988.

21.1.5 IP ownership can vary according to the circumstances under which the IP was generated. Such circumstances include:

- joint/honorary appointments/trainees;
- externally funded work;
- commissioned work; and
- collaborative projects.

21.1.6 If the ownership of IP is disputed, dated written records relating to the IP in question will be assessed to establish the inventor(s), and their proportionate contribution. If such material is not available, the Chief Executive of the Trust will make a final decision, taking professional advice if necessary.

21.1.7 Persons covered by the Intellectual Property Policy includeacceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The Foundation Trust's Code of Conduct for Directors and Employees must be followed and the Chief Executive and Director of Finance notified immediately so that the appropriate action can be taken.

21.1.8 Where offers of goods and services do not involve inducement or reward officers should not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If such gifts arrive unsolicited, the advice of the Director of Finance should be sought.

21.1.9 Officers having official dealings with contractors or other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

22 NHS PROVIDER LICENCE

22.1 The Director of Finance should ensure that Members of the Board of Directors are aware of the NHS Provider Licence, and Enforcment Notices and the SOF rating for the Trust, together with any recovery plans required

4 ATTACHMENTS	
Number	**Title**
1	Audit Committee – Terms of Reference
2	Executive Committee – Terms of Reference
3	Performance, Investment and Finance Committee – Terms of Reference
4	Quality Assurance Committee – Terms of Reference
5	Remuneration and Terms of Service Committee – Terms of Reference
6	Service User and Carer Assembly Standing Committee – Terms of Reference
7	Equality & Diversity Impact Assessment Tool

5 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
	• Intellectual Property Policy • Commercial Representatives Policy • Counter Fraud, Corruption and Bribery Policy and Response Plan • Gifts and Hospitality Policy • Disciplinary Policy • Code of Conduct Policy • The Charity's Income and Expenditure Guidance documents.

6 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	
2	
3	
Bibliography	

7 DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**

8 CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**

9 DISTRIBUTION PLAN	
Dissemination lead:	Enter the lead of the development group

Previous document already being used?	Yes / No (Please delete as appropriate)
If yes, in what format and where?	
Proposed action to retrieve out-of-date copies of the document:	
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Please detail how staff will be informed of document contents and changes. Include in the UHMB Friday Corporate Communications Roundup or Weekly News. New documents uploaded to the Document Library.

10 TRAINING Is training required to be given due to the introduction of this procedural document? *Yes / No (Please delete as required)		
Action by	**Action required**	**Implementation Date**

11 AMENDMENT HISTORY – Please complete if version 2 or higher				
Version No.	**Date of Issue**	**Section/Page Changed**	**Description of Change**	**Review Date**

Appendix 7: Equality & Diversity Impact Assessment Tool

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Equality Impact Assessment Form

Department/Function				
Lead Assessor				
What is being assessed?				
Date of assessment				
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☒	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?

Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	Impact (Positive / Negative / Neutral)	Comments ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Select	
Disability (Including physical and mental impairments)	Select	
Sex	Select	
Gender reassignment	Select	
Religion or Belief	Select	
Sexual orientation	Select	
Age	Select	
Marriage and Civil Partnership	Select	
Pregnancy and maternity	Select	
Other (e.g. caring, human rights)	Select	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

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3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

➢ This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups

➢ This should be reviewed annually.

Action Plan Summary

Action	Lead	Timescale

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.