The Princess Alexandra Hospital NHS Trust

AGENDA

Public Meeting of the Board of Directors

Date and time: Thursday 3 October 2019
09.30 – 12.30

Venue: Herts & Essex Hospital, Haymeads Lane, Bishop's Stortford, Herts CM23 5JH (Medical Secretaries Office, Ground Floor)

	Item	Subject	Action	Lead	
01 Opening Administration					
09.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting held on	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	12
02 Staff Story					
09.35	2.1	Staff Story			Verbal
03 Risk					
10.00	3.1	Significant Risk Register	Review	Chief Medical Officer	13
10.10	3.2	Board Assurance Framework 2019-20	Review	Head of Corporate Affairs	18
04 Chief Executive's Report					
10.15	4.1	CEO's Report	Discuss	Chief Executive	31
05 Patients					
10.30	5.1	Learning from Deaths Presentation (FAWS)	Discuss	Chief Medical Officer	35
10.45	5.2	Mortality Improvement Board Progress Report	Assure	Chief Medical Officer	44
11.00	5.3	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	50
11.15	5.4	Inpatient Survey Results	Inform	Director of Nursing & Midwifery	59
11.30		**Break - 10 minutes**			
06 People					
11.40	6.1	Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)		Director of People	66 74
07 Performance and Places					
11.45	7.1	Integrated Performance Report (IPR)	Discuss	Executives	78
12.00	7.2	Emergency Preparedness, Resilience and Response Annual Report	Approve	Chief Operating Officer	119
08 Governance					
12.05	8.1	Governance Manual (bi-annual review)	Approve	Chief Finance Officer/Head of Corporate Affairs	131

12.15	8.2	Reports from Committees: • WFC.23.09.19 • PAF.26.09.19 • AC.26.09.19 and Annual Report to Board • QSC.27.09.19 (including Infection Control Annual Report)	Inform	WFC Chair PAF Chair AC Chair QSC Chair	267 268 269 270 274 275
	8.3	Report from Senior Management Team meetings: September 2019	Note	Chief Executive	361
09 Questions from the Public					
	9.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
10 Closing Administration					
	10.1	Summary of Actions and Decisions	-	Chairman/All	
	10.2	New Risks and Issues Identified	Discuss	All	
	10.3	Any Other Business	Review	All	
12.30	10.4	Reflection on Meeting	Discuss	All	

Public Board Meeting Dates 2019/20

23 May 2019 (ETB)	3 October 2019
6 June 2019	5 December 2019
1 August 2019	6 February 2020

The Princess Alexandra Hospital NHS Trust

Board Purpose:

Purpose:
The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.
Quoracy:
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.
Ground Rules for Meetings:
1. The purpose of the meeting should be defined on the day (set the contract). 2. Papers should be taken as read. 3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified. 4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter. 5. Challenge should be constructive and a way of testing the robustness of information. 6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time. 7. The use of mobile phones during meetings should be avoided; phones must be set to silent. 8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

Board Membership and Attendance 2019/20			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Steve Clarke	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	George Wood	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. John Hogan	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Andrew Holden (Vice Chairman)	Chief Medical Officer	Dr. Andy Morris
Chair of the Workforce Committee (WFC)	Pam Court	Director of Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	Dr. Helen Glenister	**Executive Members of the Board (non-voting)**	
Associate Non-Executive Director (non voting)	Helen Howe	Director of Strategy	Michael Meredith
Associate Non-Executive Director (non voting)	John Keddie	Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 1 August 2019 from 09:30 – 13:00 at
Herts & Essex Hospital, Haymeads Lane, Bishop's Stortford CM23 5JH

Present:	
Steve Clarke	**Trust Chairman (TC)**
Pam Court	Non-Executive Director (NED-PC)
Lance McCarthy	Chief Executive Officer (CEO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Andrew Holden	Non-Executive Director (NED-AH)
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
Stephanie Lawton	Chief Operating Officer (COO)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Andy Morris	Chief Medical Officer (CMO)
George Wood	Non-Executive Director (NED)
Patient Story:	
Kerry Ryan	Sister/Complainant
Doreen Brennan	Mother
Roisin O'Keeffe	Sister
Lorna Hughes	Social Worker
Maxine Priest	Theatre Matron
Chris Sayer	PSQ Facilitator
Kerry Riches	Head of Patient Experience
Shahid Sardar	Associate Director Patient Experience
Steph Rea	Associate Director - EPUT
Pam Humphrey	Associate Director of Nursing – Surgery
Learning from Deaths:	
Jo Ward	Associate Director of Nursing & Therapies
In attendance:	
Laura Warren	Associate Director - Communications
Shannon Dudley (for part)	HCL Workforce Solutions
Apologies:	
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Trevor Smith	Chief Financial Officer (CFO)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the meeting.
02 PATIENT STORY	
2.1 'Paula's Story' *(57 minutes)*	
2.1	The item was introduced by the Director of Nursing & Midwifery (DoN&M) who informed members the story related to a mental health patient's experience of trying to navigate her way through complex acute services. She welcomed the patient's family and the patient's sister (PS) then took the Board through her sister's experience. Paula had been diagnosed as Paranoid Schizophrenic; a condition she had had for 45 years.
2.2	Paula had been 60 years old when she had died in ITU at PAH in October 2018 from a perforated bowel (unrelated to the complaint). The specific complaint being brought to the Board's attention related to Paula's admission for a gynaecology procedure where necessary adjustments had not been made. Whilst waiting for surgery Paula became very

	agitated and left the hospital, therefore her surgery was cancelled. The procedure was rebooked and carried out successfully on another date. Failure to apply the principles of the Learning Disability Framework to mentally ill patients meant that over a period of time Paula had been unable to access medical services for five procedures. .
2.3	The request of Paula's family that day was twofold: 1) For the Board to provide some assurances that the above would be addressed going forward by application of the principles of the Learning Disability Framework to mentally ill patients and 2) For a formal written response to their complaint.
2.4	At this point in the meeting the Theatre Matron (TM) was able to confirm some positive actions which had taken place during Paula's subsequent admission for the procedure: The patient pathway for theatres had been adjusted for Paula (first on list, fasting time minimal) which had resulted in a successful admission. There had been a round table meeting with the family to discuss their complaint. It was confirmed that a Standard Operating Procedure (SOP) for Mental Health Patients Undergoing Surgical and Anaesthetic Procedures had been developed and was awaiting approval/ratification. This covered the patient's journey from Outpatients to In-Patients and on to Discharge. An alert for mental health patients had been put in place and would instigate immediate contact with their family to agree requirements and adjustments. It was also confirmed that the Trust now had 21 trained Mental Health First Aiders who could support individuals.
2.6	The DoN&M confirmed the organisation recognised it was on a journey in terms of supporting patients with mental health issues and was strengthening its relations with partner organisations. The Board was clear on its responsibilities and a newly established Mental Health Quality Forum was currently working through what it was like for a mental health patient to navigate through acute services. In addition it was confirmed there was now an increased liaison service provided by EPUT in the form of an additional consultant for the Trust and increased nurses and support workers. There was also a plan for a further consultant and psychologist to support mentally ill inpatients. The Associate Director – EPUT (AD-E) was keen to use the paper provided that day as an instrument to develop those services further going forward.
2.7	In response to a question from Non-Executive Director Pam Court (NED-PC) in relation to the SOP it was confirmed that service-user/family feedback was awaited before it could be ratified. In the meantime processes detailed in the SOP were already being applied from pre-assessment through to discharge. It was agreed these processes may also be transferable to other areas Including ED and Outpatients
2.8	The Chief Operating Officer (COO) confirmed that in relation to the front end of the pathway (arrival in ED), work was underway with EPUT to have 24 hour support for patients, at that point in their journey, and from there onwards. The CC stated he would like, very soon, to have a target date for completion of that work.
2.9	In response to a question from NED George Wood (NED-GW) in relation to the transfer of learning to other hospitals PS confirmed the family were keen to help with the learning and for it to be used in other hospitals. Specifically it was confirmed the new SOP addressed the issue of medication although it was agreed stronger working relationships were required across the whole multi-disciplinary team and specifically between PAH and the Derwent Centre.
2.10	NED Helen Glenister (NED-HG) queried whether there was learning to be gleaned from other organisations. In response the TM confirmed she had networked in the region but had come up with very little. Her intention was that once the new SOP had been ratified she would like it to go national.
2.11	Associate NED Helen Howe (ANED-HH) was keen for the experience not to be repeated for others and queried whether the Trust's electronic patient record (EPR) system could flag patients and on a repeated basis. In response it was confirmed it could. The TM confirmed the process was slightly different now in Theatres and when a patient was booked electively an alert could be added immediately which would then be permanent.
2.12	The CEO stated he was sorry to hear of the family's experience. There had been a renewed focus over the previous 12 months to support both patients and staff with mental health issues. He applauded the work done in Theatres and gave his assurance to the

	family that the Board/organisation took their concerns very seriously and would address them. A formal written response to their complaint would be forthcoming.
2.13	As a final point PS stated she would look forward to that response which she hoped would clearly outline what the Trust intended to do, particularly in terms of its admissions procedure. She urged the organisation to set clear KPIs in order that it could measure whether or not improvements were being embedded. The Trust Chairman thanked PS and the other family members for sharing their experience with Board members and the family departed.
2.14	The TC reflected that the family's story had been very powerful and with clear expectations. He urged colleagues to ensure the required changes were made as soon as practicably possible. In terms of having a mental health champion it was agreed the Trust was about to establish an enhanced liaison service across the organisation and it would need to be embedded before additional actions were taken. The arrangement with EPUT would firmly establish the Board's duties in terms of mental health awareness and training for the Board/staff would be commissioned from them.
2.15	As a final point and in relation to concerns expressed as to the length of time taken to provide a formal written response to the family's concerns, it was confirmed the family had a very good relationship with staff in both Theatres/Patient Experience and they had been in constant dialogue with the Trust. The next step would be a formal written response.
1.1 Apologies	
1.2	As noted above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 06.06.19	
1.4	The minutes of the meeting held on 06.06.19 were agreed as a true and accurate record of that meeting with the following amendment: Minute 8.14: May's Quality & Safety Committee (QSC) had taken place on 24.**05**.19 and had been chaired by **NED Helen Glenister**.
1.4 Matters Arising and Action Log	
1.5	It was agreed action ref: TB1.06.06.19/07 could be closed. Action refs: TB1.06.06.19/05, 06 and 08 were items for discussion that day.
03 RISK	
3.1 Significant Risk Register (SRR) *(1 minute)*	
3.1	This item was presented by the Chief Medical Officer (CMO) and the paper was taken as read. The only item to highlight was the risk around Endoscopy ventilation which he clarified was a new risk which had arisen after the plan to install a new ventilation system for the department. It transpired the intended room was not compliant with COSHH (Control of Substances Hazardous to Health) standards and therefore additional work had had to be undertaken. He emphasised there had been no risk to patients or staff so the rating of that risk would now reduce.
3.2 Board Assurance Framework (BAF) *(1 minute)*	
3.2	This paper was presented by the Head of Corporate Affairs (HoCA) and the report was taken as read. BAF risks 2.2 (*Internal Communication*) and 4.1 (*Supporting Functions*) were proposed for closure and a new risk (2.3) had been added in relation to the Trust's '*Inability to recruit, retain and engage our people'* scoring 12. The Board accepted the proposed changes which had been discussed in detail and supported at the relevant committees.
04 CHIEF EXECUTIVE'S Report	
4.1 CEO's Report *(19 minutes)*	
4.1	The CEO presented his update and key highlights were as follows: **Key performance headlines:** two new indicators had been added: 1) Falls per 1000 bed

	days and 2) Agency % of pay bill (target 7%). **Urgent Care Performance:** The significant increase in activity continued (up 7% for the previous nine months) and July had seen the highest ever number of monthly attendances with 9552 recorded. Performance had been 78.3% (subject to validation). There had been no apparent changes in patient acuity and the increase in activity was being mirrored across all Essex acute trusts.
4.2	**CQC Inspection:** the final report had been published the previous day and was for the main part positive, evidencing the Trust's journey over the previous three years – a credit to staff for making huge improvements. It would be the perfect platform for the next part of the journey towards 'good' and onwards to 'outstanding'. In terms of oversight of the recommendations it was confirmed a new peer review process had been established which would link in with the NHS 10 year forward plan. The organisation would also regularly run an internal Provider Information Request (PIR). Performance meetings with the Healthcare Groups (HCGs) would focus on triangulation of all the data more effectively and using information from the CQC to provide the HCGs with KLOEs (key lines of enquiry) to ensure care improved, ensuring at the same time the driver was not solely focussed on the CQC.
4.3	Recent **Political Changes** were noted.
4.4	**Integrated Care Partnership:** Work continued with West Essex and East Hertfordshire health and care colleagues to develop system wide clinical pathways for the benefit of patients. A five year contract had recently been signed (as an Alliance with Essex Partnership University Trust (EPUT)) with WECCG for the provision of integrated Musculoskeletal services for the local population.
4.5	**Consultant Appointments**: Four panels had been held since the last meeting with recommendations for six new consultant appointments including one for the ED. The Board approved all six appointments. It was confirmed the consultant gap in Medicine was 10% and it was agreed the consultant gap across the Trust would be provided ahead of the next meeting. The COO confirmed a piece of work was underway to review medical vacancies across the Trust to provide information on costs of temporary staff and the recruitment pipeline.
ACTION **TB1.01.08.19/10**	**Provide a figure for the percentage consultant gap Trust-wide.** **Lead: Director of People**
05 PATIENTS	
5.1 Learning from Deaths (CCCS) *(20 minutes)*	
5.1	The CMO introduced the item and welcomed Jo Ward, Associate Director of Nursing & Therapies for Cancer, Cardiology & Clinical Support (ADoN&T) who then relayed the following case.
5.2	The patient had been an 82 year old female who had been admitted on 30.12.18 from home (third time in past two months) with heart failure. Her past medical history included metastatic breast cancer and aortic stenosis. A DNACPR decision had been made on admission. Over the following three weeks much clinical planning had taken place starting in Cardiology and with a referral for discharge planning immediately with medical management of her cardiac condition. She was then treated with diuretics for her heart failure and was planned for discharge. She had been due for chemotherapy so a decision was taken that she would remain in hospital for that. A treatment escalation decision was made on 18.01.19 at which point she had been seen by the Gastro and Cardiology teams and was for referral to the Urology team. On 23.01.19 an MDT meeting had taken place with the family present and a decision was made to fast-track the patient home in light of her cancer diagnosis/aortic stenosis. The patient had then deteriorated requiring clinical treatment and on 31.01.19 active end of life care commenced. The lady died the following day with her family present. The hospital was commended by the family on the care provided (even though the discharge home had not happened) but it was agreed there was some learning to be taken forward from the case.
5.3	What could have been done differently : Earlier recognition of the patient's complex needs, earlier MDT discussion to review prognosis in relation to all co-morbidities and earlier discussion with family on prognosis

	and finally reduced diagnostic investigations) with earlier referral to elderly care to support overall review.
5.4	The Board noted actions taken since including referral to elderly care for all complex patients discussed on daily board rounds, a Care of the Elderly Consultant assigned to support Cardiology. The case had also been shared with the Cancer team in terms of consideration for palliative care prior to admission.
5.5	In response to the above NED-PC asked whether or not consideration was given to referral to hospice at home. In response it was confirmed that one of the mortality improvement work-streams in heart failure meant that in the last six months joint clinics were being held with the hospices so there were now more referrals.
5.6	In terms of the Trust's Palliative Care Team and their engagement with other services in the organisation the CMO confirmed that plans were in place to expand the former in order to be able to provide a seven day service.
5.2 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	
5.7	This update was presented by the DoN&M and the paper was taken as read. There had been a small variation in month but no change to the overall fill rate. There was confidence in addressing the agreed vacancy rate of 10% with 291 job offers for Band 5 nurses in the pipeline. A monthly project group had been established with Workforce, Estates, Finance and Nursing to ensure the pipeline was expedited and managed effectively.
5.8	In response to a question from NED Andrew Holden (NED-AH) in relation to new starters in July it was confirmed it had been slightly less than the anticipated 19 due to problems with visas. The team were confident the pipeline would start to deliver and for both August and September the expected new starters were just over 20 in each month.
5.9	A short discussion then ensued around adding a statement to the report confirming that despite fill rates, all metrics provided assurance that the organisation was safe. It was agreed that whilst Appendix 2 of the report did provide some assurance around that, the DoN&M would take that offline for further thought.
ACTION TB1.01.08.19/11	**Consider adding a statement to the Hard Truths paper confirming that despite fill rates, all metrics provided assurance the organisation was safe. Lead: Director of Nursing & Midwifery**
5.3 Pathology Services *(6 minutes)*	
5.10	The CEO provided an update on progress with the STP-wide procurement for a third party pathology service. Four Supplier Questionnaire responses had been received from NHS and non-NHS organisations and would be evaluated during August. A process of competitive dialogue would be undertaken over the winter and spring with a preferred bidder identified in April 2020. Assuming sovereign Board approvals, the contract would be awarded in June/July 2020. The next key milestone (September) would be agreeing the service specification.
5.4 Maternity Incentive Scheme *(2 minutes)*	
5.11	The paper was presented by the DoN&M and taken as read. The paper had been reviewed at QSC and recommended to the Board for approval. The paper outlined the requirements of the scheme, the assurance framework and provided a summary of the evidence of achievement against all 10 standards Commissioners had reviewed the evidence, and had been assured around levels of achievement.
5.12	In response to a question from NED George Wood (NED-GW) it was confirmed the Trust had declared partial compliance the previous year (due to training compliance).
5.13	The Board received the paper as assurance that Maternity Services had demonstrated achievement of all the requirements of the Maternity Incentive Scheme and approved the submission of the Board declaration form.
5.5 Maternity Serious Incident Cluster *(6 minutes)*	
5.14	This item was presented by the DoN&M who reminded members there had been a small increase in incidents related to perinatal deaths over 2018. All had undergone investigation

	and three had gone for external review. No direct causation had been attributed to any of the cases.
5.15	In December 2018 a decision had been taken to ask NHSI to conduct a look back over the previous 13 months. Representatives from the CQC and West Essex CCG were also involved. In February 2019 the NHSI report identified themes which aligned with those identified by the Trust's internal review, for example, improvements to some pathways.
5.16	As a further level of assurance a CEO Scrutiny Panel had been conducted in April 2019 which had included an independent Consultant Obstetrician and Head of Midwifery from another hospital in the region. The panel concluded a thorough review of the cases had been undertaken and the identified actions were appropriate. It recommended, once the draft report had been finalised and individual reports had been sent to parents, that the Trust should make contact with the families. Duty of candour letters were sent to the families with regard to the NHSI report along with a copy of the individual report for each family.
5.17	The report updated the Board on the work to date, the actions in place and the conversations with the families. To date no further incidents had taken place evidencing similar themes. As a final point the CMO commended the quality of reports, the level of engagement from the Family & Women's HCG and the interaction between the midwives and the families. NED John Hogan (NED-JH) agreed and praised the way the organisation had handled a highly sensitive issue.
06 PEOPLE	
6.1 Annual Report: Medical Revalidation *(3 minutes)*	
6.1	This item was presented by the CMO and the paper was taken as read. He highlighted both the quality of appraisals and compliance rate, and improved appraisee satisfaction rates. He extended his thanks to both the Deputy Responsible Officer and the Medical Resourcing Manager for their contributions. Members had no questions.
6.2	The Board noted the report and approved the sign-off of Statement of Compliance at Appendix 1.
Members took a 10 minute break	
07 PERFORMANCE	
7.1 Integrated Performance Report (IPR)	
7.1	This report was introduced by the COO and key headlines under the 5Ps were as follows: **Patients:** An in-month reduction in pressure ulcers was noted. Assurance had been provided at QSC the organisation would be compliant in terms of cardiotocography (CTG) training by the end of August. **Performance:** Diagnostic standards had all been achieved. In terms of Cancer there were some workforce challenges in Breast due to an increase in referrals but an additional 2 Week Wait clinic had now been established. Work was also underway with Commissioners in relation to significant workforce challenges in Dermatology. Emergency Department (ED) attendances had reached 9800 in July (7% higher than in July 2018). Performance against the 4 Hour standard (subject to validation) was 78% - the same as for June but with an additional 1000 attendances. There was now a requirement for the Trust's Regulators to have weekly oversight of all attendances over 21 days and for the organisation to reduce those by 40% by the end of the year (the Trust was currently ahead of trajectory). Paediatric performance in July had been the best for 12 months and a new Associate Medical Director (AMD) would start in the ED on 09.09.19. The improvement in ambulance handover times (PAH best performing in region) had been achieved by the appointment of a Hospital Ambulance Liaison Officer (HALO) and ongoing work with ECIST to improve processes. In response to a question from NED-JH in relation to ED performance against the new metrics it was confirmed that whilst those had not yet been agreed, some 'shadow' reporting was taking place. That reporting was showing there was still room for improvement, although the Trust was no longer in the bottom third of poorly performing Trusts. It was agreed the data from the 'shadow' reporting would start to

	be shared at Board Committees.
ACTION TB1.01.08.19/12	**Share the data from reporting against the new ED metrics with the Board Committees.** **Lead: Chief Operating Officer**
7.2	In response to a further question from NED-JH the COO confirmed ED performance could be improved. The Trust was currently being supported in its recruitment of middle grades which could mean an extra 10 by the end of the year and there had been a significant improvement in performance since the new GP service had launched in ED. .
7.3	**People:** There had been a focus on temporary staffing/time to hire at Workforce Committee (WFC). Concerns were raised in relation to workforce indicators for Family & Women's Services (FAWS) which would be progressed at their Performance Review meeting. Overall statutory/mandatory training compliance had now achieved the required trajectory (90%) for five consecutive months however, there were some concerns that some important subject matters of that overall compliance had not achieved the required trajectory (Information Governance/Safeguarding). It was noted there had been some improvement in compliance with Information Governance (IG) training in relation to medical staff, and that going forward timeframes for completion of statutory/mandatory training (annual/bi annual) would be set by the STP.
7.4	**Places:** Members were informed a significant transformation was underway in terms of Domestic Services. In addition the Catering Service had seen a significant increase in demand and there would now be a focus on waste. In terms of capital works underway the Fracture Clinic was being relocated back to main site, replacement generators were being installed, there would be a new ventilation unit for ITU and a chiller on the roof. A detailed review of all capital works would begin to ensure patient/staff safety and that investments were channelled into areas of risk. . In relation to food waste it was agreed a figure for the split (retail/patient) would be provided.
ACTION TB1.01.08.19/13	**Provide a breakdown of food waste (retail/patient).** **Lead: Director of Strategy**
7.5	**Finance:** Q1 results showed a year to date deficit which was £3.1m worse than plan. A draft recovery plan was being developed for submission to the Trust's Regulator, the final version to be submitted in September. Grip and control measures had been tightened and an increased review of temporary staffing/medical agency expenditure was taking place. The financial position for M4 was improved but the Q1 shortfall needed to be addressed moving forward.
08 PLACES	
8.1 Capital Programme *(6 minutes)*	
8.1	The item was presented by the CEO who reported that the programme had already been approved by PAF due to the submission deadline being before the Board meeting. In response to a national requirement to reduce 2019/20 capital spend by 20%, the Trust had revised its programme (in conjunction with the STP) and reduced it from an opening £29.7m to £21.5m. Of that programme £10.3m remained funded from internal resources and with a revised £11.2m of schemes subject to additional PDC funding and business case submissions. In response to the above it was agreed the risks, (in terms of capacity) should be reflected in the BAF.
ACTION TB1.01.08.19/14	**Capacity issues related to a reduction in the 2019/20 capital programme to be reflected in the BAF.** **Lead: Director of Strategy**
8.2	The Board noted the revised 2019/20 capital programme and noted that 50% of the planned programme was still subject to funding approval. The Board retrospectively approved the revised Capital Programme.
09 GOVERNANCE	
9.1 Reports from Committees *(2 minutes)*	
9.1	Workforce Committee (WFC.22.07.19) – Chair NED-PC All items had been covered in discussions above.

	Performance & Finance Committee (PAF.25.07.19) – Chair NED-AH There were no questions from members. Quality & Safety Committee (QSC.26.07.19) – Chair NED-JH The shortfall in funding for Research & Development (R&D) was highlighted and members noted the Annual Report for Research & Development. Charitable Funds Committee (CFC.25.07.19) – Chair NED-HG There were no questions from members.
9.2 Report from Senior Management Team *(1 minute)*	
9.2	This paper was presented by the CEO and was for noting only.
10 QUESTIONS FROM THE PUBLIC	
10.1	There were no questions from the public. However a question had been lodged prior to the meeting from Shannon Dudley of HCL Workforce Solutions who unfortunately had not been able to stay for the duration of the meeting. Her question had been in relation to the Trust's Recruitment & Retention plans. In response the Director of People (DoP) stated that as recruitment had already been discussed above, her intention had been to talk about: 1) Health & Wellbeing initiatives for staff, including mental health and the Health Assure employee assistance programme 2) Work underway in relation to education and training and the Leadership Academy and 3) Staff Engagement initiatives e.g. the upcoming Event in a Tent, long service and staff recognition awards. As a final point she stated that the WFC kept the Board assured via the workforce KPIs.
11 CLOSING ADMINISTRATION	
11.1 Summary of Actions and Decisions	
11.1	These are presented in the shaded boxes above.
11.2 New Issues/Risks	
11.2	The risk in relation to reductions in the capital programme (see minute 8.1 above).
11.3 Reflections on Meeting	
11.3	Members agreed the room was suitable for Board meetings and enquiries would be made as to its future availability.
11.4 Any Other Business (AOB)	
11.4	There were no items of AOB.

Signed as a correct record of the meeting:	
Date:	01.08.19
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 03.10.19

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.06.19/08	Progress from MIB	Progress on work undertaken by MIB to be reported to TB1.03.10.19.	CMO	TB1.03.10.19	To be addressed at item 5.2 at TB1.03.10.19.	Proposed for closure
TB1.01.08/19/10	Consultant Vacancies	Provide a figure for the percentage consultant gap Trust-wide.	DoP	TB1.03.10.19	10.43% as at 31 August 2019 (WTE 18.93).	Open
TB1.01.08/19/11	Report against Hard Truths	Consider adding a statement to the Hard Truths paper confirming that despite fill rates, all metrics provided assurance the organisation was safe.	DoN&M	TB1.03.10.19	Verbal update to be provided at TB1.03.10.19.	Open
TB1.01.08/19/12	New ED Metrics	Share the data from reporting against the new ED metrics with the Board Committees.	COO	TB1.03.10.19	Actioned.	Closed
TB1.01.08/19/13	Food Waste	Provide a breakdown of food waste (retail/patient).	DoS	TB1.03.10.19	Verbal update to be provided at TB1.03.10.19.	Open
TB1.01.08/19/14	Capacity Risk	Capacity issues related to a reduction in the 2019/20 capital programme to be reflected in the BAF.	DoS	TB1.03.10.19	Referenced in BAFrisk 3.1 as a gap in control.	Closed

The Princess Alexandra Hospital NHS Trust

TRUST BOARD - 3 OCTOBER 2019

3.1

Agenda item:	3.1
Executive Lead:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Sheila O'Sullivan – Associate Director of Governance & Quality Lisa Flack - Compliance and Clinical Effectiveness Manager
Date prepared:	23 September 2019
Subject / title	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:	This paper presents the Significant Risk Register (SRR) and was produced from Risk Assure system using the risk registers for all our services. . There are a total of 85 risks with a score of 15 or more. • There are no risks with a score of 25 • 16 risks score 20 (reduced from 20 in August 2019) A summary of each risk and the actions planned to manage and mitigate them is detailed within this paper. • 20 risks have a score of 16, (reduced from 21 in August 2019) • 39 risks score of 15, (decreased from 44 in August 2019) 4 new risks with 2 scoring 15 and 2 scoring 16 have been raised since 1 August 2019, detailed in section 3.
Recommendation:	Trust board is asked to i) Note the content of the Significant Risk Register ii) Take assurance from the actions currently in place or planned

Trust strategic objectives:	Patients	People	Performance	Places	Pounds
	√	√	√	√	√

Previously considered by:	Risk Management Group reviews risks monthly as per annual work plan.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 23 September 2019. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each area can be reviewed in detail on a rotation.

2.0 CONTEXT

2.1 The Significant Risk Register (SRR) is a snap shot of risks across all Healthcare groups and Corporate departments at a specific point and includes all items scoring 15 and above.
The risk score is arrived at using a 5 x 5 matrix of consequence X likelihood, with the highest risk scoring 25.

2.2 There are 75 (85) significant risks on our risk register. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
CCCS	9 (7)	6 (5)	2(2)	0 (0)	**17 (14)**
Estates & Facilities	3(8)	0 (0)	0(2)	0 (0)	**3 (10)**
Finance	0 (2)	0 (0)	2 (0)	0 (0)	**2 (2)**
IM&T and IG	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Information Data Quality and Business Intelligence	1(1)	0(0)	0(0)	0(0)	**1(1)**
Non-Clinical Health & Safety	2(2)	0 (0)	0 (0)	0 (0)	**2(2)**
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Operational	1 (1)	0 (0)	4 (4)	0 (0)	**5 (5)**
Research, Development & Innovation	0(0)	0(0)	1(0)	0(0)	**1(1)**
Resilience	1 (1)	0(0)	0(0)	0(0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Child Health	2(1)	0 (0)	0 (0)	0(0)	**2 (1)**
Women's Health	3(2)	2(1)	0 (0)	0 (0)	**5 (3)**
Medicine	4 (4)	6 (7)	7 (7)	0 (0)	**17(18)**
Surgery	13 (13)	4 (4)	0 (0)	0 (0)	**17(17)**
Totals	**39 (44)**	**20 (21)**	**16(20)**	**0 (0)**	**75 (85)**

(The scores from the August 2019 paper are in brackets)

2.3 The Trust has no risks scoring 25

2.4 There are 16 risks with a score of 20, reduced from 20 in August. A summary of these risks and actions underway are:-

2.5 Patients:

- Dose reductions to be applied as directed by user and not incorrectly interpreted by the EPMA system (CMS/2019/360 on register since January 2019)
  Action: Dose reduction should be detailed in the memo tab against the chemotherapy drugs. Communication of memo tab given to all prescribers, to apply dose reductions and use a separate dose reduction box. This issue has been reported to the supplier with request for a bug fix to resolve. Anticipate this being amended in version 7, planned introduction by end of November 2019.

- Applying a dose reduction to oral chemotherapy on a different administration days needs to be correctly applied on EPMA (CMS/2019/383 on register since February 2019)
  Action: Mitigating SOP developed and cascaded. Actions for prescribers and pharmacists detailed on the protocol. Nurses required to be vigilant for doses especially when dose reductions are applied. As risk CMS/2019/360 requested the supplier provide a remedy in the next version to be launched by end of November 2019. Monitoring Datix incidents.

2.6 People

- Three clinical areas have insufficient numbers of Registered Nurses – Harold (JS02), Fleming- MAU (03) and Saunders (Saun04) all on the register since July 14),
  Action: Recruitment and retention action plans are in place with daily reviews of staffing numbers and rotation of staff to ensure safety.

2.7 Performance

- Statutory compliance risk for failure to deliver 4 hour ED standard (001/2017 on register since April 2014).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on Medicine teams register (MED57 on register since July 2016).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on the Medical teams risk register (ED012 on register since July 2016).
  Action: Daily monitoring and review of previous breaches numbers and patterns in place aimed to limit deterioration in performance. Weekly assurance of surge plan and progress against the KPIs. Improvement plan in place across the emergency care pathway with trajectory set for compliance. Performance is improving across all patient flow pathways.

- No patient will spend a journey time greater than 12 hours from arrival in ED to discharge from ED (002/2016 raised July 2016)
- No ED patient to wait for longer than 12 hours to be admitted (003/2016 on register since July 16).
  Action: Development of surge escalation plan. Improvement plan is in place across the patient pathway with trajectory set for compliance. A medical assessment improvement plan is in place. The capacity model to inform inpatient developments over the next 12 months and work to improve non-elective length of stay in progress. The trackers working in the ED escalate patients not meeting department targets to the consultant and nurse in charge.

- Failure to achieve 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Action: Speciality level recovery plan with trajectories and mitigation are in place. Monitored at weekly tumour site and trust level meetings.

2.8 Places:

- Provision of new accommodation for corporate staff currently located in Mitre building (Fin014 on register since 31/12/17, score increased August 2019). Options for temporary /permanent accommodation have not been identified.
  Action: Lease extended until 31 March 2020, options under review to deliver new accommodation early enough to give sufficient time to implement the solution.

- Endoscopy patients have interrupted service as result of decontamination washer failure which will impact JAG accreditation (Endo002 on register since October 2017).
  Action: Agreement with the Rivers hospital to decontaminate our scopes when trust machines are not working. Building work required to install the new washers to be completed by 30/9/19.

- Endoscopy unit requires an air handling unit as current facilities do not comply with H&S statutory building sector recommendations (HTM03-01) and in addition will not keep its JAG accreditation. (Endo 080719, on register since July 2019)
  Action: Plan for replacement of air handling unit for endoscopy and engineer is to create a design for the high and low pressure system. Costings and timetable for work completion needs to be confirmed.

2.9 Pounds:

- Loss of 8% budget for the Clinical Research team will impact on overheads and set up fees. (R&D17.07.1802 on register since 17 July 2012, upgraded to a 20 in April 2019)
  Action: R&D does not have control of this budget so they will continue to apply and win contracts for commercial studies to mitigate for the reduction in funding. Trust team are renegotiating with North Thames Clinical Research Network.

- Failure to deliver financial control target leading to breach of statutory duty, loss of PSF/FRM money, cash pressures leading to inability to pay our creditors. (FIN001) on register since 20/7/19 but risk score increased since August 2019).
  Action: For healthcare groups (HCGs) in distress to increase the frequency of PRMs. Completion of the HCG2019/20 financial out turn plans to inform trust recovery plan, development of pre consultation business case, HCGs to be asked to review progress on request to over deliver and assess risks and mitigations associated with our inability to over deliver. Yearend negotiations with our CCG are underway.

3.0 New Risks on the SRR

3.1 Patients:

- Failure to action incidents promptly that could lead to potential harm (Women's Heath 2019/08/03, risk score 16, placed on register August 2019)
  Action:- Daily monitoring of all new Datix incidents by patient safety team, monitoring of the numbers of incidents that are outstanding a review and escalation within the service. Additional training has been arranged to ensure all appropriate incident handlers are on the Datix system and have the skills to complete their reviews.

- IV fluids for in-patient prescriptions are currently paper documents, not part of EPMA. IV fluids can be inconsistently administered. This risk falls within the Excellence Every time work stream of the mortality improvement programme. (PathBS-19-09, risk score is 15, placed on the register August 2019), is relevant across the Trust.
  Action:- Mitigations to ensure accurate fluid balance chart monitoring, raising awareness of intravenous fluids through the Acute Kidney injury/sepsis training, critical care outreach team are supporting patients who are at risk. A fluid balance pilot is planned for pilot to commence on all adult in-patient areas. The trust is redesigning the green charts to improve the clarity of prescriptions

3.2 Places:

- Drug manufacturers recommend medicines are stored within temperatures of 15-25.C. A temperature control system is required in the pharmacy dispensary (Pharm.2019/01, risk score 16, placed on the register August 2019).
  Action:- Temporarily rented portable air conditioning units over the summer, a replacement air conditioning unit is planned for completion by 30 September 2019.

- Increase in telephone calls to the outpatient telephone booking service (Adm/2019/04, risk score 15 placed on register August 2019).
  Action:- Review the number of calls received each month, monitored by the access board. Switchboard has been advised to inform patients to phone after 5pm when lines are less busy. Patient experience/ PALs will asked specific questions from patients covering a) the number of times patients have had to phone, b) length of time patients are waiting, to see if new measures put into place are having a positive impact for patients.

4.0 RECOMMENDATION

Trust board are asked to note the content of the SRR and take assurance from the actions currently in place or planned

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board - 3 October 2019

3.2

Agenda Item:	3.2
Presented by:	Heather Schultz - Head of Corporate Affairs
Prepared by:	Heather Schultz - Head of Corporate Affairs
Date prepared:	24 September 2019
Subject / Title:	Board Assurance Framework 2019/20

Purpose:	Approval	x	Decision		Information		Assurance	
Key Issues:	The BAF risks are presented for review. The risks have been reviewed with Executive leads, discussed at the Executive Management Team meeting and at the relevant Committees in September. Appendix A provides an overview of all the risks and the proposed risk ratings. There are no changes to the risk scores this month.							
Recommendation:	The Board is asked to approve the Board Assurance Framework							

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

Previously considered by:	WFC 23 September, PAF 26 September and QSC 27 September 2019.
Risk / links with the BAF:	As indicated in the attached BAF
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Code of Governance.
Appendices:	Appendix A - summary of risks

respectful | caring | responsible | committed

5P	Executive Lead	Committee	BAF Risks August 2019	Current risk score	Trend
	Chief Nurse/Chief Medical Officer	QSC	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	⟷
	Chief Finance Officer/DoI&IT	PAF	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16	⟷
	DoP/DoN	WFC	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	16	⟷
	DoP	WFC	2.3 Workforce: Inability to recruit, retain and engage our people	12	⟷
	DoS	PAF	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	⟷
	DoS	Trust Board/ Strategy Committee	3.2 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16	⟷
	DoS	Trust Board/ Strategy Committee	3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	12	⟷
	DoS	Trust Board/ Strategy Committee	3.4 Sustainability of local services Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	16	⟷
	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	20	⟷
	CFO	PAF	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	15	⟷

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2019-20

Our Patients – we will continue to improve the quality of care and experiences that we provide **our patients** and families, integrating care
Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment
Our Places – we will maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC
Our Performance – we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators
Our Pounds – we will manage **our pounds** effectively and modernise our corporate services to achieve our agreed financial control total

The Princess Alexandra Hospital NHS
NHS Trust

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow	4 X 5= 20	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Performance management of unacceptable behaviour and revised Accountability Framework iii) Robust Appraisal/ medical revalidation process (2 positive peer reviews) - 360° feedback and Fitness to Practice process in nursing iv) RCA methodology workshops v) End of Life and deteriorating patient simulation programme for all staff. and Whole System Steering Group vi) Mandated & focused education & training in communication skills such as breaking bad news training. vii) Sharing the Learning Programme well embedded viii) Monthly Commissioner reviews of quality and Safety xii) Risk Management Training Programme xiv) Escalation prescribing processes xv) Electronic handovers and E-Obs and observation compliance reports xvi) Schwartz Rounds xviii) NHSI/NHSE Oversight xxi) Red2 Green Board rounds supported by ECIST xx) Implementation of Medical Examiners with reporting software and Board oversight xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality xxiv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xxv) Introducing '15 steps' walkabouts from January 2019 xxvi) Nursing Establishment review xxvii) Safer Staffing policy xxviii) Real time patient feeback implemented across all wards xxix) Robust management of periods onf increased incidences of Infection Control (MRSA/VRE) xxx) Robust management of variations in neonatal outcomes xxxi) Engagement in external reviews MBRRACE and LeDeR and Healthcare Safety Investigation Branch (maternity) xxxii) Medical examiners (MEs) and Lead ME appointed.	i) National Surveys ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) End of Life and Mortality Groups xiv) AKI & Sepsis Group xv) Urgent Care Improvement Board xvi) Mortality Review Group xvii) Mortality Improvement Board	i) Improvement in some areas of the National Inpatient Survey and NACEL Survey ii) CQUIN reports to SMT/PAF/QSC (June 2019) iii) CEO Assurance Panels (as required) iv) Reports to QSC on Patient Experience June 19, monthly Serious Incidents, monthly Safer Staffing, Patient Panel July 19, Safeguarding, monthly Infection Control v) Monthly Mortality Improvement report to QSC and monthly IPR report vi) Dr Foster reports, CQC inspection reports (March 18 and draft June 19) and GIRFT reports vii) Real time Dr Foster reports and engagement viii) GMC Survey results (July 2018) ix) Clinical Audit report 18/19 - tiaa (limited assurance) v) CMO/CFO Coding Meetings and quarterly Coding reports to PAF (June 19) vi) Positive staff survey outcomes (2018) measuring safety culture and engagement vii) Freedom to Speak Up Guardians quarterly reports to WFC (May 19) and Guardian of Safe Working reports to Trust Board (Dec18). viii) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19)	4x4=16	Lack of modernisation in some reporting processes including: i) Evolving clinical audit approach- improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site capacity and constraints iv) Access to Qlikview **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality iv) Review of quality/safety and risk leadership structure v) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	02/07/2019	Risk rating not changed	4x3 =12 (Target date Dec 2019 - to review progress against Mortality Improvement Strategy workstreams
			Effects: i) Poor reputation ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds - we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total**													
BAF 1.2	**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) Training programme. v) Super users in place to deliver focused support. vi) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability vii) Access Policy viii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) ix) Development of capacity planning tools/information x) PWC review and actions identified ~~xi) DQ meetings re-structured~~ xii) ICT Newsletter issued ~~xiii) New training process for locums~~ ~~xv) New daily Cambio meetings/roadmap~~ xvi) Daily ICT/COSMIC meetings ongoing xvii) Real time data now available ~~xviii) OBS requirements reviewed to assess gaps~~ ~~xix) Contract review completed~~ xx) CDS 011 now live xxi) Maternity MDS configuration completed. ~~will be complete by 17/5/19.~~ CI 2.2 testing completed ~~planned.~~ xxii) Monthly Contract Performance monitoring meeting with supplier established	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings	i) Weekly Data Quality reports to Access Board and EDB ii) External Audit reports to Audit Committee on Quality Account Indicators (July 19 - adverse conclusion) iii) Monthly DQ reports to PAF (September 19) and quarterly ICT updates (July 19) iv) EPR outline business case developed and presented to SMT and PAF September 19.	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance).	Sep-19	Risk rating unchanged	**4x3=12** **December 2019 (subject to monthly review of progress)**
		Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately								**ACTIONS:** i) Ongoing training and support ii) Restructure of IT team (resourcing) iii) Re-establishing relationship/engagement with Cambio iv) Refresher training underway v) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR				

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 2.1		**Nurse Recruitment** Inability to recruit sufficient numbers of registered nurses.	**Causes:** National shortages of appropriately qualified staff Competition from neighbouring hospitals Locality of PAHT	**5 X 4 =20**	Director of People and Director of Nursing **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity and proactive recruitment campaigns iii) Apprenticeships and work experience opportunities iv) Use of new roles in line with national direction v) Use of recruitment and retention premia as necessary vi) Use of TRAC recruitment tool vii) Use of a system to recruit pre-qualification students viii) Working in collaboration with STP and LWAB ix) Lead Nurse for Recruitment and Retention appointed	i) PAF, QSC, WFC, EMT, SMT, Workforce and Board meetings ii) PRMs and Health Group Boards iii) Recruitment and Retention Group iv) People Board	i) Safer Staffing Reports (monthly to QSC and Board) ii) Workforce report (progress on recruitment, retention, bank and agency) to WFC 22.07.19 iii) Incident reporting and monthly SI reports to QSC iv) Internal Audit report 18/19 on Recruitment (substantial assurance) v) International Nurse recruitment business case to SMT, PAF (June 2019) and Board (July 2019) vi) Monthly IPR report	**4 x 4 = 16**	~~i) Dedicated nurse recruiter resources for nursing recruitment~~ i) Limited ability to influence some of the pre-employment timeframes due to external requirements e.g. NMC registration Actions: Registered nurse vacancy rate to be included in IPR Ongoing monitoring of pre-employment phase of recruitment process to minimise delays	None noted.	12/09/2019	**Risk rating not changed**	**4 x 3 = 12** **January 2020**
			Effects: i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale and impact on engagement iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Lower staff retention rates v) Reduced attendance at training courses vi) Impact on patient experience										

Risk Key		
Extreme Risk		15-25
High Risk		8-12
Medium Risk		4-6
Low Risk		1-3

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Causes:** High vacancies in some critical areas/roles High turnover in some areas Capacity and capability of some managers and leaders Large cohort of new starters Inability to recruit from Europe due to uncertainty around Brexit Staff not fully engaging in and understanding the modernisation agenda Trust's proximity to London Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff awards held locally and trust wide annually	i) WFC, QSC, SC, PAF, WFC, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards	i) Workforce KPIs reported to WFC bi-monthly and IPR (monthly) ii) People strategy deliverables iii) Staff survey results and action plans (WFC July 19) iv) Staff friends and family results (WFC May 19) v) Medical engagement surveys and action plans (WFC November 2018)	**4 x3 = 12**	Pulse surveys targeted for all staff Communications strategy Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Actions i) Behaviour workshops - Q2 implementation of communicaiton strategy - Q4 ii) Recruitment plans for medical staff - Q2 iii) New consultant development programme - Q2 iv) Extranet for staff - Q1 20/21	None identified.	09/09/2019	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in March 2020)**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) Under-investment in training of estate management & site development viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in wards areas. x) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed as part of Project Genesis (Our New Hospital) x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place x) Sustainability Manager in post	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings ~~viii) First Impressions Count project group~~ ix) Project Genesis Steering Group	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and quarterly to PAF (July 19). v) Ventilation audit report vi) Water Safety Report (PAH site) vii) Annual and quarterly report to PAF: Estates and Facilities (July 19) viii) PLACE Assessments (Audit report May 18) ix) IPR monthly	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks ii) Ventilation systems iii) Sewage leaks and drainage iv) Electrical Safety/Rewiring (gaps) v) Maintaining oversight of the volume of action plans associated with compliance. ~~vii) Lack of authorised persons within estates and facilities teams.~~ vii) Sustainability Management Group to be established ~~(launch in April) and Sustainability manager to be recruited~~. **ACTIONS:** i) Backlog maintenance review underway and alignment of capital to identified risks with business cases to support investments. ~~ii) Recruitment of Sustainability Manager underway~~ ii) EBME review underway	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required iv) PAM assurance not robustly updated.	09/09/2019	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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Medium Risk		4-6												
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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Strategy Committee	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. ~~ix) MSK contract being developed with system partners and due diligence submission (9.01.19)~~ viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed.	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates iii) STP report to Strategy Committee (July 2019) iv) STP lead's presentation to Trust Board (Aug '19).	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams		20/09/2019	**No changes to risk rating.**	**4x3=12 March 2020**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to ~~influence both internally and externally the required strategic changes~~ work in partnership to develop an Integrated Care Trust.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ~~ii) Change fatigue and continuous change in leadership~~ iii) Scale, pace and complexity of change required. iv) Infrastructure (IT, buildings) not supportive of change v) Financial resources lacking to support change vi) Focus on immediate operational and financial priorities versus the longer term strategic planning vii) Lack of clarity regarding contracting and organisational models in support of ICP viii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed. ~~ix) Lack of shared vision and key drivers for change~~ ~~xi) Internal programme for development and implementation of 5P plans.~~ ix) Uncertainty around future CCG structure and relationships	**4 X 4= 16**	DoS Strategy Committee	~~i) SMT meetings~~ ~~ii) Clinical specialty meetings~~ iii) Good relationships with key partner organisations iv) CEO chairing ICP Board ~~v) Project Genesis Steering Group~~ vi) CEO and Chair attending STP meetings ~~vii) Programme plan in place - health planners engaged, transport study, strategic estates advisors engaged.~~ viii) Clinical Strategy being developed. ix) Strategy Committee established ~~in April 2019~~ x) Development of MSK service and engagement of senior clinicians. xi) One Health and Care Partnership established xii) Financial principles for integrated working developed	~~i)Workshops with clinical leads~~ i) ICP and STP meetings ~~including acute and back-office workstream meetings~~ ~~iii) Project Genesis Steering Group~~ ii) Expert Oversight Groups and workstreams (finance,people, IT) iii) ICP senior leaders meetings	i) ICP Reports to Strategy Committee ~~ii) Board workshop sessions held in September: site options and clinical strategy.~~ ~~iii) System workshop held on new hospital design (Nov 18)~~ ~~iv) Well led rating assigned by CQC - good~~ ~~iv) Preferred Way Forward decision at Trust Board in March 2019.~~ ~~v) Board to Board with West Essex CCG held 4 July 2019.~~ ~~vi) STP update to Strategy Committee (July 2019).~~ ii) CEO report to Board (bi-monthly) iii) Joint Executive meeting held with West Essex CCG 12.09.19	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision and mission statement being refreshed and 5P plans underway ~~as part of Clinical Strategy work - to be agreed at Leadership event scheduled for July 2019.~~ Strategy team being developed PAH long term strategy being developed	Reporting from EOGs/workstreams to be established Development of governance structures for integration	09/09/2019	**Risk rating not changed.**	4 x 2= 8 ~~September 2019~~ **March 2020**
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

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edium Risk		4-6												
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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance,			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3 : Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	4 X 4= 16	Director of Strategy **Trust Board**	i) Potential new build/location of new hospital ~~ii) KPMG Review~~ iii) STP Footprint and Estate Strategy developed. iv) Herts & West Essex STP Estates workstream v) Pathology workstream led by CEO vi) Estates and Facilities Infrastructure subgroup for West Essex vii) SOC affordability model viii) SOC approved and submitted to NHSI ~~and further financial analysis template submitted to DH~~ ~~ix) Site analysis Phase I complete~~ x) Detailed analysis of current site option commissioned xi) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. xii) Alignment of strategic capital and tactical capital plans xiii) MSK service developments underway xiv) Capital funding of £9.5m received	i) PAF and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings ~~v) SOC Steering Group~~	i) STP reports to Strategy Committee and Board via CEO Report (August 2019) ii) Reports to SMT iii) STP work plans iv) Our New Hospital reports to Strategy Committee (July 2019 and September 2019) ~~PAF~~ and updates to Board. v) PAHT 2030 report to Strategy Committee (July 2019) vi) PCBC approved at Trust Board (September 2019) vii) MAU business case approved at Trust Board September 2019	4 x 4 = 16	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway ~~PCBC work commissioned~~ ~~Regular meetings held with regulators.~~ ~~Newly established Strategy Committee~~	i) Strategy in development	09/09/2019	**No change to residual risk rating.**	**4 x 3 =12** ~~**Sept 2019**~~ **March 2020**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. vi Attendances continue to rise annually (5.1% over the last 2 years). viii) Changes to working practice and modernisation of systems and processes ix) Delays in decision making, patient discharges and delays in social care and community impacting on flow x) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Daily call with ~~NHSI/~~ CCG/~~NHSE~~, daily report on performance. vii) Work in progress to develop new models of care viii) Local Delivery Board in place ix) Daily specialty response times monitored x) System reviewing provision of urgent care xi) Exec attendance at safety huddles daily xii) ED action plan reported to PAF/Board xiii) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xv) Protection of assessment capacity work underway xvi) Additional capacity in place xvii) Weekly Urgent Care operational meetings and Urgent Care Board in place xix) On site support from ECIST and NHSI medical lead	i) Access Board meetings ii) Board, PAF and EMB meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) Daily system executive teleconference vii) Fortnightly escalation meetings with NHSI/NHSE viii) Weekly HCG reviews ix) System Operational Group	i) Daily ED reports to NHSI ii) Monthly escalation reports to NHSE iii) Monthly PRM reports from HCGS iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance. v) Presentation on ED performance and 'next steps' to PAF and Board (May/June 19)	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	20/09/2019		**4x3 =12 March 2020 (on delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 03.10.19

4.1

Agenda item:	4.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	01.10.19
Subject / title:	CEO Update

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - Urgent care and flow - New hospital funding - PM visit - Development of Integrated Care Provider - Event in a Tent
Recommendation:	The Trust Board is asked to note the CEO report.

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

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

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The Princess Alexandra Hospital NHS
NHS Trust

Chief Executive's Report
Trust Board: Part I – 3 October 2019

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

(1) Key performance headlines

Some key summary performance headlines outlined below for the latest month. More detail on each of these and other key performance indicators are shown in the revised and updated Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (August)	Comparison to last report
ED 4-hour performance	77.0%	↓ (worse); target = 95%
SHMI	113.7 (Feb 18 – Jan 19)	→; higher than expected
CDiff (hospital onset)	0	↓ (better)
MRSA	1	↓ (worse); first since 2014
Never Events	0	→
Incidents reported	870	↓ (better)
No harm / minor harm incidents	97.5%	↑ (better)
Falls / 1,000 bed days	8.23	↓ (better)
6-week diagnostic standard	99.4%	↑ (better)
Stat Man training	93.0%	↑ (better)
Agency % of paybill	4.7%	↓ (better)

(2) Urgent care performance and flow

Performance against the 95% 4-hour access target remains significantly below where we would wish it to be. Numbers of attendances continue to increase materially (>7% increase (November 18 – September 19 when compared to November 17 – September 19)).

The new integrated GP and ENP service at the front of ED continues to function well, seeing 20% of total ED attendances, increasing physical and ED resource capacity. This is aligned with the ongoing work that we are undertaking with the Emergency Care Intensive Support Team and our local partners to improve access and flow for our urgent care patients. The key areas of focus remain:

- Medical staffing numbers in ED
- Provision of additional intermediate care capacity out of hospital
- Increased space for the assessment of medical patients
- Increased inpatient capacity

More detail on actions to support our urgent care patients will be picked up later in the agenda.

(3) New hospital funding

I am delighted to report that an announcement was made by the Prime Minister and the Secretary of State for Health on Sunday 29 September, that we would receive the capital funding for a new hospital in Harlow.

This is fantastic news for all of our people, our patients and the public in the local communities that we support and is as a result of many years of hard work from many of our people.

I'd like to take this opportunity to thank everyone who has worked on developing the plans over many years, and also to Robert Halfon MP and all in the 5 local authorities who have supported this.

We are still awaiting the exact details that support the announcement but this now enables us to fast forward the discussions we have been wanting to have with our people and the local population about our plans, to hear their concerns and to help us shape something that will support the local population for many years to come.

It will take us approximately 15-18 months to complete this process and the detailed business cases and development of the detailed plans, and we hope and expect to break ground in 2021.

Our preferred way forward, agreed by the Trust Board in March 2019, is to build a new hospital on a greenfield site next to the new junction 7a on the M11. This announcement enables us to develop these plans quickly and in more detail and I will keep the Board updated on a regular basis with progress.

(4) PM visit

We welcomed The Rt Hon Boris Johnson MP to the Trust on Friday 27 September and had the opportunity to show him first hand the need for a new hospital. The Prime Minister took the opportunity to take a tour of some of the estate, to talk to some of our people and also to talk to patients. He also made an announcement about government funding of £200m in to increased scanners across 80 hospitals to support earlier diagnosis for cancer and support improvements across the country in early detection times. Additional imaging support here will help us to reduce both our waiting times for cancer diagnostics but also for ED diagnostics and help us to improve our urgent care pathway flow.

(5) Development of Integrated Care Providers (ICP)

We continue to work at pace and closely with our West Essex and East Hertfordshire health and care colleagues to develop system wide clinical pathways for the benefit of our patients.

Our new 5-year contract as an Alliance with Essex Partnership University Trust (EPUT), with West Essex CCG, for the provision of integrated Musculoskeletal services for the local population is now in the early stages of its delivery phase and we are continuing to develop further plans for taking on the Lead Provider role for other services and pathways from April 2020.

(6) Event in a Tent

Our 3rd annual Event in a Tent took place last week (24-26 September). This was a fantastic opportunity to say thank you, to recognise and to support many of our amazing people. It was also an opportunity for our colleagues to share good practice, to learn and to have fun.

Many events were undertaken over the 3 days, including:

- Daily briefings on our vision and plans for the future, PAHT 2030, as we strive to be outstanding
- Our Annual our Amazing People Awards, recognising the fantastic achievements of many of our colleagues
- Recognition and thanks for our longest serving staff, celebrating the 183 colleagues who have worked at PAHT for more than 20 years
- Very good series of talks from Dr Chris Turner about how 'Civility saves lives'
- Fantastic day of QI, including a poster celebration with more than 120 posters, some mini TED talks from a range of staff and external speakers, including Roy Lilley and Chris Pointon and some very innovative café-style discussions to support QI thinking
- Excellent Schwartz round focussed on mental health

- A range of health and wellbeing events, including support for stress, menopause and mental health and opportunity to join various activities and groups locally in and around Harlow
- Highly memorable quiz night to finish the Event off, won for 3rd consecutive year by the information department

Thank you to everyone who was involved in organising this year's events and to those who took part in them and for making this year's Event in a Tent so memorable.

Author: **Lance McCarthy, Chief Executive**
Date: **1 October 2019**

The Princess Alexandra Hospital NHS Trust

Learning from a short life
Skylar's Story

Fiona Lodge

Head of Children's Nursing and Services

Your future | Our hospital

respectful | caring | responsible | committed

The Princess Alexandra Hospital
NHS Trust

Skylar-Rose-Lilly

27/11/2016 – 11/04/2019

Your future | Our hospital

respectful | caring | responsible | committed

Skylar

The Princess Alexandra Hospital NHS Trust

- Born very prematurely at PAH and developed chronic lung disease
- She required non invasive ventilation, oxygen and round the clock care
- Problems with her digestion and needed tube feeding
- A looked after child in foster care
- Loved Baby Shark and sensory play
- Often very irritable, but she was also playful, smiley and interactive
- Much loved patient by the ward team.

Family Perspectives

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- Birth mum and foster mum's good relationship
- Felt things were well explained
- Compassion of the medical team
- Lots of opportunities for cuddles
- Support from consultant in withdrawal of care
- Ward staff purchased a baby grow for Skylar after she died.

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Professional Perspectives

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- PAH team easy to work with
- Palliative care team support to PAH
- Good communication between all teams regarding long term ventilation and symptom control
- Ward receptive to palliative care
- Excellent liaison between acute and chronic and palliative care
- Staff felt Skylar's death was best possible, calm, peaceful with both foster parents and birth parents prepared, present and ready.

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Professionals Perspectives

- Different teams worked as a single virtual team
- Skylar at the heart of all planning and discussions
- Staff felt supported by Senior nursing team at PAH released to attend funeral
- Chaplain involvement was supportive
- First child death on Dolphin for 2 years so very inexperienced staff.

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Challenges for family

- Birth mother understanding treatment pros and cons and decision making about escalation of treatment
- Impact of social services on birth mother
- Foster parents previously cared for a child who had also died at PAH
- Legalities around EOL decisions

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Professional Perspective Challenges

- Too little support for foster parents
- Skylar's symptoms were extreme and complex she did not respond to many conventional medications
- Distance from Hospice
- Court order around EOL plan was not clear initially in particular around CPR, which left PAH feeling they may act against her best interests

Recommendations

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- Use of the ReSPECT document and CYPACP
- Regular meetings with EACH Symptom Management service for staff learning
- Write a document for the withdrawal of non invasive ventilation
- Community Nursing Team need support in being able to provide more end of life support

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Trust Board – 03.10.19

5.2

Agenda item:	5.2							
Presented by:	Dr Andy Morris/Jim McLeish							
Prepared by:	Quality First Triumvirate							
Date prepared:	September 2019 (reporting on August 2019 performance/progress)							
Subject / title:	Mortality Improvement (Improving Patient Outcomes)							
Purpose:	Approval		Decision		Information	x	Assurance	x
Key issues:	The Trust is a national outlier as it has a significantly high Hospital Standardised Mortality Ratio (HSMR).							
Recommendation:	For the Board to review progress and performance of the Mortality Improvement (Improving Patient Outcomes) work and associated measures for assurance and information purposes.							

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

Previously considered by:	Mortality Improvement Board via project highlight reports QSC.27.09.19
Risk / links with the BAF:	Quality Improvement has the potential to support the mitigation of a number of risks in the organisation, but to highlight two specifically: 3.4 Strategic Change and Organisational Structure 1.1 Inconsistent Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Mortality Improvement Performance and Progress Tracker

1.0 Purpose/issue

The Trust is a national outlier as it has a significantly high Hospital Standardised Mortality Ratio (HSMR). Quality and Safety Committee are asked to review progress and performance of the Mortality Improvement (Improving Patient Outcomes) work and associated measures for assurance and information purposes.

2.0 Progress updates (exception reporting only)

Care Bundles: The actions being taken to address performance are:

- **Fractured Neck of Femur:** for the 4 measures within this project, none met the trajectory in the most recently reported month.
  - There is a focus on time to theatre and time from the emergency department (ED) to Tye Green starting with a root cause analysis to inform actions and quality improvement tests of change.
  - The ED coordinator is playing an enhanced role in navigating fractured neck of femur (#NOF) patients through the ED efficiently.
  - Priority list for trauma is being developed.
  - Golden patient concept (first patient on list) to be enhanced and enforced.
- **Acute Abdomen:** of the 5 measures within this project, 4 have met trajectory for the most recently reported month.
- **COPD and Pneumonia:** the mortality rate has continued to decrease (improve) despite not currently meeting the trajectory.
  - Workshop to be facilitated by Quality First Team with specialty leads, general practitioners (GPs) and wider pathway stakeholders to better understand the root causes for mortality rate performance.
  - There is an understanding the work that is commencing with the Reporting and Recording Programme will aim to address weaknesses in coding and recording of the 'first episode of care'.
- **Sepsis:** the reduction in mortality rate for sepsis has been sustained.

Excellence Every Time Group 1

- **Vital Signs:** the measure for this project has continued to improve month on month, and it is expected that the trajectory will be met in subsequent months.
  - Actions to improve compliance are held locally within Healthcare Groups.
- **Fluid Balance Charts:** the measure of this project has exceeded the trajectory but is not outstanding.
  - Sarah Webb (DDoN) and Ian Hanmore (CNIO) are leading a project to scope the possibility of using Nerve Centre to record fluid balance to deliver a further stepwise improvement in care to improve outcomes of patients with AKI and prevent patients developing AKI while in hospital.
- **AKI:** 3 of the 4 measures within this project have not met trajectory for the most recently reported month, with the performance expected to improve following training and education on the wards.
  - There is a significant delay to introduce prescribing of fluids on JAC (e-prescribing) since the initial planned go live date of 18th March 2019.
  - There is an active group working to introduce this challenging improvement successfully. It is hoped this will deliver a stepwise improvement in reducing AKI.
  - AKI mortality alert from Dr Foster received July 2019. There is a new deputy clinical lead for AKI (Dr Panos Michael) helping to lead improvements in fluid management for all patients at PAHT.

- **Diabetic Emergencies:** the measure for this project has increased in the most recent month, a new 'hypo box' was implemented in August, which should see a return to expected performance.

Excellence Every Time Group 2

- **Antibiotics Stewardship:** For the data we have available we continue to see a fall in LoS for those patients on antibiotics. Over 200 clinicians at PAHT have downloaded the antibiotic app that was introduced in 6th August, which we hope to see support our efforts to increase compliance against antibiotic policy and improve stewardship practice.

Reporting and Recording

- **Medical Examiners:** the measure in this project has not met trajectory but has continued to improve month on month until August. The process and focus for the project is being reviewed by the Deputy Chief Medical Officer and Lead Medical Examiner who is starting at PAHT in September 2019.
- **Documentation:** The measure (against trajectory) was not met. The 'first episode of care' will be an initial focus going forwards as there is understanding that if we get diagnosis recorded well as the beginning of care in hospital will inform better clinical decision making and care planning.

Hospital at Night

- 15th July hospital at night was successfully implemented and sustained through the introduction of junior doctors.

3.0 "Improving Patient outcomes" summary from July 2019 - September 2019

- The acute abdomen and sepsis projects of the care bundles programme show mortality as expected which is a significant improvement.
- #NOF mortality has slightly increased. The issues to address which are most likely to impact on mortality are achieving 36 hours of time to theatres from arrival at ED and fast track to ortho-geriatric ward.
- Vital signs monitoring and performance has improved significantly and has moved to BAU.
- The medical examiners work stream and learning from deaths is moving forward with a clear vision under the leadership of Deputy CMO Jo Howard.
- The trust needs to focus significant work onto improving the prescribing of fluids, fluid monitoring to reduce the risk of acute kidney injury (AKI), with an in depth report recommended for the next Q&S committee.
- The new antibiotic prescribing app (Microguide) has been introduced and well received by clinical teams.
- Documentation has been identified as a major work stream requiring a multidisciplinary approach. The Quality First Team are working with all the involved groups to ensure the trust moves forward in a coordinated fashion to support reduction in patient deterioration.
- The mortality rate has stabilised as opposed to continually increasing suggesting early work has started to deliver improvements.

Authors: **Dr. Andy Morris, Jim McLeish, Lindsay Hanmore, Robert Ayers and Miss Helen Pardoe**

Date: **September 2019 (reporting on August 2019 performance/progress)**

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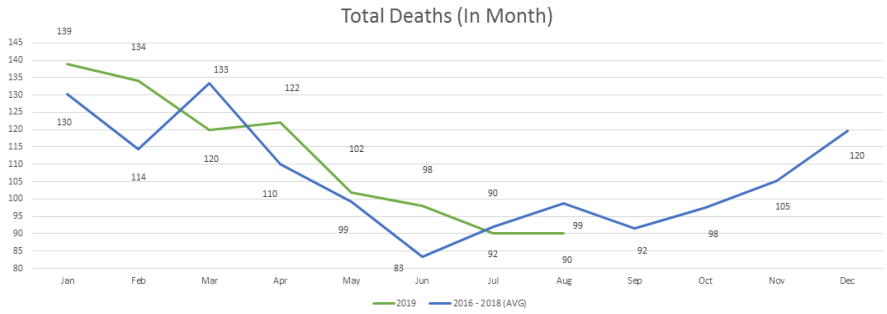
APPENDIX 1: Mortality Improvement Performance and Progress Tracker

Mortality improvement progress and performance tracker (our goal)

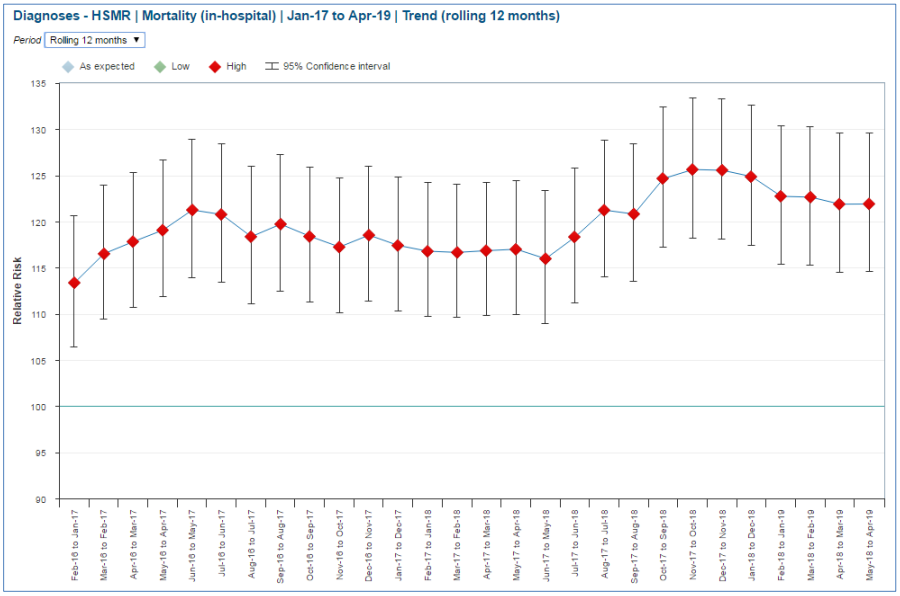
Our goal

Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.

Our progress & performance



Dec 18 | Aug 19
Jan 19 | Sep 19
Feb 19 | Oct 19
Mar 19 | Nov 19
Apr 19 | Dec 19
May 19 | Jan 20
Jun 19 | Feb 20
Jul 19 | Mar 20



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5.2

Programme	Project	Aim		Success measures: Measure	Type of Measure	Trajectory Vs Actual	Performance and progress tracker: Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Trend
Care Bundles	Fractured Neck of Femur	Reduce mortality to expected level i.e. from 8.5% to 6% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	1	#NOF mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	8.3%	8.2%	8.0%	7.9%	7.8%	7.6%	7.5%	7.4%	7.2%	7.1%	7.0%	
						Actual	8.3%	8.4%	7.6%	8.0%	9.1%	8.8%	8.1%					
				#NOF HSMR (relative risk 12 month rolling) via Dr Foster			148.4	155.0	146.6	150.3	170.9	155.7	152.2					
			2	% #NOF patients admitted to Tye Green (NOF ward)	Process	Trajectory	90%	90%	90%	90.0%	90.0%	90.0%	90.0%	95.0%	95.0%	95.0%	95.0%	
						Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	38.2%	72.7%	53.3%	54.5%	
			3	% of #NOF patients in theatres within 36 hours of arrival at A&E	Process	Trajectory	80%	80%	80%	80.0%	80.0%	80.0%	81.7%	83.3%	85.0%	86.7%	88.3%	
						Actual	94.4%	88.2%	85.3%	91.7%	84.8%	93.5%	77.1%	88.5%	80.0%	89.3%	86.2%	
			5	% #NOF patients admitted into Tye Green within 4 hours of ED attendance	Balance	Trajectory					49.9%	53.3%	56.8%	60.3%	63.8%	67.2%	70.7%	
						Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	38.2%	72.7%	53.3%	54.5%	
	Acute Abdomen	Reduce mortality to expected level i.e. from 8.7% to 7.1% by March 2020 (intestinal obstruction, based on Dr Foster Data from reporting period Nov17-Oct18)	6	Intestinal obstruction mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	8.60%	8.51%	8.42%	8.34%	8.25%	8.16%	8.07%	7.98%	7.89%	7.81%	7.72%	
						Actual	8.60%	8.3%	6.3%	6.8%	6.8%	7.1%	6.3%					
				Intestinal Obstruction HSMR (relative risk 12 month rolling) via Dr Foster			123.8	119.4	91.2	97.3	93.9	101.0	98.2					
			7	Case ascertainment in NELA	Process	Trajectory	66.0%		66%		72.8%			79.6%			86.4%	
						Actual	66.0%				99.0%							
			8	Arrival in theatre within a timescale appropriate for urgency	Process	Trajectory	82.0%		82%		83.6%			85.2%			86.8%	
						Actual	82.0%				96.0%							
			9	% of Em Lap patients admitted to HDU/ITU (with NELA risk score >5) post operatively	Process	Trajectory	77.0%		77%		78.6%			80.2%			81.8%	
						Actual	77.0%				64.0%							
			10	Consultant anaesthetist and surgeon present in theatre if NELA risk score >5%	Process	Trajectory	83.0%		83%		86.4%			89.8%			93.2%	
						Actual	83.0%				93.0%							
	COPD	Reduce mortality to expected level i.e. from 6.6% to 4.1% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	11	COPD mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	6.4%	6.3%	6.1%	6.0%	5.8%	5.7%	5.6%	5.4%	5.3%	5.1%	5.0%	
						Actual	6.4%	7.2%	6.8%	6.6%	6.4%	5.9%	6.0%					
				COPD HSMR (relative risk 12 month rolling) via Dr Foster			162.2	173.6	168.1	158.6	153.0	142.9	141.0					
			12	Administer nebuliser and steroids within 4 hours of attendance	Process	Trajectory												
						Actual					6.3%	15.2%	13.8%					
	Pneumonia	Reduce mortality to expected level i.e. from 19.6% to 15.3% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	13	Pneumonia mortality rate (% of patients who died)	Outcome	Trajectory	16.1%	16.0%	15.8%	15.7%	15.5%	15.4%	15.2%	15.1%	14.9%	14.8%	14.6%	
						Actual	16.1%	16.3%	16.2%	15.8%	16.0%	16.0%	16.8%					
				Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster			119.8	121.1	122.5	118.6	120.6	120.2	126.2					
			14	Aspiration pneumonia mortality rate (%of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	47.0%	46%	45%	44.0%	43.0%	42.0%	41.0%	40.0%	39.0%	38.0%	37.0%	
						Actual	47.0%	44.0%	43.2%	43.0%	44.6%	45.2%	43.4%					
				Aspiration Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster			155.7	150.0	146.6	140.8	142.9	148.2	142.7					
			15	Oxygen prescribed within 1 hour of attendance	Process	Trajectory												
						Actual					0.0%	4.76%	0.0%	9.1%				
			16	Chest x-ray within 4 hours of attendance	Process	Trajectory	42.9%	42.9%	42.9%	42.9%	42.9%	61.1%	67.9%	74.7%	81.5%	88.3%	95.0%	
						Actual	84.6%	82.6%	83.3%	80.0%	42.9%	64.0%	82.4%					
	Sepsis	5% reduction in Sepsis mortality by March 2020	17	Sepsis mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	20.5%	20.2%	19.9%	19.6%	19.3%	19.0%	18.7%	18.4%	18.2%	17.9%	17.6%	
						Actual	20.5%	19.9%	19.1%	17.5%	16.0%	15.9%	15.6%					
				Sepsis HSMR (relative risk 12 month rolling) via Dr Foster			131.7	130.0	126.9	117.8	110.7	108.8	104.3					
			18	95% of all patients admitted to ED with a NEWS score of 3 are screened for sepsis by May 2019	Outcome	Trajectory	82.0%	82.0%	82.0%	84.6%	87.2%	89.8%	92.4%	95.0%	95.0%	95.0%	95.0%	
						Actual	85.0%	76.0%	84.0%	84.0%	84.0%	86.0%						
			19	% sepsis patients receiving treatment within one hour (ED)	Process	Trajectory	87.0%	87.0%	87.0%	89.0%	90.0%	92.0%	93.0%	95.0%	95.0%	95.0%	95.0%	
						Actual	91.0%	83.0%	88.0%	89.0%	94.0%	94.0%						

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5.2

Programme	Project		Aim		Success measures			Performance and progress tracker											Trend
					Measure	Type of Measure	Trajectory Vs Actual	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	
Excellence Every Time group 1	Vital Signs	Timely recording of vital signs observation and adequate & effective equipment for undertaking and recording vital signs	To improve compliance with timely vital signs observation leading to early detection and escalation of deteriorating patient	20	% of Observations on patients with a EWS ≥5 within 30 minutes of due time	Process	Trajectory				70.0%	75.0%	80.0%	85.0%	90.0%	95.0%	95.0%	95.0%	
							Actual				63.2%	69.0%	72.2%	75.3%	76.4%	81.5%	81.6%	86.0%	
	Fluids & Electrolytes	Accurate input/ output Fluid Balance chart	To improve compliance with fluids & electrolytes management with early detection and treatment leading to reduction in harm caused by fluid and electrolytes imbalance	21	% of completed fluid balance charts	Process	Trajectory				0.0%					40.0%	45.5%	51.1%	
							Actual				0.0%			28.0%	51.8%	47.2%	61.4%	63.6%	
		Management of Acute Kidney Injuries (AKI)		22	Renal disease comorbidity mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	10.5%	10.4%	10.2%	10.0%	9.9%	9.8%	9.7%	9.6%	9.5%	9.3%	9.2%	
							Actual	10.5%	10.4%	10.1%	9.8%	10.1%	10.1%	10.0%					
					Renal Disease HSMR (relative risk 12 month rolling) via Dr Foster			126.4	127.1	127.1	125.5	130.4	131.2	130.6					
				23	Number of patients with AKI alert	Outcome	Trajectory				98	105	101	100	98	95	95	90	
							Actual				98	105	101	100	98	110	121	117	
				24	Percentage of patients with alerts that have remained the same or improved during their admission	Process	Trajectory	89.8%	89.8%	89.8%	89.8%	89.8%	89.8%	89.8%	91.1%	92.4%	93.7%	95.0%	
							Actual	86.0%	85.0%	89.0%	87.0%	91.0%	88.5%	88.0%	89.8%	87.3%	87.5%	98.0%	
		Diabetic Emergencies		26	Number of hypos	Process	Trajectory	878	852	711	765	751	738	724	710	697	683	669	
							Actual	878	852	711	765	544	501	607	460	533	740	690	
Excellence Every Time group 2	Antibiotics Stewardship		Correct antibotic use for patient need (right drug, right patient, right time, right route)	31	LoS for patients who have antibiotics during their admission (non elective and elective)	Balance	Trajectory	7.97	7.97	7.97	7.97	7.97	7.97	7.97	7.89	7.80	7.71	7.61	
							Actual	8.13	8.44	8.52	8.90	8.38	8.43	8.03	8.40	8.08			
	Timely Decision Making		95% Compliance with completion of TEP for all adult (>16yrs) in-patients	32	% compliance with completion of TEP forms for all patients over 16 years old	Outcome	Trajectory							43.0%	58.0%	61.7%	65.4%	69.1%	
							Actual							43.0%	58.0%	48.8%	72.5%	37.1%	
Reporting and recording	Medical Examiners		100% adult deaths (>16yrs) reviewed by ME and evidence of shared learning against reviews	35	% of completed Mortality Reviews by an ME	Outcome	Trajectory							25.0%	25.0%	30.0%	40.0%	50.0%	
							Actual							17.8%	19.0%	24.0%	28.4%	23.0%	
					Number of completed reviews	Process	Actual							22	18	28	25	21	
	Documentation (meeting standards, recording care accurately and communicating mangement plans)		Every entry in the patient notes are compliant with GMC and NMC standards	36	Compliance with documentation standards in Perfect Ward Audit tool	Process	Trajectory						95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
							Actual						95.0%	98.0%	95.0%	97.0%	91.9%	92.1%	
Hospital at Night	Doctor Handover		Implementation of structured handover of patients for all specialities out of hours	39	Number of unexpected escalations to critical care (excluding ED)	Balance	Trajectory	11	11	11	11	11	8	7	6	6	6	6	
							Actual	3	13	4	5	11	8	7	6	8	4		
				40	Percentage of unexpected return to theatres (excluding ED)	Process	Trajectory	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.90%	0.90%	0.90%	
							Actual	0.53%	0.55%	1.15%	1.45%	0.95%	0.96%	0.99%	0.58%	0.94%	0.64%	0.40%	
				41	Average attendance at handover recorded - % of full H@N clinical team (required vs actual)	Process	Trajectory										75.0%	95.0%	
							Actual										84.0%	68.0%	
	Electronic Handover		Implementation of electronic handover	42	% of tasks allocated and succesfully closed by the following day	Process	Trajectory										30%	39%	
							Actual										98.07	97.02	
				43	Implementation of an electronic nighttime handover	Outcome	Trajectory										100%	100%	
							Actual										100%	100%	
	Hospital at night (task allocation)		Implementation of Hospital at Night software	44	Maximum number of calls to the 2222 number out of hours	Balance	Trajectory												
							Actual						53		63	54	65	72	

Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position.

5.3

Agenda Item:	5.3
Executive Sponsor	Sharon McNally – Director of Nursing & Midwifery
Presented by:	Sharon McNally - Director of Nursing and Midwifery
Prepared by:	Andy Dixon - Matron for Quality Improvement Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	Sept 2019
Subject / Title:	Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	■	Assurance	■

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper sets out the regular nursing and midwifery retrospective staffing report for the month of August 2019 (part A), and provides an update to the workforce position (part B). Headlines: • The RN/M fill rate for days has increased by 4.1% in month. The overall fill rate for RN/RM has increased by 2%. • The overall nursing vacancy position has reduced in August to 22.7% and the Band 5 rate at 34%. This is positive against the overall forecast but is slightly behind the Band 5 planned forecast vacancy rate. The RAG rating remains green as the variance is less than 2% behind forecast and it is expected that there will be a significant catch up next month. • Shift fill 'Red Flag' data is now included under section 3.7. • Data quality review: Fleming and the Maternity Service wards were not included in the UNIFY national data report for the month of August. A focused review of the rota and data capture is underway for these areas. • An exception report detailing the analysis of the rota fill, any impact on quality and actions is included in appendix.2.
Recommendation:	The committee is asked to note the information within this report

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

Previously considered by:	23rd September WFC: fill in A&E, Theatres and Endoscopy reviewed and data quality corrected. 27th September QSC.
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Ward staffing exception reports

1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in August 2019. To provide an update to the nursing vacancy rate, that the plans to further reduce the vacancy rate over 2019/20.

2.0 BACKGROUND

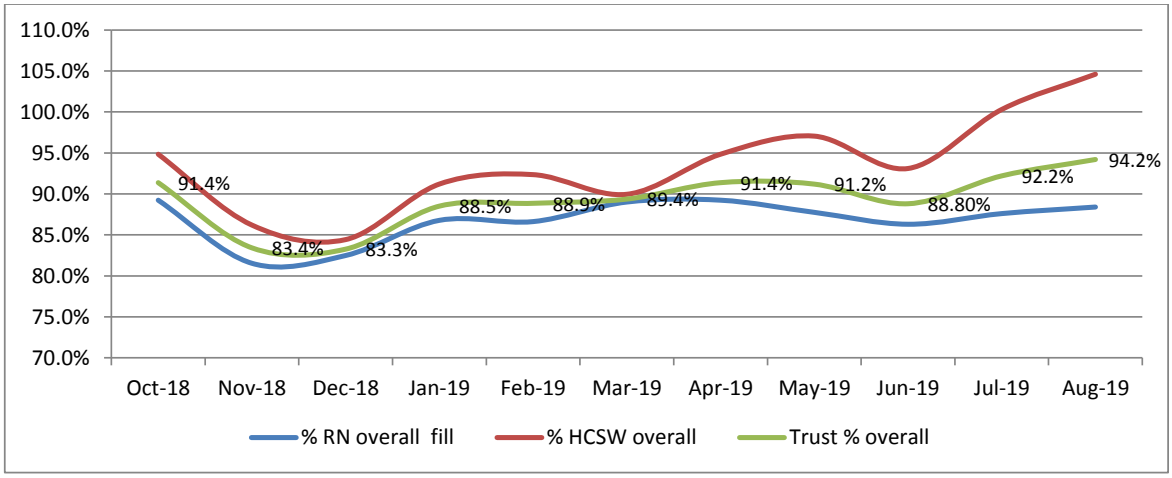
The report is collated in line with The National Quality Board recommendations (June, 2016).

3.0 ANALYSIS

3.1 This report provides an analysis based on the actual coverage in hours against the agreed static demand templates for the calendar month of August 2019.

3.2 The summary position for the Trust Safer Staffing Fill rates for August 2019 is included in the table below with a comparison with June.

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
Trust average August (excluding WMS and Sup)	90.1%	98.2%	86.1%	114.5%	88.4%	104.6%	94.2%
Trust average July (excluding WMS and Sup)	86.0%	94.4%	89.7%	109.4%	87.6%	100.3%	92.2%
Change against July	↑4.1%	↑3.8%	↓3.6%	↑5.1%	↑0.8%	↑4.3%	↑2%

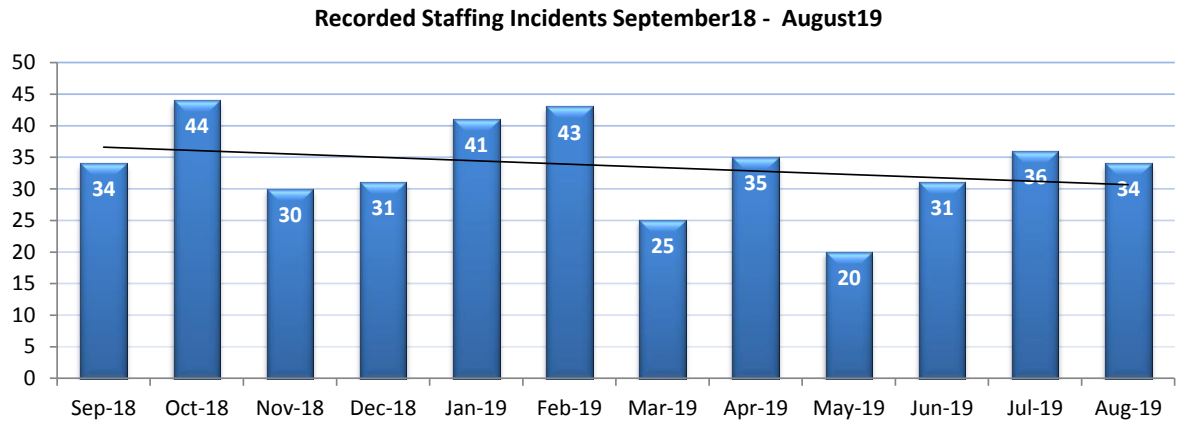


3.4 Exception reporting: Appendix 2 shows the exception report for the wards where the fill rate is low or the Associate Director of Nursing (ADoN). The report includes analysis of the position, impact on quality, safety or experience and details actions in place to mitigate and improve the position where safe staffing is of concern**.**

3.4.1 National reporting is for inpatient areas, and therefore does not include areas including the emergency department or day units. To ensure the Board is sighted to the staffing in these areas, the data for these areas is included below using the same methodology as the full UNIFY report. It is noted that the fill rate is significantly reduced for theatres; this was due to decreased activity during planned estates works and reduction in some lists due to medical annual leave.

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	95.9%	101.9%	94.4%	94.2%
PAH Theatres	64.3%	63.3%	80.2%	
Endoscopy Nursing	101.8%	125.5%	-	-

3.5 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows a downward trend over the 12 months reporting period. All incidents continue to be reviewed by the safety and quality review process.



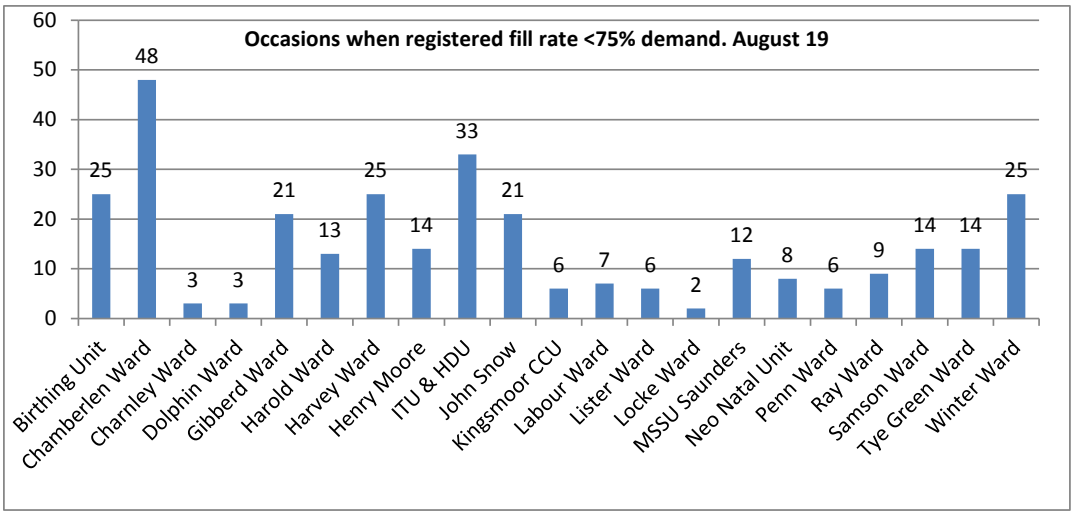
3.6 There were no beds closed as a direct result of safer staffing concerns during August 2019, however, it was agreed that the capacity on Gibberd ward would be reduced by 5 beds to enable a focused period of additional support and training.

3.7 Red flag data

The Trust has commenced collating and validating red flag events. A red flag event occurs when registered nurse fill rate drops below 75% of the planned demand.

The graph below demonstrates the number of occasions/shifts where the reported fill rate has fallen below 75% by ward. The change of report is enabling Associate Directors of Nursing to undertake a deeper dive of underlying data and identified that some staff moves and alternative measures to support staffing such as redeploying community or non-clinical staff are not being captured. This is particularly relevant to maternity services who redeploy staff across all the maternity areas to ensure patient safety.

The accuracy of the data will improve of the coming months but provides baseline information.



5.3

3.8 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). The table below shows data calculated using the Model Hospital methodology. Current model hospital data for national median is based on latest available data.

	August 2019 data	National Median (May 2019)	Variance against national median
CHPPD Total	7.1	8.1	-1
CHPPD RN	4.3	4.03	0.27
CHPPD HCA	2.8	3.2	-0.4

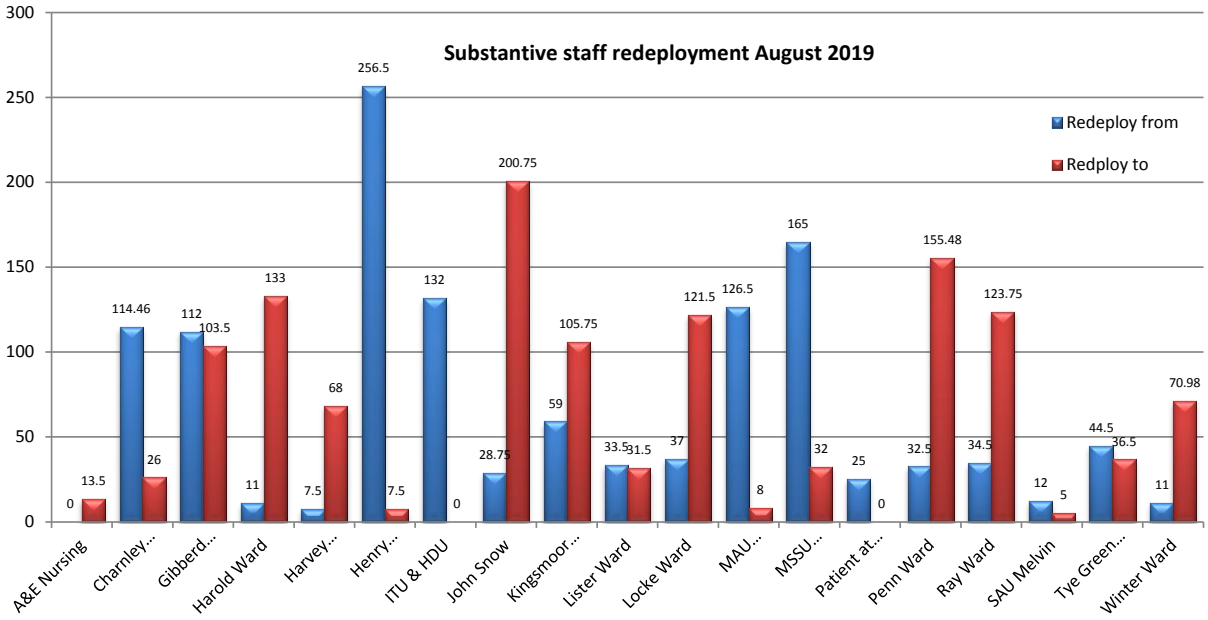
3.9 Mitigation:

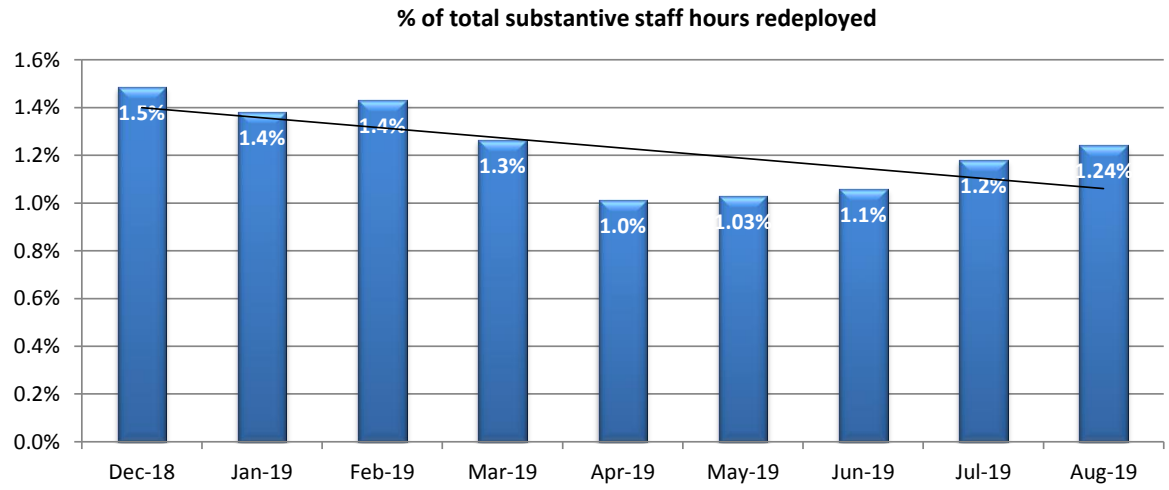
The day to day management of safer staffing across the organisation is managed through the daily staffing huddles and information from SafeCare to ensure support is directed on a shift: shift basis as required in line with actual patient acuity and activity demands. Ward managers support safe staffing by working in the numbers which continues to compromise their ability to work in a supervisory capacity.

3.10 Redeployment of staff:

The 2 graphs below show how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The graph only shows the redeployment of substantive Trust staff and does not capture the moves of bank or agency staff. The maternity wards and Dolphin have been excluded from this report as they flex staff across the whole service dependant on patient and service needs.

The first graph shows the number of hours of staff redeployed from and to the adult inpatient ward to support safe staffing while the second graph shows the percentage of the total number of staff hours that are redeployed which shows an increasing trend over the past 3 months.





The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare system.

While essential to ensure the safe staffing across the Trust moving substantive staff can impact on staff satisfaction and retention rates and therefore is monitored closely to minimise the impact on staff.

3.11 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was an increase in registered demand (↑305 shifts) in August. There was a decrease in NHSP and agency fill for RN, resulting in an overall reduction in fill

rate for RNs in month but an increase compared to the same time period in 2018. The HCSW demand shows a small increase (↑56 shifts) with the overall fill rate down against July.

RN/M temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2019	4,610	1,771	38.4%	1,251	27.1%	65.6%	1,588	34.4%
June 2019	4,518	1,718	38.0%	1,204	26.6%	64.7%	1,596	35.3%
July 2019	3560	1698	47.7%	1158	32.5%	80.2%	704	19.8%
August 2019	3865	1652	42.7%	1071	27.7%	70.4%	1141	29.6%
August 2018	3944	1459	37.0%	899	22.8%	59.8%	1586	40.2%

HCA temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2019	2,275	1,854	81.5%	0	0%	81.5%	421	18.5%
June 2019	2,353	1,841	78.2%	0	0%	78.2%	512	21.8%
July 2019	2534	1988	78.5%	0	0%	78.5%	546	21.5%
August 2019	2590	1964	75.8%	0	0%	75.8%	626	24.2%
August 2018	2233	1532	68.6%	0	0%	68.6%	701	31.4%

The December 2018 bank staffing initiative continued in place to the end of August 2019. The impact of removing the incentive will to be reviewed and assessed at the daily staffing huddles. Review of temporary staffing process has identified that we could potentially improve the fill rate by increasing the number of shifts being sent to NHSP at time of confirming the roster. Ward managers and matrons have been reminded of the process.

In addition, from the 23rd August specialist codes with enhanced rates will be robustly managed to ensure that only staff who work in areas that require those codes (e.g. Critical Care and Emergency Department) are paid these rates. The impact of these changes will need to be tracked closely.

B: Workforce:

Nursing Recruitment Pipeline

The nurse vacancy rate remains one of the Trusts biggest challenges however the vacancy rate in August fell to 21.8% which is slightly below the forecast rate of 22.7% as a result of sustained recruitment activity.

Band 5 posts make up the bulk of the vacancy rate and in August the vacancy rate fell to 34.0% slightly behind the forecast rate of 32.8%. The trajectory remains green due to a less than 2% variance against the plan. At the end of August the overseas nurse recruitment plan was rephrased to ensure there is catch up of the overall plan in the final 6 months.

The following table shows confirmed recruitment figures (in green) against the planned trajectory.

Establishment V Staff in Post												
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61
Actual RN Vacancy Rate	25.3%	24.7%	24.6%	24.0%	21.8%	19.3%	15.8%	12.7%	9.3%	7.2%	5.8%	5.7%
Forcast Vacancy Rate in Business Plan	26.8%	26.9%	25.4%	24.0%	22.7%	19.3%	16.2%	13.1%	10.8%	9.7%	9.4%	9.3%

Band 5 Establisment V Staff in Post	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93
Actual Band 5 Vacancy Rate	40.8%	39.7%	39.3%	38.1%	34.0%	29.1%	22.3%	16.4%	9.8%	5.7%	3.1%	2.9%
Forcast Vacancy Rate in Business Plan	40.8%	41.0%	38.1%	35.4%	32.8%	26.2%	20.3%	14.3%	9.8%	7.8%	7.2%	7%

Projected Starters Pipeline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5)	1	1	2	2	4	1	1	1	1	1	1	1
Band 5 Newly Qualified + Local	3	2	0	1	1	3	4	0	10	0	0	0
Band 5 International Recruitment	6	5	7	7	21	27	35	35	28	26	19	7
Band 5 Starters	**9**	**7**	**7**	**8**	**22**	**30**	**39**	**35**	**38**	**26**	**19**	**7**
Total Starters	10	8	9	10	26	31	40	36	39	27	20	8
Planned Overseas Nurse starters as per B/C	6	5	20	19	19	32	35	35	18	16	9	7
Planned Band 5 Starters (domestic and overseas)	**6**	**5**	**20**	**19**	**19**	**38**	**35**	**35**	**28**	**16**	**9**	**7**
Revised Overseas Nurse starters Plan rephased @ M5	**6**	**5**	**7**	**7**	**21**	**25**	**35**	**35**	**28**	**26**	**19**	**7**

Projected Leavers WTE	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5) Leavers	2	3	3	3	3	1	1	1	1	1	1	1
Band 5 Leavers	3	2	5	2	2	6	6	6	6	6	6	6
Total Leavers	**5**	**5**	**8**	**5**	**5**	**7**	**7**	**7**	**7**	**7**	**7**	**7**

Weekly planned skype interviews and offers	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Planned Skype Interviews	50	50	50	50	50	50	50	50	50	51	52	53
Offers	25	25	31	132	0							

Work continues to ensure we maximise both the international pipeline and local recruitment. An overseas recruitment campaign to India was held in early July and 132 offers were made to nurses. including 12 ED nurses, 14 ITU, 13 scrub nurses and 11 theatre staff for PACU as well as general nurses. The team used this as an opportunity to refresh the recruitment brochure tailored to international nurses to ensure we sell the benefits of working at PAH and living in Harlow to overseas nurses.

A Lead Nurse for Recruitment and Retention has commenced on secondment from The Royal Papworth Hospital for 9 months, this will enable pick up and acceleration of the recruitment activity already in place and focus on the retention strategy for the Trust.

4.0 RECOMMENDATION

The Board is asked to receive the information describing the position regarding nursing and midwifery recruitment, retention and vacancies and note the plan to review and make further recommendations to improve the trajectory.

Author: Andy Dixon. Matron for Quality Improvement,
Sarah Webb, Deputy Director of Nursing and Midwifery

Date: 6th September 2019

Appendix 1.

Ward level data: fill rates August 2019.

Please note due to a data quality review: Fleming and the Maternity Service wards were not included in the UNIFY national data report for the month of August. A focused review of the rota and data capture is underway for these areas.

	Day		Night				
	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	% RN overall fill	% overall HCSW	% overall ward fill
Dolphin Ward	130.8%	114.5%	87.7%	146.3%	112.6%	124.5%	115.6%
Kingsmoor Cardiac Care Unit	80.8%	113.7%	90.7%	129.5%	85.0%	119.7%	97.4%
Medical Assessment Unit Fleming	66.1%	100.8%	58.2%	89.8%	63.0%	96.6%	75.5%
Tye Green Ward	90.6%	105.1%	68.5%	121.7%	81.2%	112.3%	94.4%
Harvey Ward	80.1%	79.7%	77.4%	105.5%	79.0%	89.4%	83.4%
ITU & HDU	92.1%	129.8%	94.5%	169.9%	93.3%	146.4%	99.1%
John Snow	80.9%	122.2%	96.5%	109.3%	87.2%	117.3%	99.8%
Charnley Ward	89.9%	98.0%	104.6%	113.3%	95.1%	103.8%	98.5%
Lister Ward	131.1%	96.6%	93.6%	173.0%	115.8%	120.6%	118.0%
Locke Ward	91.0%	123.3%	92.7%	146.3%	91.7%	132.0%	106.2%
Neo-Natal Unit	101.6%	48.1%	85.3%	59.0%	93.8%	53.3%	82.3%
Penn Ward	89.6%	100.9%	102.2%	146.3%	94.1%	118.2%	103.3%
Ray Admissions Unit	99.0%	92.0%	100.0%	150.4%	99.4%	110.4%	104.5%
Medical Short-Stay Unit Saunders	80.8%	87.8%	85.7%	105.0%	82.9%	94.8%	88.1%
Harold Ward	76.5%	94.3%	99.1%	149.1%	84.5%	115.1%	96.3%
Henry Moore Ward	89.5%	98.4%	98.8%	113.3%	93.2%	102.9%	96.1%
Gibberd Ward	86.8%	116.1%	84.0%	102.1%	85.6%	109.4%	98.3%
Winter Ward	75.5%	106.0%	89.2%	151.6%	80.4%	123.3%	96.9%
Chamberlen Ward	72.3%	60.3%	61.3%	45.2%	67.0%	53.1%	63.5%
Labour Ward	106.5%	73.5%	95.6%	71.4%	101.3%	72.5%	94.9%
Samson Ward	116.1%	78.5%	81.8%	85.8%	99.7%	81.3%	91.3%
Birthing Unit	73.4%	84.3%	60.9%	53.6%	67.7%	70.4%	68.4%
	90.1%	98.2%	86.1%	114.5%	88.4%	104.6%	94.2%

Appendix 2

Ward staffing exception reports
Reported where the fill is < 75% - 80% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Maternity Services	Data quality review: not reporting on UNIFY this month: NHSP hours are not included in the rota fill data equating to an additional 557 hours (day) and 1061 (night) across the service. Detailed focus of the maternity rotas and data quality underway.	Nil	Staff from Labour Ward, Samson Ward and Birthing Unit used to support overall safety. Community staff pulled in to cover, On call worked clinically to support. Birthing unit closed x3 nights to support patient safety.
Neo-Natal Unit	53% fill rate for HCSW bringing down overall fill rate	Nil. Activity lower than plan in August. RN numbers supported acuity and demand.	Changes to validation process will improve accuracy
Fleming	Data quality review: not reporting on UNIFY this month	Nil reported	Deep dive into roster fill and template to ensure accurate data in September
Harvey	79% overall RN fill rate	No reported impact on quality/outcomes	Harvey Ward currently has a reduction in bed capacity by 5 beds to accommodate HDU, supporting Critical Care to carry out refurbishment. This reduction in activity has not been reflected in the roster template as it was a temporary measure.

The Princess Alexandra Hospital NHS Trust

Trust Board: 3 October 2019

5.4

Agenda item:	5.4
Presented by:	Sharon McNally, Director of Nursing, Midwifery and AHPs
Prepared by:	Shahid Sardar, Associate Director Patient Engagement
Date prepared:	25 Sept 2019
Subject / title:	Inpatient Survey Results 2018/19

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	The results of the 2018/19 National Inpatient Survey (published July 19) demonstrates: • Significant improvement in 13 areas, with 10 areas remaining to improve vs 18 last year. • Most significantly, based on survey data, doctors' communication is no longer as significant a concern as has historically been the case. • Patients rated the Trust higher for ED waits, planned surgery, doctors' communication and treatment, nurse numbers, involvement in discharge planning and four different questions on medication. • Further improvement l needed in 10 areas food, discharge information, timely attention, worries and fears and being asked about quality and complaints - the report notes the actions in place to continue the patient experience improvement work.
Recommendations:	• To note the results of the 2018/19 National Inpatient Survey for information and assurance

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

Previously considered by:	Quality and Safety Committee, July 2019
Risk / links with the BAF:	PAHT: BAF Risk 1.1
Legislation, regulatory, equality, diversity and dignity implications:	The Equality Act 2010 The Local Authority Social Services and NHS Complaints (England) Regulations 2009
Appendices:	Appendix 1: Summary Visuals: Patient Experience Data for 2018/19

The Princess Alexandra Hospital NHS Trust

Title: Inpatient Survey Results 2018/ 19
September 2019

1. Purpose

This report is intended to the give the Board an overview of the results of the benchmarked PAHT National Inpatient Experience Survey 2018/19 published on 21 June 2019 based on fieldwork in the month of July 2018.

2. National Inpatient Experience Survey (IPES) 2018/19

Communication has historically been the underlying issue in complaints and often in the past the evidence from complaints reporting has been backed up by data from the National Inpatient Survey.

This year that has changed. The latest National Inpatient Survey 18/19 shows that questions 23 and 24 on **important questions** and **confidence and trust** in doctors are no longer outside of the expected range.

The graphic below illustrates that PAHT medical doctors now score in the middle quintiles and demonstrate performance comparable to any other hospital in the survey.

Figure 1: Questions 23, 24 and 25, doctors gave clear answers to questions, doctors engendered confidence and trust and doctors did not talk in front of patients as if they were not there.

This change appears to triangulate with evidence from complaints activity which shows the subject matter of complaints over the last year and a SPC chart showing the frequency of communication related complaints since April 2014.

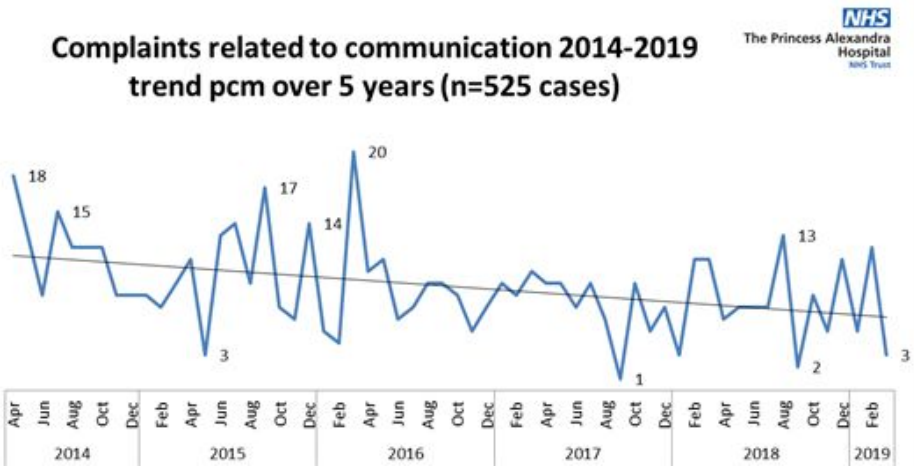


Figure 2

The Princess Alexandra Hospital NHS NHS Trust

Year	2018-19													
Row Labels	Jun	Jul	Au	Se	Oc	No	De	Jan	Fel	Ma	Ap	Ma	Jun	Tot
A06 - Medical Care/ Expect.	8	5	9	2	12	5	2	2	2	3	6	6	5	67
A08 - Communication	2	2	1	1	7	7	2	3	4	3	2	3	2	39
A03 - Delay	0	2	0	2	4	0	2	3	2	2	1	1	1	20
A07 - Nursing	1	1	0	4	3	2	2	1	0	2	1	2	1	20
A05 - Attitude	2	0	2	1	0	0	0	0	4	0	1	0	1	11

Figure 3: Heat-map of most frequently occurring complaint themes 2018/19

The other areas where the Trust improved were as follows:

- the **Emergency Department**: Questions 3 and 9 on **information received** and the **length of wait in ED;**
- **planned/ surgical care**: Question 7 on the **number of times admission dates** were changed by the hospital for planned care;
- **nursing numbers**: Question 29 on there being **enough nurses to care** for you;
- **discharge planning**: Questions 34, 35 and 48 on **involvement and confidence in decision making** and **involvement in discharge planning**;
- **medication**: Questions 57, 59, 60 and 61 on the **purpose of medications**, **understanding of how to take them**, **clear written information on danger signals** and **contact numbers** if worried;

Previous analysis of the sub-subjects of communications complaints over one year showed that they related primarily to a lack of information for relatives and carers and poor communication between professionals. This was evidenced by evidence from the national end of life NACEL audit about keeping carers updated and the current IPS results reinforce this evidence.

8 of the 10 questions outside of the expected range relate to communication. They are as follows:

- questions 20 and 21, being offered a **choice of food and support with meals**;
- questions 30,32, 37 and 43 **having a named nurse, staff working well together, someone to talk to about worries and fears and getting timely attention**;
- questions 49 and 62 about **doctors and nurses providing information to carers and notice of discharge** and;
- questions 70 and 71 whether patients are **asked about quality of care or provided information on complaints processes**

All of these questions except questions 20 and 21 and possibly 32 are about a communication process. Actions are being taken to address all of these issues in the IPES and a more detailed action plan will be provided, but in summary:

- the Trust is currently engaged in a trust wide audit of protected meal times and is refreshing its processes with regard to meal ordering
- ward level staffing arrangements and numbers continue to improve. Regarding worries and fears, mental health literacy is being addressed through a range of programmes including new reporting on mental health in integrated performance reports (IPR), working in partnership with the mental health trust, a new partnership with the British Red Cross led by patient experience 'Resilient Responders', medical student led Schwartz Rounds and Mental Health First Aid training for managers

- new information being developed and published regarding estimated date of discharge led by the complex discharge team and a refresh of the carer card led by the corporate nursing team
- an information campaign going to all patient areas on the complaints service, 300 leaflets were distributed in the first week following the survey result as slips on meal trays and 210 tent cards were distributed to patient areas explaining how to contact the patient experience team. An ongoing communication campaign continues to address this need.

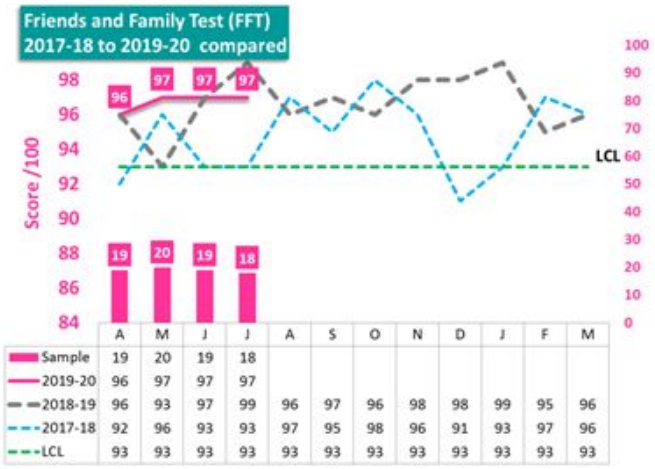
3. Recommendations:

3.1 Receive this report for information and assurance

The Princess Alexandra Hospital NHS Trust

Appendix 1: Summary Visuals: Patient Experience Data for 2018/19

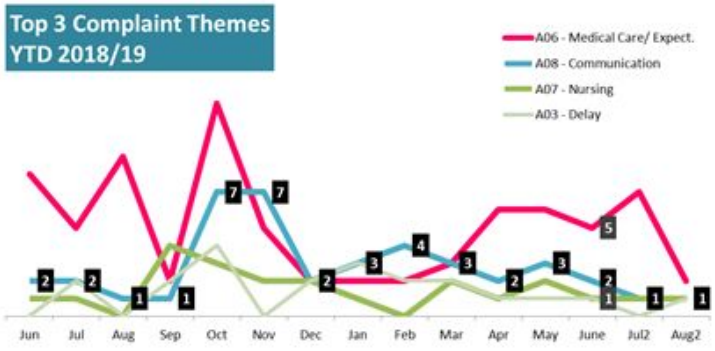
Month	Feb	Mar	Apr	May	Jun	July	Spark
Complaints	16	12	11	14	11	13	
FFT Score	95	96	96	97	97	97	
PALS Concerns	201	323	292	280	229	350	
Compliments	44	412	100	150	166	281	
Choices	5	2	2	1	7	4	



Visual 1: FFT for three years to 2019/20

Year	2018-19															
Row Labels	Jun	Jul	Au	Se	Oc	No	De	Jan	Feb	Ma	Ap	Ma	Jun	Jul	Au	Tot
A06 - Medical Care/ Expect.	8	5	9	2	12	5	2	2	2	3	6	6	5	7	2	76
A08 - Communication	2	2	1	1	7	7	2	3	4	3	2	3	2	1	1	41
A07 - Nursing	1	1	0	4	3	2	2	1	0	2	1	2	1	1	1	22
A03 - Delay	0	2	0	2	4	0	2	3	2	2	1	1	1	0	1	21
A05 - Attitude	2	0	2	1	0	0	0	0	4	0	1	0	1	1	0	12

Visual 2: Complaint themes, 13 month running total ranked by frequency, led by medical care

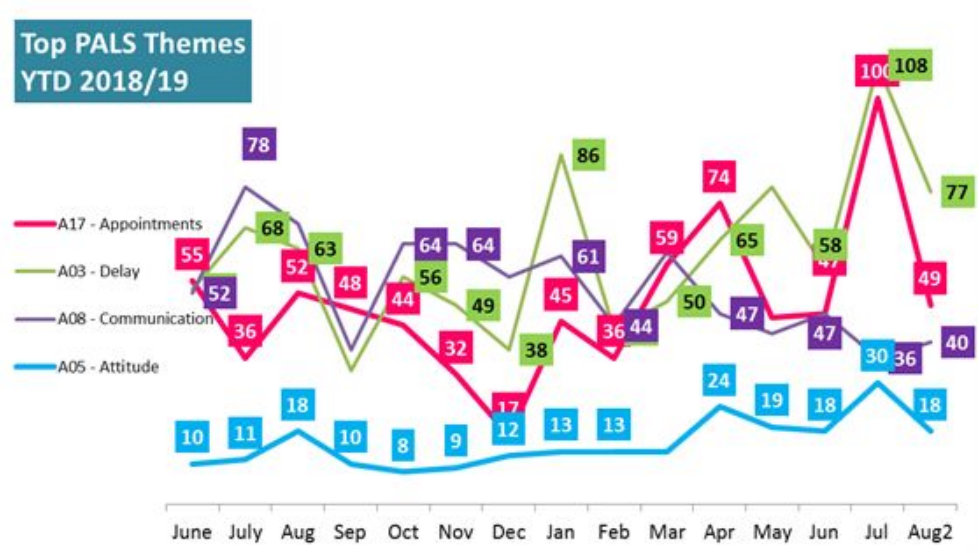


Visual 3: Most frequently occurring complaint themes, graphic of trajectories

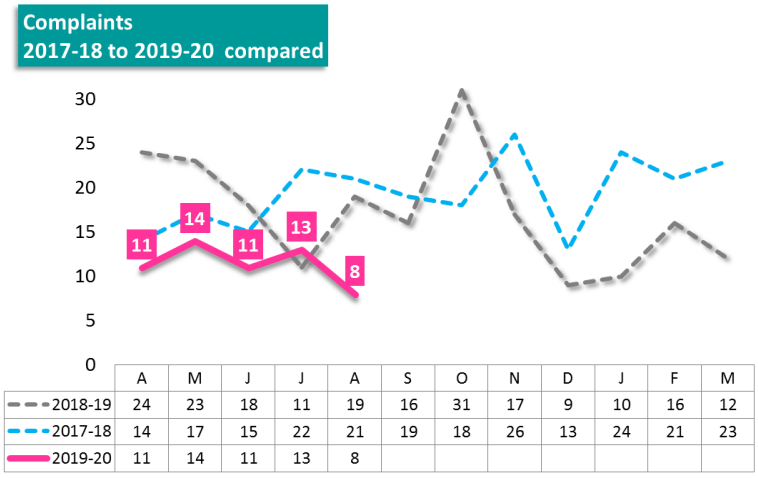
The Princess Alexandra Hospital NHS Trust

Year	2018-19																
Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Tot
A03 - Delay	53	68	63	33	56	49	38	86	43	50	65	78	58	108	77	925
A08 - Communication	52	78	69	38	64	64	56	61	44	62	47	42	47	36	40	800
A17 - Appointments	55	36	52	48	44	32	17	45	36	59	74	46	47	100	49	740
A05 - Attitude	10	11	18	10	8	9	12	13	13	13	24	19	18	30	18	226
A06 - Medical Care\ Expect.	8	7	11	8	15	11	7	14	9	7	26	36	10	29	26	224
A04 - Cancellations	3	5	2	2	4	6	1	6	10	12	17	10	13	15	13	119
A01 - Adm. Disch & Trans	7	6	5	7	7	6	3	12	10	9	3	6	2	3	5	91
A07 - Nursing	6	4	4	3	5	7	4	4	7	6	3	6	8	11	11	89

Visual 4: PALS themes, 13 month running total ranked by frequency, led by communication



Visual 5: PALS themes, 13 month rolling graphic of trajectories



	A	M	J	J	A	S	O	N	D	J	F	M
2018-19	24	23	18	11	19	16	31	17	9	10	16	12
2017-18	14	17	15	22	21	19	18	26	13	24	21	23
2019-20	11	14	11	13	8							

Visual 6: Complaints over 3 years

5.4

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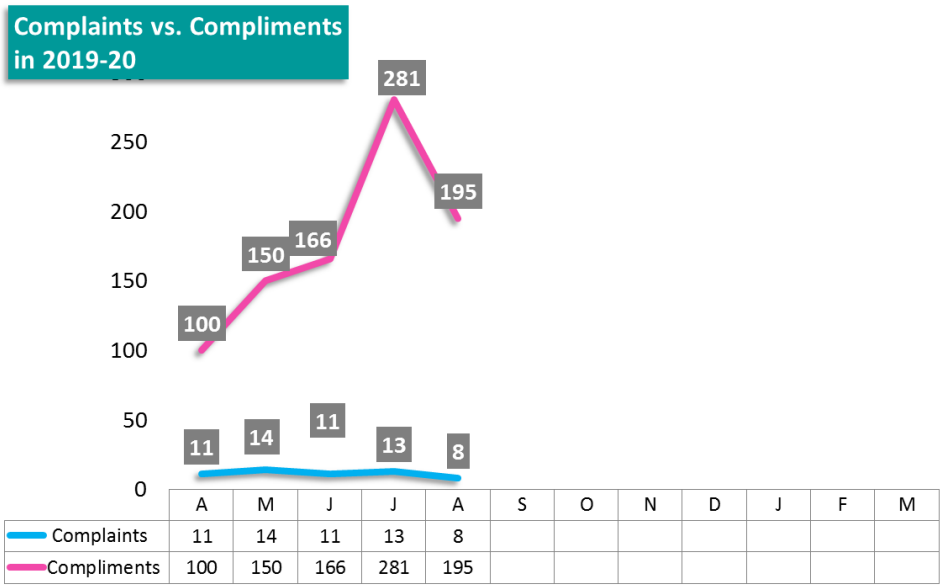
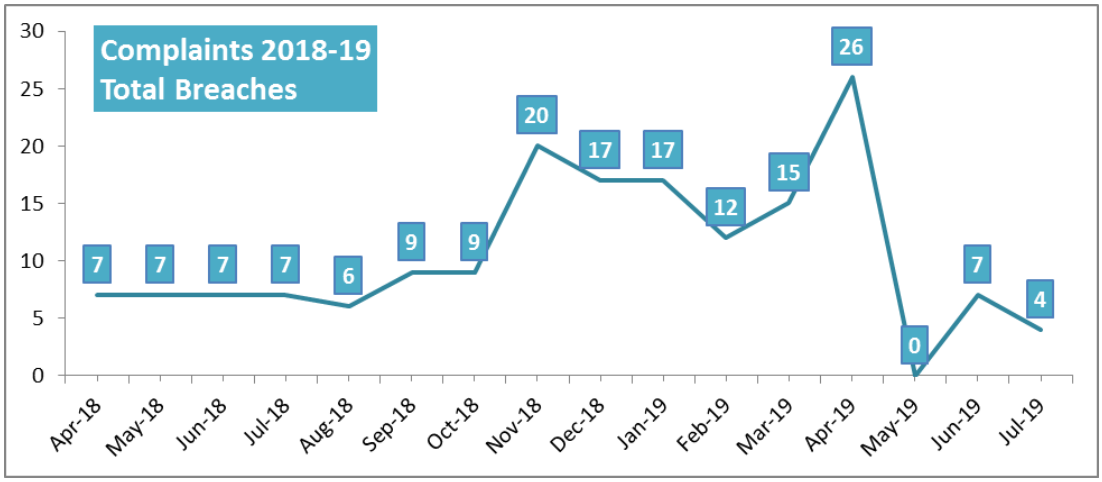


Visual 7: Compliments vs Complaints



Visual 8: SPC Chart re breaches of deadlines at month end

The Princess Alexandra Hospital NHS Trust

Trust Board 03.10.19

6.1

Agenda item:	6.1
Presented by:	Ogechi Emeadi, Director People OD & Communications
Prepared by:	Nathaniel Williams, People Information & Systems Lead
Date prepared:	16.09.2019
Subject / title:	Workforce Race Equality Standard

Purpose:	Approval	X	Decision		Information		Assurance	

Key issues:	BME staff experiencing harassment, bullying and or abuse from the public e.g. patients and internal staff has increased Total number of non-clinical BME staff employed in band 8 and above decrease in 2019
Recommendation:	To present the Workforce Committee with key findings of the Trusts Workforce Race Equality Standard (WRES) report for approval

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

Previously considered by:	Equality and Inclusion Steering Group (02.09.19) Workforce Committee (23.09.19)
Risk / links with the BAF:	Increase risk of high turnover and the inability to recruit. This could also lead to reputation risk. BAF 2.1 nurse recruitment BAF 2.3 inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	The Trust has a number of statutory duties arising from the Equality Act 2010
Appendices:	WRES data WRES action plan

The Princess Alexandra Hospital NHS Trust

PURPOSE

The purpose is to provide oversight of the Trust Workforce Race Equality Standard report (WRES) for Trust wide publication and submission to NHS England.

This paper presents the revised recommendation for 2019/20, which builds on from staff survey action and key objectives of the Black & Minority Ethnicity Staff Network

CONTEXT

The Workforce Race Equality Standard (WRES) was introduced in 2015 as part of the NHS standard contract to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. This is vital as the evidence shows that a motivated, inclusive and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisation.

The WRES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010.

WRES is self-assess against 9 indicators four of which relate specifically to workforce data, four are based on data from the national NHS staff Survey questions and the final one consider BME representation on the Trust board.

The data is to enable the Trust to adopt a 'learning organisation' approach and produce an action plans to build cultures of continuous improvement. This will be essential steps in helping to bring about a workplace that is free from discrimination

This year's action plan looks at areas for improvement but also areas where we feel we are performing well, to ensure we continue to evidence this.

Report By: Nathaniel Williams

Date: 16.09.19

The Princess Alexandra Hospital NHS Trust

WRES Indicator No.	WRES Report March 2018	WRES Report March 2019	Direction
BME Staff employed within the Trust	27%	26%	
Proportion of staff who have self-reported their ethnicity	94%	94%	
1. Percentage of non-clinical staff in each Pay band AFC Band 1-9 & VSM	Non clinical – 90% White in band 1-9 and VSM compare to 10% BME	Non clinical – 90% White in band 1-9 and VSM compare to 10% BME	
Percentage of clinical staff in each Pay band AFC Band 1-9 & VSM	Clinical -72% White in band 1-9 and VSM compare to 28% BME	Clinical -70% White in band 1-9 and VSM compare to 29% BME	
Percentage of Medical & Dental Staff	33% White Medical & Dental Staff compare to 66% BME	36% White Medical & Dental Staff compare to 64% BME	
2. Relative likelihood of staff being appointed from Shortlisting across all posts	White staff are 1.52 times more likely to be appointed from shortlisting across all post	White staff are 1.30 times more likely to be appointed from shortlisting across all post	
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	BME Staff are 0.79 times more likely to enter a formal disciplinary process	BME Staff are 0.40 times more likely to enter a formal disciplinary process	
4. Relative likelihood of staff accessing non-mandatory training and CPD	White staff are 0.69 times more likely to accessing non mandatory training	White staff are 0.51 times more likely to accessing non mandatory training	
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 month	White – 29.60% BME – 28.50%	White – 26.80% BME – 35.10%	
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White – 24.91% BME – 28.50%	White – 26.80% BME – 29.60%	
7. Percentage believing that trust provides equal opportunities for career progression or promotion	White – 84.80% BME – 70.70%	White – 86.80% BME – 71.70%	
8. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White – 7.00% BME – 16.30%	White – 6.50% BME – 12.50%	
9. Percentage difference between PAH Board voting Membership and its overall workforce Percentage difference between PAH Executive board membership and its overall workforce	White = 100% BME = 0% White = 88.9% BME = -11.1%	White = 100% BME = 0% White = 87.5% BME = -12.5%	

6.1

Key Findings

The 2019 data shows that there is still work to do to positively improvement BME staff in the trust according to the WRES 1-9 data indicator. The bullet points below highlight the key finding of this data.

- The total number of BME staff employed within the trust has decrease by 1% in 2019
- The total number of non-clinical BME staff employed in band 8 and above decrease in 2019
- BME clinical staff in band 1 to 9 and consultants increase in 2019 compared to 2018
- White staff are 1.30 times more likely to be appointed from shortlisting across all post an improvement from 1.52 times in 2018. A figure below ”1” would indicate that white staff are less likely than BME candidates to be appointed from shortlisting
- The likelihood of BME staff entering into formal disciplinary process has improved from last year. The likelihood has reduced to 0.40 times from 0.79 times
- BME staff experiencing harassment, bullying and or abuse from the public e.g. patients and internal staff has increased
- There is a positive increase on both BME and White staff believing the trust is providing equal opportunities for career progression and promotion in the last 12 months
- A significant improvement of 3.8% decrease for BME staff experiencing discrimination at work from manager, team leader and other colleagues

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NHS Trust

WORKFORCE RACE EQUALITY ACTION PLAN

OBJECTIVE	WRES INDICATOR	ACTION	
Increase overall visibility of equality and inclusion at Trust Board	1 to 9	Greater awareness to Trust Board around equality issues (using patient /staff stories to highlight issues)	Director of people
		Commence reverse mentoring for executive directors.	BME inclusion champions
		Engaging/involving senior leaders with celebrations and events throughout the year to further improve visibility of inclusion.	DoP, equality champions
Develop the understanding of managers and employees in managing the formal disciplinary process	3	To identify the mechanisms and causes of the disproportionality to address the root causes. To implement and evaluate models of better practice, improve understanding of the mechanisms and causes of this disproportionality so that it can be reduced or eliminated over time. This will	DDoP

		include implementation of integrated approach to the triage process. With a robust decision tree model and supporting material. Evidence based model with HR business partners support to provide alternatives to disciplinary. Monthly data return with analysis of themes, and demographical data on staff member entering the disciplinary. Roll out of the training, using a targeted approach for those areas that are the highest priority based on existing data,	
To reduce the disparity of appointment from shortlisting between white and BME staff	2	Improve awareness, understanding and roll out of unconscious bias training to all staff involved in the recruitment and selection process. Robust structured interview assessment form that is	

		transparent, including a scoring methodology which is reflective of the trusts values. Audit for all band 8a successful and unsuccessful applicants and managers. Improve shadowing and secondments opportunity to support internal career progression to senior posts with development training programmes.	
To improve the representation of BME staff in senior posts	9	Job shadowing and secondment opportunities are offered in areas where it is possible for the service to accommodate. Promote success stories of staff. Publicising success stories of BME staff and who are in senior leadership positions. This will be an ongoing initiative in order to keep the	

		agenda as a high priority.	
Percentage of staff who personally experienced discrimination at work from manager or other colleague	5, 8	BAME staff network, will be involved in ongoing work to support the action plan of the WRES.	

The Princess Alexandra Hospital NHS Trust

Trust Board 03.10.19

6.1

Agenda item:	6.1
Presented by:	Ogechi Emeadi, Director People OD & Communications
Prepared by:	Nathaniel Williams, People Information & Systems Lead
Date prepared:	16.09.2019
Subject / title:	Workforce Disability Equality Standard

Purpose:	Approval	X	Decision		Information		Assurance	

Key issues:	There is significant disparity with staff who declare their disability on electronic Staff Record and those that complete the staff survey. There is little or no evidence of disabled staff entering the formal capability process on the grounds of ill health and capability as to non-disabled staff as the data is not held centrally. There is a misrepresentation of staff in AfC Band 8a and above & VSM that have no self-declaration of disability reported. Board members are asked to note that there is no detailed action plan at this time as it is a new report. However, the Trust will pursue achieving disability confident employer status.
Recommendation:	To present the Workforce Committee with key findings of the Trusts first Workforce Disability Equality Standard (WDES) report for approval

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

Previously considered by:	Equality and Inclusion Steering Group (02.09.19) Workforce Committee (23.09.19)
Risk / links with the BAF:	Increase risk of high turnover and the inability to recruit. This could also lead to reputation risk. BAF 2.1 nurse recruitment BAF 2.3 inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	The WDES was introduced in April 2019 and it is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.
Appendices:	WDES Data

The Princess Alexandra Hospital NHS Trust

PURPOSE

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and non-disabled staff. This information will then be used by to develop a local action plan, and enable us to demonstrate progress against the indicators of disability equality.

The WDES has been commissioned by the Equality and Diversity Council (EDC) and developed through a pilot and extensive engagement with Trusts and key stakeholders. It is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.

This paper presents recommendation which builds on from staff survey action and Equality and Inclusion Steering group Key Objectives for 2019/20.

CONTEXT

The WDES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010

WDES is assessed against 10 evidence based metrics three of which relate specifically to workforce data, six are based on data from the national NHS staff Survey questions and the final one consider disabled and non-disabled representation on the Trust board. The report take effect from 1 April 2019 based on 2018/19 financial year data

WDES is to improve workplace experience and career opportunities for disabled people working or seeking employment within the NHS

The data is to enable the Trust to adopt a 'learning organisation' approach and produce an action plans to build cultures of continuous improvement. This will be essential steps in helping to bring about a workplace that is free from discrimination

This year's action plan looks at areas for improvement but also areas where we feel we are performing well, to ensure we continue to evidence this.

Report By: Nathaniel Williams

Date: 16.09.19

WDES Indicator No.	WDES Report March 2019
Proportion of staff who have self-reported their disability	**1.7%**
1) Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce. **Non Clinical** AfC Band 1, 2, 3 and 4 AfC Band 5, 6 and 7 AfC Band 8a and 8b AfC Band 8c, 8d, 9 and VSM (including Executive Board members) **Clinical** AfC Band 1, 2, 3 and 4 AfC Band 5, 6 and 7 AfC Band 8a and 8b AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Medical and Dental staff, Consultants Medical and Dental staff, Non consultant career grade Medical and Dental staff, Medical and dental trainee grades	 2% disabled compare to 43% non-disabled 1% disabled compare to 42% non-disabled 6% disabled compare to 56% non-disabled 6% disabled compare to 42% non-disabled 2% disabled compare to 51% non-disabled 2% disabled compare to 49% non-disabled 1% disabled compare to 48% non-disabled 0% disabled compare to 50% non-disabled 0% disabled compare to 31% non-disabled 0% disabled compare to 32% non-disabled 0% disabled compare to 19% non-disabled
2) Relative likelihood of Disabled staff compared to non-disabled staff being appointed from Shortlisting across all posts. This refers to both external and internal posts	Disabled staff are 1.16 times less likely to be appointed from shortlisting across all post compared to non-disabled staff
3) Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Disabled staff are 0.00 times more likely to enter a formal capability process compared to non-disabled staff
4a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: • Patients/service users, their relatives or other members of the public • Managers • Other colleagues	 Disabled **37.4%** non-disabled **26.7%** Disabled **19.6%** non-disabled **15.0%** Disabled **25.6%** non-disabled **19.0%**
4b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled **50.5%,** non-disabled **45.0%**
5) Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Disabled **75.7%,** non-disabled **85.5%**
6) Percentage of Disabled staff compared to non-disabled staff saying that they have felt	Disabled **32.7%,** non-disabled **26.0%**

pressure from their manager to come to work, despite not feeling well enough to perform their duties	
7) Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled **36.0%,** non-disabled **48.0%**
8) Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	Disabled **68.9%**
9a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Disabled **6.6,** non-disabled **7.1**
9b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? Yes or No	**Yes**
10) Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the board • By Executive membership of the board	Disabled **0%,** non-disabled **20%** Disabled **0%,** non-disabled **25%**

Key Findings

- There is significant disparity with staff who declare their disability on electronic Staff Record and those that complete the staff survey
- There is little or no evidence of disabled staff entering the formal capability process on the grounds of ill health and capability as to non-disabled staff as the data is not held centrally
- Non disable staffs are likely to be appointed from shortlisting compared to disabled staff. It should be less than 1.00 times
- There is a misrepresentation of staff in AfC Band 8a and above & VSM that have no self-declaration of disability reported. Staffs at these banding will require training, coaching and support on how to manage and or work alongside disabled staff/colleagues.

Trust Board – 03.10.19

Agenda Item:	7.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team, Executive Directors
Date prepared:	20the September 2019
Subject / Title:	Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Key Issues:

Patients: A refresh of the Mortality is underway to facilitate further progress on mortality improvements and implement a PAH mortality framework.

Performance: Diagnostics and RTT continued to be achieved. Areas of ongoing focus are emergency care and cancer.

People: The Trust's vacancy rate continues to improve in August due to the new starters recruited as part of the overseas recruitment campaign underway.

Pounds: Trust has a £15.2m deficit, £3.1m behind plan. This is an improvement on previous months results mainly due to reduced temporary staff costs (£2.5m vs £3.1m in M4). The Trust is in the process of finalising its recovery plan to further improve future results. In accordance with National and STP requirements the Trust is currently reviewing its capital programme requirements for 19/20.

Places: Capital works continue to progress on plan, while ensuring all clinical services continue to care for our patients.

Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

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

Previously considered by:	Executive Management Team / Senior Management Team PAF.26.09.19 and QSC.27.09.19
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

7.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

August 2019

The purpose of this report is to provide the Board of Directors with an analysis of quality performance.
The report covers performance against national and local key performance indicators.

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Contact:

Lance McCarthy, Chief Executive Officer
Andy Morris, Chief Medical Officer
Sharon McNally, Director of Nursing
Trevor Smith, Deputy CEO & Chief Financial Officer
Stephanie Lawton, Chief Operating Officer
Jim McLeish, Director of Quality Improvement
Ogechi Emeadi, Director of People
Michael Meredith, Director of Strategy

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Trust Objectives

The Princess Alexandra Hospital NHS Trust

Our Patients
Continue to improve the quality of care we provide **our patients**, improving our CQC rating.

Our People
Support **our people** to deliver high quality care within a culture that improves engagement, recruitment and retention and improvements in our staff survey results.

Our Places
Maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC for a new build, aligned with the development of our local Integrated Care Alliance.

Our Performance
Meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators.

Our Pounds
Manage **our pounds** effectively to achieve our agreed financial control total for 2019/20.

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5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

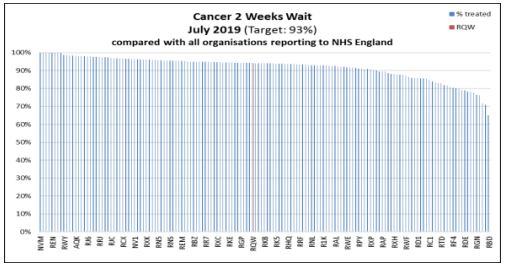
People

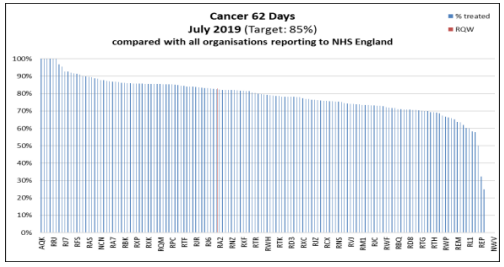
Pounds

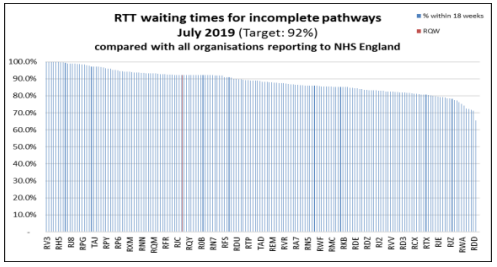
Places

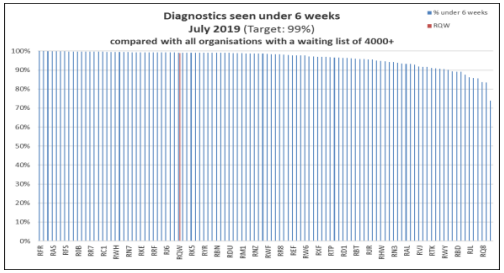
National Benchmarking
Compared with all organisations reporting to NHS England

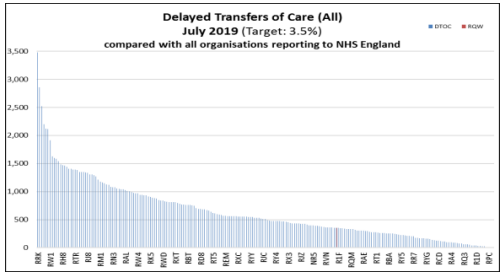
NHS
The Princess Alexandra Hospital
NHS Trust

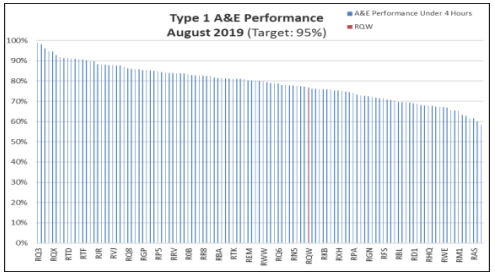


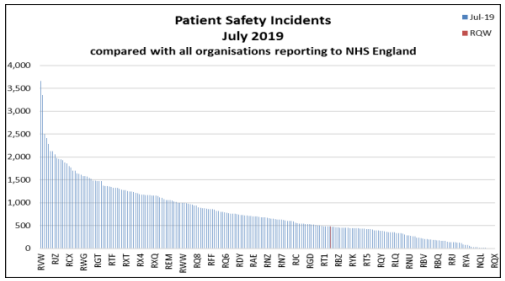


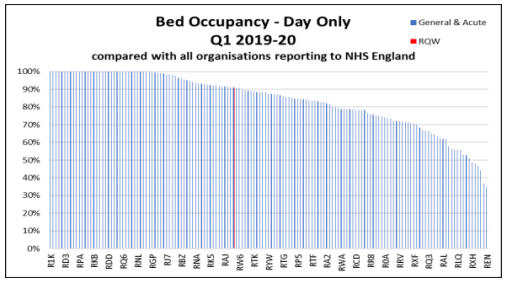


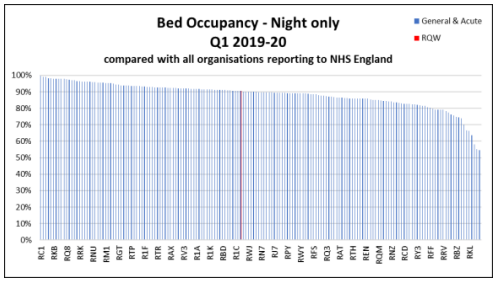












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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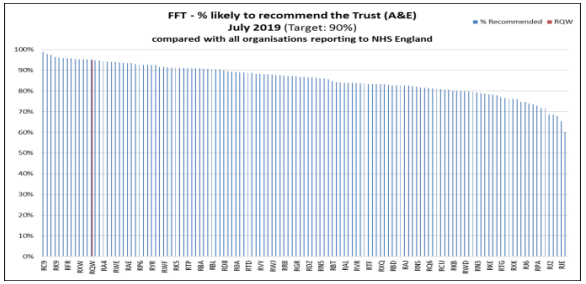
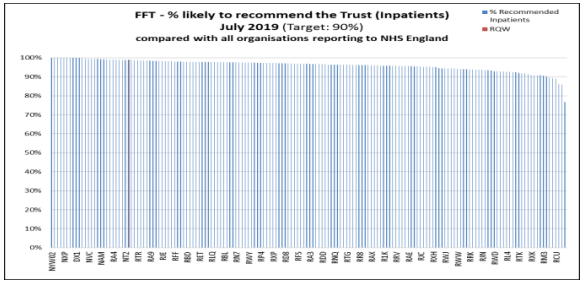
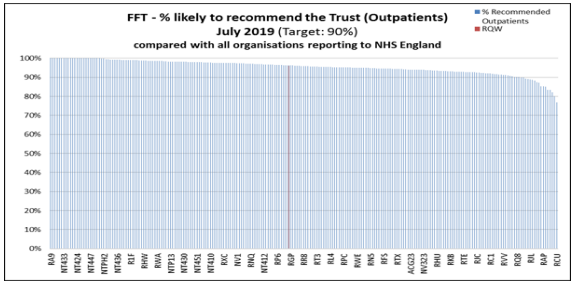
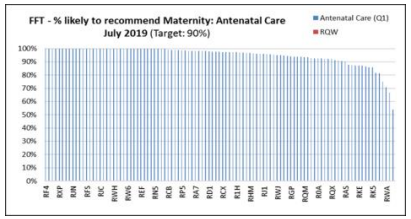
National Benchmarking
Compared with all organisations reporting to NHS England

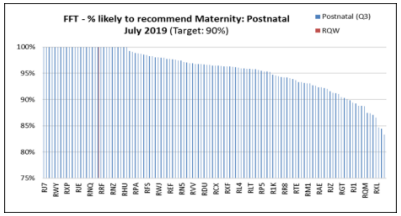
The Princess Alexandra Hospital NHS Trust

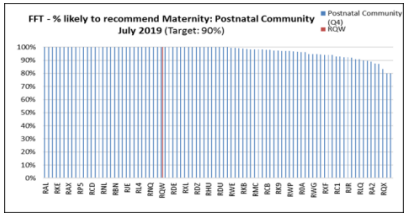


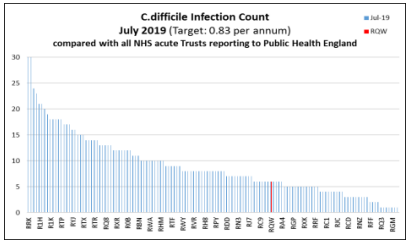


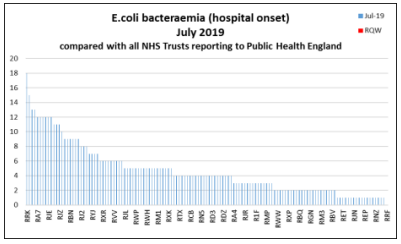


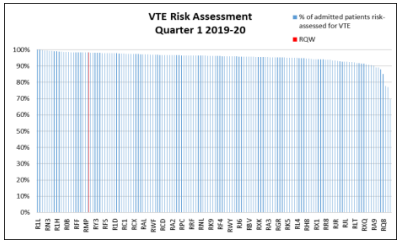


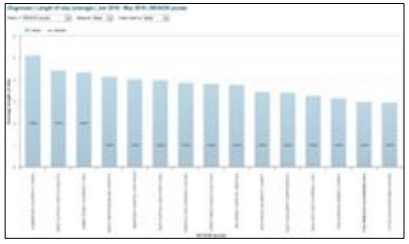












Your future · Our hospital

Data Source: NHS England Statistics/Public Health England/Dr Foster

respectful | caring | responsible | committed

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Harm Free Care:
Section 1.2: There have been 2 falls reported in the month resulting in severe harm, both are being investigated under the SI framework. In addition, the DoN chaired a overview scrutiny meeting of all falls resulting in harm (2019) and requested a deep dive review of falls which will report into the Patient Safety and Quality Committee (PSQ)

Infection Control:
Section 1.3: To note that the organisation reported an MRSA bacteraemia in August, this is the first hospital MRSA bacteraemia since 2014. Further details are included under the IC section of the report.

Mortality:
There is a refresh of the mortality programme as detailed under section 1.8.

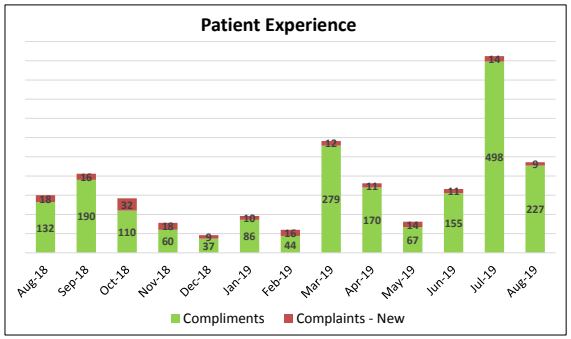
Maternity: The PPH rate is recognised to be reporting higher than expected rate: improvement work is underway to understand the drivers and required action.

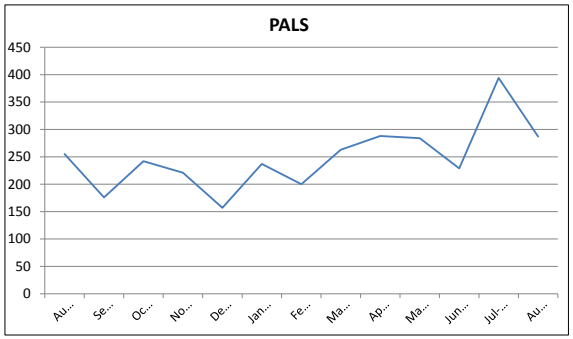
Patient Experience

1 Our Patients Summary 1.1 Patient Experience

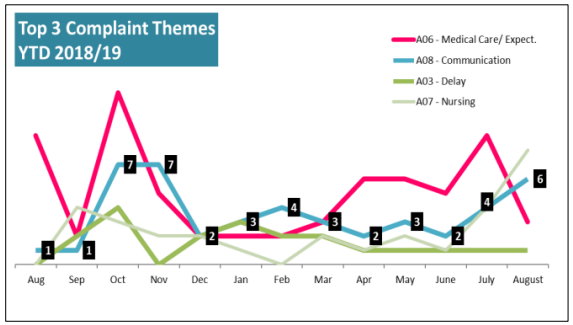
The Princess Alexandra Hospital NHS Trust

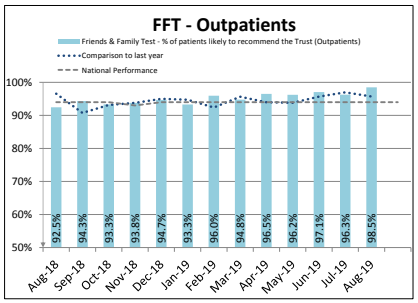
There are no significant changes in the data this month from patient experience. PALS cases (point of care resolution) have remained high as the patient experience team conduct regular ward walks to support the HCGs.
Compliments have increased with the introduction of our Patient Experience Assistant. All compliments are responded to within 48 hours with a personalised letter and forwarded to the individual staff involved on the same day.

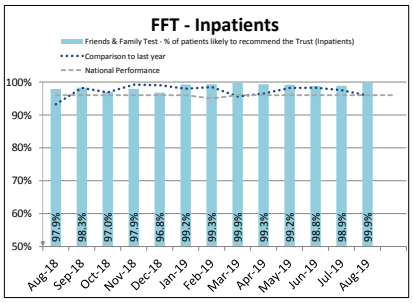


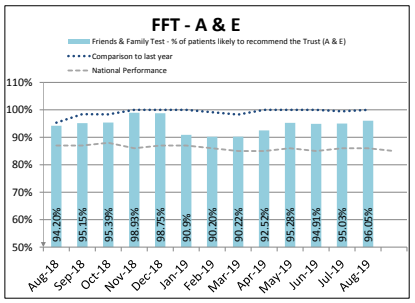


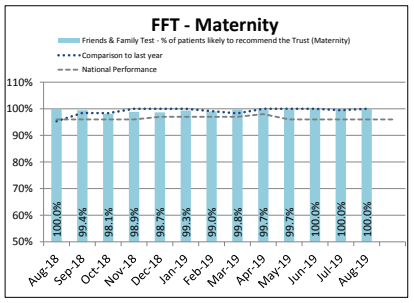
PALS converted to Complaints	
Aug-18	2
Sep-18	3
Oct-18	6
Nov-18	4
Dec-18	1
Jan-19	2
Feb-19	2
Mar-19	0
Apr-19	1
May-19	2
Jun-19	2
Jul-19	1
Aug-19	1







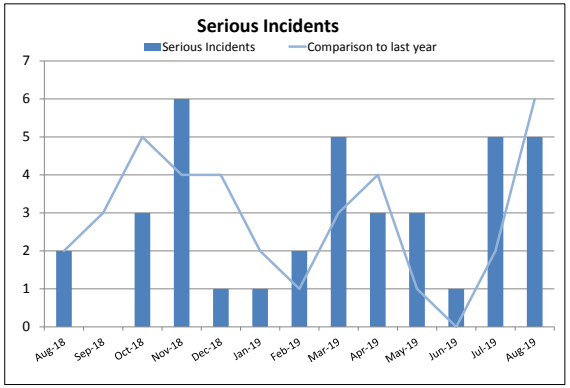


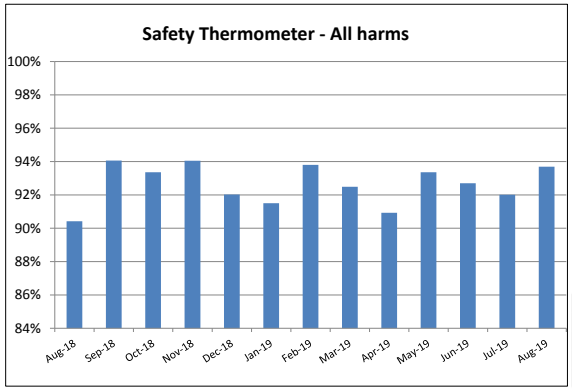


Patient Safety

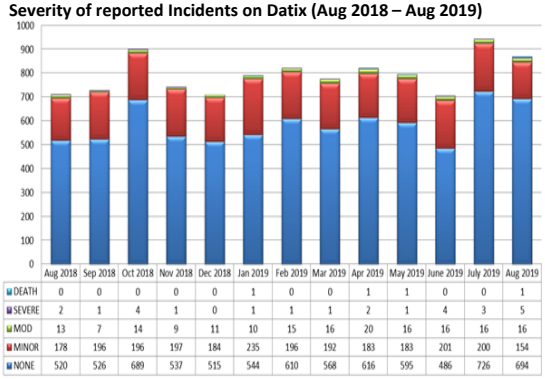
In August from the total of 1098 incidents raised, 870 were PAH incidents.
No harm incidents were 694 no harm and 154 minor harm incidents (making up 97.5%).
16 (1.8%) were graded as moderate harm, 5 (0.6%) were severe harm and 1 incident graded as death.
Each of the moderate, severe & death harm incidents will be discussed at SIG once a case review is completed to ensure we assign the correct incident severity grading & to determine if each meets the criteria for a serious incident requiring investigation.

5 incidents were raised as Serious Incidents and escalated externally:
- A fall from height (patients bed). Patient deceased, declared SI.
- Fall with confirmed subdural haematoma, patient deceased. Declared SI.
- Delay in treatment of hypoglycemia, patient deceased. Declared as RED incident.
- Potential delay in treatment. Undergoing harm review.
- Delay in antibiotic treatment for a patient with infective diarrhoea,. Declared SI.

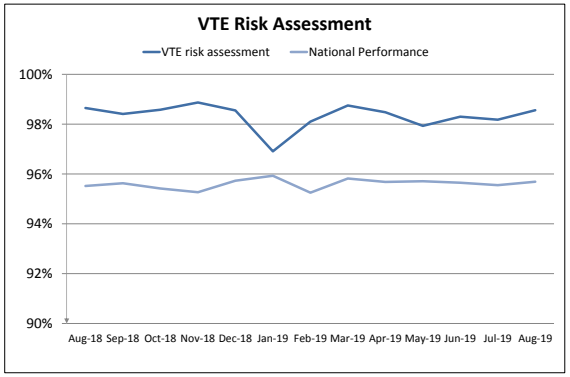


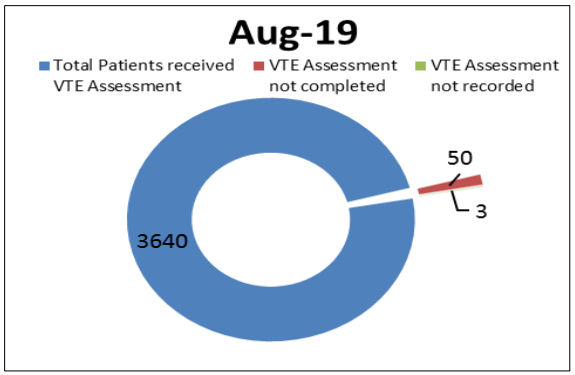


Severity of reported Incidents on Datix (Aug 2018 – Aug 2019)



	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	June 2019	July 2019	Aug 2019
DEATH	0	0	0	0	0	1	0	0	1	1	0	0	1
SEVERE	2	1	4	1	0	1	1	1	2	1	4	3	5
MOD	13	7	14	9	11	10	15	16	20	16	16	16	16
MINOR	178	196	196	197	184	235	196	192	183	183	201	200	154
NONE	520	526	689	537	515	544	610	568	616	595	486	726	694





MRSA
The Trust has had its first MRSA bacteraemia since 2014. This is a Trust acquired case as correct processes for managing a patient with MRSA were not followed. The Trust will be following up through its normal governance processes. A number of learning opportunities were identified from the investigation process and these are being taken forward by the Medicine HCG and the Infection Prevention and Control Team to ensure there is shared learning across the Trust.

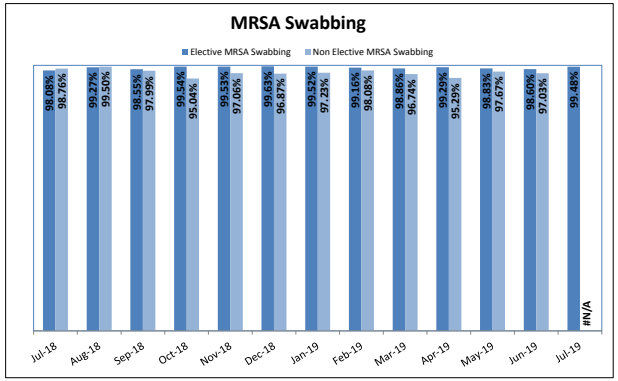
MSSA
The Trust continues to have low numbers of MSSA bacteraemia and remains in the top quarter of best performing hospitals nationally. During August there were no Trust cases.

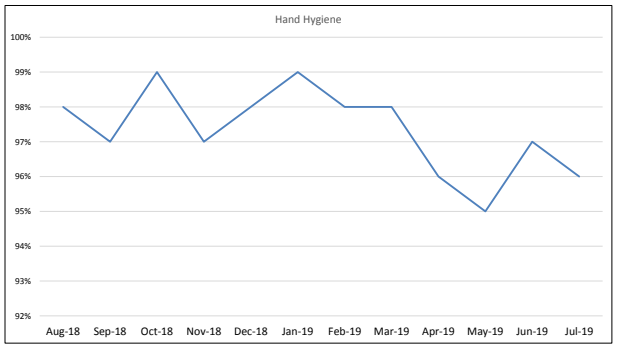
C.difficile
The trajectory for 2019-20 is 27 cases for the year (which is a total of hospital onset-healthcare associated and community onset-healthcare associated cases).
During August there was one case of hospital onset-healthcare associated C.difficile; this case will be discussed at the October C.difficile Appeals Panel.
The August C.difficile Appeals Panel took place and four cases were presented; all appeals were successfully upheld (one from S&CC and three from Medicine HCG).

Gram Negative Blood Stream Infections (GNBSIs)
The Trust remains in a good position when compared nationally with other hospitals (in the top performing quarter) & we have a collaborative approach to tackling GNBSIs across the health care economy. The Trust has been recognised nationally for reducing our GNBSIs & we have been asked to share how this was achieved.

MRSA screening – The Trust has consistently met its trajectory of over 95% compliance for non-elective MRSA screening. The most recent data was still in the process of being validated at time of writing.

Hand Hygiene Audits – All wards/clinical department are expected to participate in monthly audits and these are undertaken as 'cross-over' audits, meaning staff do not audit themselves. The expectation is that 100% of clinical areas participate and the performance standard is 95% compliance. During August there were seven areas that scored less than 95% compliance and two areas that didn't undertake the audits. Wards/departments are expected to discuss their results and agree appropriate actions within their Health-Care Group.





MSSA	
Aug-18	3
Sep-18	0
Oct-18	0
Nov-18	0
Dec-18	0
Jan-19	0
Feb-19	1
Mar-19	2
Apr-19	0
May-19	1
Jun-19	1
Jul-19	0
Aug-19	0

C-DIFF Total (to March 2019)	
Aug-18	1
Sep-18	0
Oct-18	1
Nov-18	0
Dec-18	1
Jan-19	3
Feb-19	0
Mar-19	1

C-DIFF (New categories including community from April 2019)					
Month	Hospital Responsible		Community Responsible		Total
	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	
Apr-19	2	1	1	0	4
May-19	1	1	1	0	3
Jun-19	0	1	0	2	3
Jul-19	1	0	0	5	6
Aug-19	0	0	1	2	3

E Coli	
Aug-18	1
Sep-18	1
Oct-18	1
Nov-18	1
Dec-18	1
Jan-19	1
Feb-19	2
Mar-19	1
Apr-19	2
May-19	1
Jun-19	2
Jul-19	0
Aug-19	2

Klebsiella	
Aug-18	1
Sep-18	0
Oct-18	0
Nov-18	0
Dec-18	1
Jan-19	2
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	1
Jul-19	0
Aug-19	0

Pseudomonas	
Aug-18	0
Sep-18	0
Oct-18	1
Nov-18	0
Dec-18	0
Jan-19	0
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	0
Jul-19	0
Aug-19	0

1 Our Patients Summary 1.4 Patient Safety

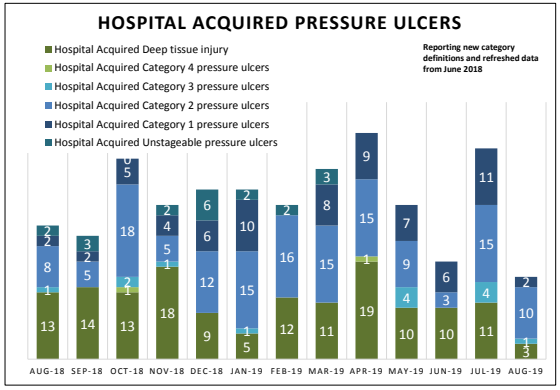
The Princess Alexandra Hospital NHS Trust

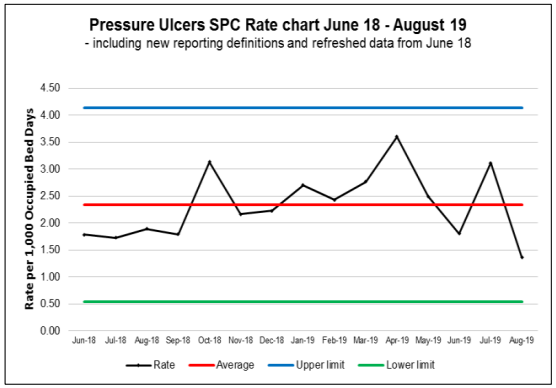
Falls in August saw a very slight decrease in the absolute number of falls to 109, down from 113 in July. This was accompanied by a decrease in the number of falls per 1000 OBD (occupied bed days) to 8.23, down from 8.38 in July.

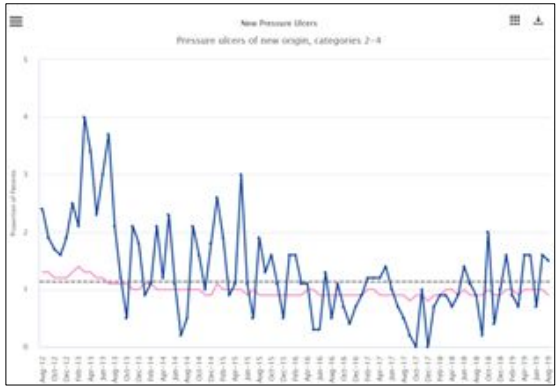
As a Trust we aim to ensure our levels of harm remain low and this is still the case with 97%+ PAH falls recorded as low or minor harm in August. One 'moderate harm' was reported and two 'severe harms'. The Rapid review process is embedded now and feedback from the ward staff has been positive.

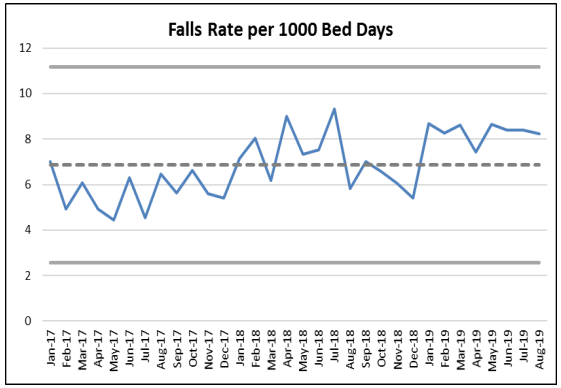
Whilst absolute numbers of falls are generally higher than past years this needs to be balanced against the large increase in numbers of admissions we are seeing year on year, as more admissions means more patients, but more crucially this means more acutely unwell patients are with us more often, which equals more falls. To highlight this - by the end of August we have surpassed the number of admissions we saw in the same time period (Jan-Aug) for both 2017 and 2018. For Jan-Aug this year we have seen 14186 admissions, 2017 saw 10391 admissions, whilst 2018 saw 12520 over the same time period. And whilst the falls per 1000 OBD figure does partially account for the increase in absolute demand, it does not account for the expected increase in patient acuity that would result from greater admissions.

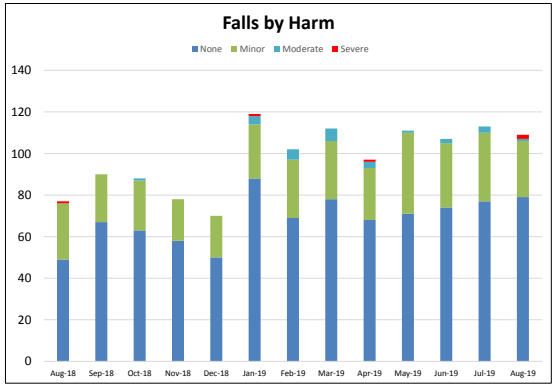
There has been a decrease in hospital acquired pressure ulcers this month from 42 in July to 18 in August. This represents a 57% decrease.
In terms of severity, the majority of pressure ulcers are category 2 and deep tissue injuries, with no reported category 4 or unstageable pressure ulcers for the last 4 to 5 months.
Three of the pressure ulcers were medical device related from nasal specs and stockings. TVNs are continually providing Intensive support to the wards concerned.

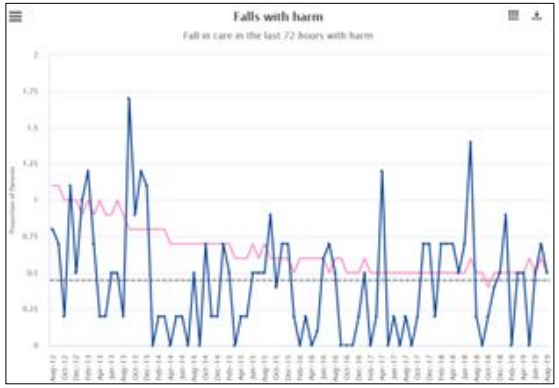










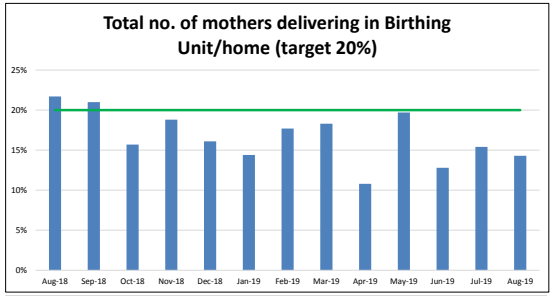


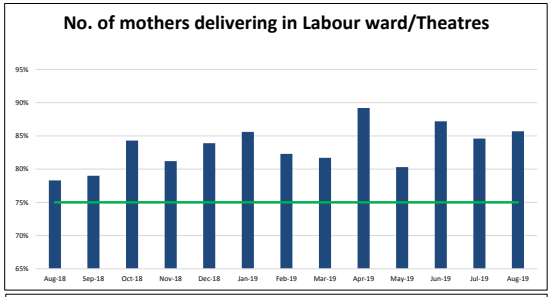
Family & Women's Service

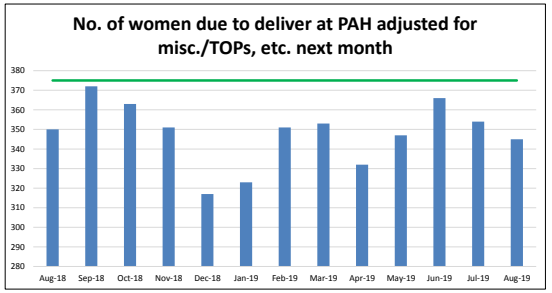
2 Our Patients Summary 1.5 Family & Women's Service

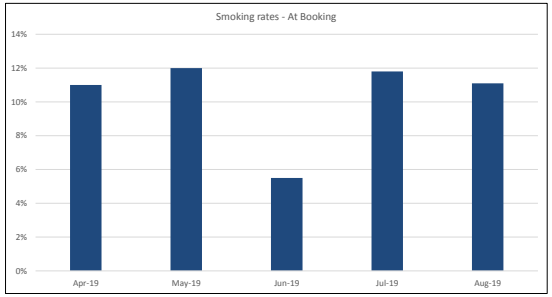
The Princess Alexandra Hospital NHS Trust

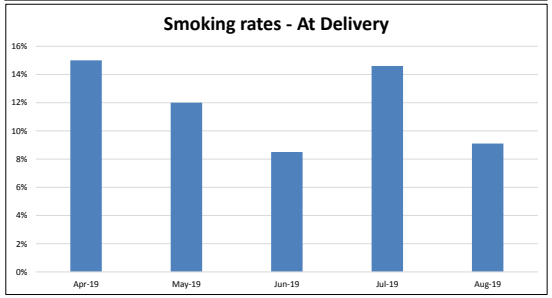
Following the benchmarking of our PPH Rate with surrounding Trusts a new PPH checklist and Risk Assessment will be introduced in September. The purpose of this is to look more closely at women with risk factors for PPH at the time of admission in labour. This will enable a proactive management plan to be followed during the woman's labour.

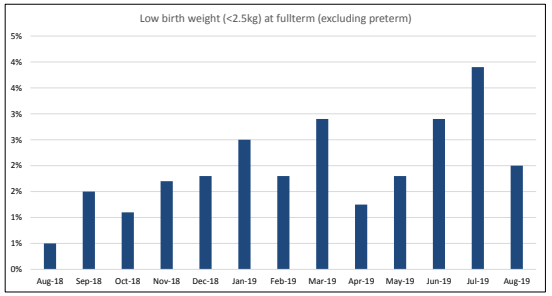


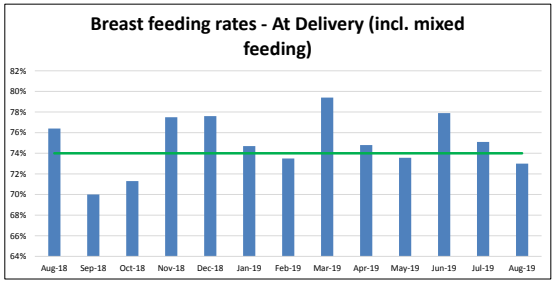


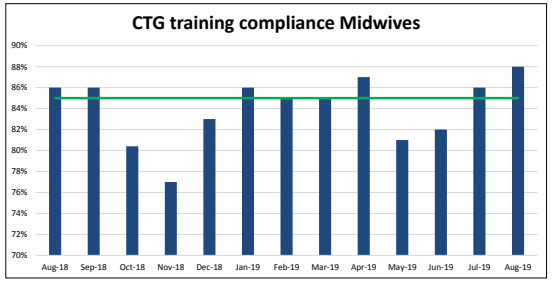


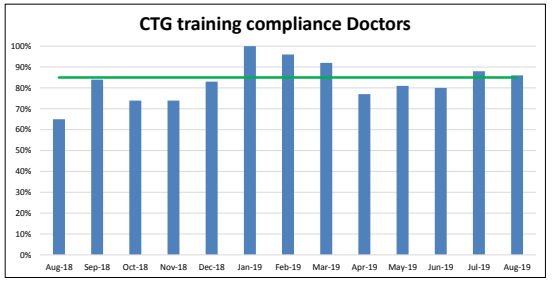




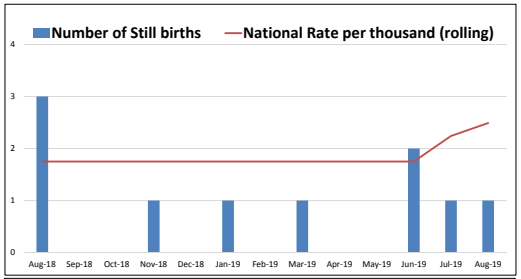


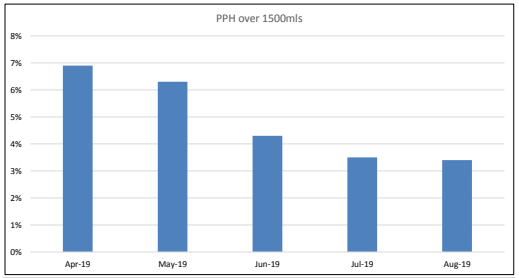


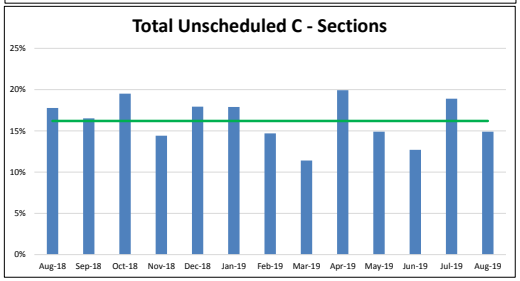


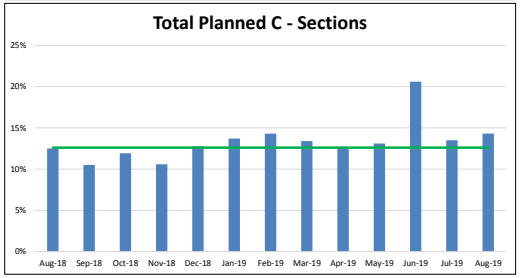


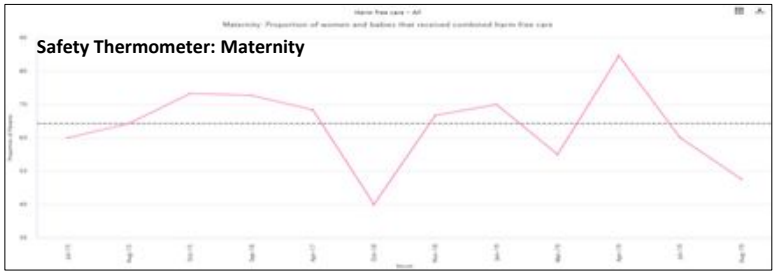
Family & Women's Service

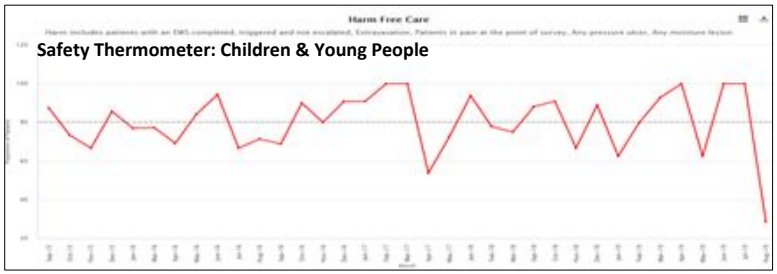










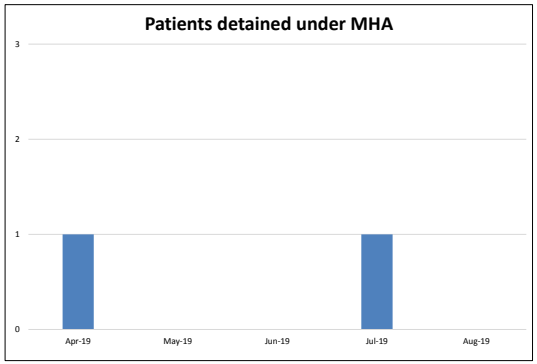


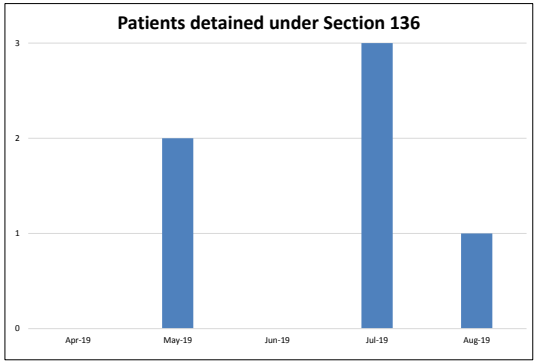
Mental Health

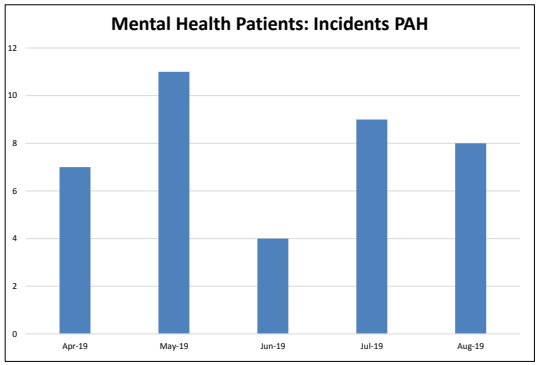
1 Our Patients Summary 1.7 Mental Health

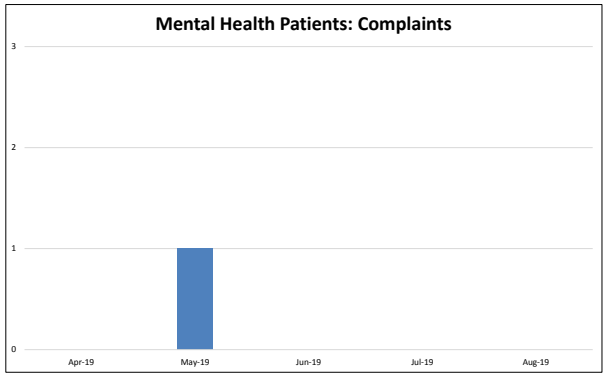
The Princess Alexandra Hospital NHS Trust

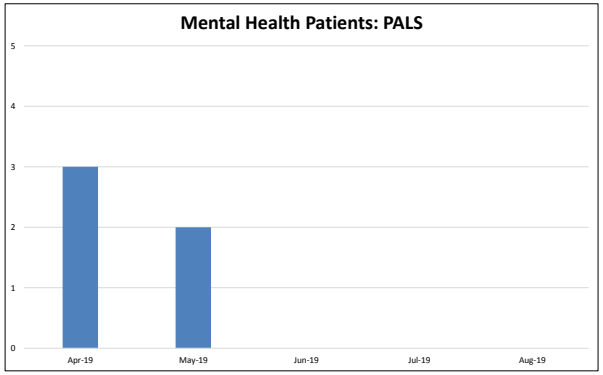
The Mental Health Quality Forum is focused on: undertaking a training needs analysis to ensure our staff are confident and skilled in managing the needs of mental health patients and the Mental Health Act; finalising a SLA with our mental health partner to administrate and support the mental health act at PAH; completing an audit of the NCEPOD 'Treat As One' and identifying areas of further improvement.





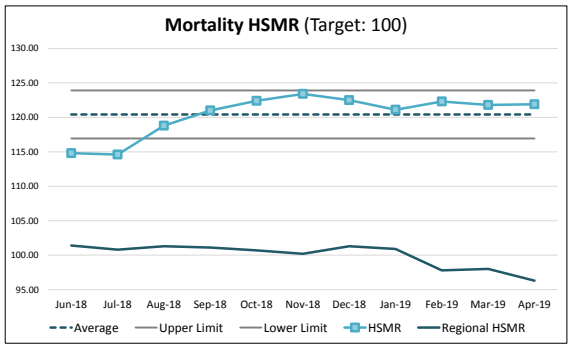






Mortality

We are undergoing a process to implement a refreshed mortality framework to embed the National Learning from Deaths agenda and prospectively identify themes for improvement. Reporting will move from the tracking of improvement projects, to board assurance (via the Quality and Safety Committee) around oversight, integration and learning from high quality mortality reviews in line with the trust's vision, values and standards.



Mortality SHMI	
Aug-18	
Sep-18	116.7
Oct-18	
Nov-18	
Dec-18	114.1
Jan-19	114.3
Feb-19	113.6
Mar-19	
Apr-19	
May-19	
Jun-19	
Jul-19	
Aug-19	

Mortality Outlier Alerts (QA)	
May 17 - Apr 18	4
Jun 17 - May 18	4
Jul 17 - Jun 18	4
Aug 17 - Jul 18	6
Sep 17-Aug 18	6
Oct 17 - Sep 18	9
Nov 17 - Oct 18	8
Jan 18 - Dec 18	7
Feb 18 - Jan 19	6
Mar 18 - Feb 19	8
Apr 18 - Mar 19	7
May 18 - Apr 19	7

Mortality Improvement progress and performance tracker (project level)

The Princess Alexandra Hospital NHS Trust

Programme	Project		Aim		Success measures: Measure	Type of Measure	Trajectory Vs. Actual	Performance and progress tracker: Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Trend
Care Bundles	Fractured Neck of Femur		Reduce mortality to expected level i.e. from 8.5% to 6% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	1	#NOF mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	8.0%	8.2%	8.0%	7.9%	7.8%	7.6%	7.5%	7.4%	7.2%	7.1%	7.0%	
							Actual	8.3%	8.4%	7.6%	8.0%	9.1%	8.8%	8.1%					
					#NOF HSMR (relative risk 12 month rolling) via Dr Foster			148.4	151.0	144.0	150.3	170.9	153.7	152.2					
				2	% #NOF patients admitted to Tye Green (#NOF ward)	Process	Trajectory	90%	90%	90%	90.0%	90.0%	90.0%	90.0%	95.0%	95.0%	95.0%	95.0%	
							Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	58.2%	72.7%	53.3%	54.5%	
				3	% of #NOF patients in theatres within 36 hours of arrival at A&E	Process	Trajectory	80%	80%	80%	80.0%	80.0%	80.0%	81.7%	83.3%	85.0%	86.7%	88.3%	
							Actual	94.4%	88.2%	85.3%	91.7%	84.8%	93.5%	77.1%	98.5%	80.0%	89.3%	86.2%	
				4	% of #NOF patients in theatres within 36 hours of arrival at A&E (excluding NSTAC patients)	Process	Trajectory	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	81.7%	83.3%	85.0%	86.7%	88.3%	
							Actual	94.4%	88.2%	85.3%	91.7%	84.8%	93.5%	77.1%	98.5%	80.0%	89.3%	86.2%	
				5	% #NOF patients admitted into Tye Green within 4 hours of ED attendance	Balance	Trajectory					69.9%	53.3%	56.8%	60.3%	63.8%	67.2%	70.7%	
							Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%	58.2%	72.7%	53.3%	54.5%	
	Acute Abdomen		Reduce mortality to expected level i.e. from 8.7% to 7.1% by March 2020 (intestinal obstruction, based on Dr Foster Data from reporting period Nov17-Oct18)	6	Intestinal obstruction mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	8.60%	8.51%	8.42%	8.34%	8.25%	8.16%	8.07%	7.98%	7.89%	7.81%	7.72%	
							Actual	8.60%	8.3%	6.3%	6.8%	6.8%	7.1%	6.3%					
					Intestinal Obstruction HSMR (relative risk 12 month rolling) via Dr Foster			121.8	119.4	91.2	97.3	93.9	101.0	98.2					
				7	Case ascertainment in NELA	Process	Trajectory	66.0%		66%		72.0%			79.6%			86.4%	
							Actual	66.0%			99.0%								
				8	Arrival in theatre within a timescale appropriate for urgency	Process	Trajectory	82.0%		82%		83.6%			85.2%			86.8%	
							Actual	82.0%			96.0%								
				9	% of Em Lap patients admitted to HDU/ITU (with NELA risk score >5) post operatively	Process	Trajectory	77.0%		77%		78.6%			80.2%			81.8%	
							Actual	77.0%			64.0%								
				10	Consultant anaesthetist and surgeon present in theatre if NELA risk score >5%	Process	Trajectory	83.0%		83%		86.4%			89.8%			93.2%	
							Actual	83.0%			93.0%								
	COPD		Reduce mortality to expected level i.e. from 6.4% to 4.1% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	11	COPD mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	6.4%	6.3%	6.1%	6.0%	5.8%	5.7%	5.6%	5.4%	5.3%	5.1%	5.0%	
							Actual	6.4%	7.2%	6.8%	6.6%	6.4%	6.3%	6.0%					
					COPD HSMR (relative risk 12 month rolling) via Dr Foster			162.2	171.6	168.1	158.6	153.0	142.9	141.0					
				12	Administer nebuliser and steroids within 4 hours of attendance	Process	Trajectory												
							Actual					4.3%	15.2%	13.8%					
	Pneumonia		Reduce mortality to expected level i.e. from 19.6% to 15.3% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	13	Pneumonia mortality rate (% of patients who died)	Outcome	Trajectory	16.1%	16.0%	15.8%	15.7%	15.5%	15.4%	15.2%	15.1%	14.9%	14.8%	14.6%	
							Actual	16.1%	16.1%	16.2%	15.8%	16.0%	16.1%	16.3%					
					Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster			130.8	131.1	122.1	118.6	120.1	122.2	126.1					
				14	Aspiration pneumonia mortality rate (%of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	47.0%	46%	45%	44.0%	43.0%	42.0%	41.0%	40.0%	39.0%	38.0%	37.0%	
							Actual	47.0%	44.0%	41.2%	43.0%	40.0%	45.2%	43.4%					
					Aspiration Pneumonia HSMR (relative risk 12 month rolling) via Dr Foster			131.7	150.0	146.6	140.8	142.9	148.2	142.7					
				15	Oxygen prescribed within 1 hour of attendance	Process	Trajectory						4.76%		5.10%				
							Actual												
				16	Chest x-ray within 4 hours of attendance	Process	Trajectory	42.9%	42.9%	42.9%	42.9%	42.9%	61.1%	67.9%	74.7%	81.5%	88.3%	95.0%	
							Actual	84.6%	82.6%	82.3%	80.0%	82.9%	64.0%	82.4%					
	Sepsis		5% reduction in Sepsis mortality by March 2020	17	Sepsis mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	20.5%	20.2%	19.9%	19.6%	19.3%	19.0%	18.7%	18.4%	18.2%	17.9%	17.6%	
							Actual	20.5%	19.9%	19.3%	17.5%	16.0%	15.9%	15.6%					
					Sepsis HSMR (relative risk 12 month rolling) via Dr Foster			136.7	130.0	126.9	117.8	110.7	108.8	104.3					
				18	95% of all patients admitted to ED with a NEWS score of 3 are screened for sepsis by May 2019	Outcome	Trajectory	82.0%	82.0%	82.0%	84.6%	87.2%	89.8%	92.4%	95.0%	95.0%	95.0%	95.0%	
							Actual	85.0%	76.0%	84.0%	84.0%	84.0%	86.0%						
				19	% sepsis patients receiving treatment within one hour (ED)	Process	Trajectory	87.0%	87.0%	87.0%	89.0%	90.0%	92.0%	93.0%	95.0%	95.0%	95.0%	95.0%	
							Actual	91.0%	83.0%	88.0%	89.0%	94.0%	94.0%						
				20			Trajectory					70.0%	75.0%	80.0%	85.0%	90.0%	95.0%	95.0%	
Excellence Every Time group 1	Vital Signs	Timely recording of vital signs observation and adequate & effective equipment for undertaking and recording vital signs	To improve compliance with timely vital signs observation leading to early detection and escalation of deteriorating patient		% of Observations on patients with a EWS ≥5 within 30 minutes of due time	Process	Actual				63.2%	68.0%	72.2%	75.3%	76.4%	81.5%	83.6%	86.0%	
	Fluids & Electrolytes	Accurate input/ output Fluid Balance chart	To improve compliance with fluids & electrolytes management with early detection and treatment leading to reduction in harm caused by fluid and electrolytes imbalance	21	% of completed fluid balance charts	Process	Trajectory				0.0%				40.0%	45.9%	51.3%		
							Actual				0.0%			28.0%	51.8%	67.2%	61.4%	63.6%	
		Management of Acute Kidney Injuries (AKI)		22	Renal disease comorbidity mortality rate (% of patients who died - 12 months rolling) - via Dr Foster	Outcome	Trajectory	10.5%	10.4%	10.2%	10.0%	9.9%	9.8%	9.7%	9.6%	9.5%	9.3%	9.2%	
							Actual	10.5%	10.4%	10.1%	9.8%	10.1%	10.1%	10.0%					
					Renal Disease HSMR (relative risk 12 month rolling) via Dr Foster			136.4	127.3	127.5	125.5	130.4	131.2	130.6					
				23	Number of patients with AKI alert	Outcome	Trajectory				98	101	101	100	98	95	95	90	
							Actual				98	101	101	100	98	110	121	117	
				24	Percentage of patients with alerts that have remained the same or improved during their admission	Process	Trajectory	89.8%	89.8%	89.8%	89.8%	89.8%	89.8%	89.8%	91.1%	92.4%	93.7%	95.0%	
							Actual	84.0%	85.0%	89.0%	87.0%	91.0%	88.5%	88.0%	89.8%	87.3%	87.5%	98.0%	
		Diabetic Emergencies		26	Number of hypos	Process	Trajectory	878	852	711	765	751	798	724	710	697	683	668	
							Actual	878	852	711	765	546	921	627	460	530	740	690	
Excellence Every Time group 2	Antibiotics Stewardship		Correct antibiotic use for patient need (right drug, right patient, right time, right route) and a reduction in overall	31	LoS for patients who have antibiotics during their admission (non-elective and elective)	Balance	Trajectory	7.97	7.97	7.97	7.97	7.97	7.97	7.97	7.89	7.80	7.71	7.62	
							Actual	8.13	8.44	8.52	8.90	8.38	8.43	8.03	8.40	8.08			
	Timely Decision Making		95% Compliance with completion of TEP for all adult (>16yrs) in-patients	32	% compliance with completion of TEP forms for all patients over 16 years old	Outcome	Trajectory							43.0%	58.0%	61.7%	65.4%	69.1%	
							Actual							43.0%	58.0%	48.6%	72.5%	37.1%	
Reporting and recording	Medical Examiners		100% adult deaths (>16yrs) reviewed by ME and evidence of shared learning against reviews	35	% of completed Mortality Reviews by an ME	Outcome	Trajectory							25.0%	25.0%	30.0%	40.0%	50.0%	
							Actual							17.8%	19.0%	24.0%	28.4%	23.0%	
					Number of completed reviews	Process	Actual							22	18	18	25	21	
	Documentation (meeting standards, recording care accurately and communicating management plans)		Every entry in the patient notes are compliant with RCMC and NMC standards	36	Compliance with documentation standards in Perfect Ward Audit tool	Process	Trajectory							95.0%	95.0%	95.0%	95.0%	95.0%	
							Actual							95.0%	98.0%	95.0%	97.0%	95.9%	92.1%
Hospital at Night	Doctor Handover		Implementation of structured handover of patients for all specialities out of hours	39	Number of unexpected escalations to critical care (excluding ED)	Balance	Trajectory	11	11	11	11	11	8	7	6	6	6	6	
							Actual	8	13	4	5	13	8	7	6	8	4		
	Electronic Handover		Implementation of an electronic nightime handover	43	Implementation of an electronic nightime handover	Outcome	Trajectory										100%	100%	
							Actual										100%	100%	
	Hospital at night (task allocation)		Implementation of Hospital at Night software	44	Maximum number of calls to the 2222 number out of hours	Balance	Trajectory												
							Actual						53		63	52	65	72	

Your future | Our hospital

respectful | caring | responsible | committed

Mortality Tracker - Narrative

The Princess Alexandra Hospital NHS Trust

Care Bundles

- Fractured Neck of Femur: for the 4 measures within this project, none met the trajectory in the most recently reported month. The actions being taken to address performance
  - o There is a focus on time to theatre and time from the emergency department (ED) to Tye Green starting with a root cause analysis to inform actions and quality improvement tests of change.
  - o The ED coordinator is playing an enhanced role in navigating fractured neck of femur (#NOF) patients through the ED efficiently.
  - o Priority list for trauma is being developed.
  - o Golden patient concept (first patient on list) to be enhanced and enforced.
- Acute Abdomen: of the 5 measures within this project, 4 have met trajectory for the most recently reported month.
- COPD and Pneumonia: the mortality rate has continued to decrease (improve) despite not currently meeting the trajectory.
  - o Workshop to be facilitated by Quality First Team with specialty leads, general practitioners (GPs) and wider pathway stakeholders to better understand the root causes for mortality rate performance.
  - o There is an understanding the work that is commencing with the Reporting and Recording Programme will aim to address weaknesses in coding and recording of the 'first episode of care'.
- Sepsis: the reduction in mortality rate for sepsis has been sustained.

Excellence Every Time Group 1

- Vital Signs: the measure for this project has continued to improve month on month, and it is expected that the trajectory will be met in subsequent months.
  - o Actions to improve compliance are held locally within Healthcare Groups.
- Fluid Balance Charts: the measure of this project has exceeded the trajectory.
- AKI: 3 of the 4 measures within this project have not met trajectory for the most recently reported month, with the performance expected to improve following training and education on the wards.
- Diabetic Emergencies: the measure for this project has increased in the most recent month, a new 'hypo box' was implemented in August, which should see a return to expected performance.

Excellence Every Time Group 2

- Antibiotics Stewardship: For the data we have available we continue to see a fall in LoS for those patients on antibiotics. Over 200 clinicians at PAHT have downloaded the antibiotic app that was introduced in 6th August, which we hope to see support our efforts to increase compliance against antibiotic policy and improve stewardship practice.

Reporting and Recording

- Medical Examiners: the measure in this project has not met trajectory but has continued to improve month on month until August. The process and focus for the project is being reviewed by the Deputy Chief Medical Officer and Lead Medical Examiner who is starting at PAHT in September 2019.
- Documentation: The measure (against trajectory) was not met. The 'first episode of care' will be an initial focus going forwards as there is understanding that if we get diagnosis recorded well as the beginning of care in hospital will inform better clinical decision making and care planning.

Hospital at Night

- 15th July hospital at night was successfully implemented and sustained through the introduction of junior doctors.

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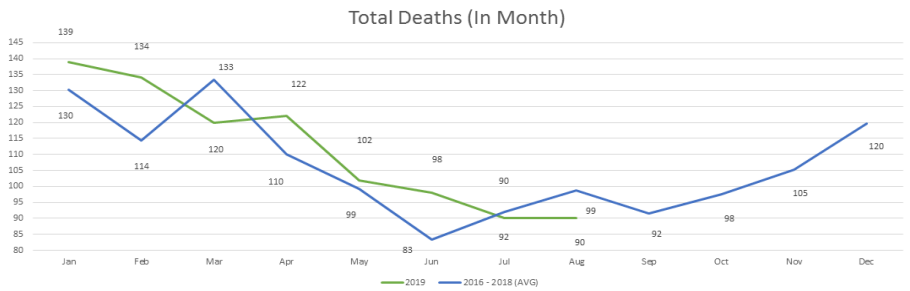
The Princess Alexandra Hospital NHS Trust

Mortality improvement progress and performance tracker (our goal)

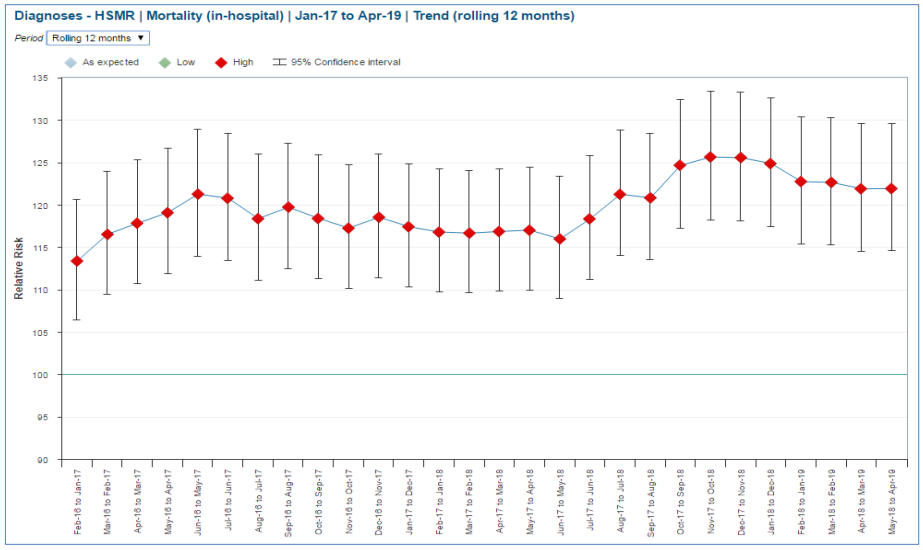
Our goal

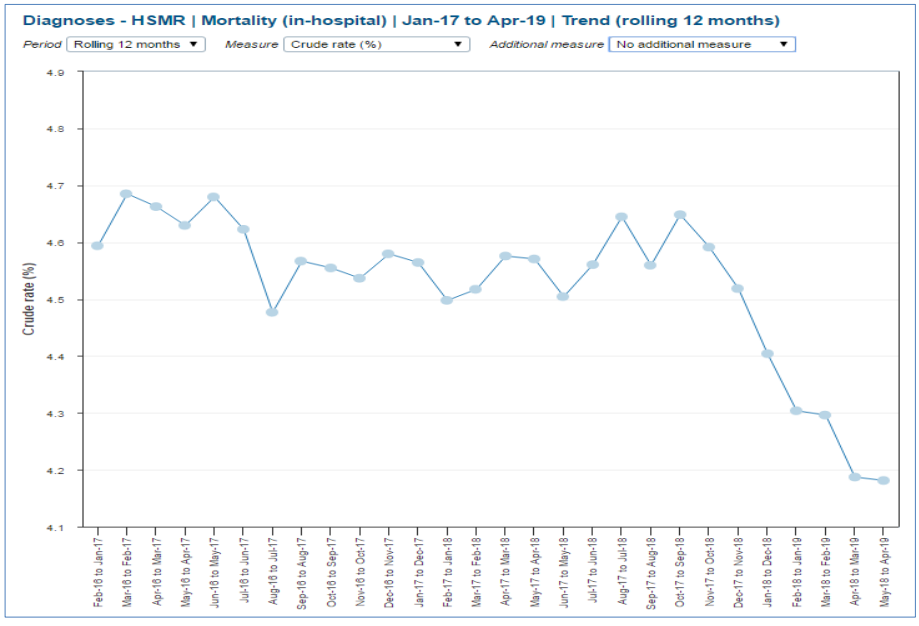
Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.

Our progress & performance



Dec 18 | Aug 19
Jan 19 | Sep 19
Feb 19 | Oct 19
Mar 19 | Nov 19
Apr 19 | Dec 19
May 19 | Jan 20
Jun 19 | Feb 20
Jul 19 | Mar 20





respectful | caring | responsible | committed

7.1

Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

Cancer

Both the 2 week wait & Breast Symptomatic performance were achieved for the first time in several months. There is a clear trajectory in place for recovery of 62 Day performance. The Trust was slightly ahead in month at just over 0.5%. Compliance is expected to be reached in November. Workforce issues remain in head & neck tumour site with discussions and plans being worked through with the tertiary centres. There are ongoing capacity issues in Endoscopy which are being addressed with the clinical teams, change in job plans and template reviews.

RTT and ASIs

A review of outpatient capacity is underway across all specialties taking into account waiting list patients, current PTL patients, ASIs and TCI's. This will be closely linked into the review of all consultant and MDTs.

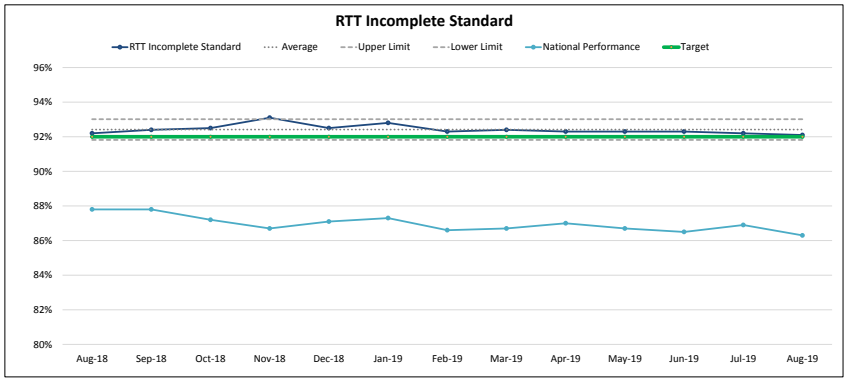
ED

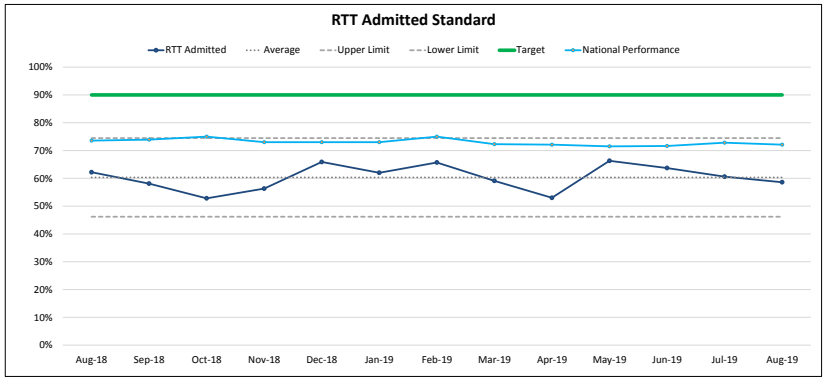
Our performance against the 4 hour standard for August was consistent with the previous two months, it was still significantly below the 95% standard, at 77%. The main reasons for the performance were gaps in the medical rota in the Emergency Department which led to delays in patients being seen & limited bed occupancy, particularly on our surgical wards. Our minors performance maintained its current level at 89%, but is still some way short of the 95% standard. However, our Paediatric performance exceeded 95% for the first time since August 2018. We continue to deliver good performance in relation to ambulance handover times, with a significant improvement in our ability to take patients within the 15 minute standard. This has contributed to a reduction in the longer delays of ambulance handovers & we continue to be one of the best performing hospitals in the region for handover delays. In August we only reported seven handover delays over 60 minutes all month.

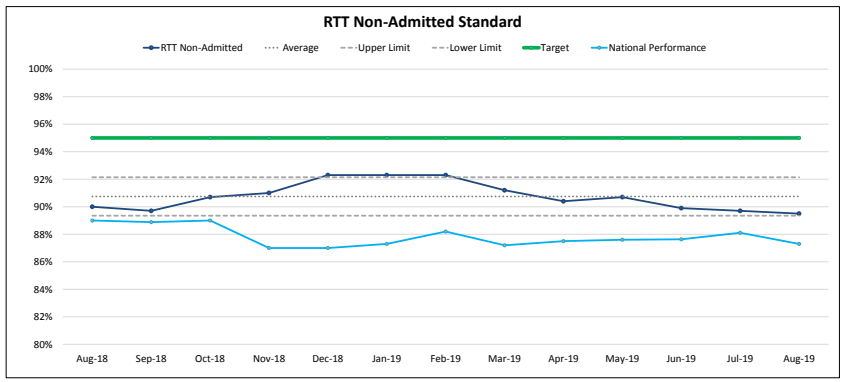
Recruitment plans are progressing well with our new Associate Medical Director in post & offers have been made to full recruit to our Specialty Doctor gaps. New appointees are expected to be in post by December 2019. A review of current rotas, job plans and ways of working are already underway with the AMD and senior operational team.

Our long length of stay reduction programme is continuing to perform ahead of trajectory with weekly Board level reviews taking place across all inpatient areas.

RTT


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
96%
94%
92%
90%
88%
86%
84%
82%
80%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


RTT Admitted Standard
RTT Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
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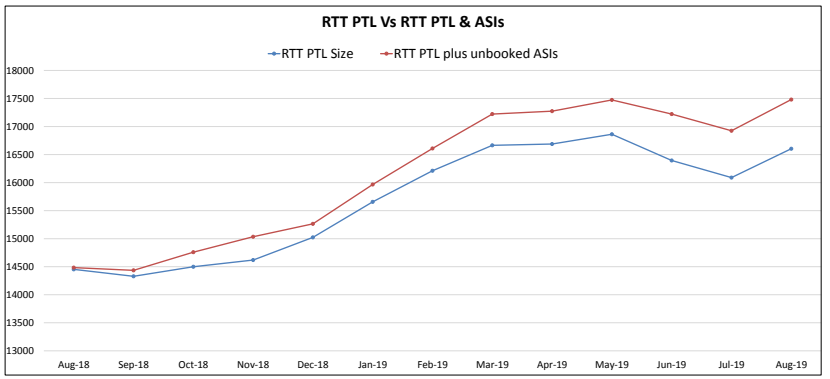
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19

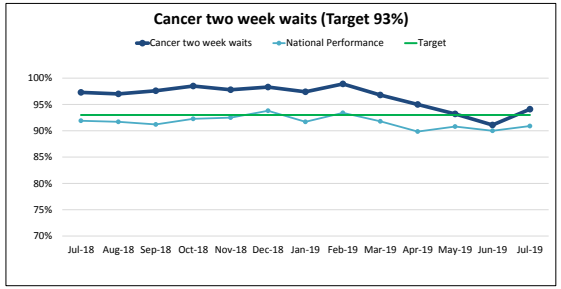
2 Our Performance Summary

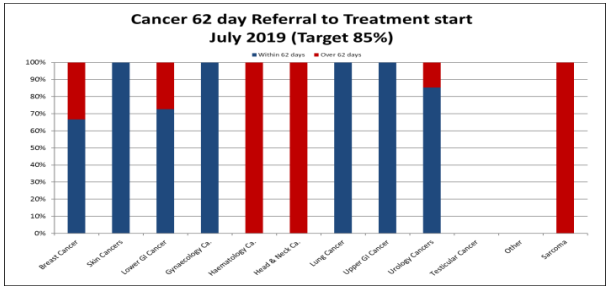
2.2 Responsive

The Princess Alexandra Hospital NHS Trust

	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Jul-18	97.70%	97.40%	100.00%	100.00%
Aug-18	99.40%	95.20%	100.00%	100.00%
Sep-18	99.20%	97.70%	100.00%	100.00%
Oct-18	98.80%	96.70%	100.00%	100.00%
Nov-18	97.30%	96.70%	100.00%	100.00%
Dec-18	96.90%	100.00%	100.00%	100.00%
Jan-19	97.40%	97.00%	100.00%	100.00%
Feb-19	96.70%	97.30%	100.00%	100.00%
Mar-19	86.90%	96.90%	100.00%	100.00%
Apr-19	91.00%	100.00%	100.00%	100.00%
May-19	92.60%	97.80%	92.90%	75.00%
Jun-19	76.10%	98.10%	100.00%	100.00%
Jul-19	95.70%	99.00%	100.00%	100.00%

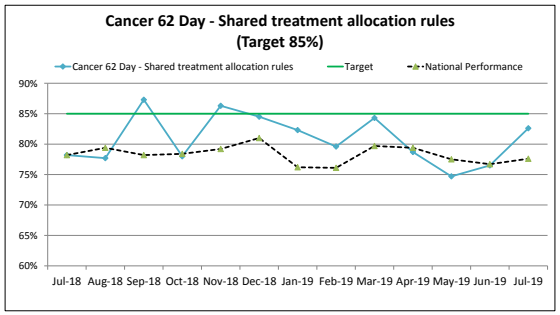
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

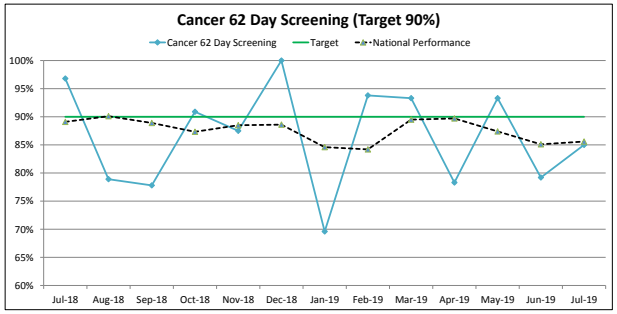


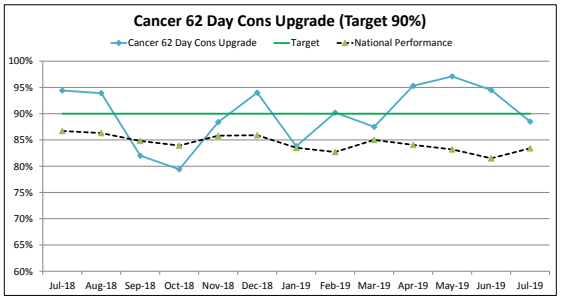


July performance by tumour group

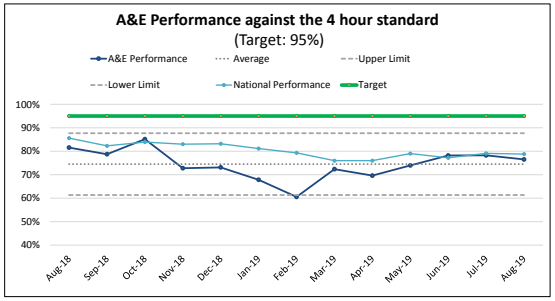
Target Wait Group	14 day target performance %	31d day first seen performance %	62 day standard performance %	62 day Screening performance %	62d CU performance %	31d day subsequent drugs performance %	31d day subsequent surgery performance %
Acute Leukaemia	100.0%						
Breast Cancer	96.3%	100.0%	66.7%	83.3%	100.0%	100.0%	
Brain/CNS	66.7%						
Gynaecology Ca.	97.4%	100.0%	100.0%		75.0%		100.0%
Haematology Ca.	88.9%	100.0%	0.0%		100.0%	100.0%	
Head & Neck Ca.	96.7%		0.0%				
Children's cancer	87.5%						
Lower GI Cancer	93.4%	92.3%	72.7%	100.0%	100.0%	100.0%	100.0%
Lung Cancer	96.4%	100.0%	100.0%		65.4%	100.0%	
Skin Cancers	91.2%	100.0%	100.0%		100.0%		100.0%
Testicular Cancer	100.0%						
Upper GI Cancer	89.8%	100.0%	100.0%		100.0%		
Other					100.0%		
Urology Cancers	99.1%	100.0%	85.4%		100.0%	100.0%	
Total performance	94.1%	99.0%	82.6%	85.0%	88.5%	100.0%	100.0%
Symptomatic Breast Refern	95.2%						

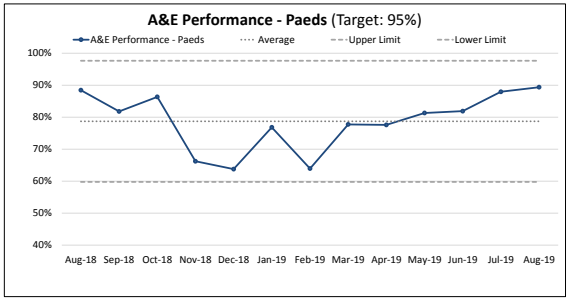


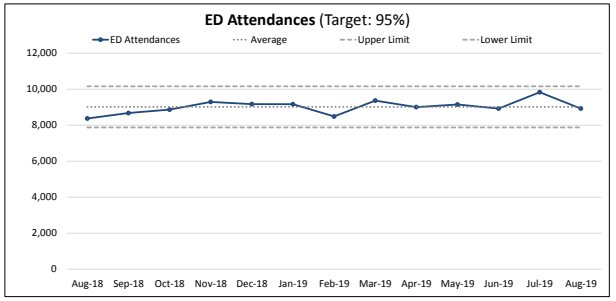


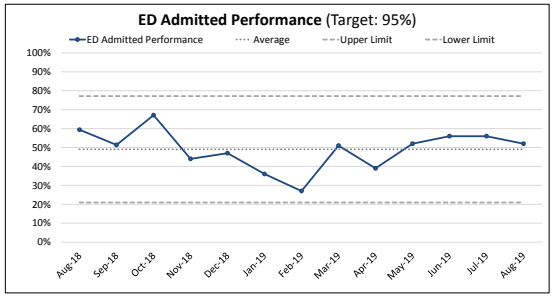


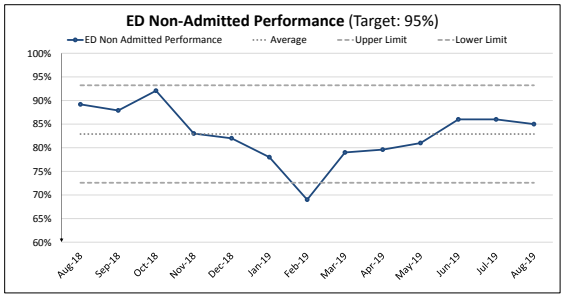
ED





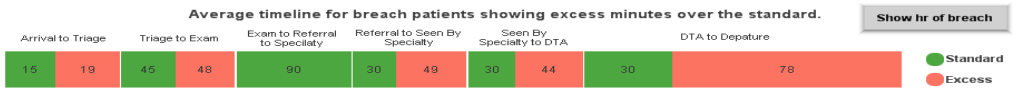


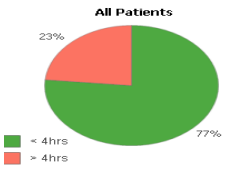




ED Internal Professional Standards

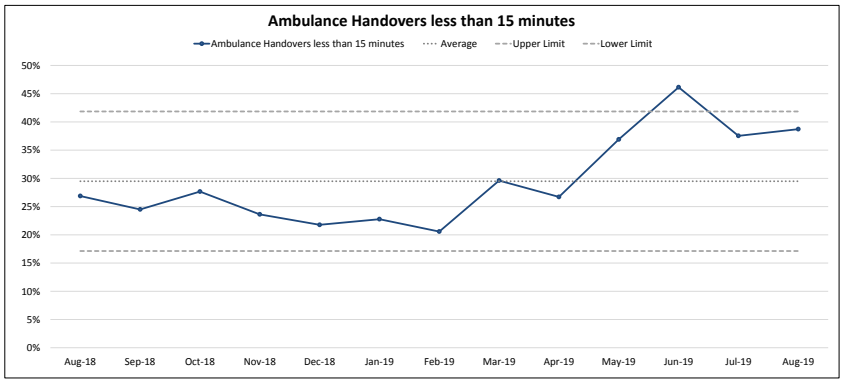
	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Arrival to Triage - Average Wait (Minutes)	28	31	29	36	34	37	43	35	38	33	26	38	34
Triage to Exam - Average Wait (Minutes)	79	82	74	91	94	106	118	106	99	99	91	90	93
Exam to Referral to Specialty - Average Wait (Minutes)	74	78	72	80	83	85	97	81	82	80	82	81	83
Referral to Seen by Specialty - Average Wait (Minutes)	70	69	68	83	82	84	85	73	75	69	67	65	79
Seen by Specialty to DTA - Average Wait (Minutes)	77	86	77	94	97	105	109	82	93	72	78	73	74
DTA to Departure - Average Wait (Minutes)	119	161	123	223	209	312	308	171	197	147	120	115	108

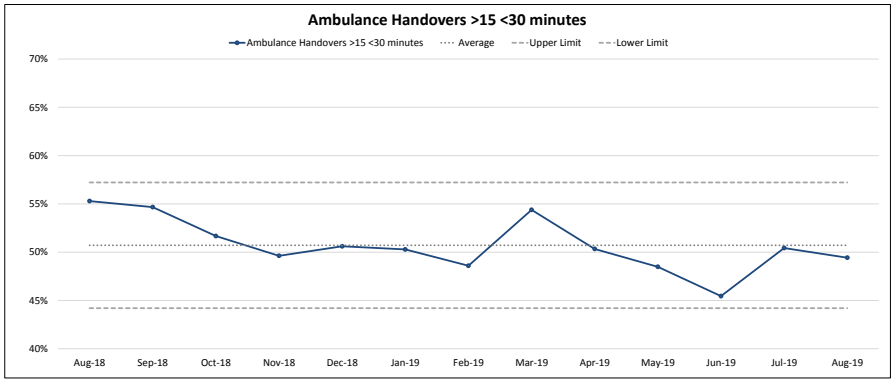


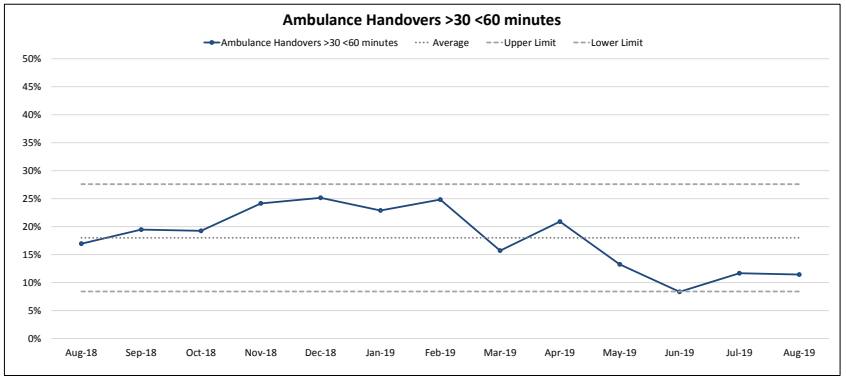


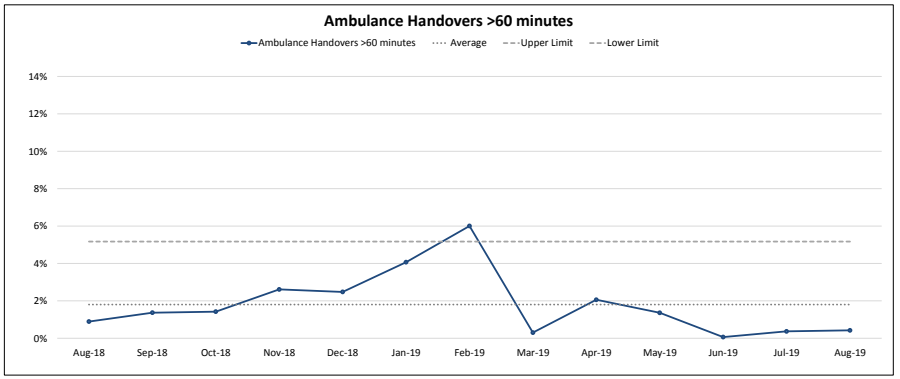
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	34	19	8,577	4,760	55%	
Triage to Exam	45	93	48	7,873	4,054	51%	
Exam to Referral to Specialty	90	83	0	2,545	469	18%	
Referral to Seen by Specialty	30	79	49	2,641	1,717	65%	
Seen by Specialty to DTA	30	74	44	1,577	799	51%	
DTA to Depature	30	108	78	2,230	1,211	54%	

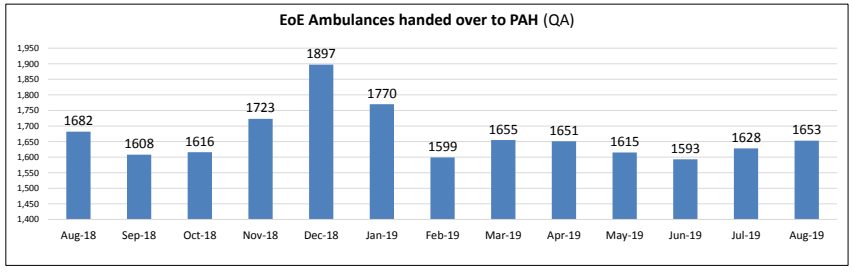
Ambulance


Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
70%
65%
60%
55%
50%
45%
40%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
14%
12%
10%
8%
6%
4%
2%
0%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


EoE Ambulances handed over to PAH (QA)
1,950
1,900
1,850
1,800
1,750
1,700
1,650
1,600
1,550
1,500
1,450
1,400
1682
1608
1616
1723
1897
1770
1599
1655
1651
1615
1593
1628
1653
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
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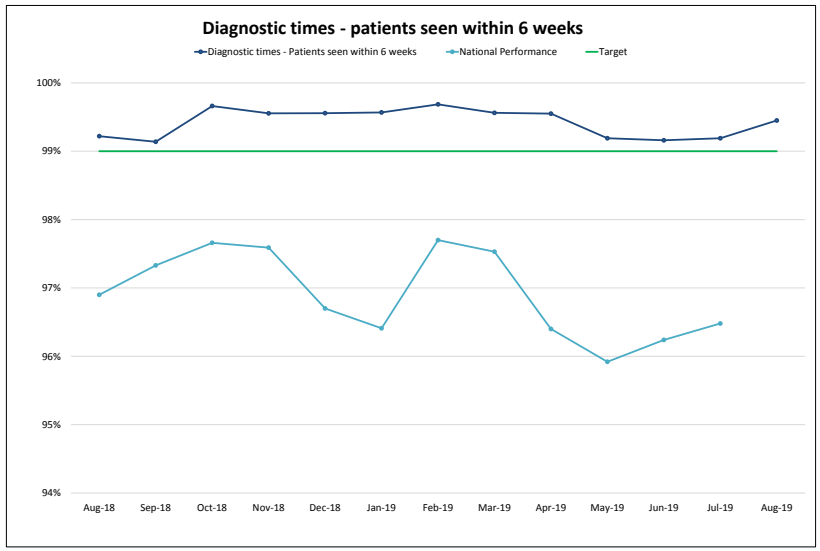
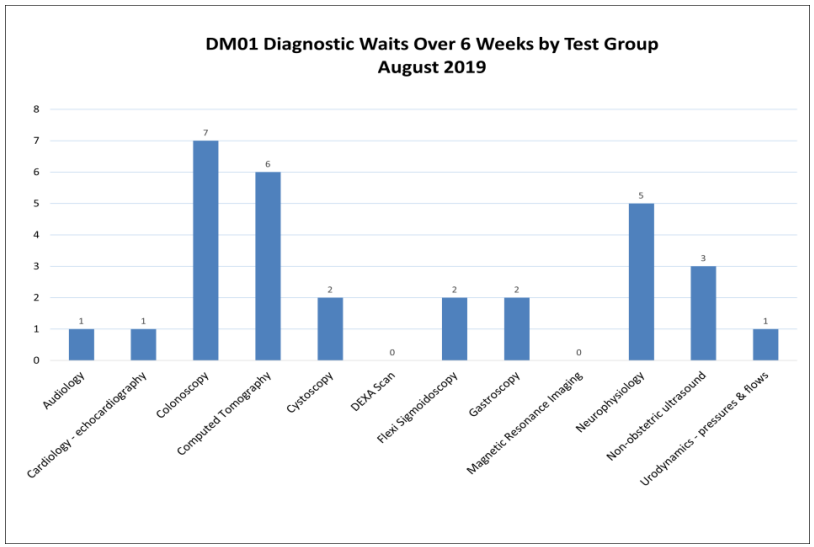
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19

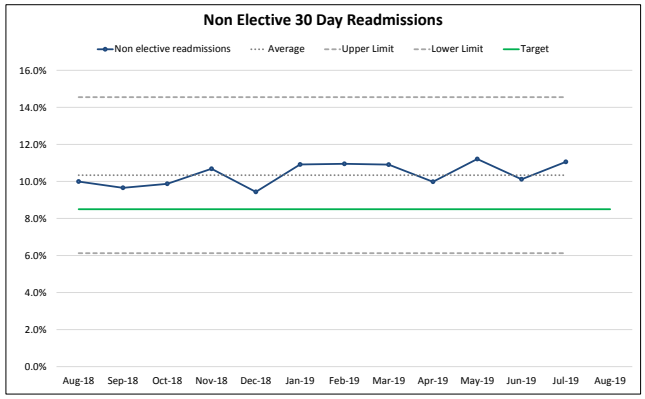
Diagnostics

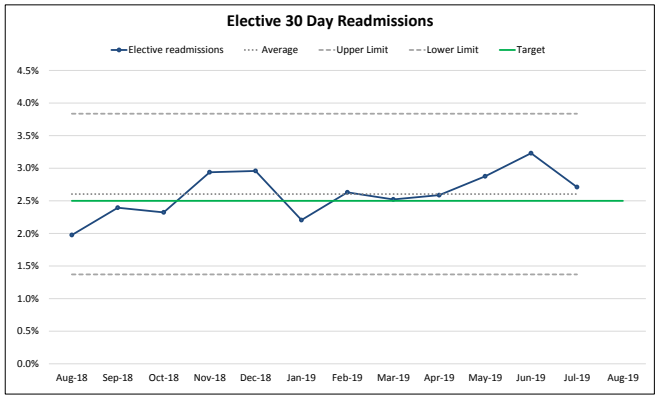


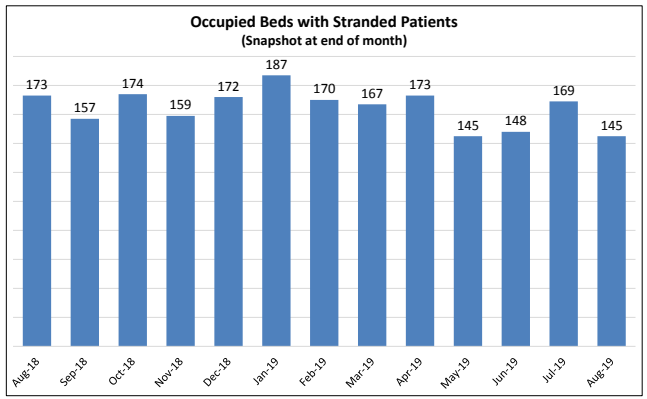


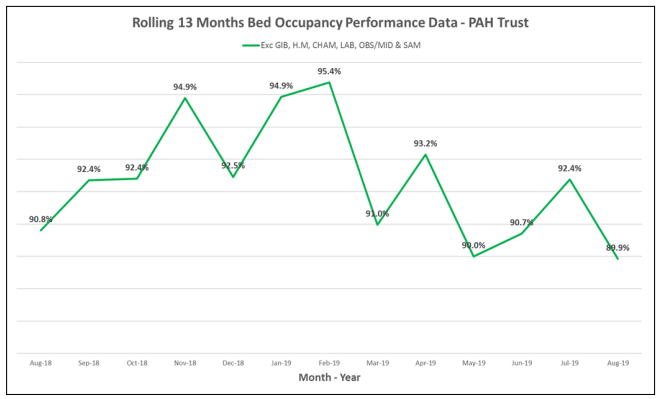
Test	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Magnetic Resonance Imaging (MRI)	100.00%	100%	100%	100%	100%	100%	100%	99.92%	100.00%	99.77%	100.00%	100.00%	100.00%
Computed Tomography (CT)	99.84%	100%	100.00%	100.00%	100%	100%	100%	99.85%	99.73%	99.32%	100.00%	100.00%	99.09%
Non-Obstetric Ultrasound	99.92%	99.92%	99.71%	99.92%	99.96%	100%	100%	100.00%	99.76%	99.92%	99.92%	100.00%	99.86%
DEXA	100%	100.00%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology - Audiology Asessments	100.00%	100%	100%	99%	100%	98%	99%	98.18%	99.58%	98.50%	98.80%	100.00%	99.51%
Cardiology - Echocardiography	95%	98.20%	100.00%	100.00%	100%	100%	100%	100.00%	99.75%	100.00%	100.00%	100.00%	99.86%
Neurophysiology	100%	100%	93%	100%	100.00%	100%	100%	100%	100%	100%	83%	50%	66.67%
Urodynamics	96%	74.47%	92.68%	56.76%	80.00%	70%	82%	90.00%	86.84%	89.66%	92.59%	90.00%	95.24%
Colonoscopy	97.87%	89.16%	97.35%	98.61%	95.93%	98%	98%	95.24%	96.76%	90.71%	88.11%	84.62%	94.81%
Flexi Sigmoidoscopy	95%	97%	96.97%	97.62%	95.56%	97%	100%	90.91%	97.67%	90.00%	93.10%	89.66%	92.86%
Cystoscopy	100.00%	96.30%	100%	100.00%	100%	100%	100%	94.74%	100.00%	90.91%	92.31%	95.65%	93.55%
Gastroscopy	94.87%	95.19%	97.41%	98.20%	92.38%	99%	100%	95.00%	95.35%	92.52%	88.46%	88.79%	96.83%

Readmissions & Stranded Patients

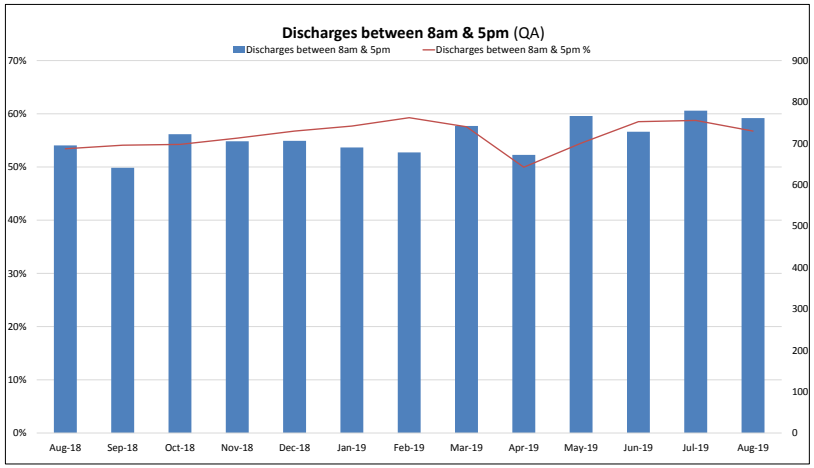


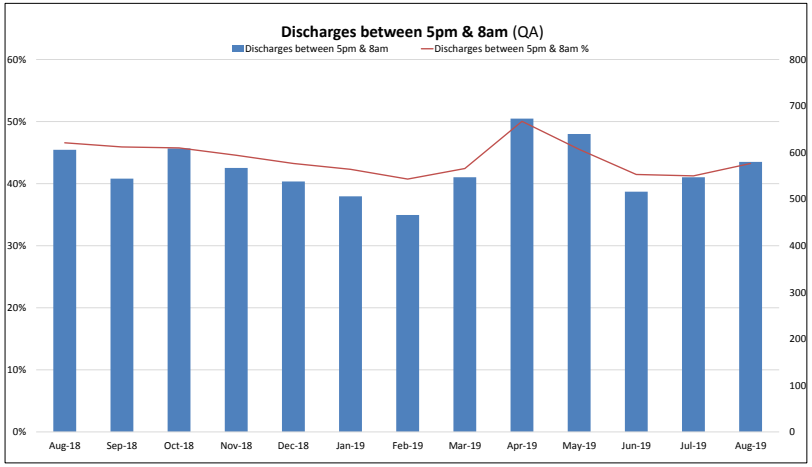


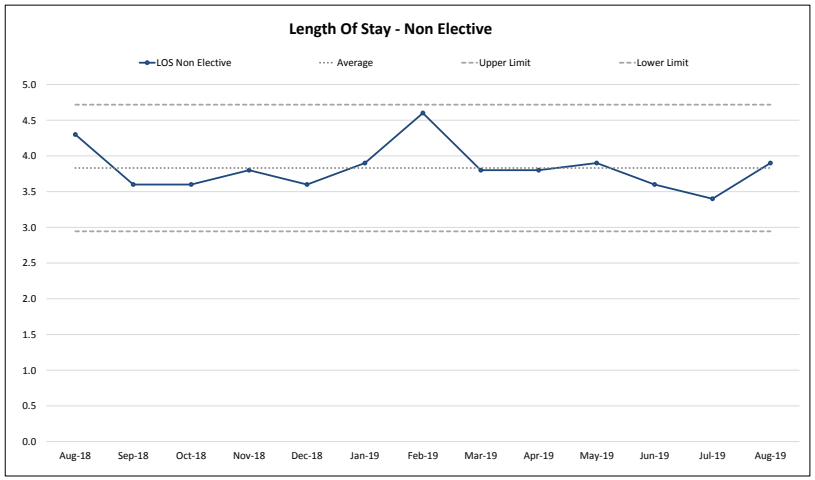


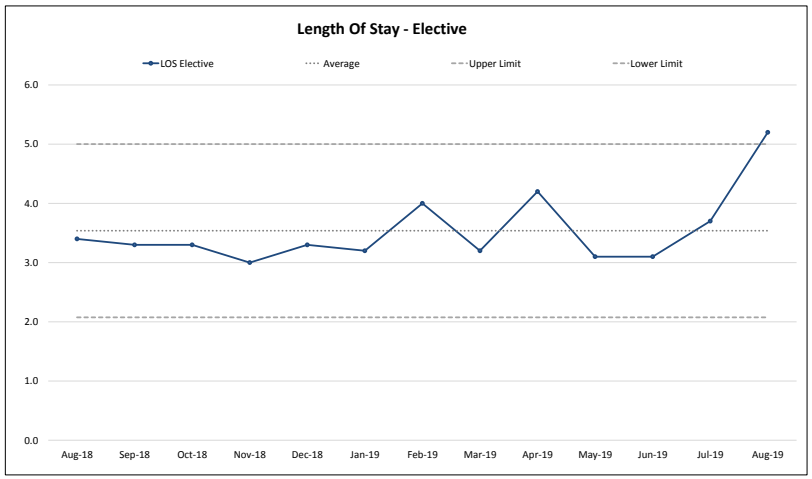


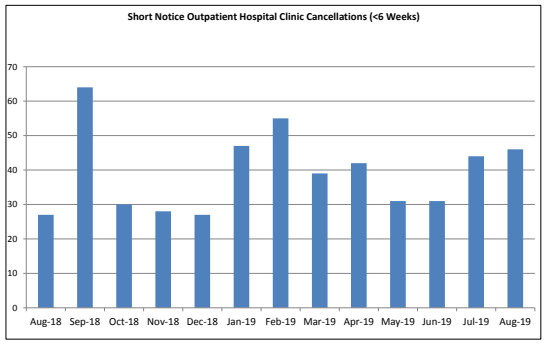
Discharges & LOS

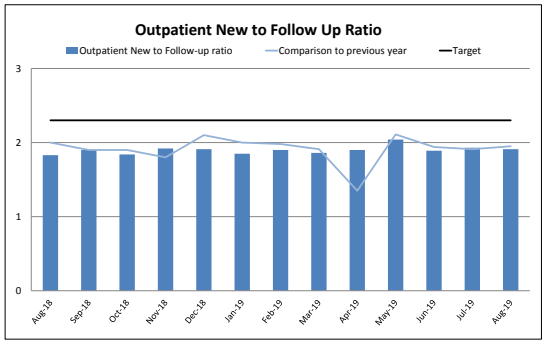


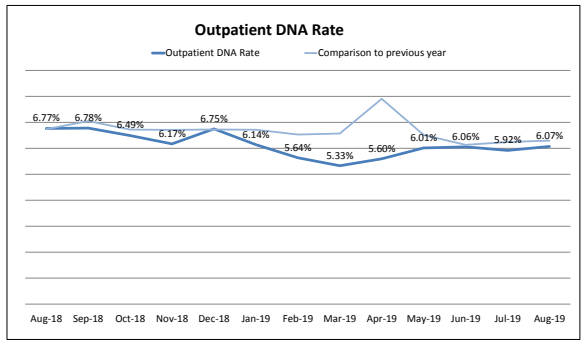


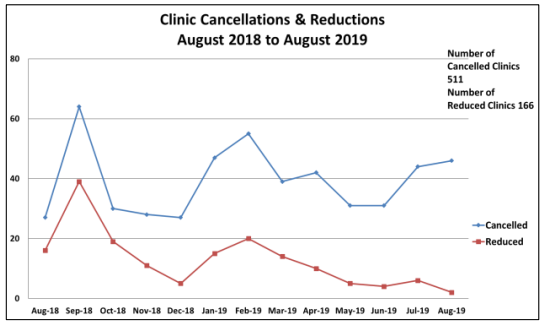


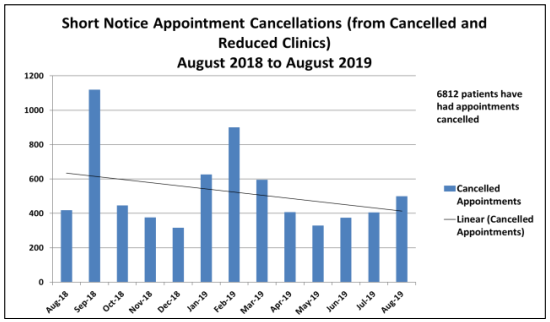


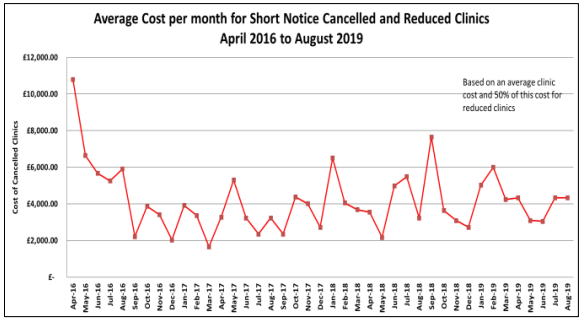












DNA Rate for Follow Up Appointments per Specialty for August

Specialty & Performing Unit	Anaesthetics	Anticoagulant Service	Breast Surgery	Cardiology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Gynaecology	Haematology	Medical Oncology	Medicine for the Elderly	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Baby	Total
DNA Rate	0.00%	11.76%	6.69%	7.13%	6.38%	1.20%	1.67%	4.28%	5.79%	4.92%	10.71%	2.29%	6.60%	9.84%	0.00%	4.89%	3.59%	5.01%	1.13%	100.00%	0.00%	2.54%	5.04%	7.41%	3.85%	6.61%	5.36%	22.73%	8.25%	9.51%	3.37%	4.73%	10.56%	5.86%	10.26%	3.60%	5.69%

Cancelled Operations	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Cancelled Operations for Non Clinical reasons	17	21	14	8	29	43	39	24	14	22	TBC	TBC	TBC
Cancelled Operations - breach of 28 day standard	0	1	2	0	0	3	0	1	1	0	TBC	TBC	TBC
Urgent operations cancelled (Non Medical)	0	0	1	0	0	0	0	0	0	0	0	0	1
Urgent operations cancelled for a second or more time (Non medical)	0	0	0	0	0	0	0	0	0	0	0	0	0

Executive Summary Our People

NHS
The Princess Alexandra Hospital
NHS Trust

Trust vacancy rate in August is 12.05% which is a reduction of 1.45%. In August there was a decrease in Nursing vacancies from 25% in April to 21.8% in August. Band 5 vacancies have reduced from 41% in April to 32.8% in August; this reduction in month is attributed to the overseas recruitment campaign. A campaign to recruitment international medical staff has been implemented with offers being made to a number staff that are expected to start in the coming months.

Sickness rates for August 2019 are slightly above the trust Target of 3.9% by 0.2%.

Non-Medical Appraisal rates have reduced by 3% below the trust target of 90%. Managers in the HCG are being reminded of the need to forward-plan and ensure appraisals are booked and taking place in advance of the appraisal being required, thus ensuring individual compliance does not drop.

Workforce Indicators Summary

Agency Spend 4.74%
Bank Spend 12.63%

Staff In Post
3156
WTE

Training
93%

Sickness
3.6%

12.1%

Turnover
12%

Medical 100%
Non-Medical 87%

Scorecard

People Measures as at 31st August 2019	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3614.98	876.41	466.25	891.01	760.75	279.18	130.75	54.68	155.95
Vacancy Rate	8.0%	12.05%	6.04%	9.14%	17.31%	17.39%	9.70%	0.00%	10.99%	16.15%
Agency % of paybill	7.0%	4.7%	2.7%	3.8%	5.6%	7.0%	0.0%	0.0%	0.0%	0.0%
Bank Usage - wte	n/a	343.00	42.33	35.51	162.35	59.75	18.47	9.04	5.00	10.98
Agency Usage -wte	n/a	130.40	18.67	8.07	62.42	35.39	0.00	5.85	0.00	0.00
Previous Month Sickness Absence	3.7%	3.9%	3.4%	4.1%	4.5%	3.0%	7.4%	2.7%	2.1%	2.1%
Long Term Sickness	1.85%	1.9%	1.6%	2.1%	1.9%	1.5%	4.2%	1.4%	1.7%	0.7%
Short Term Sickness	1.85%	2.0%	1.8%	2.0%	2.6%	1.5%	3.2%	1.3%	0.4%	1.4%
Rolling Turnover (voluntary)	12%	11.7%	11.3%	13.2%	12.4%	10.9%	10.3%	11.7%	14.8%	11.8%
Statutory & Mandatory Training	90%	93%	97%	88%	90%	90%	96%	97%	97%	97%
Appraisal	90%	87%	91%	75%	89%	85%	90%	91%	94%	80%
FFT (care of treatment) Q1	70%	76%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FFT (place to work) Q1	61%	65%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Starters (wte)		127.59	19.00	12.00	49.93	37.67	0.00	3.00	3.00	3.00
Leavers (wte)		29.15	4.95	2.72	6.88	10.00	4.60	0.00	0.00	0.00
Time to hire (Advert to formal offer made)	31Days	43	45	53	70	37	n/a	33	n/a	n/a

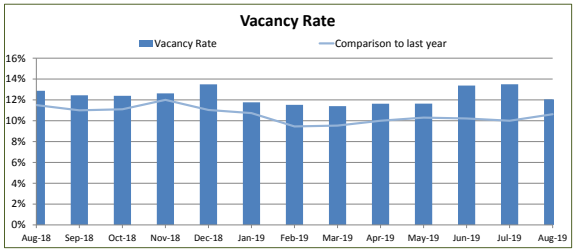
Above target	
Improvement from last month/above or below target	
Underachieving target	

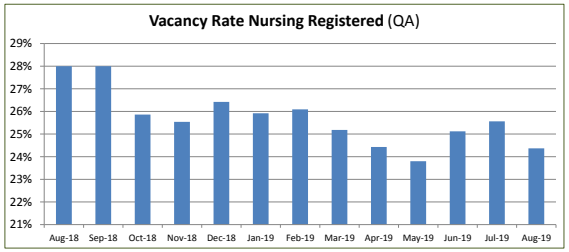
Workforce Indicators

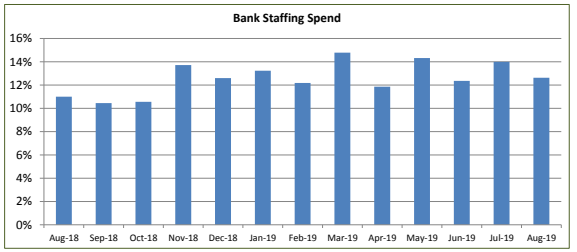
3 Our People Summary

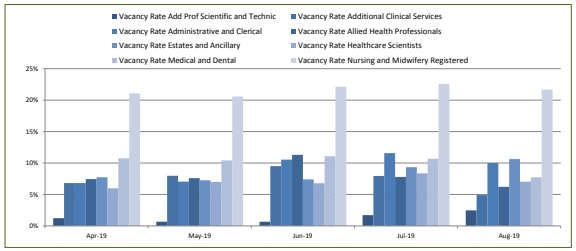
3.3 Well Led

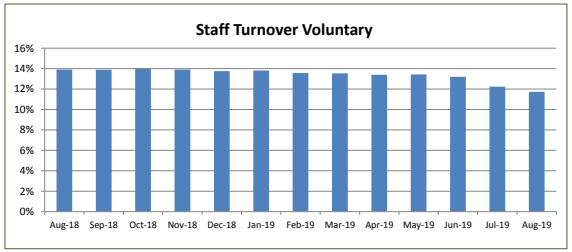
The Princess Alexandra Hospital NHS Trust

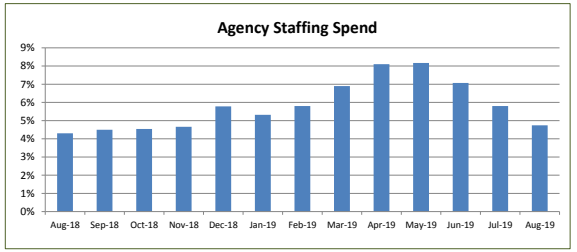


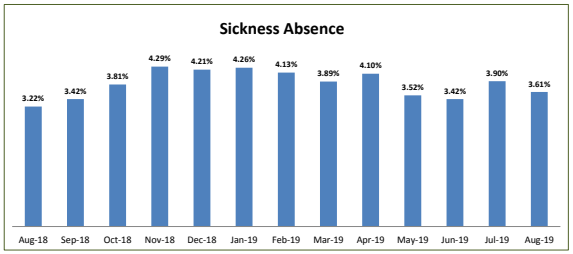


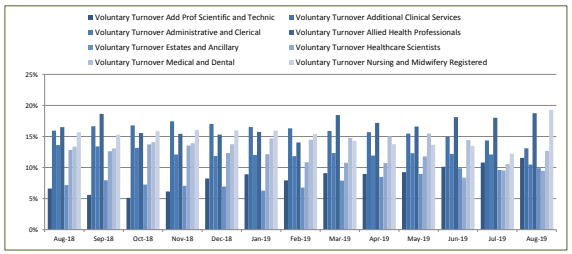


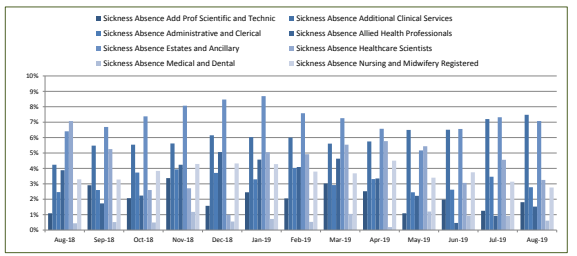










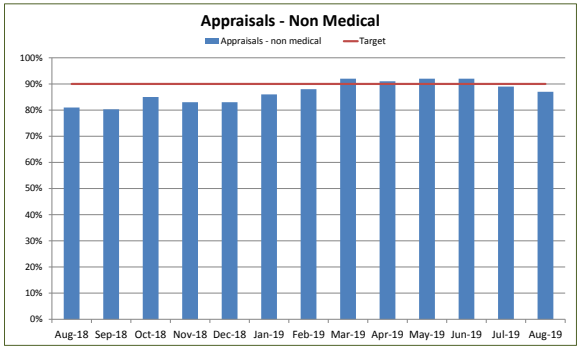


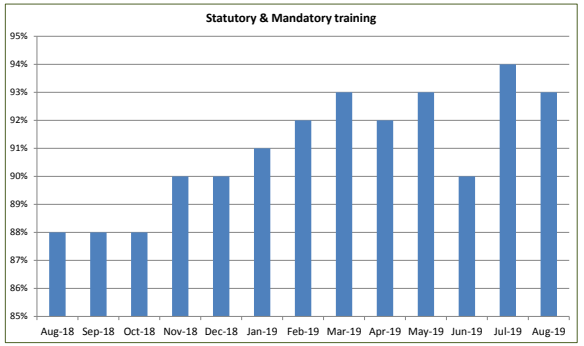
3 Our People Summary

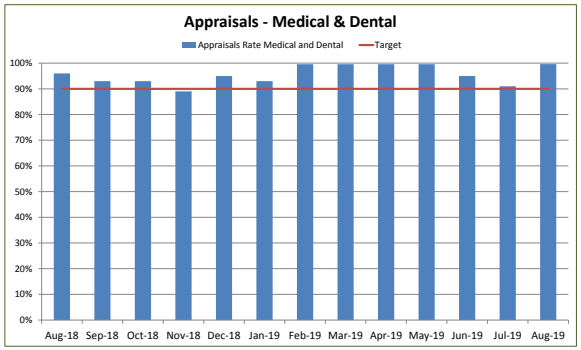
3.4 Well Led

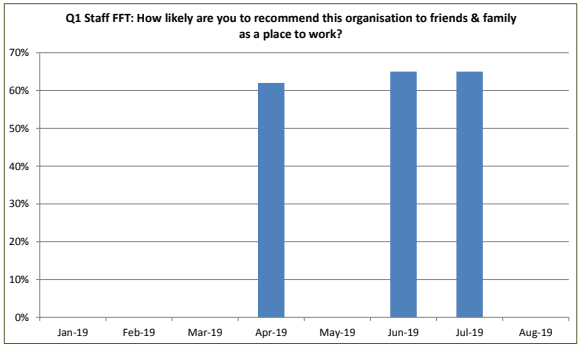
The Princess Alexandra Hospital NHS Trust

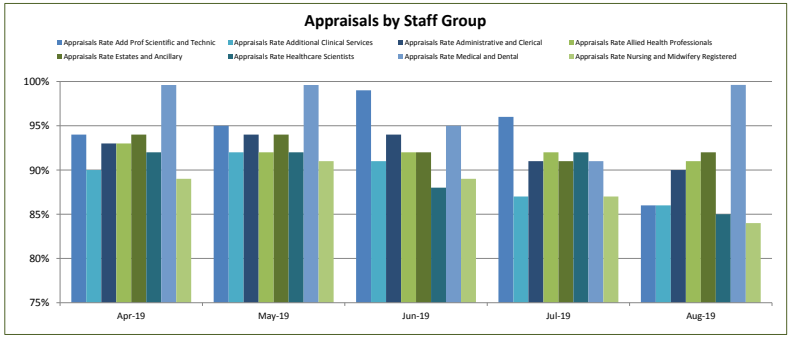
Workforce Indicators

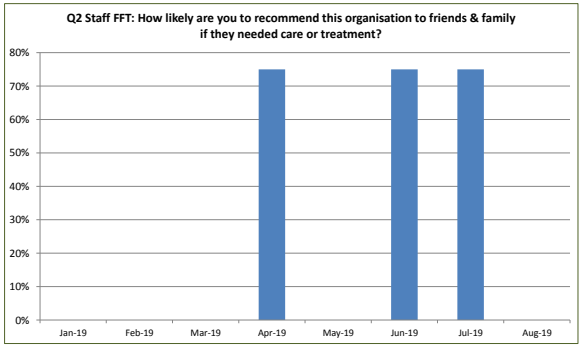












Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Domestic Services – Both the very high risk and the high risk areas achieved the national standards of cleanliness. The modernisation of the domestic services has commenced with sub groups now set up for the different aspects of the modernisation, e.g. equipment & consumable. The Facilities Compliance manager has been tasked with ensuring all audits are carried out and any required actions are taken in a timely manner.

Catering Services – Due to more precise food waste process being implemented the food waste has shown a dramatic increase. Both the catering team and the domestic team are working closely with the ward staff to educate them on the process of ordering for the patient meals. An increase in meals per day of 8.6% over the previous month.

Capital Services – Future Investment: The outline programme for 2019/20 is still to be finalised with the Executive Team. Planning is underway for the continued development of the investment business cases for a new urgently needed Medical Assessment Unit. Scheme will be delivered to RIBA level 2 for Board submission and prior to formal submission to the STP as part of wider regional bid for capital investment schemes c9.5M.
Fracture Clinic - Completion due Jun 2020: Main building contractor have taken full possession of the contracted site area now and the temporary diverted lit and signed walkway in place around the build site with full revised closure.
Full intrusive surveys have been undertaken on build site drainage, asbestos and services validations.
Asbestos removal completed and now into demolition phase until end of Sept 19.

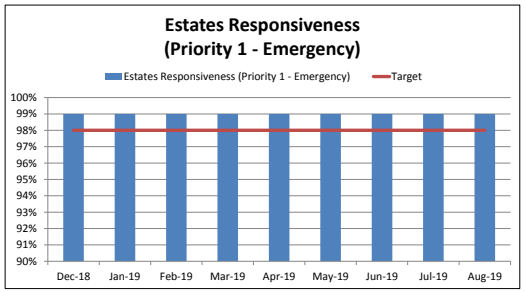
Mandatory Training and Appraisals – In July EFM achieved 95% on Stat man training, the main area of concern is Fire (87%) and IG (71%), these have been highlighted to the managers who have been concentrating on getting these up to the Trust target of 90%. Appraisals slipped to 91% with the 2 main areas of non-compliance being Catering (71%), Portering 85% and the Restaurant at 86%. The managers have been tasked with ensuring all staff who require the appraisals in line with the Trust policy are completed and that they reach at least 95% compliance.

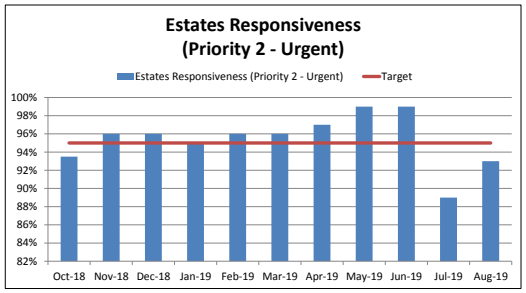
Places

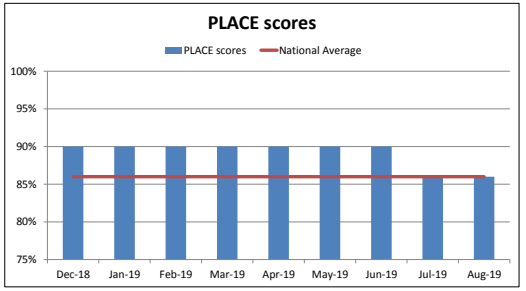
4 Our Places Summary

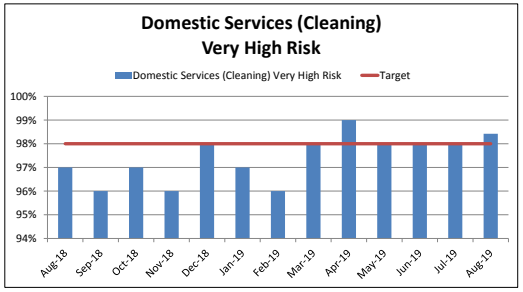
4.1 Cleanliness & Catering

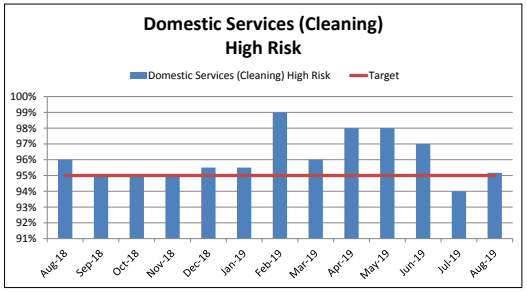
The Princess Alexandra Hospital NHS Trust

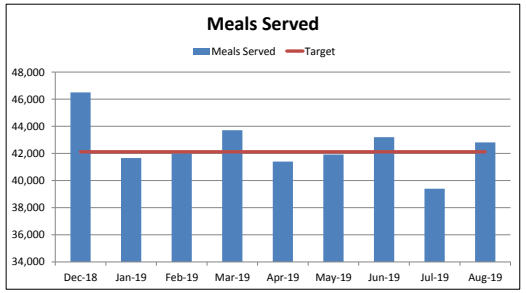


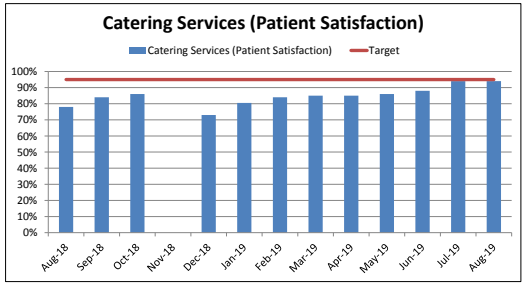


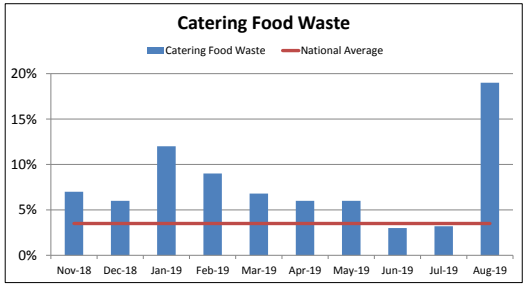












Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

The Trust has a £15.2m deficit, £3.1m behind plan. This is an improvement on previous months results mainly due to reduced temporary staff costs (£2.5m vs £3.1m in M4). The Trust is in the process of finalising its recovery plan to further improve future results.

The key risks to delivery of financial plan are:-

a) Commissioner QIPP - original £2m of QIPP outside of CCG contracts.
b) Assessment Space & Front door pricing challenges
c) Recruitment costs, with increase in cost base including international nursing
d) Transformation schemes
e) CIP delivery including over delivery to recover financial position
f) Containing temporary staff costs
g) Additional revenue costs associated with additional capacity / birth rate plus
h) Activity under-performance, with HCG on weekly activity reporting
i) Under-recovery of CQUIN

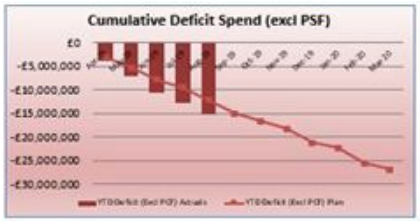
Pounds

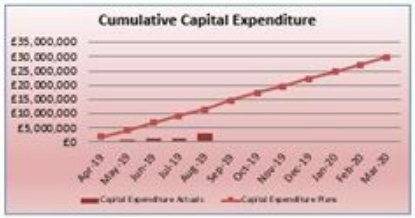
5 Our Pounds Summary

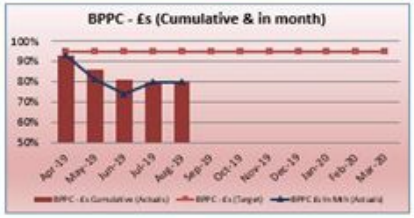
5.1 Overall financial position

The Princess Alexandra Hospital NHS Trust

OUR POUNDS		
Metric	Annual Plan (Standard)	Latest Month
YTD Deficit (Excl. PSF)	-£26,942,000	-£15,246,428
Cumulative Agency Spend £s	-£10,292,000	-£5,202,705
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	7%
Cumulative Capital Expenditure	-£29,714,000	-£3,154,000
BPPC Volume	95%	87%
BPPC - £s	95%	80%
Cash Balance	£1,000,000	£1,810,000







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Commissioning for Quality and Innovation

2019/20 CQUIN Forecast

	Scheme	Target	Current Trajectory					Max FY Value
			Q1 Act	Q2	Q3	Q4	FY	
CCG1a	Antimicrobial Resistance - Lower Urinary Tract Infections in Older People	90%	61%	70%	80%	90%	75%	244,128
CCG1b	Antimicrobial Resistance - Antibiotic Prophylaxis in Colorectal Surgery	90%	0%	0%	65%	90%	39%	244,128
CCG2	Staff Flu Vaccines	80%				80%	80%	488,257
CCG3a	Alcohol and Tobacco - Screening	80%	100%	90%	90%	90%	93%	162,752
CCG3b	Alcohol and Tobacco - Tobacco Brief Advice	90%	68%	85%	90%	90%	83%	162,752
CCG3c	Alcohol and Tobacco - Alcohol Brief Advice	90%	52%	65%	80%	90%	72%	162,752
CCG7	Three High Impact actions to Prevent Hospital Falls	80%	25%	26%	80%	80%	53%	488,257
CCG11a	SDEC - Pulmonary Embolus	75%	66%	75%	75%	75%	73%	162,752
CCG11b	SDEC - Tachycardia with Atrial Fibrillation	75%	80%	75%	75%	75%	76%	162,752
CCG11c	SDEC - Community Acquired Pneumonia	75%	93%	75%	75%	75%	80%	162,752
								2,441,283

Q1 CQUIN performance totalled c52% with good performance on the SEDC and Alcohol/Tobacco screen schemes. The work to date in implementing the schemes should result in improved performance from quarter 2, with most schemes delivering the target measures from Q3.
The current trajectory reaches a forecast of c70% for the full year. Focus is being put on The Anti-microbial Resistance and Falls schemes (CCG1, CCG7) to improve performance.

CQUIN

QIP

NHS
The Princess Alexandra Hospital
NHS Trust

Governance process for Quality Improvement

Introduction
The Trust will be using our tried and tested Quality Improvement methodology to enable a consistent and sustained approach to the achievement and maintenance of compliance with regulatory and quality standards.

Informing our Regulators, our staff and the public
The high level Improvement plan (detailing our aims for each of these projects) is to be agreed by the executive lead and senior responsible officer (SRO) by 20/8/19.
The SRO will appoint a project team to undertake the actions to achieve the desired outcomes. The focus will be to describe what success will look like and begin to identify the first step trajectories for achievement.
The project team will include representation from staff in Informatics, Quality Improvement, HCG PSQ teams and other interested parties.
Staff identified to lead a project or an action will be offered support through attendance at existing learning and development sessions; leading change and leading projects, planning to be completed during September 2019.
There will be 2 specific approaches to addressing the recommendations from CQC;
Where there are clear and straightforward actions identified to ensure compliance. The SRO will lead the development of an action plan with SMART objectives and key performance indicators (KPI).
Where the SRO and executive lead identify the need for an improvement project to comprise a dedicated team that will be responsible for exploring what success will look like, develop KPI's and milestones for achievement using the full quality improvement methodology..
The SRO will be responsible for ensuring that each project has a full suite of KPI's and milestone's identified. By 30 September 2019
The improvement plan will be a dynamic document requiring regular updating and this will be done on a quarterly basis.

Informing our Regulators, our staff and the public
The high level Improvement plan is to be submitted to the CQC by 30 August.
At this time the plan will be uploaded onto the Trust website.
The improvement plan will be shared at the Trust annual Event in A Tent in September 2019 and further sharing events will be planned.

Assurance monitoring
Reporting on the KPI's and achievement against agreed milestones will commence from the **end of October 2019.**
This will be through the Trust Quality Compliance Improvement Group (QCIG), chaired by the Executive Nurse Director and meetings are scheduled on a monthly basis. The Trust Board will have oversight through reports submitted to the Quality and Safety Committee, a sub-committee of the Trust Board.

Other activities.
Two other initiatives have been launched to oversee the achievement of improvements and to identify any other areas with variable compliance that will require improvement.

Peer Review Compliance Inspections
On 31 July 2019 we relaunched a schedule of clinically led peer inspections overseen by Associate Directors of Nursing and their senior leadership teams. Everyone is invited to participate. The schedule of audits associated with best practice standards are in the form of peer reviews. The aim is to develop a culture of "fresh eyes" with the responsibility and authority to lead the inspections sitting with the health group triumvirates.
A schedule of dates for inspections has been created and these will take place every month. In terms of attending one of the monthly inspections; all staff and partner organisations are invited. Each month the Trust will endeavour to inspect 3 or 4 areas depending upon attendance.
Findings will be reviewed by the relevant Health care Group and reported through the monthly Quality Compliance Improvement Group.

Bi annual Provider Information data collection commencing September 2019.
During the CQC PIR process leading up to our most recent CQC inspection we identified areas where improvements would be beneficial. To ensure a consistent, business as usual approach to the collation and presentation of our data, Health Care Groups and Corporate functions will populate a generic PIR template twice per year.
HCG's and Corporate services will interrogate the data to identify any gaps in evidence that require addressing. They will then be able to provide assurance to the Executive team; reporting variation by exception in the PRM.
In the longer term this consistent approach to gathering and collating evidence will support the Trust in preparing for future CQC RPIRs.

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Source: Sheila O'Sullivan

	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST		
ADoQ - Asociate Director of Quality ADoTED - Associate Director of Training, Education and Development CMO - Chief Medical Officer COO - Chief Operating Officer DCMO - Deputy Chief Medical Officer DoN - Director of Nursing	DDoN - Deputy Director of Nursing DoP - Director of People DoS&E - Director of Strategy and Estates EoL - End of Life Group HoCN - Head of Childrens Nursing HoM - Head of Midwifery HoIPC - Head of Infection Prevention and Control	HS&GM - Health Safety and Governance Manager MIB - Mortality Improvement Board NUM - Neonatal Unit Manager SHoPS&F - Strategic Head of Property Services and Development UCB - Urgent Care Board	

CQC INSPECTION March 2019: QUALITY IMPROVEMENT PLAN JULY 2019 (DRAFT)

MUST Recommendations

Theme	Must / Should No	KLOE	Trust wide	CQC Recommendation	Theme	Lead / Executive lead	Desired Outcome	Milestones towards achievement	BRAG
Governance	M1	Safe	Trust wide	The Trust must ensure that structures and processes for governance are fully embedded at all levels throughout the Trust to enable timely response to risk and safety issues	Governance (structure)	ADoQ / DoN			
	M6	Safe	Medical care (including older people's care)	The service must ensure that systems and processes to identify risk at ward level are embedded.	Governance (structure)	ADoQ / DoN			
	M11	Responsive	Surgery	The service must ensure that actions to protect patient safety are put in place in a timely manner	Governance (structure)	ADoQ / DoN			
	M14	Effective	Surgery	The service must ensure that policies are reviewed in a timely manner and that they are shared with staff	Governance (policies / clinical effectiveness)	ADoQ / CMO			
	M21	Safe	Maternity	The service must ensure all incidents are reviewed in a timely way to promote learning and service improvement	Governance (structure)	ADoQ / DoN			
	M22	Well Led	Maternity	The service must ensure risk registers accurately reflect the risks identified, are updated in a timely way and risks are closed appropriately once all actions are completed	Governance (risk management)	ADoQ / CMO			
	S3	Effective	Medical care (including older people's care	The service should monitor national audits and use the results to improve outcomes for patients	Governance (audits / Clinical effectiveness)	ADoQ / CMO			
	S4	Effective	Surgery	The service should consider revising the consenting of patients on the day of surgery in line with best practice	Governance (Clinical effectiveness - Consent / audit)	ADoQ / CMO			
	S12	Well led	Maternity	The trust should ensure managers use effective change management processes to facilitate required improvements in a timely way	Governance (structue / QI)	HoM / DoN (DoQI)			
	S13	Well led	Maternity	The trust should ensure detailed minutes of meetings are recorded to accurately reflect discussions, actions and responsibilities	Governance (structure)	HoM / DoN			

Documentation	**M2**	**Safe**	**Urgent and emergency services**	The service must ensure that staff keep detailed records of patient care and treatment	Documentation	DDoN / DCMO / DoN			
	M7	**Responsive**	**Medical care (including older people's care)**	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient falls and pressure ulcers	Documentation	DDoN / DCMO / DoN			
	M15	**Safe**	**Maternity**	The service must ensure staff accurately complete women's care records with all necessary assessments required to safely monitor mothers and their babies	Documentation	DDoN / DCMO / DoN			
	S16	**Safe**	**Services for children and young people**	The service should ensure discharge summaries are sent to GPs within 72 hours of discharge	Documentation	DDoN / DCMO / CMO			
Training	**M3**	**Safe**	**Urgent and emergency services**	The service must ensure that medical staff training meets the compliance target of 90%.	Mandatory training	ADoTED / DoP			
	M9	**Safe**	**Medical care (including older people's care)**	The service must ensure that medical staff training meets the trust compliance target of 90%.	Mandatory training	ADoTED / DoP			
	M19	**Safe**	**Maternity**	The service must ensure staff compliance with basic life support training meets the trust's compliance target of 90%.	Mandatory training	ADoTED / DoP			
	M23	**Safe**	**Maternity**	The service must ensure that staff complete mandatory training to meet the trust's compliance target	Mandatory training	ADoTED / DoP			
	S2	**Safe**	**Medical care (including older people's care**	The service should ensure all staff complete safeguarding training in line with national guidance	Mandatory training	ADoTED / DoP			
	S14	**Safe**	**Services for children and young people**	The service should continue to ensure staff complete safeguarding training, in line with national guidance	Mandatory training	ADoTED / DoP			
	S15	**Safe**	**Services for children and young people**	The service should ensure there is a nurse trained in advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on every shift, in line with guidelines from the Royal College of Nursing	Training	ADoTED / DoP			
Nurse Vacancy	**M4**	**Safe**	**Urgent and emergency services**	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment	Nursing vacancy	DDoN / DoN			
	M5	**Safe**	**Medical care (including older people's care)**	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment	Nursing vacancy	DDoN / DoN			
	M12	**Safe**	**Surgery**	The service must continue to monitor and actively recruit to ensure staffing with the appropriate skill mix is in line with national guidance	Nursing vacancy	DDoN / DoN			

Maternity Action Plan	**M16**	**Safe**	**Maternity**	The service must ensure staff complete foetal growth charts at each appointment	Maternity Action plan	HoM / DoN			
	M17	**Safe**	**Maternity**	The service must ensure staff complete and annotate cardiotocograph traces in line with national guidance	Maternity Action plan	HoM / DoN			
	M18	**Effective**	**Maternity**	The service must ensure policy and guidance documents are reviewed in a timely way and reflect current working practices to enable staff to be able to give women the most up to date information	Maternity Action plan	HoM / DoN			
	S9	**Safe**	**Maternity**	The trust should ensure senior midwives and consultants participate in skill simulation training.	Maternity Action plan	HoM / DoN			
Estates	**M8**	**Safe**	**Medical care (including older people's care)**	The service must ensure broken crockery and glass is safely disposed of on all wards.	Estates	SHoPS&F/DoS&E			
	S8	**Safe**	**Maternity**	The trust should ensure that electrical equipment is up-to-date with safety testing	Estates	SHoPS&F/DoS&E			
H&S	**M10**	**Safe**	**Medical care (including older people's care)**	The service must ensure that hazardous chemicals are kept in a locked cupboard.	H&S	HS&GM / COO			
	M20	**Safe**	**Maternity**	The service must ensure medicines and hazardous substances are stored securely.	H&S	HS&GM / COO			
MIB	**M13**	**Safe**	**Surgery**	The service must ensure that assessments are updated in patient records and that there is oversight of NEWS2 observation timeliness for deteriorating patients.	MIB	MIB			
Urgent Care	**S1**	**Responsive**	**Urgent and emergency services**	The trust should ensure that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department	UCB	COO			
Infection Control	**S5**	**Safe**	**Maternity**	The service should ensure there is an arrangement in place for a dirty utility in the antenatal clinic	Infection Control	HoIPC / DoN			
	S6	**Safe**	**Maternity**	The trust should ensure staff circulating in theatres wear personal protective equipment in line with national guidance to prevent health care associated infections	Infection Control	HoIPC / DoN			
	S7	**Safe**	**Maternity**	The trust should ensure reusable equipment is cleaned appropriately after its use	Infection Control	HoIPC / DoN			

Workforce	**S10**	**Effective**	**Maternity**	The trust should ensure maternity services have access to designated maternity physiotherapy practitioners	Workforce	HoM / DoP			
	S18	**Effective**	**Services for children and young people**	The service should improve access to allied health professionals, specifically in the Neonatal Intensive Care Unit	Workforce	NUM/DoP			
Strategy	**S11**	**Well led**	**Maternity**	The trust should ensure improved sustainability and transformation partnership working in maternity services	Strategy	HoM/DoS			
CYP	**S17**	**Responsive**	**Services for children and young people**	The service should continue to improve transitional arrangements for young people moving to adult services	CYP	HoC / DoN			
EoL	**S19**	**Effective**	**End of life care**	The trust should continue to work towards providing a seven-day face to face service to support the care of patients at the end of life	EoL	EoL			

The Princess Alexandra Hospital NHS Trust

Trust Board – 03.10.19

7.2

Agenda item:	7.2
Presented by:	Stephanie Lawton – Chief Operating Officer / Accountable Emergency Officer Chris Allen – Emergency Planning and Resilience Manager / Prevent Lead
Prepared by:	Chris Allen – Emergency Planning and Resilience Manager / Prevent Lead
Date prepared:	19th September 2019
Subject / title:	Emergency Planning, Resilience and Response (EPRR) Annual Report and Assurance

Purpose:	Approval	X	Decision		Information		Assurance	X

Key issues:	As an organisation the Trust scored substantially compliant for this year's NHS England and Improvement Core Standards Assurance. This is based on 64 core standards (compared to 72 standards in the previous year), of which the Trust is fully compliant in 62 of the core standards, and partially compliant in 2 of the core standards. The Trust was also fully compliant with 16 and partially compliant with 4 of the unscored deep dive questions.
Recommendations:	i. That the Trust Board is **ASSURED** as to the work undertaken with regard to Emergency Preparedness. ii. To **APPROVE** the Annual EPRR Core Standards Assurance return.

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

Previously considered by:	NHS England and Improvement / Mid Essex CCG Confirm and Challenge Meeting – 5th September 2019 PAF.26.09.19
Risk / links with the BAF:	BAF 2.2 BAF 3.1 BAF 4.1
Legislation, regulatory, equality, diversity and dignity implications:	Civil Contingencies Act 2004 Health and Social Care Act 2012 NHS England EPRR Core Standards NHS England EPRR Framework 2015 NHS Standard Contract
Appendices:	Core Standards for EPRR Return

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1.0 Purpose/issue

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2013 and on its annual core standards assurance return to NHS England.

2.0 Background

i. The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into two categories, imposing a different set of duties on each. Category 1 responders are those organisations at the core of the response to most emergencies, and are subject to the full set of civil protection duties. Category 2 responders have a lesser set of duties and are required to co-operate and share relevant information with other Category 1 and 2 responders.

ii. The Trust is a Category 1 responder, and as such the Trust is subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- cooperate with other local responders to enhance co-ordination and efficiency

iii. To ensure compliance of provider and commissioner organisations, NHS England and Improvement undertake a yearly Core Standards Assurance process, which is approved by the board of the relevant organisation.

3.0 Analysis

3.1 As an organisation the Trust scored substantially compliant for this years NHS England and Improvement Core Standards Assurance.This is based on 64 core standards (compared to 72 standards in the previous year), of which the Trust is fully compliant in 62 of the core standards, and partially compliant in 2 of the core standards.

3.2 Where we have scored partially compliant and actions plans have been developed to obtain full compliance, with these plans monitored via the Local Health Resilience Partnership.

3.3 There were no standards showing as non-compliant.

3.4 In addition to the core standards, on which the Trust overall assessment score is based, there were a further 20 Deep Dive questions related to Severe Weather Response and Long Term Adaption Planning. The Trust was fully compliant with 16 and partially compliant with 4 of the unscored deep dive questions.

3.5 The EPRR Core Standards document defines compliance levels as:

i. Non-Compliant - Not compliant with core standard and not in the EPRR work plan within the next 12 months.
ii. Partial Compliance - Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.
iii. Fully Compliant - Fully compliant with core standard.

3.6 It should be noted that the question sets change yearly within the Core Standards, and therefore there is not the opportunity to compare compliance with previous years.

4.0 Areas of partial compliance

4.1 Core Standard 37 – *Warning and informing – Communication with partners and stakeholders*

Whilst there are arrangements in place, there is a specific requirement for "Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response". This is not currently in place, but will be included in the next iteration of the social media policy by end of Q3 2019/2020.

4.2 Core Standard 51 – *Business Continuity – Business Continuity Plans*

When the confirm and challenge meeting was undertaken, the representatives from NHS England and Improvement were confident with the Business Continuity Arrangements but requested that the version control was updated yearly on the policy to evidence the yearly review. This has been discussed with the Director of Nursing for Surgery in their capacity as Chair of the Trust Policy Group, and a process has been agreed to enable these updates to be made yearly. This will be enacted by the end of Q3 2019/2020.

4.3 Once these 2 areas of partial compliance have been addressed the Trust will move to full compliance status.

4.4 Within the deep dive section, there were 4 areas of partial compliance (Reference 16, 18, 19, 20) related to long term adaptation planning. All of these areas are currently under review by the Environment and Sustainability Officer, and these areas will be reviewed at the Environment and Sustainability Steering Group, of which the Emergency Planning and Resilience Manager is a member.

5.0 Benchmarking

5.1 The Core Standard report was reviewed along side the other Acute Trust's in Essex as part of a Confirm and Challenge meeting, chaired by NHS England and Improvement, and attended by the Lead CCG for Essex, and the Acute Trusts.

5.2 The review showed that all of the Acute Trusts in Essex received a Substantially Compliant rating, with similar areas of work required, and involved reviews of both the Core Standard Returns and Evidence Packs to ensure that there was equity applied to the self scoring.

6.0 Forward Look

6.1 The key focus for the coming months will be the management of winter pressure within the organisations, and the management of any impacts that may be experienced for the departure of the United Kingdom from the European Union. Along side these work streams there is an ongoing programme of training, education and exercising to ensure that the Trust remains in a position to respond to any emergencies that may occur.

The Princess Alexandra Hospital NHS Trust

7.0 Recommendations

i. That the Trust Board is **ASSURED** as to the work undertaken with regard to Emergency Preparedness.
ii. To **APPROVE** the Annual EPRR Core Standards Assurance return.
iii. .

Author: Christopher Allen – Emergency Planning and Resilience Manager
Date: 19th September 2019

Please select type of organisation: **Acute Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	2	1	0
Cooperation	4	4	0	0
Business Continuity	9	8	1	0
CBRN	14	14	0	0
Total	64	62	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	1	4	0
Total	20	16	4	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Stephanie Lawton - Chief Operating Officer	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Major and Critical Incident Plan	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Annual Report and Core Standards to Board	Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Work programme	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Major and Critical Incident Plan	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	EPRR Debriefing SOP	Fully compliant				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Risk Register and Risk Management Group	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Register and Risk Management Group	Fully compliant				
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Work with internal and external partners when planning	Fully compliant				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major and Critical Incident Plan	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major and Critical Incident Plan	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave plan	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold weather plan	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Pandemic influenza plan	Fully compliant				
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Infection Control and Outbreak Plans	Fully compliant				

17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Antibiotic Collection Centre Plans in place for management of mass countermeasures which can be dynamically adjusted as required	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major and Critical Incident Plan includes Mass casualty plans	Fully compliant				
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Unknown patient process in place within ED	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation Plan	Fully compliant				
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Plan	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Highprofile patient plan	Fully compliant				
23	Duty to maintain plans	Excess death planning	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Work along side ERF partners to ensure planning in line with national and local requirements	Fully compliant				
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	On call maintained 24/7	Fully compliant				
25	Command and control	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	On call training and exercising, all Golds undertaking MAGIC	Fully compliant				
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Training evidence maintained	Fully compliant				
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Range of exercises undertaken, as per schedule	Fully compliant				
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation.	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Training evidence maintained	Fully compliant				
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	ICC Plan	Fully compliant				
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Electronic copies on RD, hard copies in ICC	Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Business Continuity Policy and Plans	Fully compliant				

33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records	Loggists in place	Fully compliant				
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Sitrep process in place as evidenced by EU Exit response	Fully compliant				
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard cop	Copies in ED and electronically	Fully compliant				
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard cop	Copies in ED and electronically	Fully compliant				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Arrangements in place for management of communications including tracking information, specific communication plans in place for winter etc. All gold commanders have undertaken communications training. All current processes are under a full review by new Associate Director of Communications	Partially compliant	Social media polisy is currently under review, and will ensure that incident response use of personal social media accounts is included	Ass. Director of Communications	End Q3 2019/20	
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Arrangements in place for management of communications including tracking information, specific communication plans in place for winter etc. All gold commanders have undertaken communications training. All current processes are under a full review by new Associate Director of Communications	Fully compliant				
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Arrangements in place for management of communications including tracking information, specific communication plans in place for winter etc. All gold commanders have undertaken communications training. All current processes are under a full review by new Associate Director of Communications	Fully compliant				
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings	EP&RM holds full delegated authority when attending on behalf of AEO, letter provided to NHS England in 2018	Fully compliant				
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	EP&RM regularly attends LRF meetings	Fully compliant				
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Mutual aid agreements signed	Fully compliant				
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	ISP Signed by Trust	Fully compliant				
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitmement to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity Policy	Fully compliant				
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continuity Policy	Fully compliant				
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Business Continuity Policy	Fully compliant				
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	DPST	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity Policy and Plans	Partially compliant	To include yearly review date within the version control section as well as the 3 yearly review and put through policy group for approval.	EP&R Manager	End Q3 2019/20	
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Business Continuity Policy	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Business Continuity Policy	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	EPRR Debriefing SOP	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/suppler business continuity arrangements	Business Continuity Policy	Fully compliant				
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Information held within ED, ICC and On Call Packs	Fully compliant				

57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	CBRN/Hazmat Plan and Major and Critical Incident Plan	Fully compliant				
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste	Y	• Impact assessment of CBRN decontamination on other key facilities	CBRN/Hazmat Plan and Major and Critical Incident Plan	Fully compliant				
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Teams in place	Fully compliant				
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Inventory	Fully compliant				
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Inventory	Fully compliant				
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Checks in place	Fully compliant				
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	PPM in place with respirex	Fully compliant				
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	CBRN/Hazmat Plan and Major and Critical Incident Plan	Fully compliant				
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	Training records	Fully compliant				
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Training records	Fully compliant				
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Training records	Fully compliant				
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Training records	Fully compliant				
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		FFP3 in place	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant)** = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	Heatwave plan	Fully compliant				
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Heatwave plan	Fully compliant				
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	Cold weather plan Business Continuity Plans	Fully compliant				
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	Cold weather plan Business Continuity Plans	Fully compliant				
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Cold weather plan Business Continuity Plans	Fully compliant				
6	Severe Weather response	Access	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	E&F plans include third part gritting and snow clearence	Fully compliant				
7	Severe Weather response	Assessment	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	Cold weather plan Heatwave Plan	Fully compliant				
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	PPM In place for estate	Fully compliant				
9	Severe Weather response	Flood response	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	Trust engages fully with ERF All on call staff have access to ResilienceDirect	Fully compliant				
10	Severe Weather response	Warning and informi	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	Cold Weather Plan Heatwave Plan Winter plans	Fully compliant				
11	Severe Weather response	Flood response	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	Risks are assessed as required and recorded on risk registers, risk registers reviewed at Risk Management Group (Board Committee)	Fully compliant				
12	Severe Weather response	Risk assess	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Risks are assessed as required and recorded on risk registers, risk registers reviewed at Risk Management Group (Board Committee)	Fully compliant				

13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Procurement department business continuity arrangements	Fully compliant				
14	Severe Weather response	Exercising	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Yes, used live during heat wave 2019 with lessons identified	Fully compliant				
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	ICT BC exercise in 2019	Fully compliant				
Domain: long term adaptation planning											
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Sustanability strategy as part of STP including climate change, air pollution etc	Partially compliant	Risk register to be included on sustanability risk register.	Environment & Sustainability Steering Group	End Q3 2019/20	
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Recorded on risk registers	Fully compliant				
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Sustainability included as part of all new builds and all builds comply with HTM. Sustainability strategy as part of STP including climate change, air pollution etc	Partially compliant	Long term planning for adaptation is being included as part of the Trust Sustainability and Environment Plan	Environment & Sustainability Steering Group	End Q3 2019/20	
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Sustainability included as part of all new builds and all builds comply with HTM. Sustainability strategy as part of STP including climate change, air pollution etc	Partially compliant	Long term planning for adaptation is being included as part of the Trust Sustainability and Environment Plan	Environment & Sustainability Steering Group	End Q3 2019/20	
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	Sustainability included as part of all new builds and all builds comply with HTM. Sustainability strategy as part of STP including climate change, air pollution etc	Partially compliant	Long term planning for adaptation is being included as part of the Trust Sustainability and Environment Plan	Environment & Sustainability Steering Group	End Q3 2019/20	

Overall assessment:										
Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
37	Warning and informir	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Arrangements in place for management of communications including tracking information, specific communication plans in place for winter etc. All gold commanders have undertaken communications training. All current processes are under a full review by new Associate Director of Communications	Partially compliant	Social media polisy is currently under review, and will ensure that incident response use of personal social media accounts is included	Ass. Director of Communications	End Q3 2019/20	
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity Policy and Plans	Partially compliant	To include yearly review date within the version control section as well as the 3 yearly review and put through policy group for approval.	EP&R Manager	End Q3 2019/20	
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Sustanability strategy as part of STP including climate change, air pollution etc	Partially compliant	Risk register to be included on sustanability risk register.	Sustainability Group	End Q3 2019/20	
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Sustanability included as part of all new builds and all builds comply with HTM. Sustanability strategy as part of STP including climate change, air pollution etc	Partially compliant	Long term planning for adaptation is being included as part of the Trust Sustainability and Environment Plan	Sustainability Group	End Q3 2019/20	
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Sustanability included as part of all new builds and all builds comply with HTM. Sustanability strategy as part of STP including climate change, air pollution etc	Partially compliant	Long term planning for adaptation is being included as part of the Trust Sustainability and Environment Plan	Sustainability Group	End Q3 2019/20	
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	The organisation has relevant documentation that it is including adaptation plans for all new builds	Sustanability included as part of all new builds and all builds comply with HTM. Sustanability strategy as part of STP including climate change, air pollution etc	Partially compliant	Long term planning for adaptation is being included as part of the Trust Sustainability and Environment Plan	Sustainability Group	End Q3 2019/20	

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board - 3 October 2019

Agenda Item:	8.1
Presented by:	Chief Finance Officer – Trevor Smith
Prepared by:	Colin Forsyth - Head of Financial Services/ Heather Schultz - Head of Corporate Affairs
Date prepared:	19 September 2019
Subject / Title:	Governance Manual (bi-annual review)

Purpose:	Approval	x	Decision		Information		Assurance	

Key Issues:	The Governance Manual has been reviewed and is presented to Audit Committee prior to it being considered by the Trust Board on 3 October 2019. The main changes to the manual are: i. Reflecting changes in Director responsibilities ii. Strengthening approval limits on capital projects iii. Amendments to the thresholds required for quotations prior to expenditure commitments iv. The schedule of items where a purchase order is not required has been updated v. Job titles and names of regulatory bodies have been updated vi. Forms for declarations of interests/gifts and hospitality have been consolidated (from two forms to one) and all references to Counter fraud have been reviewed and updated.
Recommendation	Trust Board is asked to i) Approve the proposed changes and content of the Manual.

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

Previously considered by:	SMT, Audit Committee on26.09.19
Risk / links with the BAF:	The NHS code of governance requires NHS trusts to follow standing orders, SFIs and standards of business conduct that follow best practice
Legislation, regulatory, equality, diversity and dignity implications:	NHS code of conduct and accountability
Appendices:	Appendix 1 – Schedule of proposed updates Appendix 2 - Governance Manual

8.1

The Princess Alexandra Hospital NHS
NHS Trust

GOVERNANCE MANUAL REVIEW 2019

1.0 PURPOSE

The Trust's bi-annual review of the Governance Manual is due for completion by October 2019. The Audit Committee has reviewed and recommended the manual to the Board for approval.

2.0 CONTEXT

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

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

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

3.0 PROPOSED AMENDMENTS

The current version of the Governance Manual was adopted by the Trust in October 2017. It is not proposed to make any significant changes to the overarching governance framework; the proposed changes are reflected on the manual in tracked changes.

The key changes are summarised below:

- Tenders and Contracts (SFIs Section 16) – updated to remove references to paper based tenders; documents are now required to be received electronically.
- Quotation delegated limits (Scheme of Delegation Para. 5) – limits for obtaining quotes have been updated (**see appendix 1**)
- Authorisation of capital invoices/orders (Scheme of Delegation Para. 3c) – limits amended to more closely align to revenue sign-off limits to create consistency (**see appendix 1**)
- Textual updates to reflect both national regulatory frameworks and internal structural changes. This includes changes to the Provider Monitoring regime and structural Department of Health changes, as well as some changes to Trust directors' responsibilities (including estates and capital responsibilities).
- Updates to the schedule of items where a purchase order is not required Scheme of Delegation, section 5) e.g. losses payments, volunteer expenses.
- Job titles and names of regulatory bodies have been updated throughput the document.
- Forms for declarations of interests/gifts and hospitality have been consolidated (from two forms to one) and all references to Counter fraud have been reviewed and updated in the Standards of Business Conduct.

4.0 RECOMMENDATION

The Trust Board is asked to approve the Governance Manual.

Authors: Colin Forsyth, Head of Financial Services and Heather Schultz, Head of Corporate Affairs
Date: 19 September 2019

The Princess Alexandra Hospital NHS
NHS Trust

Appendix 1 - September 2019 Governance Manual schedule of updates

Current	Proposed
Quotation, Tendering & Contract Procedures: Quotes/Tenders should be obtained and opened/approved by (according to value) – revised limits, including that need three written quotations for goods/services over £5k	
i) Obtaining two minimum quotations for goods/services up to £7,499.	One quote required for goods/services under £500. Limit on two quotations reduced to £4,999
Obtaining three written quotations for goods/services from £7,500 - £24,999	Requirement for 3 quotes now applies for goods/services from £5,000 - £24,999.
ii) Obtaining written competitive tenders for goods/services over £25,000	No Change
Authorisation of Non Pay Capital Expenditure/Invoices/ Ordering/Payment of Goods & Services – Align limits to be more consistent across revenue and capital invoices/orders	
i) up to £74,999 - Capital Scheme Budget Holder ii) £75,000 to £149,999 - Capital Scheme Budget Holder together with Deputy Chief Financial Officer (Operational Finance) or Chief Financial Officer iii) £150,000 plus - Capital Scheme Budget Holder together with Deputy Chief Financial Officer (Operational Finance) with Chief Financial Officer or Chief Executive	i) invoices up to £19,999 - Level 4 (Heads of Service) and Capital Project Lead ii) invoices from £20,000 to £49,999 – as above and Level 3 (Associate/Deputy Directors) iii) invoices up to £50,000 to £99,999 – As above with Deputy Chief Financial Officer (Operational Finance) or Chief Financial Officer iv) invoices from £100,000 to £249,999 – as per revenue (Two Executive Directors, one of whom is the Chief Financial Officer) v) invoices from £250,000 to £999,999 – as per revenue (Chief Executive & Chief Financial Officer) vi) invoices over £1,000,000 – as per revenue (Agreement by Trust Board authorised by Chief Executive, Chief Financial Officer & Chairman)

The Princess Alexandra Hospital NHS Trust

Governance Manual
Contents

1. Standing Orders
2. Standing Financial Instructions
3. Matters Reserved to the Trust Board and Scheme of Delegation
4. Standards of Business Conduct

8.1

~~October 2017~~
October 2019

Authors:	Head of Corporate Affairs, Head of Procurement and Head of Financial Services ~~and Deputy Chief Financial Officer~~
Owners:	Head of Corporate Affairs and Deputy Chief Financial Officer
Date of Issue:	October 201~~7~~9
Approved by:	Trust Board
Review date:	October 20~~19~~21

FOREWORD

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

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

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

8.1

8.1

INTERPRETATION
Unless otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Trust Board).

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document shall have the same meaning as set out in the National Health Service Act 2006 and the Health & Social Care Act 2012 or any secondary legislation made under the National Health Service Act 2006 and the Health & Social Care Act 2012. References to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

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

Headings are for ease of reference only and are not to affect interpretation.

DEFINITIONS
The following defined terms shall have the specific meanings given to them below:

Accountable Officer means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

Trust Board Advisor means an independent person who supports the Trust Board but has no voting rights and does not influence decisions of the Trust Board. A Trust Board Advisor is usually a specialist in their own right and is brought in with a specific brief and for a defined time period.

Trust Board means the Chairman, Executive Members and Non-Executive Members of the Trust collectively as a body.

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

Budget Holder means the Officer with delegated authority to manage finance (income and/or expenditure) for a specific area of the Trust.

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

Chief Executive means the Chief Executive Officer of the Trust.

Chief Financial Officer means the Chief Financial Officer of the Trust.

Clear Day means a day of the week not including a Saturday, Sunday or public holiday.

Close Family Member means either a:

a) Spouse;
b) Person whose status is that of "Civil Partner" as defined in the Civil Partnerships Act 2004 or a co-habitee;
c) Parent;
d) Child, step child or adopted child;
e) Sibling;
f) Nephew, niece or first cousin; or
g) Spouse, Civil Partner or co-habitee of any of (c) to (f) listed above.

Commissioning means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

Committee means a Committee created and appointed by the Trust Board, which reports to the Trust Board.

Committee Member means a person formally appointed by the Trust Board to sit on or to chair a specific Committee.

Contracting and Procuring means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

Corporate Trustee means that the Trust Board members are jointly responsible for the management and control of the charitable funds and are accountable to the Charity Commission.

Director means a member of the Trust Board and any other Officer employed as a Director.

Employee means a person paid via the payroll of the Trust, or for whom the Trust has responsibility for making payroll arrangements but excluding Non-Executive Directors.

Executive Director means an Executive member of the Trust Board of the Trust who has voting rights.

Executive Team means the Chief Executive's direct reports.

Charitable Funds means those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. ~~Such funds may or may not be charitable.~~

Member means a Non-Executive Member or Executive Member of the Trust Board as the context permits. Member in relation to the Trust Board does not include its Chairman.

Membership, Procedure and Administration Arrangements Regulations means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

Meeting Chairman means the person presiding over a meeting, committee or event.

Motion means a formal proposition to be discussed and voted on during the course of a meeting of the Trust Board.

Nominated Officer means an Officer charged with the responsibility for discharging specific tasks within the Standing Orders and Standing Financial Instructions.

Non-Executive Director (NED) means a Non-Executive Member of the Trust.

Non-Executive Director (NED) Designate or Associate means a NED who has been identified by NHS Improvement (NHSI) ~~(formerly the NHS Trust Development Authority (TDA))~~ to fulfill a NED vacancy on the Trust Board when a vacancy arises.

Officer means an Employee of the Trust or any other person holding a paid appointment or office with the Trust.

Secretary or Head of Corporate Affairs means a person appointed to act independently of the Trust Board to provide advice on corporate governance issues to the Trust Board and the Chairman and monitor the Trust Board's compliance with the law, Standing Orders, and guidance issued by the Secretary of State and ~~Department of Health~~Department of Health and Social Care.

Secretary of State for Health and Social Care

SFIs mean Standing Financial Instructions.

SOs means Standing Orders.

Trust means The Princess Alexandra Hospital NHS Trust.

Vice-Chairman means the non-officer member appointed by the Trust Board to take on the Chairman's duties if the Chairman is absent for any reason.

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Princess Alexandra Hospital NHS Trust (the Trust) is a statutory body which came into existence on 01 April 1995 under the National Health Service Trust (Establishment) Order 1995 No 3149 (the Establishment Order).

(1) The principal place of business of the Trust is Hamstel Road, Harlow, Essex CM20 1QX.

(2) NHS Trusts are governed by Acts of Parliament, mainly the National Health Service (NHS) Act 1977, the NHS and Community Care Act 1990 as amended by the Health Authorities Act 1995, the Health Act 1999, the NHS Act 2006 and the Health and Social Care Act 2012 and any secondary legislation.

(3) The functions of the Trust are conferred by this legislation.

(4) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies. Furthermore the Trust has delegated powers under the NHS Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

(5) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

(6) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

8.1

1.2 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the ~~Department of Health~~Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Accountability requires that, inter alia, Trust Boards draw up a schedule of decisions reserved to the Trust Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a Scheme of Delegation). The Code also requires the establishment of Audit and Remuneration Committees with formally agreed Terms of Reference. The Code of Conduct requires a register of possible and actual conflicts of interest of members of the Trust Board and how those conflicts are addressed.

(3) The Freedom of Information Act 2000 sets out the requirements for public access to information held in the Public Sector.

1.3 Delegation of Powers

(1) The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (Standing Order 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Matters Reserved to the Trust Board and Scheme of Delegation).

(2) Delegated Powers are covered in a separate document entitled *Matters Reserved to the Trust Board and Scheme of Delegation* and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

(1) In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Trust Board shall be:

(a) The Chairman of the Trust (appointed by NHSI);

(b) Up to five non-officer members (appointed by NHSI);

(c) Up to five officer members (but not exceeding the number of non-officer members) including:
(i) the Chief Executive;
(ii) the Chief Financial Officer.

(2) The Trust shall have not more than eleven and not less than eight members (unless otherwise determined by the ~~Secretary of State for Health~~Secretary of State for Health and Social Care and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

(3) In line with the expectations of the sector regulator for health services in England, the Trust will also have amongst its officer members:
(a) One Executive Director who is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984);
(b) One of the Executive Directors is to be a registered nurse or a registered midwife.

8.1

2.2 Appointment of Chairman and Non-Executive Directors of the Trust

(1) Appointment of the Chairman and Non-Executive Directors of the Trust is by NHSI or successor body.

2.3 Terms of Office of the Chairman and Members

(1) The terms of office of the Chairman and Non-Executive Directors are determined by NHSI.

2.4 Appointment and Powers of Vice-Chairman

(1) Subject to Standing Order 2.4 (2) below, the Chairman and Members of the Trust Board may appoint one of their number, who is not also an Officer Member, to be Vice-Chairman, for such period, not exceeding the remainder of his term as a member of the Trust Board, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman and the Secretary. The Chairman and Members may thereupon appoint another Member as Vice-Chairman in accordance with the provisions of Standing Order 2.4 (1).

(3) Where the Chairman of the Trust has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

(2) Where the office of a member of the Trust Board is shared jointly by more than one person:
(a) either or both of those persons may attend or take part in meetings of the Trust Board;
(b) if both are present at a meeting they should cast one vote if they agree;
(c) in the case of disagreements, no vote should be cast;
(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.8 (Quorum).

2.6 Role of Members

The Trust Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. The Trust Board will operate as a Unitary Board: that means all members of the Trust Board have joint responsibility for every decision of the Trust Board regardless of their individual skills or status. All Directors must take decisions objectively and in the best interests of the Trust and must avoid conflicts of interest.

(1) Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) Chief Financial Officer

The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) Non-Executive Members

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

(5) Chairman

(a) The Chairman shall be responsible for the operation of the Trust Board and chair all Trust Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.
(b) The Chairman shall liaise with NHSI over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance and removal where required.
(c) The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Trust Board in a timely manner with all the necessary information and advice being made available to the Trust Board to inform the debate and ultimate resolutions.

2.7 Corporate Role of the Trust Board

(1) All business shall be conducted in the name of the Trust.

(2) All Charitable Funds received shall be held in the name of the Trust as Corporate Trustee. Directors acting on behalf of the Trust as Corporate Trustees are acting as quasi-trustees.

~~(3)~~ In relation to Charitable Funds, powers exercised by the Trust as Corporate Trustee shall be exercised separately and distinctly from those powers exercised as the Trust. Accountability for Charitable Funds is to the Charity Commission. ~~Accountability for non-charitable funds is to NHSI.~~

~~(3)~~

(4) The powers of the Trust established under statute shall be exercised by the Trust Board meeting in public session except as otherwise provided for in Standing Order 3.16.

(5) The Trust Board has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session. These powers and decisions are set out in the *Matters Reserved to the Trust Board and Scheme of Delegation.*

(6) The Trust Board and each Director individually shall at all times seek to comply with the Trust's Standards for Business Conduct and the NHS Foundation Trust *Code of Governance*, (updated July 2014) in the extent to which it applies. The Trust Board should also comply with the 7 Principles of Public Life (Nolan Principles).

(7) The Trust Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.8 Schedule of Matters reserved to the Trust Board and Scheme of Delegation

(1) The Trust Board resolves that certain powers and decisions may only be exercised by the Trust Board in formal session. These powers and decisions are set out in the *Matters Reserved to the Trust Board and Scheme of Delegation* and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to Officers and other bodies are contained in the Scheme of Delegation.

2.9 Lead Roles for Trust Board Members

(1) The Chairman will ensure that the designation of Lead roles or appointments of Trust Board members as required by the ~~Department of Health~~Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Trust Board Member with responsibilities for Infection Control or Safeguarding etc.).

3. MEETINGS OF THE TRUST BOARD

3.1 Calling meetings

(1) Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may determine.

(2) The Chairman, or the Secretary, of the Trust may call a meeting of the Trust Board at any time.

(3) One third or more members of the Trust Board may requisition a meeting by giving written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Trust Board, the Secretary shall give notice of the meeting, specifying the business proposed to be transacted at it and authorised for issue by the Chairman. The notice shall be delivered or sent to every Director and want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman, those Directors calling the meeting shall authorise that no business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.5.

(3) Before each meeting of the Trust Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)). Details will also be displayed on the Trust's website.

(4) If, in exceptional circumstances, a decision or assurance is required outside the schedule of Trust Board or associated Committee meetings, the Chairman (or Meeting Chairman) has the authority from the Trust Board with two other members of the Trust Board or relevant Committee to take Chairman's action and report back to the next meeting of the Trust Board or Committee.

3.3 Agenda and Supporting Papers

Supporting papers will be sent with the agenda and will be dispatched no later than three clear days before the meeting, save in emergency. Whenever possible, the agenda and supporting papers will be sent to members five Clear Days before the meeting. If sent by electronic transmission, dispatch prior to 12 noon will count as one Clear Day.

3.4 Setting the Agenda

(1) The Trust Board may determine that certain matters shall appear on every agenda for a meeting as "Standing Items".

(2) A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Trust or Meeting Chairman (as the case may be) and the Secretary at least 15 Clear Days before the meeting. In the case of Trust Board meetings, the request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 Clear Days before a meeting may be included on the agenda at the discretion of the Trust or Meeting Chairman.

(3) No business may be transacted at any meeting of the Trust Board which is not specified in the notice of that meeting unless the Trust or Meeting Chairman, as the case may be, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered as a matter of urgency. The matter shall be recorded in the minutes of that meeting.

(4) Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Petitions and Motions

Petitions

(1) Where a petition has been received by the Trust, the Chairman shall include it as an item for the agenda of the next meeting of the Trust Board. Any petitions received shall be given to the communication team and the item on the agenda shall be led by the Director with responsibility for public relations.

Motions

(2) A Director desiring to move or amend a motion shall send a written notice thereof at least ten Clear Days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This Standing Order shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.

(3) A member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, and up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency and whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. If in order, it shall be declared by the Chairman at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

(4) At a meeting of the Trust Board, a motion, or an amendment to a motion, may be proposed by the Chairman of the meeting or any member of the Board of the Directors present. It must also be seconded by another member.

(5) When a motion is under discussion or immediately prior to discussion, it shall be open to a member of the Trust Board to move:

(a) an amendment to the motion;
(b) the adjournment of the discussion, or the meeting;
(c) that the meeting proceed to the next business (to ensure objectivity, this motion may only be put by a member of the Trust Board who has not previously taken part in the debate and who is eligible to vote);
(d) that the motion should be now voted on (to ensure objectivity, this may only be put forward by a member of the Trust Board who has not previously taken part in the debate and who is eligible to vote);
(e) the appointment of an 'ad hoc' Committee to deal with a specific item of business;
(f) that a member/director be not further heard;
(g) a motion under Standing Order 3.16 to exclude the public, including the press.

(6) No amendment shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion. The Chairman shall put such proposals to the vote without debate. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(7) A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

(8) The Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised, if it is carried that:
(a) the meeting proceed to the next business; or
(b) the motion should now be voted on; or
(c) the discussion on the matter is closed; or
(d) the motion is amended.

(9) When any issue has been dealt with by the Trust Board, it shall not be competent for any member of the Trust Board other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee of the Trust Board or the Chief Executive.

(10) A notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Trust Board who gives it and also the signature of three other members of the Trust Board who support it.

3.6 Adjournment

(1) Any meeting of the Trust Board may be adjourned by the Chairman (whether or not it has commenced) where, acting reasonably, it appears to the Chairman that:
- (a) any Directors wishing to attend the meeting cannot be properly or conveniently accommodated in the place appointed for the meeting;
- (b) the conduct of the persons present prevents, or is likely to prevent, the orderly continuation of the business of the meeting; or
- (c) an adjournment is otherwise necessary so that the business of the meeting may be properly conducted; and
- (d) any business remaining on the agenda shall stand adjourned until that adjourned meeting to such time and place as the Chairman shall state.

(2) In addition, the Chairman may at any time adjourn the meeting where a quorum is present to another place and time with the consent of the meeting and shall be obliged to do so if directed by a majority of those present at the meeting.

(3) Notice of the adjourned meeting shall be dispatched to all Directors not present at the Trust Board meeting as soon as possible, but in any event no later than two days prior to the date of the adjourned meeting (if possible).

(4) No business other than that properly remaining on the agenda shall be discussed at the adjourned meeting.

3.7 Chairman of Meeting and Chairman's Ruling

(1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Trust Board has appointed one), if present, shall preside. If the Chairman and Vice-Chairman are absent, another Member of the Trust Board (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

(2) If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Vice Chairman, if present, shall preside. If the Chairman and Vice Chairman are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

(3) All meetings shall be controlled by the Chairman or the designated Meeting Chairman and any ruling made by the person presiding over the meeting in relation to the conduct of the meeting shall be final.

(4) At the meeting, the decision of the Chairman or the designated Meeting Chairman on questions of order, relevancy and regularity and any other matters (including procedure on handling motions and interpretation of the Standing Orders) shall be final.

(5) Statements of Directors made at meetings of the Trust Board shall be relevant to the matter under discussion at the material time. The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.8 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Members (including at least one Member who is also an Officer Member of the Trust and one Member who is not) is present.

(2) An Officer in attendance for an Executive Director (Officer Member) but without formal acting-up status may not count towards the quorum.

(3) If the Chairman or Member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

(4) The Trust Board may agree that its Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

(5) The requirement for at least two executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Trust Board considers the recommendations of the Remuneration and Nomination Committee).

3.9 Voting

(1) When an issue at a meeting of the Trust Board requires a vote, each voting member of the Trust Board shall have one vote each.

(2) Every motion or question put to a vote at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and Directors present and voting on the motion or question. In the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second and casting vote.

(3) All questions put to the vote shall, at the discretion of the Chairman or Meeting Chairman, be determined by oral expression or by a show of hands. A paper ballot may also be used if Chairman directs it or it is proposed, seconded and carried that a vote should be taken in this way.

(4) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(5) If a member so requests, their vote shall be recorded in the minutes by name (other than by paper ballot).

(6) A Director may only vote if present at the time of the vote on which the question is to be decided. In no circumstances may an absent Member vote by proxy. Absence is defined as being absent at the time of the vote.

(7) A manager who has been formally appointed to act-up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(8) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting-up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

(9) For the voting rules relating to joint members see Standing Order 2.5.

(10) No resolution of the Trust Board shall be passed or opposed by a majority composed only of Executive Directors or Non-Executive Directors.

3.10 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision, any direction made by the Secretary of State or the rules relating to quorum, any one or more of the Standing Orders may be suspended or waived at any meeting, providing that the meeting is quorate and that a majority of those present vote in favour of the suspension (including at least one member who is an Officer Member of the Trust and one member who is not). The reason for the suspension shall be recorded in the Trust Board's minutes.

(2) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust Board.

(3) No formal business may be transacted while Standing Orders are suspended.

(4) The Audit Committee shall review every decision to suspend Standing Orders.

3.11 Variation and Amendment of Standing Orders

(1) These Standing Orders shall not be varied except in the following circumstances:

(a) that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;

(b) providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.12 Waiver, variation and amendment of Standing Orders

(1) These Standing Orders shall not be waived or varied except in the following circumstances:

a) Upon a notice of motion under SO 3.5;

b) Upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;

c) That two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment;

d) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.13 Reporting of Waivers of Standing Orders and Standing Financial Instructions

(1) All waivers of Standing Orders should be reported to the Audit Committee after approval has been granted. The Audit Committee should ensure that waivers have only been granted in compliance with the regulations and where necessary. However, these provisions do not apply where the competitive tendering process is to be omitted or modified. Approval should then be sought as detailed in the relevant section of the Standing Financial Instructions. All such waivers will be reported retrospectively to the Trust's Audit Committee

3.14 Record of Attendance

(1) The names of the Chairman and Directors/Members present at the meeting shall be recorded.

3.15 Minutes

(1) The minutes of the proceedings of a meeting shall be drawn up and maintained as a record by the Secretary and submitted for agreement at the next ensuing meeting where they shall be signed by the person chairing the meeting.

(2) No discussion shall take place upon the minutes except upon their accuracy or where the Trust Chairman or Meeting Chairman (as the case may be) considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

(3) Minutes shall be circulated in accordance with Directors' wishes. Minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded.

(4) A record of matters discussed in private will be drawn up and maintained as a record by the Secretary and approved by the Trust Board.

3.16 Admission of the Public and the Press

(1) The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Trust Board but shall be required to withdraw upon the Trust Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."

Or

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete business without the presence of the public."

(2) The Chairman shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and the representatives of the press. This shall include deciding to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting.

(3) Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they may please without the prior agreement of the Trust Chairman or Meeting Chairman.

(4) Matters to be dealt with by the Trust Board following the exclusion of the public and representatives of the press above shall be confidential to the Directors. Members of the Trust Board and others in attendance at the request of the Trust Chairman or Meeting Chairman shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without express permission from the Chairman. For the avoidance of doubt, this means that Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence'. This also applies to minutes headed 'Items Taken in Private' outside of the Trust and this prohibition shall apply equally to the content of any discussion during the Trust Board meeting which may take place on reports or papers.

(5) The reasons for passing such a resolution shall be due to the sensitive or confidential nature of the discussion which might include information relating to:

a) employees, former employees or applicants;
b) occupiers or former occupiers of accommodation provided by or at the expense of the Trust;
c) patients or service users;
d) information relating to the financial or business affairs of a particular person;
e) the interests of public order, the meeting should be adjourned, for a reasonable, specified period, to enable the meeting to complete business without the presence of the public or the press;
f) publicity would be prejudicial to the public interest by reason of the confidential nature of

the business to be transacted;

g) there is another special reason, which shall be stated in the resolution, which requires that members of the public and representatives of the press be excluded.

3.17 Observers at Trust Board meetings

(1) The Chairman will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as he deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Committees of the Trust Board

(1) The Trust Board is required to establish an Audit Committee and a Committee dealing with Executive remuneration and nomination. The Trust Board shall also have a Charitable Funds Committee and further Committees dealing with Quality and Finance.

(2) The Trust Board may also establish (or dissolve) other formal Committees, sub-committees or working groups (collectively referred to as “Committees”) consisting wholly or partly of the Chairman and Directors as required to discharge the responsibilities of the Trust Board. The Trust Board may elect to change the Committees of the Trust Board without requirement to amend these Standing Orders.

(3) There is no requirement to hold meetings of these Committees, sub-committees or working groups in public.

4.2 Terms of Reference of Committees

(1) Each such Committee, sub-committee or working group shall have such terms of reference and powers and be subject to such conditions the Trust Board shall decide. Such terms of reference shall be in accordance with the NHS Framework and any directions and guidance issued by the Secretary of State and shall have effect as of incorporated into the Standing Orders.

4.3 Appointment of Committees

(1) A Committee appointed under this Standing Order may, subject to such directions and guidance as may be given by the Trust Board of the Secretary of State, appoint sub-committees or working groups consisting wholly or partly of members of the Committee.

(2) Committees will normally only make recommendations and provide advice to the Trust Board unless the Trust Board has specifically delegated powers to the Committee.

(3) Where Committees are authorised to establish sub-committees or working groups, they may not delegate their powers to the sub-committees or working groups unless expressly authorised by the Trust Board.

4.4 Approval of Appointments to Committees

(1) The Trust Board shall approve the appointments of each of the Committees that it has formally constituted.

(2) The Trust Board shall elect one of the Directors to chair each of its Committees.

(3) Where the Trust Board determines, and legislation, regulations and directions or guidance issued by the Secretary of State permit that persons who are not members of the Trust Board shall be appointed to a Committee, the terms of such appointment shall be determined by the Trust Board. The Trust Board shall define the powers of such appointees and shall agree allowances and/or expenses. Save where permitted under legislation, persons who are not Directors will not have a vote.

4.5 Applicability of Standing Orders and Standing Financial Instructions to Committees

(1) The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust Board. In which case the term "Chairman" is to be read as a reference to the chairman of the Committee as the context permits and the term "member" is to be read as a reference to a member of the Committee as the context permits.

4.6 Confidentiality

(1) A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Trust Board or shall otherwise have concluded on that matter.

(2) A Director shall not disclose any matter reported to the Trust Board or otherwise dealt with by a Committee, notwithstanding that the matter has been reported or action has been concluded, if the Trust Board or Committee shall resolve that it is confidential.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other Bodies

(1) Subject to such directions as may be given by the Secretary of State, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, of any of its functions by a Committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the Trust, or by another body as defined in Standing Order 5.1 (2) below, in each case subject to such restrictions and conditions as the Trust thinks fit.

(2) The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with the Trust (Membership, Procedure and Administration Arrangements) Regulations 2000, the functions of the Trust may also be carried out in the following ways:

(a) by another Trust;
(b) jointly with any one or more of the following: NHS trusts, NHS Improvement (NHSI) or Clinical Commissioning Groups (CCGs);
(c) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;
(d) in relation to arrangements made under S63 (1) of the Health Services and Public Health Act 1968, jointly with one or more NHSI, NHS Trusts or CCG.

(3) Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and Urgent Decisions

(1) The powers which the Trust Board has reserved to itself within these Standing Orders may, in emergency or for an urgent decision, be exercised by the Chief Executive and the Chairman after having consulted at least one Non-Executive Director and one Executive Director. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

(1) The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by Committees which it has formally constituted in accordance and which are comprised of members of the Executive Team. The constitution and terms of reference of such Committees and their specific executive powers shall be approved by the Trust Board.

(2) When the Trust Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

(3) When the Trust Board is meeting or gathering but not in its capacity as the Trust Board, these Standing Orders shall not apply to any such meeting or gathering and no business shall be transacted or decisions made.

5.4 Delegation to Officers

(1) Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to other Committees shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate Officers to undertake the remaining functions for which he will still retain accountability to the Trust.

(2) The Chief Executive shall prepare a Scheme of Reservation and Delegation *Matters Reserved to the Trust Board and Scheme of Delegation* identifying his proposals which shall be considered and approved by the Trust Board, subject to any amendment during the discussion. The Chief Executive may periodically propose amendment to the *Matters Reserved to the Trust Board and Scheme of Delegation* which shall be considered and approved by the Trust Board.

(3) Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Trust Board of the Chief Executive, the Chief Financial Officer, Executive Directors and other members of the Executive Team to provide information and advise the Trust Board in accordance with statutory or ~~Department of Health~~Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Financial Officer, other Executive Directors and members of the Executive Team shall be accountable to the Chief Executive.

8.1

(4) The arrangements made by the Trust Board as set out in the *Matters Reserved to the Trust Board and Scheme of Delegation* shall have effect as if incorporated in these Standing Orders.

5.5 Over-riding Standing Orders (and Standing Financial Instructions)

(1) If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Head of Corporate Affairs or the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy Statements: General Principles

(1) The Trust will from time to time agree and approve policy statements/procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in the minutes of an appropriate Committee and will be deemed to be part of the Trust's Governance Manual.

(2) The Trust's Standing Orders and Standing Financial Instructions must be read in conjunction with the Governance Manual and the Trust's staff disciplinary and appeals procedures both of which shall have effect as if incorporated in these Standing Orders.

6.2 Standing Financial Instructions

(1) Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.3 Specific Guidance

(1) Notwithstanding the application of Standing Order 6 (1) above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the ~~Secretary of State for Health~~Secretary of State for Health and Social Care:

(a) Caldicott Guardian 1997;
(b) Human Rights Act 1998;
(c) Freedom of Information Act 2000.
~~(c)~~(d)

7. DUTIES AND OBLIGATIONS OF TRUST BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

(1) The Trust has a duty to have in place principles and procedures to minimise, manage and register potential conflicts of interests, which could be deemed, or assumed, to affect the decisions made by those involved in the business of the Trust.

(2) If Trust Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Secretary.

(3) When assessing the relevance of an interest, influence as well as the immediacy of the relationship is an important consideration. Therefore interests conferred through close family members are also to be disclosed.

7.2 Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest

(1) A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body ; or
(b) of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(2) A Director has a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

7.3 Declarations by Directors

(1) Directors have a duty to inform the Head of Corporate Affairs in writing within seven Clear Days of becoming aware of the existence of a relevant or material interest.

(2) If a Director is present at a meeting of the Trust Board and has an interest of any sort in any matter which is the subject of consideration, the Director shall at the meeting and as soon as practicable after its commencement, disclose the fact. At the time the interest is declared, it should be recorded in the minutes of the meeting.

(3) Unless in the case of a Director, the conflict of interest has been authorised by the Trust Board, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chairman having the casting vote.

(4) Any changes in interests should be officially declared at the next relevant meeting of the Trust Board following the change occurring.

(5) Relevant and material interests of Directors, including interests with companies, bodies or organisations likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding

Annual Reports.

Register of Interests

(1) The Head of Corporate Affairs shall be responsible for compiling and maintaining a Register of Interests to formally record interests of Trust Board or Committee members.

(2) These details will be kept up to date by means of an annual review of the Register and by virtue of a Standing Agenda item requiring Trust Board and Committee members to declare any relevant interests at the start of each meeting, following which the Register of Interests will be updated.

(3) The Register of Interests will be kept up to date and available to the public.

7.4 Standards of Business Conduct

(1) All Trust staff and members of the Trust Board must comply with the Trust's Standards of Business Conduct, based on the national guidance contained in HSG(93)5 on "Standards of Business Conduct for NHS Staff" and Conflicts of Interest Policy both of which are set out in the Governance Manual.

7.5 Interests of Officers in Contracts

(1) Any Officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Head of Corporate Affairs as soon as practicable.

(2) An Officer should also declare to the Chief Executive or Director responsible for Workforce any other employment or business or other relationship of a Close Family Member that conflicts, or might reasonably be predicted, could conflict with the interests of the Trust.

(3) The Trust will require interests, employment or relationships so declared to be entered in a Register of Interests of staff.

7.6 Canvassing of, and recommendations by, Members in Relation to Appointments

(1) Canvassing of members of the Trust or any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph shall be included in application forms or otherwise brought to the attention of candidates.

(2) Members shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph shall not preclude a Member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

(3) Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee in question.

7.7 Relatives of Members or Officers

(1) Insofar as they are aware of any such application, Directors and Officers of the Trust should ensure that relatives applying for positions within the Trust complete the section disclosing the relationship. They should also ensure relatives are made aware that failure to disclose such a relationship shall disqualify them as a candidate and, if appointed, render the individual liable to instant dismissal.

(2) The Chairman, every other member of the Trust Board and Officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that Trust Board member or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(3) Prior to appointment and acceptance of appointment, a new member of the Trust Board should disclose to the Trust Board if they are related to any Officer in the Trust.

7.8 Waiver of Standing Orders made by the ~~Secretary of State for Health~~Secretary of State for Health and Social Care

(1) Power of the Secretary of State to make waivers Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of „Chairman" for the purpose of interpreting this waiver. For the purposes of paragraph 7.9(3) (below), the "relevant chairman" is:
a) At a meeting of the Trust, the Chairman of that Trust;
b) At a meeting of a Committee:
   i) In a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;
   ii) In the case of any other member, the Chairman of that Committee.

(3) Application of waiver
A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to:

a) A member of Princess Alexandra Hospital NHS Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:
   i) Services under the National Health Service Act 1977; or
   ii) Services in connection with a pilot scheme under the National Health Service Act 1997; for the benefit of persons for whom the Trust is responsible.

b) Where the "pecuniary interest" of the member in the matter which is the subject of consideration at a meeting at which he is present:
   i) Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;
   ii) Has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:
      (i) Are members of the same profession as the member in question;
      (ii) Are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest.
The removal is subject to the following conditions:

(a) The member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;
(b) The relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.9(2)(b) above, except where that member is the Chief Executive;
(c) **In the case of a meeting of the Trust**:
   (i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May not vote on any question with respect to it.

(d) In the case of a meeting of the Committee:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May vote on any question with respect to it; But

(iii) The resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

(1) The Common Seal of the Trust shall be kept by the Chief Executive or Head of Corporate Affairs or other nominated Officer in a secure place.

8.2 Sealing of Documents

(a) The Trust Board shall nominate Officers with power to sign and or seal documents on their behalf and report such use to the Trust Board.

(b) Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Officers, duly authorised, and shall be attested by them. The two Officers shall not be from the originating department.

(c) A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed.

(d) Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Financial Officer (or an Officer nominated by him), and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department).

8.3 Register of Sealing

(1) An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

(2) The Trust Board shall receive a report once the seal has been used. The report shall contain details of the seal number, the description of the document and date of sealing.

8.4 Signature of Documents

(1) Where the signature of any document will be a necessary step in legal proceedings involving the Trust it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

9. MISCELLANEOUS

9.1 Joint Finance Arrangements

(1) The Trust Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Services Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Trust Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under the National Health Services Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

9.2 Governance Manual to be given to Directors and Officers

(1) It is the duty of the Chief Executive to ensure that existing Directors of the Trust Board, Officers and all new appointees are notified of their responsibilities within the Governance Manual. Updated copies shall be issued to staff designated by the Chief Executive and copies shall also be placed on the Trust's public folders to allow ease of access to the latest version.

(2) New designated officers shall be informed in writing and shall be made aware of, receive copies or have access to the Governance Manual. Trust Board members and Senior Managers' will be expected to sign a declaration of receipt and intention to honour the requirements of the Governance Manual

9.3 Review of Standing Orders

(1) The Trust Board shall ensure that the Governance Manual is reviewed biennially The Governance Manual will be treated as a "Controlled Document" and updates will be communicated and distributed in accordance with the Controlled Document Policy.

STANDING FINANCIAL INSTRUCTIONS

10.0 INTRODUCTION

10.1 General

(1) The Code of Accountability requires that each NHS Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the code. They shall have effect as if incorporated in the Standing Orders (SOs).

(2) These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve accountability, probity, openness, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Matters Reserved to the Trust Board and Scheme of Delegation adopted by the Trust.

(3) These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units and the Charitable Funds administered by the Trust in its role as Corporate Trustee. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

(4) Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Financial Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

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

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

(7) Variations to the Standing Financial Instructions shall only be made by the Trust Board, and normally on the recommendation of the Audit Committee.

10.2 Responsibilities and Delegation to the Trust Board

(1) The Trust Board exercises financial supervision and control by:

(a) formulating the financial strategy;
(b) requiring the submission and approval of budgets within approved allocations/overall income;
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
(d) defining specific responsibilities placed on members of the Trust Board and employees as indicated in the Scheme of Delegation document.

(2) The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These are set out in the document entitled *Matters Reserved to the Trust Board and Scheme of Delegation.* All other powers have been delegated to Officers or such other Committees as the Trust Board has established.

(3) The Trust Board will delegate responsibility for the performance of its functions in accordance with the Matters Reserved to the Trust Board and Scheme of Delegation

document adopted by the Trust Board.

(4) The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

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

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

(7) The Chief Financial Officer is responsible for:

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

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

(i) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include the provision of financial advice to other members of the Trust Board and employees;

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

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

(8) All members of the Trust Board and Employees, are responsible for:

(a) the security of the property, assets and resources of the Trust;

(b) avoiding loss;

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

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures, Matters Reserved to the Trust Board and Scheme of Delegation, and other relevant regulations.

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

(10) For all members of the Trust Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Trust Board and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

11.0 AUDIT

11.1 Audit Committee

(1) In accordance with Standing Orders, the Trust Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit, and Counter Fraud services;
(b) reviewing financial systems;
(c) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
(d) monitoring compliance with Standing Orders and Standing Financial Instructions;
(e) reviewing schedules of waivers, losses and special payments making recommendations to the Trust Board;
(f) reviewing schedules of debtors/creditors when and where appropriate;
(g) reviewing the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Trust Board and advising the T r ust Board accordingly;
(h) Periodically (as defined in its Terms of Reference) reviewing the Waiver Register;
(i) Acting as the Trust's Auditor Panel in line with the Local Audit and Accountability Act 2014

(2) 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 Chair of the Audit Committee should raise the matter at a full meeting of the Trust Board. Exceptionally, the matter may need to be referred to the ~~Department of Health~~Department of Health and Social Care or NHS Improvement (NHSI) . The matter should be raised to the Chief Financial Officer in the first instance and the Local Counter Fraud Specialist (LCFS) should be involved where issues of fraud, bribery and corruption are suspected.

It is the responsibility of the Chief Financial Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if there is a proposal to review or change the provision of Internal Audit services.

11.2 Chief Financial Officer

(1) The Chief Financial Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
(b) ensuring the Internal Audit is adequate and meets the NHS mandatory audit standards;
(c) ensuring that the Trust maintains adequate Counter Fraud and Corruption arrangements and deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Trust Board. The report must cover:
    (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the ~~Department of Health~~Department of Health and Social Care including for example compliance with control criteria and standards;
    (ii) major internal financial control weaknesses discovered;
    (iii) progress on the implementation of internal audit recommendations;
    (iv) progress against plan over the previous year;
    (v) strategic audit plan covering the coming three years;
    (vi) a detailed plan for the coming year.

(2) The Chief Financial Officer or designated auditors are entitled without necessarily giving

prior notice to require and receive:
(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) access at all reasonable times to any land, premises or members of the Trust Board or employees of the Trust;
(c) the production of any cash, stores or other property of the Trust under the Trust Board and an employee's control; and
(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

(1) Internal Audit will review, appraise and report upon:
(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) the adequacy and application of financial and other related management controls;
(c) the suitability of financial and other related management data;
(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences;
ii) Waste, extravagance, inefficient administration;
iii) Poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with relevant guidance;
(f) the economic acquisition and the efficient use of resources;
(g) efficient operation of systems and departments;
(h) the adequacy of follow up action to audit reports;
(i) other matters as requested by directors and senior managers and agreed by the Head of Internal Audit, or considered appropriate by the Head of Internal Audit.

(2) Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

(3) 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.

(4) Internal audit reports will be distributed to relevant directors and managers who will be responsible for the implementation of agreed recommendations. Failure to act on audit reports within a reasonable period will be reported to relevant directors and the Audit Committee.

(5) The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall comply with the guidance on reporting contained in the The Public Sector Internal Audit Standards (PSIAS)

11.4 External Audit

(1) The External Auditors are appointed by the Trust under the powers set out in the Local Audit and Accountability Act 2014.

(2) The External Auditor should annually express an opinion on his ability to rely on the work of internal audit.

(3) The External Auditor's statutory responsibilities and powers are set out in the 'Local Audit and Accountability Act 2014' and the Code of Audit Practice issued by the Comptroller and Auditor

General of the National Audit Office.

11.5 Fraud, Bribery and Corruption

(1) In line with their responsibilities as set out in the Local Anti-Fraud, Bribery and Corruption Policy, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance with the ~~Secretary of State for Health~~Secretary of State for Health and Social Care ~~Service Condition Section 24 of the Standards NHS Contract directions to NHS Trusts~~ as well as NHS contractual obligations, in addition to any other requirements as may be instructed by NHS Counter Fraud Authority (formerly NHS Protect) periodically.

(2) The Trust shall nominate a suitable person to carry out the duties of the LCFS as specified by the NHS Anti-Fraud Manual issued by the NHS Counter Fraud Authority.

(3) The LCFS shall report to the Chief Financial Officer and shall work with staff in accordance with the NHS Anti-Fraud Manual issued by the NHS Counter Fraud Authority.

(4) The LCFS will provide a written report, at least annually, on counter fraud and corruption work within the Trust.

11.6 Security Management

(1) The Trust's Chief Executive will monitor and ensure compliance with the ~~Secretary of State for Health~~Secretary of State for Health and Social Care's directions on NHS Security Management Measures. The Chief Executive has overall responsibility for controlling and coordinating security however key tasks will be delegated to the Security Management Director. The Chief Executive shall also nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the ~~Secretary of State for Health~~Secretary of State for Health and Social Care guidance on NHS security management.

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

12. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

12.1 Preparation and Approval of Plans and Budgets

(1) The Chief Executive will compile and submit to the Trust Board an annual business plan which takes into account the Trust's financial requirements, forecast income and expenditure plans and cash resources. The annual business plan will contain:-

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

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

(2) This plan will be in line with the requirements of NHSI.

(3) Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Trust Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan;
(b) accord with workload and workforce plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds; and
(e) identify potential risks.

(4) The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Trust Board.

(5) Budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

(6) All budget holders will sign up to their allocated budgets and ongoing compliance with the Trusts Governance Framework at the commencement of each financial year.

(7) The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

12.2 Budgetary Delegation

(1) The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
- (a) the amount of the budget;
- (b) the purpose(s) of each budget heading;
- (c) individual and group responsibilities;
- (d) authority to exercise virement in accordance with the Trusts virement policy;
- (e) achievement of planned levels of service; and
- (f) the provision of regular reports.

(2) The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Trust Board.

(3) Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement in accordance with the Trust's virement policy.

(4) Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

(5) Budgets shall only be used for the purpose for which they were established.

12.3 Budgetary Control and Reporting

(1) The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:
- (a) monthly financial reports to the Trust Board in a form approved by the Trust Board containing:
  - (i) A Statement of Comprehensive Income to date showing trends and forecast year-end position;
  - (ii) A Statement of Financial Position showing trends and forecast year-end position;
  - (iii) Movements in cash and projected outturn against plan;
  - (iv) Capital project spend and projected outturn against plan;
  - (v) Explanations of any material variances from plan;
  - (vi) Details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;
- (b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- (c) investigation and reporting of variances from financial, workload and workforce budgets;
- (d) monitoring of management action to correct variances; and
- (e) arrangements for the authorisation of budget transfers.

(2) Each Budget Holder is responsible for ensuring that:
- (a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Financial Officer or the Chief Executive;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the virement policy; and
(c) no permanent or temporary employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Trust Board.

(3) The rules and process that apply in the approval of budget virement are set out in the Trust's virement policy and include:
a) A virement is not normally permitted :
i) Between pay and non-pay;
ii) Between non recurrent and recurrent expenditure;
iii) Where it would be in breach of the rules on earmarked or ring fenced funding arrangements;
iv) Where it would increase management costs (unless approved in writing by the Executive Team).
b) Adjustment to reflect changes that could not have been foreseen at the start of the year.
c) Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purpose.
d) Authority delegation levels.

(4) The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual business plan and a balanced budget.

(5) The Chief Financial Officer shall keep the Chief Executive and the T r u st Board informed of the financial consequences of changes in policy, pay awards and trends affecting budgets, and shall advise on the financial and economic aspects of future plans and projects.

12.4 Capital Expenditure

(1) The general rules applying to delegation and reporting shall also apply to capital expenditure.

12.5 Monitoring Returns

(1) The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation e.g. NHSI.

13. ANNUAL ACCOUNTS AND REPORTS

13.1 Governance Process

(1) The Chief Financial Officer, on behalf of the Trust, will:
(a) prepare financial returns in accordance with the accounting policies and guidance given by the ~~Department of Health~~Department of Health and Social Care, the Trust's accounting policies, and generally accepted accounting practice;
(b) prepare and submit annual financial reports to the ~~Department of Health~~Department of Health and Social Care certified in accordance with current guidelines;
(c) submit financial returns to the ~~Department of Health~~Department of Health and Social Care and NHSI for each financial year in accordance with the timetable prescribed by the ~~Department of Health~~Department of Health and Social Care.

(2) The Trust's annual accounts must be audited by an auditor appointed by the Trust in accordance with the Local Audit and Accountability Act 2014. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

(3) The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the ~~Department of Health~~Department of Health and Social Care's Group Accounting Manual.

(4) The Trust's Annual Report and audited Annual Accounts must be presented to a public

meeting on or before 30 September each year.

14. BANK ACCOUNTS

14.1 General

(1) The Chief Financial Officer is responsible for managing the Trust's banking arrangements in accordance with the Trust's Cash and Treasury Management Policy and for advising the Trust on the provision of banking services and operation of accounts.

(2) The Performance and Finance Committee will, on behalf of the Trust Board, approve the Trusts Cash and Treasury Management Policy, operational cash management procedures and the use of banking institutions.

14.2 Bank Accounts

(1) The Chief Financial Officer is responsible for:

a) Government Banking Service (GBS) accounts;
b) establishing separate bank accounts for the Trust's non-exchequer funds;
c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
d) ensuring that GBS accounts do not become overdrawn;
e) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn;
f) monitoring compliance with ~~Department of Health~~Department of Health and Social Care guidance on the level of cleared funds;
g) establishing a Working Capital Facility in the manner required by NHSI.

14.3 Banking Procedures

(1) The Chief Financial Officer will prepare detailed instructions on the operation of GBS and other bank accounts which must include:

(a) the conditions under which the GBS and other bank accounts are to be operated;
(b) those approved to sign cheques or other orders drawn on the Trust's accounts.

(2) The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which the account will operate.

(3) All funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer shall open any bank account in the name of the Trust.

(4) The Chief Financial Officer shall be authorised to make payments using BACS, CHAPS and Faster Payment systems and to establish appropriate procedures in accordance with locally agreed arrangements.

(5) All payment instruments shall be treated as controlled stationery, with appropriate records being maintained.

(6) Where payments are made by direct debit, each mandate shall be approved by the Chief Financial Officer and in accordance with the bank mandate requirements.

14.4 Tendering and Review

(1) The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

(2) Competitive tenders for commercial banking services should be sought at least every five years. The results of the tendering exercise should be reported to the Trust Board.

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

15.1 Income Systems

(1) The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collecting and coding of all monies due.

(2) The Chief Financial Officer is also responsible for the prompt banking of all monies received.

15.2 Raising Invoices

(1) All invoices must be raised by the Finance Directorate's Debtors Section, unless specifically agreed otherwise by the Chief Financial Officer.

15.3 Fees and Charges

(1) The Trust shall follow the advice in the 'Approved Costing Guidance' published by NHSI in setting prices for NHS service agreements.

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

(3) The Chief Financial Officer will lead and coordinate an executive review of fees and charges on an annual basis.

(3) All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

(4) No officer of the Trust, except within the boundaries of any delegated authority, is allowed to confirm or agree with a third party (whether NHS or Non-NHS), any reduction to or waiver of the Trusts normal charges, without the prior express authority of the Chief Financial Officer if less than £100,000, the Trust Board if over £100,000.

15.4 Debt Recovery

(1) The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

(2) The Chief Financial Officer is responsible for establishing and maintaining procedures for the issuing of credit notes and the write-off of debt, within delegated limits, the Trust must demonstrate all reasonable steps have been taken to secure payment.

(3) Income not received should be dealt with in accordance with losses procedures.

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

(5) A list of amounts written off shall be submitted for information by the Chief Financial Officer to the Audit Committee at every meeting. Any proposed write offs over £50,000 will also require the approval of the Audit Committee.

15.5 Security of Cash, Cheques and other Negotiable Instruments

(1) The Chief Financial Officer is responsible for:

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

(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

(2) Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

(3) Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported to the Chief Financial Officer. Any significant trends should also be reported. Where there is prima facie evidence of fraud, bribery or corruption this should be reported in accordance with the Trust's Fraud and Corruption Reporting Arrangements and the guidance provided by NHS Counter Fraud Authority. The referral will be investigated by the Trust counter fraud specialist. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses
and Compensations Procedures.

(4) All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

(5) The opening of incoming post should wherever possible be undertaken by two officers, unless otherwise formally agreed by the Chief Financial Officer. All cash, cheques, postal orders and other forms of payment received by an officer other than a cashier shall be entered immediately in an approved form of register. The remittances shall be passed to the cashier from whom a signature shall be obtained.

(6) An official receipt shall be made out by the cashier for all cash received, together with a reason for the payment. Receipts for cheque payments etc. will be issued on demand.

(7) The opening of cash tills, telephone and other coin operated machines, and the counting and recording of the takings shall be undertaken by two officers together.

(8) Any employee who has any indication that the safe custody of cash etc. on the Trust's premises or in transit may be at risk, must immediately notify the Chief Financial Officer.

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

16. TENDER & CONTRACTS PROCEDURES

16.1 Duty to comply with Standing Orders and Standing Financial Instructions

(1) The ~~Department of Health~~Department of Health and Social Care requires NHS bodies to comply with the requirements of the Bribery Act 2010. Failure to do so may, in the event of a prosecution against a Trust employee or supplier for a bribery offence, result in the Trust also being liable for prosecution of a corporate offence under section 7 of the Act.

(2) Sufficient and appropriate due diligence is required in respect of every potential and actual Trust supplier, regardless of how their services have been procured. Further advice and guidance may be obtained from the Procurement Department in the first instance.

(3) The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions.

16.2 European Union (EU) Directives Governing Public Procurement

(1) Directives by the Council of the EU (EU Directives) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

16.3 Capital Investment and Business Cases

(1) The Trust shall comply as far as is practicable with the requirements of the NHSI's *Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts* in respect of capital investment and estate and property transactions. The Trust will also comply as far as is practicable with current best practice required by the ~~Department of Health~~Department of Health and Social Care or the Cabinet Office.

16.4 Private and Alternative Financing for Capital Procurement

(1) Private and Alternative Financing MUST be authorised by the Trust Board.

16.5 Formal Competitive Tendering

(1) The Trust shall ensure that competitive quotations, proposals or tender, as appropriate are invited for:

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

(b) the provision of services including all forms of management consultancy services (other than specialised services sought from or provided by the ~~Department of Health~~Department of Health and Social Care or NHS body, where a competitive process is prescribed when deemed necessary);

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

16.6 Waiver Process

(1) Where the Trust elects to invite tenders for the supply of goods and/or services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tending procedure. The related procurement directive, as applicable, should also be observed.

~~(1)~~(2) The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a management consultant originally appointed through a competitive procedure.

~~(2)~~(3) Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

~~(3)~~(4)

a) Formal tendering procedures need not be applied where:

i) the estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 including VAT; ~~ask NHSI~~

ii) the supply is proposed under special arrangements negotiated by the ~~Department of Health~~Department of Health and Social Care or its agencies (including Supply Chain Corporation Limited SCCL)~~,~~ in which event the said special arrangements must be complied with;

iii) national/regional public sector contracts or contract frameworks are in place;

~~iv) the prices obtained by the Trust are lower than the national/regional public sector contracts or framework contracts; (A waiver report is still to be made to the Audit Committee)~~

~~v)~~iv) a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

~~vi)~~v) the requirement is covered by an existing contract and the value of the variation is within +/- 10% of contract value, and is within originally specified scope.

b) Formal tendering procedures may be waived in the following circumstances and where

supporting evidence is provided:

i) Urgency: where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

ii) Specialist knowledge available from single source: where specialist expertise is required and is available from only one source. This provision does NOT cover management consultancy;

iii) Continuity (1): when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

~~ii)~~iv)

~~iii)~~v) ~~Continuity (2): there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;~~

~~iv)~~vi) Compatibility: where the objects of procurement forms a compatibility complex with other equipment in use, in the Trust;

~~v)~~vii) Standardised products or equipment: where the objects of procurement forms part of standardised products or equipment formulary in the Trust. This justification MUST not be used however, if there is a clear business case to alter standard practice or change suppliers. Where appropriate, expenditure relating to standardised products MUST be reviewed if it is expected to exceed tendering threshold required by Public Contracts Regulations 2015;

~~vi)~~viii) Extension pending conclusion of a tendering process;

~~vii) Lowest price not accepted: this is not applicable to tenders where award criteria are specified as "most economically advantageous". This is applicable for published tenders where criteria for award are specified as "lowest price" but there is clear justification of inability to accept the offer. This is also applicable if the lowest priced proposal or lowest priced quotation is not accepted;~~

~~viii)~~ix) There is a sole supplier of the goods and/or services ~~(this has to be evidenced).~~

~~(4)~~(5) ~~The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a management consultant originally appointed through a competitive procedure.~~

~~(5)~~(6) ~~Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.~~

16.7 List of Approved Firms

(1) The Trust shall ensure that the firms/individuals invited to tender are technically competent to undertake to fulfil the supply of goods and services. Contracts should only be awarded to firms/individuals who are financially and technically competent. To reflect requirements of Public Contracts Regulation 2015, ~~acceptable list of approved firms MUST be procured through a Dynamic Purchasing System.~~

CONTRACTING/TENDERING PROCEDURE

16.8 Invitation to Tender

(a) All Trust tenders will be conducted using the eSourcing (eTendering) system as default. ~~In exceptional circumstances, paper based tender can be conducted~~. All invitations to tender shall state the date and time as being the latest time for the receipt of tenders. every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(2)

~~(3) In the case of a paper based tender return all invitations to tender shall state that no paper based tender will be accepted unless:~~

~~(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive;~~

~~(b) that tender envelopes / packages shall not bear any names or marks indicating the sender. The use of courier / postal services must not identify the sender on the envelope or on any receipt so required by the deliverer;~~

~~(c)~~(a) ~~every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.~~

~~**16.9 Receipt and Safe Custody of Tenders**~~

~~(1) The Chief Financial Officer or his nominated representative will be responsible for the receipt, endorsement and safe custody of paper based tenders received until the time appointed for their opening.~~

~~(2) The date and time of receipt of each tender shall be endorsed on the tender envelope/package. All envelopes/packages must be kept within the destruction period (i.e. seven years).~~

~~16.10~~16.9 **The Electronic Return of Tenders**

(1) Tenders ~~may be sought and~~ must be returned electronically via an E-Procurement Portal ~~external service system~~ approved by the procurement team ~~the Chief Executive/Chief Financial Officer~~, provided that:

(a) Such systems will be configured so that responses are secure and visible to the delegated staff only, upon the expiry of the published response deadline only.

(b) The electronic system will not detract in any way from the provisions of this document in any other way.

(2) Tender responses will be accessed electronically by approved/delegated staff, whereupon all offers will be printed and recorded in the same way as hard copy tenders.

~~**16.11 Opening Tenders and Register of Tenders (Paper Based Responses)**~~

~~(1) As soon as practicable, the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two approved officers. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.~~

~~(2) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Financial Officer or any approved Senior Manager from the Finance Directorate from serving as senior managers to open tenders.~~

~~(3) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department for paper based tenders.~~

~~(4) Every tender received shall be marked with the date of opening and initialled by those present at the opening on the pricing document.~~

~~(5) A register shall be maintained by the Chief Financial Officer, or a person authorised by him, to show for each set of competitive tender invitations despatched:~~

~~(a) the name of all firms individuals invited;~~

~~(b) the names of firms individuals from which tenders have been received;~~
~~(c) the nature and extent of due diligence undertaken;~~
~~(d) the date the tenders were opened;~~
~~(e) the persons present at the opening;~~
~~(f) the price shown on each tender;~~
~~(g) a note where price alterations have been made on the tender;~~
~~(h) declaration of interests/gifts and hospitality for those involved in the opening/evaluation process, if required.~~

~~(6) Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.~~

~~(7) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.~~

~~16.12~~16.10 Opening Tenders and Register of Tenders (Electronic Responses) – Procurement Department Only

(a) The Trust uses an eSourcing system for its tendering exercise. The secured time-lock facility is enabled for electronic tenders.
(b) The time-lock facility must be secured and only provides access to the tender returns AFTER the tender exercise is closed.

(1) A register shall be maintained by ~~the Associate Director of~~ Procurement, ~~or a person authorised by him,~~ to show for each set of competitive tender invitations despatched:
(a) the name of all firms/individuals invited;
(b) the names of firms/individuals from which tenders have been received and for electronic tenders;
(c) the date the tenders were opened;
~~(d) the persons present at the opening;~~
~~(e)~~(d) the price shown on each tender;
~~(f)~~(e) a note where price alterations have been made on the tender.

~~16.13~~16.11 Late Tenders

(1) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer. The Associate Director of Procurement shall provide a recommendation in these circumstances.

(2) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Financial Officer or his/her nominated officer or if the process of evaluation and adjudication has not started.

(3) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Financial Officer or his/her nominated officer.

~~16.14~~16.12 Acceptance of Formal Tenders

(1) Any discussions with a tenderer which are deemed necessary shall be communicated through the E-Procurement Portal in line with public contracts regulations 2015 and OJEU legislation. ~~to clarify the technical aspects of his tender before the award of a contract will not disqualify the tender.~~

~~(2) The default ratio for tender evaluation criteria is 60% quality and 40% price/commercial.~~

~~Variation to this default ratio can only be approved by the Chief Financial Officer through recommendation from the Associate Director of Procurement or the Head of Procurement.~~

~~(3) Acceptance and award criteria include:~~
~~(a) Most economically advantageous;~~
~~(b) Lowest price; OR~~
~~(c) If payment is to be received by the Trust, the most economically advantageous, or highest revenue/income.~~

~~(4) Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.~~

~~(5)~~(2) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

~~(6)~~(3) The use of these procedures must demonstrate that the award of the contract was:
~~(a) not in excess of the going market rate / price current at the time the contract was awarded;~~
~~(b)~~(a) that best value for money was achieved.
~~(c)~~(b) All tenders should be treated as confidential and should be retained for inspection.

~~16.15~~16.13 Contract ~~Acceptance Report~~ Award Process

(1) Contract ~~Acceptance Report~~ award papers ~~for OJEU tenders~~ will be ~~written up~~ drafted with recommendations for award. The authoriser of the Contract ~~Acceptance Report~~ award paper is dependent on delegated authority outlined in Scheme of Delegations.

(2) In exceptional circumstances, the Contract ~~Acceptance Report~~ award paper for contract values above £1,000,000 Inclusive of VAT must be authorised by the Trust Board ~~£1,000,000 Inclusive of VAT must be authorised by the Trust Board~~.

~~16.16~~16.14 Financial Standing and Technical Competence of Contractors

(1) The Chief Financial Officer through his/her nominated officer may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

~~16.17~~16.15 Procurement & Supplies Management

(1) The Procurement Team will ~~Associate Director of Procurement and Director of Estates & Facilities should~~ seek to ensure that all ~~firms~~ contractors who the Trust enters into a contract with are technically and financially competent to undertake to fulfil the supply of goods and services~~, making use of national and regional public sector contractors.~~

QUOTATIONS

~~16.18~~16.16 General Position on Quotations

(1) ~~Three~~ Qquotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, ~~or is reasonably expected to exceed £7,500 but not exceed~~ £24,999 inclusive of VAT. For spend totalling more than £25,000, whole life cost, this will need to be formally tendered and published via contracts finder. The requirements of the Bribery Act 2010 (evidencing sufficient due diligence and confirmation of prospective suppliers anti-bribery arrangements) must still be complied with.

2 All quotations sought are done so on the premise of one-off requests, with no further commitment to spend. In the case where additional spend may be required, this should be identified at the identification of need stage and liaised with procurement to ascertain the process that is to be followed

~~16.19~~16.17 Quotations to be within Financial Limits

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

~~16.20~~16.18 Competitive Quotations

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

(2) Quotations ~~should~~ must be in an ~~n~~ ~~writing/~~electronic format and all quotations should be submitted through the e-procurement ~~system~~ portal. ~~(EROS at the time of writing).~~ The Chief Executive or his nominated Officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation, ~~if payment is to be made by the Trust, or if the highest payment is to be received by the Trust,~~ ~~then~~ the choice and the reasons why should be recorded in the E-Procurement Portal. ~~in permanent record. This permanent record can be in the form of a waiver of quotation (lowest value not accepted).~~

~~16.21~~16.19 Authorisation of Tenders and Competitive Quotations

(1) Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff to the value of agreed authorised limits, as specified in the Scheme of Delegation.

(2) These levels of authorisation may be varied or changed and need to be read in conjunction with the Scheme of Delegation.

(3) Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

~~16.22~~16.20 Notifying Successful and Unsuccessful Bidders

(1) Successful and unsuccessful bidders are notified in accordance to the applicable standstill period. ~~(Alcatel period). Final contract is only awarded after all debrief are satisfactorily concluded.~~

~~16.23~~16.21 Compliance Requirements for all Contracts

(1) The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:
(a) The Trust's Standing Orders and Standing Financial Instructions;
(b) EU Directives and other statutory provisions;
(c) ~~Such of the~~ NHS Standard Contract Conditions ~~as are applicable.~~
(d) Contracts with other NHS Trust's must be in a form compliant with appropriate NHS guidance.
(e) ~~Where appropriate~~ Ccontracts must ~~shall~~ be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(2) In all contracts made by the Trust, the Trust Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

(3) Where appropriate ~~A~~ all contracts entered in to by the Trust should use the ~~Trusts~~ NHS standard terms and conditions. Where no~~ne~~ standard terms and conditions are proposed (either by internal Trust staff or an external supplier), those terms MUST be reviewed by the Trusts ~~Associate Director~~ Head of Procurement who will advise on the acceptability of those alternative terms and conditions before contracts are entered in to.

~~16.24~~16.22 Personnel and Agency or Temporary Staff Contracts

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

(2) Any situations where it is proposed that agency staff should be remunerated at a rate above the agency cap rate must be approved in accordance with the Trusts Policy in this area.

(3) Any Bank staff rate variations to be approved by Chief Executive and Chief Financial Officer.

~~16.25~~16.23 Disposals

Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned medical devices or equipment , which should be disposed of in accordance with the Management of Medical Devices & Equipment policy of the Trust;

(c) Medical Devices & Equipment. The process for disposal is outlined within the policy at 16.27(ib), with an asset value review carried out by the Capital Accountant/ Deputy Chief Financial Officer;

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

(e) land or buildings concerning which ~~Department of Health~~Department of Health and Social Care guidance has been issued but subject to compliance with such guidance.

~~16.26~~16.24 In-House Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering. In all cases where the Trust Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

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

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

(c) Evaluation team, comprising normally a specialist officer, ~~Associate Director of Procurement~~ and a Chief Financial Officer representative;

(d) The evaluation team shall make recommendations to the Trust Board.

~~16.27~~16.25 Applicability of Standing Financial Instructions on Tendering and Contracting to Charitable Funds

The general principles of these Standing Financial Instructions shall apply to works, services and goods purchased from the trust's Charitable Funds and private resources, including charities funding.

~~16.28~~16.26 Determination of Contracts for Failure to Deliver Goods or Materials

(1) There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

17. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

17.1 Standard NHS Contracts

(1) The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enter into suitable Service Level Agreements (SLA) or contracts with commissioners or other providers for the provision of NHS services, using the NHS Standard Contract or other formats that are in line with regulator guidance.

17.2 Cancellation of Contracts

(1) Except where specific provision is made in model Forms of Contracts or Standing Schedules of Conditions approved for use within the NHS, there shall be inserted in every written contract

a clause empowering the Trust to cancel the contract and to receive from the contractor the amount of any loss resulting from such cancellation :

(a) if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward (contrary to the Bribery Act 2010) for doing or forbearing to do or having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or
(b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust; or
(c) if the like act as shall have been done by any person employed by him/her or acting on his/her behalf (whether with or without the knowledge of the contractor); or
(d) if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.

17.3 Involving Partners and Jointly Managing Risk

(1) A good SLA / contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA / contract will apportion responsibility for handling a particular risk to the party or parties the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

18. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF EXECUTIVE DIRECTORS OF THE TRUST BOARD

18.1 Committee dealing with Remuneration and Terms of Service

(1) In accordance with Standing Orders the Trust Board shall appoint a Remuneration Committee of Non-Executive Directors. The Remuneration Committee shall have delegated responsibility for setting the remuneration and terms of service of the Trust's Chief Executive, Executive Directors and Very Senior Managers within the overall pay framework of the Trust .

(2) The Committee will:
(a) Agree and keep under review the overall remuneration policy of the Trust
(b) Determine the broad framework and policy for the employment, remuneration and terms and conditions of service of the Trust's Chief Executive, Executive Directors and Senior Managers in accordance with all relevant Trust guidelines including:
(i) salary (including any performance-related pay or bonus);
(ii) provisions for other benefits (including pensions and cars);
(iii) allowances.
(c) Agree a performance management framework for the Chief Executive and other Executive Directors;
(d) Receive reports on performance against objectives set for the previous year and note forward objectives for the Chief Executive (prepared by the Chairman) and the Executive Directors (prepared by the CEO). Performance of other Senior Managers will be monitored and evaluated by their line managers;
(e) Ensure that remuneration packages are affordable and enable people of appropriate high ability to be recruited, retained and motivated (this may require the Remuneration Committee to seek advice about pay structures and the state of the market for the role under recruitment);
(f) Undertake an annual review of Director salaries/remuneration packages;
(g) Receive reports on the Clinical Excellence Awards and other management allowances paid to medical staff;
(h) Ensure that all decisions are publicly defensible.

(3) The Remuneration Committee shall report to the Trust Board after each meeting (in private if required); if the matters discussed pertain to Executive Directors, these may be covered in the Chief Executive's report to the Trust Board.

(4) The Committee will ensure that emoluments for the Trust Board are accurately reported in the required format in the Trust's Annual Report and Accounts.

(5) The Trust will pay allowances to the Chairman and non-officer members of the Trust Board in accordance with instructions issued by the ~~Secretary of State for Health~~Secretary of State for Health and Social Care.

18.2 Staff Appointments

(1) No employee shall engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in remuneration without Executive approval unless:
- (a) It is within the limit of their approved budget and funded establishment; and
- (b) It is within the structure of the NHS National Pay Frameworks (e.g. Agenda for Change) and
- (c) For agency staff, the remuneration rate is within the published rate caps.

(2) The Trust Board will approve procedures presented by the Chief Executive or by delegation to the Director responsible for Workforce, for the determination of commencing pay rates, condition of service, etc., for employees.

(3) All time sheets and other pay records and notifications shall be in a format approved by the Chief Financial Officer and Director of Workforce, and shall be certified and submitted in accordance with instructions issued by the Chief Financial Officer.

(4) A signed copy of the appointment form and other such documents as they may require shall be sent to the Chief Financial Officer and Director of Workforce immediately upon a new employee commencing duty.

(5) The Chief Financial Officer and Director of Workforce shall be notified immediately and in a prescribed format, upon the effective date of change in the state of employment or personal circumstances of an employee being known.

(6) The Trust will use the VSM National Pay Framework, to inform any local VSM reviews that are undertaken by Remuneration Committee.

18.3 Funded Establishment

(1) The workforce plans incorporated within the annual budget form the funded establishment.

(2) The funded establishment of any department may not be varied without the approval of the Chief Executive. Budget Holders may change bands within the funded establishment as long as the overall establishment budget is not exceeded and the Departmental Finance Manager and HR Manager have been consulted.

18.4 Off –Payroll Engagements

No Executive Director or employee may engage or re-engage any individual who is not to be paid via the Trusts payroll unless the IR35 Review process has been applied by the Trusts HR Department and a decision to engage or reengage via an off-payroll arrangement has been approved by the Chief Financial Officer and the Director responsible for Workforce or their nominated deputies.

18.5 Processing Payroll

(1) The Director responsible for Workforce is responsible for:
- (a) specifying timetables for submission of properly authorised time records and other notifications;
- (b) the final determination of pay and allowances;
- (c) making payment on agreed dates; and
- (d) agreeing method of payment.

(2) The Director responsible for Workforce will issue instructions regarding:
(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act;
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheque, bank credit, or cash to employees and officers;
(I) procedures for the recall of cheques and bank credits;
(i) pay advances and their recovery;
(j) maintenance of regular and independent reconciliation of pay control accounts;
(k) separation of duties of preparing records and handling cash; and
(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

(2) Appropriately nominated managers have delegated responsibility for:
(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;
(c) maintaining detailed and accurate records of hours worked which will result in enhanced payments (e.g. overtime, unsocial hours, call outs, etc.); and
(d) maintaining detailed absence records for all employees and completing absence returns as specified by the Director responsible for Workforce.;
(e) submitting termination forms and other such documents as the Director responsible for Workforce may require in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement;
(f) Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left the Trust without notice, the Director responsible for Workforce must be informed immediately.

(3) Regardless of the arrangements for providing the payroll service, the Director responsible for Workforce 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.

(4) Overall responsibility for the determination of pay, including verification that rate of pay and relevant conditions of service is in accordance with current agreements, shall rest with the Director responsible for Workforce. The Chief Financial Officer shall have overall responsibility for the proper compilation of the payroll, and for payments made.

(5) All employees shall be paid by bank credit transfer, unless otherwise agreed by the Chief Financial Officer.

(6) Overall responsibility for payment of staff expenses shall rest with the Chief Financial Officer, or an authorised agent, in accordance with Trust policy, upon receipt of a prescribed claim form, duly completed and signed by a designated signatory. It is the duty of designated signatories to assure themselves that the claims they certify are genuine and correct.

18.6 Contracts of Employment

(1) The Trust Board shall delegate responsibility to the Director responsible for Workforce for:
- (a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Trust Board and which complies with employment legislation; and
- (b) dealing with variations to, or termination of, contracts of employment.

(2) The Director responsible for Workforce will prepare detailed procedures for the preparation, variation to and termination of contracts of employment, and ensure these are notified to managers.

19. NON-PAY EXPENDITURE

19.1 Delegation of Authority

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

(2) The Chief Executive will set out:
- (a) the list of managers who are authorised to place requisitions for the supply of goods and services;
- (b) the maximum level of each requisition and the system for authorisation above that level.

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

19.2 Requisitioning, Ordering, Receipt and Payment for Goods and Services

(1) The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

(2) All purchases of goods, works and services must be supported by appropriately certified orders before the acquisition of those goods, works or services is contractually committed, unless the Chief Financial Officer agrees otherwise.

(3) The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims supported by appropriately certified orders. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

(4) The Chief Financial Officer will:
- (a) advise the Trust Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in to Standing Orders and Standing Financial Instructions and regularly reviewed;
- (b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds (Note: Purchase orders/requisitions must be completed for the full cost of the service and must not be split into separate elements to circumvent delegated limts);
- (c) be responsible for the prompt payment of all properly authorised accounts and claims;
- (d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
  - (i) A list of employees or holders of office (including specimens of their signatures) authorised to approve the placing of orders and/or certify invoices;
  - (ii) Certification that:
    1. goods have been duly received, examined and are in accordance with specification and the prices are correct;

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

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

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

(e) be responsible for ensuring that payment for goods and services is only made once the goods, works and services are received.

19.3 Prepayments

(1) Prepayments are only permitted where exceptional circumstances apply and following approval by the Chief Financial Officer. In such instances:

(a) Pre-payments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

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

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

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

(e) In the case of contracts which require payments to be made on account during progress of the work / delivery of equipment, the Chief Financial Officer shall make progress payments on receipt of a certificate / invoice signed by the Director of Estates & Facilities or Associate Director of Procurement . Prior to payment of the final account, the Chief Financial Officer may arrange a financial examination of the project as he thinks appropriate.

19.4 Official Orders

(1) Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Financial Officer;

(c) state the Trust's terms and conditions of trade; and

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

19.5 Duties of all Staff

(1) All staff must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation),

leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

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

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

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
   (i) isolated gifts to the Trust of a trivial character or inexpensive seasonal gifts to the Trust, such as calendars;
   (ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

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

(j) changes to the list of directors / employees authorised to certify invoices are notified to the Chief Financial Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer; and

(l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

(2) The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE (Health Building Note 00-08). The technical audit of these contracts shall be the responsibility of the relevant Director.

19.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

(1) Payments to local authorities and voluntary organisation's made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

20. EXTERNAL BORROWING

(1) The Chief Financial Officer will advise the Trust Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the ~~Department of Health~~Department of Health and Social Care. The Chief Financial Officer is also responsible for reporting periodically to the Trust Board concerning the PDC debt and all loans and overdrafts.

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

(3) The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

(4) All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the ~~Department of Health~~Department of Health and Social Care.

(5) Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Trust Board must be made aware of all short term borrowings at the next Trust Board meeting.

(6) All long-term borrowing must be consistent with the plans outlined in the current Financial Planning Return (FPR) and be approved by the Trust Board.

21. INVESTMENTS

(1) Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Trust Board.

(2) The Chief Financial Officer is responsible for advising the Trust Board on investments and shall report periodically to the Trust Board concerning the performance of investments held.

(3) The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

22. FINANCIAL CONTROL TOTAL

(1) The Chief Financial Officer should ensure that members of the Trust Board are aware of the Trusts Financial Control Totals that have been agreed with NHSI and the Single Oversight Framework for NHS Providers which sets out the basis of assessing the level of support a Trust may require to deliver its financial responsibilities. The Chief Financial Officer should also ensure that the Trust Board is regularly updated on the delivery of the Financial Control Total.

(2) The Chief Financial Officer will regularly update the Trust Board on current and future NHSI regulatory requirements and/or restrictions.

23. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

23.1 Capital Investment

(1) The Chief Executive:

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

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

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

(3) For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies; and

(iii) appropriate project management and control arrangements;

c) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

(4) For capital schemes where the contracts stipulate stage payments, the Chief Executive will

issue procedures for their management, incorporating the recommendations of CONCODE or ESTATECODE(Health Building Note 00-08) .

(5) The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

(6) The Chief Financial Officer shall issue procedures for the regular reporting of capital expenditure and commitment against authorised expenditure.

(7) The approval of a capital programme shall not constitute approval for expenditure on any scheme.

(8) The Chief Executive shall issue to the manager responsible for any scheme:
(a) specific authority to commit expenditure;
(b) authority to proceed to tender;
(c) approval to accept a successful tender

(9) The Chief Executive will issue a scheme of delegation for capital investment management in accordance with ESTATECODE(Health Building Note 00-08)/CONCODE guidance and the Trust's Standing Orders.

(10) The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes.

23.2 Private and Alternative Financing

(1) The Trust should normally test for Private and Alternative Financing when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its allocations, the following procedures shall apply:
(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
(b) Where the sum involved exceeds delegated limits, the business case must be referred to NHSI for a risk assessment and decision to approve the borrowing.
(c) The proposal must be specifically agreed by the Trust Board.
(d) Where a capital scheme is funded using Private or Alternative Financing, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

23.3 Asset Registers

(1) The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year. All discrepancies revealed during the verification exercise shall be notified to the Chief Financial Officer.

(2) The Trust shall maintain an asset register f or recording fixed assets. The minimum data set to be held within this register shall be as specified in the ~~*Department of Health*~~*Department of Health and Social Care* *Group Accounting Manual* ~~issued by the Department of Health~~.

(3) Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:
(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including

appropriate overheads;
(c) lease agreements in respect of assets held under a finance lease and capitalised.

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

(5) The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

(6) The value of each asset shall be indexed to current values in accordance with methods specified in the ~~*Department of Health*~~*Department of Health and Social Care Group Accounting Manual* ~~issued by the Department of Health~~.

(7) The value of each asset shall be depreciated using methods and rates as specified in the ~~*Department of Health*~~*Department of Health and Social Care Group Accounting Manual* ~~issued by the Department of Health~~.

(8) The Chief Financial Officer shall calculate and pay capital charges as specified in the ~~*Department of Health*~~*Department of Health and Social Care Group Accounting Manual* ~~issued by the Department of Health~~.

23.4 Security of Assets

(1) The overall control of fixed assets is the responsibility of the Chief Executive.

(2) Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:
(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset;
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

(3) All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

(4) Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Trust Board Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

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

(6) Where practical, assets should be marked as Trust property.
(7) Assets valued at more than £5,000 shall be recorded in the Asset Register, and under this value should be entered in ward and department inventories.

24. STORES AND RECEIPT OF GOODS

24.1 General Position

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

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

~~(c)~~(d) Subject to regular product reviews to ensure value for money (VFM) and in line with current legislation and directives.

24.2 Control of Stores, Stocktaking, Condemnations and Disposal

(1) Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated within the procurement team structure. ~~to an employee by the Chief Executive.~~ The day-to-day responsibility ~~may be~~is delegated ~~by him to departmental~~ to employees and stores managers and materials management staff~~/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer.~~ The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

(2) The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

(3) The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

(4) Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year, to coincide with the financial year end (unless a continuous stock checking system is in operation). The physical check shall involve at least one officer other than the person responsible for the stock / store. Stocktaking records shall be in a format prescribed by the Chief Financial Officer be numerically controlled and signed by the officers undertaking the check.

(5) Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

(6) The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

(7) Any surpluses or deficiencies revealed on stocktaking shall be reported to the Chief Financial Officer who may investigate if appropriate. Known losses of stock items not subject to stores control shall be reported to the Chief Financial Officer.

(8) Stocks which have been damaged, deteriorated or are not usable for any other reason than their intended purpose, or may have become obsolete, shall be written down to their net realisable value. Managers seeking to write off such values should follow procedures for reporting losses as laid down by the Chief Financial Officer.

(9) All goods received shall be entered onto an appropriate goods receive/stock record on the day of receipt. A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods.

(10) All goods received shall be checked as regards quantity and/or weight and be inspected as to quality and specification. If goods received are unsatisfactory, the record shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short delivery, they shall only be accepted on the authority of the departmental manager or the Supplies Manager, and the supplier shall be notified immediately.

The issue of stocks shall be supported by an authorised requisition note. Where a 'top up' system is used, a record shall be maintained as approved by the Chief Financial Officer.

24.3 Goods Supplied by Supply Chain Corporation Limited (SCCL) ~~NHS Supply Chain~~SCCL/Neutral Wholesaler

(1) For goods supplied via the Supply Chain Corporation Limited (SCCL) ~~NHS Supply Chain~~SCCL/Neutral Wholesaler, the Chief Financial Officer shall identify those authorised to requisition and accept goods from the store if relevant. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.

25. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

25.1 Disposals and Condemnations

(1) The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

(2) When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

(3) All unserviceable articles shall be:
(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;
(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer 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 Chief Financial Officer.

(4) The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

25.2 Losses and Special Payments

(1) The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

(2) Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer must inform the relevant LCFS and NHS Counter Fraud Authority regional team in accordance with ~~Secretary of State for Health~~Secretary of State for Health and Social Care's Directions.

(3) The Chief Financial Officer must notify NHS Counter Fraud Authority and the External Auditor of all frauds.

(4) For losses apparently caused by theft, arson, neglect of duty or gross carelessness,

except if trivial, the Chief Financial Officer must immediately notify:
(a) the Trust Board, and
(b) the External Auditor.

(5) Within limits delegated to it by the ~~Department of Health~~Department of Health and Social Care, the Trust Board shall approve the writing-off of losses.

(6) The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

(7) For any loss, the Chief Financial Officer shall consider whether any insurance claim can be made.

(8) The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

(9) No special payments exceeding delegated limits shall be made without the prior approval of the ~~Department of Health~~Department of Health and Social Care. These shall be approved by the Trust Board.

(10) All losses and special payments must be reported to the Audit Committee on a regular basis.

26.0 INFORMATION TECHNOLOGY

26.1 Responsibilities and duties of the Chief Financial Officer

(1) The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:
(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, the Trust or damage, having due regard for the Data Protection Act 1998;
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

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

(4) The Director responsible for Communications and Stakeholder Engagement shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

26.2 Responsibilities and Duties of Other Directors and Officers in relation to Computer Systems of a General Application

(1) In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the local health economy wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial

Officer:
(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

26.3 Contracts for Computer Services with Other Health Bodies or Outside Agencies

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

(2) Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

26.4 Risk Assessment

(1) The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

26.5 Requirements for Computer Systems which have an Impact on Corporate Financial Systems

(1) Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:
(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Chief Financial Officer staff have access to such data; and
(d) such computer audit reviews as are considered necessary are being carried out.

27. PATIENTS' PROPERTY

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

(2) The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:
(a) notices and information booklets;
(b) hospital admission documentation and property records;
(c) the oral advice of administrative and nursing staff responsible for admissions.

(3) The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

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

(5) Where ~~Department of Health~~Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

(6) In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

(7) Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

(8) Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

28. CHARITABLE FUNDS

28.1 Corporate Trustee

(1) The Trust has responsibilities as a Corporate Trustee for the management of funds it holds on Trust, and needs to comply with the Charity Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

(3) The Chief Financial Officer shall ensure that each Trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

8.1

28.2 Accountability to Charity Commission and ~~Secretary of State for Health~~Secretary of State for Health and Social Care

(1) The Trustee's responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for Charitable Funds and to the Secretary of State for all Charitable Funds.

(2) The Schedule of Matters Reserved to the Trust Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board Directors and Trust officers must take account of that guidance before taking action.

28.3 Applicability of Standing Financial Instructions to Charitable Funds

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of Charitable Funds.

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

ACCEPTANCE OF GIFTS TO TRUSTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

(1) The Chief Financial Officer shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts, hospitality and sponsorship and other benefits in kind by staff. This policy follows the guidance contained in the ~~Department of Health~~Department of Health and Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions. The 'Code of Conduct for NHS Managers' and 'Managing Conflicts of Interest in the NHS' shall also apply.

29. RETENTION OF RECORDS

(1) The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with ~~Department of Health~~Department of Health and Social Care guidelines.

(2) The records held in archives shall be capable of retrieval by authorised persons.

(3) Records held in accordance with latest ~~Department of Health~~Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive.

30. RISK MANAGEMENT AND INSURANCE

30.1 Programme of Risk Management

(1) The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Trust Board.

(2) The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;
(b) engendering among all levels of staff a positive attitude towards the control of risk;
(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
(f) a clear indication of which risks shall be insured; and
(g) arrangements to review the risk management programme.

(3) The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current ~~Department of Health~~Department of Health and Social Care guidance.

30.2 Insurance: Risk Pooling Schemes administered by NHS RESOLUTION

(1) The Trust Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution ~~(formerly NHS Litigation Authority)~~ or self- insure for some or all of the risks covered by the risk pooling schemes. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

30.3 Insurance Arrangements with Commercial Insurers

(1) There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust's may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
(b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
(c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation

activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the ~~Department of Health~~Department of Health and Social Care.

30.4 Arrangements to be followed by the Trust Board in agreeing Insurance Cover

(1) Where the Trust Board decides to use the risk pooling schemes administered by the NHS Resolution, the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Trust Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Trust Board is informed of the nature and extent of the risks that are self- insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

MATTERS RESERVED TO THE TRUST BOARD AND SCHEME OF DELEGATION

31. INTRODUCTION

The purpose of this document is to set out how powers are reserved to the Trust Board, generally matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. The Trust Board remains accountable for all of its functions, even those delegated to the Chairman, individual directors or officers or committees of the Trust Board, and must therefore receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Requirements under Other Framework Documents
Details of the reservation of powers by the Trust Board and of where powers may be delegated are laid out within several documents. These include, The Accountable Officer Memorandum and issued codes of accountability (included within the Trusts Standing Orders)

In particular, Standing Orders (S 5.1) provides that "subject to such directions as may be given by the Secretary of State, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, of any of its functions by a Committee or sub-committee appointed by virtue of Standing Order 4,or by an officer of the Trust, or by another body as defined in Standing Order 5.1 (2) below, in each case subject to such restrictions and conditions as the Trust Board thinks fit". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust Board.

Application of Powers and Responsibilities of Officers

Role of the Chief Executive
All powers of the Trust which have not been retained as reserved by the Trust Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive has a responsibility to prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other directors and officers.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer the Chief Executive is accountable to the Accounting Officer of NHS Improvement for the funds entrusted to the Trust.

Caution over Use of Delegated Powers
Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for public concern.

Directors' Ability to Delegate their own Delegated Powers
The Scheme of Delegation provides direction on the "top level" of delegation within the Trust and on certain detailed delegated powers. It is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Absence of Directors of Officers to Whom Powers have been Delegated
In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by the director or officer's superior unless alternative arrangements have been approved by the Trust Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Chairman or Vice Chairman in the Chairman's absence after taking appropriate advice from the Chief Financial Officer.

33.0 DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions that may have a far-reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

LEVEL	BUDGET HIERARCHY	Limit
0	External Approval e.g. NHSI	
1	Trust Board [(1)],	>£1,000,000
2a	2b below plus Chief Executive approval	£250,000 to £999,999
2b	2c below plus Chief Financial Officer approval	£100,000 to £249,999
2c	~~Executive Management Board~~Senior Management TeamSenior Management Team, Healthcare Group Board, Chief Executive, Chairman, Executive Board Director (Voting & Non-Voting),	(£50,000 - £99,999
3	Associate Medical Directors, Associate Nursing Directors, Associate Operational Directors, Corporate Service Directors, Deputy Directors, ICT Board	£20,000 - £49,999
4	Head of Services, Head of Nursing, Clinical Service Leads, General Manager, Chief Pharmacist	£10,000 - £19,999
5	Deputy Head, Service Manager, Matrons	£2,500 – £9,999
6	Budget Holders	0 – £2,499
7	Non Budget Holder - No Financial Authority	None

(1) Or delegated committee

Delegated Matter	Authority Delegated To
A. Accountability	
a) Accountable officer to NHS Improvement for stewardship of NHS resources	Chief Executive
b) Ensuring expenditure by Trust complies with NHS Improvement requirements is prudent, efficient, economical and effective	Chief Executive and Chief Financial Officer
c) Advice to Trust Board on matters of probity	Chief Executive, Chief Financial Officer and Head of Corporate Affairs
B. Strategy and Plans	
a) Approve the strategic aims and objectives of the Trust	Trust Board
b) Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State and relevant regulatory bodies	Trust Board
c) Approve the Trust's policies for the management of risk and the requirements of being a Category One Responder laid down by the Civil Contingencies Act 2004	Trust Board
d) Approve the Trust's organisational development plan including values, standards and behaviours	Trust Board
C. Regulations and Control	
a) **Approve Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Trust Board and all other instructions for the regulation of its proceedings and business**	Trust Board
b) **Suspend Standing Orders and ratify any instances of failure to comply with Standing Orders**	Trust Board (decisions reviewed by Audit Committee)
c) Vary or amend Standing Orders, Standing Financial Instructions or Matters Reserved to the Trust Board	Trust Board
d) Ratify urgent decisions taken outside the Trust Board cycle	Trust Board
e) Final authority in interpretation of Standing Orders	Chairman and Chief Executive
f) Final authority in interpretation of Standing Financial	Chief Financial Officer

Instructions	
g) Approve the Scheme of Delegation and powers from Trust Board to Committees	Trust Board
h) Consider declarations of interest and any conflicts which may arise	Chairman/Meeting Chairman
i) Approve arrangements for dealing with complaints	Trust Board (may be delegated to Quality and Safety Committee)
j) Establish Terms of Reference and reporting arrangements for all Committees of the Trust Board	Chairman and Head of Corporate Affairs on behalf of the Trust Board
k) Receive reports from Committees and act on recommendations as required	Trust Board
l) Approve arrangements relating to the discharge of the Trust's responsibilities for acting as Corporate Trustee for Charitable Funds	Trust Board
m) Approve management policies including personnel policies	Trust Policy Group
n) Approve arrangements for arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property	Chief Financial Officer on behalf of Trust Board
D. Business Cases and Authority to Invest (Inclusive of VAT)	
a) Business cases up to £50,000	Healthcare Group Boards and Capital Working~~Planning~~ Group where appropriate Recommended by Healthcare Group Boards subsequently approved by ~~Executive Management Board~~Senior Management Team & Capital Working~~Planning~~ Group where appropriate
b) Business Cases £50,000 to £999,999	
c) Business cases £1,000,000- £5,000,000 or 3% of the Trusts Audited accounts for the previous year(1)	~~Executive Management Board~~Senior Management Team & Capital ~~Planning~~ Working Group where appropriate, with subsequent recommendation by Performance and Finance Committee & Trust Board approval.
d) Business Cases Above £5,000,000 or 3% of the Trusts Audited accounts for the previous year(1)	Capital ~~Planning~~ Working Group, ~~Executive Management Board~~Senior Management Team & Performance and Finance Committee, Trust Board & NHS Improvement
e) Authority to Invest – Equipment Replacement and Capital Expenditure up to £50,000	Healthcare Group Boards with Deputy Chief Financial Officer –Operational Finance, Capital ~~Planning~~ Working Group and Medical Devices Group Lead where appropriate.
(1)Prevailing NHS Improvement guidance in place when Business Case Approved	

1. Management of Budgets	
a) Responsibility of keeping expenditure within budgets	
i) At individual budget level (Pay and Non Pay)	Budget Holder (usually a senior manager/nurse)
ii) At Healthcare Group or Corporate level	Associate Chief Medical Officer of Healthcare Group/Executive Director
iii) Overall responsibility for the budgets	Chief Executive
b) Virement (Budget Transfer between Department) of Resource	in accordance with Trust Policy
2. Bank Accounts and Loans	
a. Opening and Closing of Bank Accounts	Chief Financial Officer
b. Maintenance and operation of bank accounts	Chief Financial Officer
c. Loan arrangements	Chief Financial Officer
d. Working Capital Facility (DH guidance)	Trust Board
3. Non-Pay Revenue Expenditure/Requisitioning/ Ordering/Payment of Goods & Services (Note: Purchase orders/requisitions must be completed for the full cost of the service and must not be split into separate elements to circumvent delegated limits)	
a) Authorisation of Non-Stock Requisitions	
i) requisition up to £2,499	Level 6
ii) requisition from £2,500 to £9,999	Level 5
iii) requisition from £10,000 to £19,999	Level 4
iv) requisition from £20,000 to £49,999	Level 3
v) requisition from £50,000 to £99,999	Level 2
vi) requisition from £100,000 to £249,999	Two Executive Directors, one of whom is the Chief Financial Officer
vii) requisitions from £250,000 to £999,999	Chief Executive and Chief Financial Officer
viii) requisitions over £1,000,000	Agreement by Trust Board authorised by Chief Executive, Chief Financial Officer & Chairman

The transactions below do not require a requisition: i) Eye vouchers, ii) Child Care Vouchers or any other deduction from staff pay that falls due to an external organisation iii) Refund of interview expenses ~~iv) Gas, water and electricity bills~~ ~~v) Rent and Rates~~ ~~vi)~~iv) NHS Resolution v) Compensation under legal obligation vi) Individual Trust Credit card purchases vii) Volunteer Expenses ~~vii)~~viii) Ex gratia payments for losses of Patients Personal effects	
b) Authorisation of Invoices i) invoices up to £2,499 ii) invoices from £2,499 to £9,999 iii) invoices from £10,000 to £19,999 iv) invoices from £20,000 to £49,999 v) invoices from £50,000 to £99,999 vi) invoices from £100,000 to £249,999 vii) invoices from £250,000 to £999,999 viii) invoices over £1,000,000	Level 6 Level 5 Level 4 Level 3 Level 2 Two Executive Directors, one of whom is the Chief Financial Officer Chief Executive & Chief Financial Officer Agreement by Trust Board authorised by Chief Executive, Chief Financial Officer & Chairman
c) Authorisation of Non Pay Capital Expenditure/Invoices/ Ordering/Payment of Goods & Services i) up to £74,999 - Capital Scheme Budget Holder ii) £75,000 to £149,999 - Capital Scheme Budget Holder together with Deputy Chief Financial Officer (Operational Finance) or Chief Financial Officer iii) £150,000 plus - Capital Scheme Budget Holder together with Deputy Chief Financial Officer (Operational Finance) with Chief Financial	i) invoices up to £19,999 - Level 4 (Heads of Service) and Capital Project Lead ii) invoices from £20,000 to £49,999 – as above and Level 3 (Associate/Deputy Directors) iii) invoices up to £50,000 to £99,999 – As above with Deputy Chief Financial Officer (Operational Finance) or Chief Financial Officer

Officer or Chief Executive	iv) invoices from £100,000 to £249,999 – as per revenue (Two Executive Directors, one of whom is the Chief Financial Officer) v) invoices from £250,000 to £999,999 – as per revenue (Chief Executive & Chief Financial Officer) vi) invoices over £1,000,000 – as per revenue (Agreement by Trust Board authorised by Chief Executive, Chief Financial Officer & Chairman)
~~**c) Authorisation of Non Pay Capital Expenditure/Invoices/ Ordering/Payment of Goods & Services**~~ ~~i) up to £74,999~~ ~~ii) £75,000 to £149,999~~ ~~iii) £150,000 plus~~ ~~*All authorisations are subject to Business Case and Authority to Invest Approval as quoted in Section D above.*~~ ~~**For projects managed by external project managers the above applies.**~~	~~Capital Scheme Budget Holder~~ ~~Capital Scheme Budget Holder together with Deputy Chief Financial Officer – Operational Finance or Chief Financial Officer~~ ~~Capital Scheme Budget Holder together with Deputy Chief Financial Officer – Operational Finance with Chief Financial Officer or Chief Executive~~

d) ~~NHS Supply Chain~~SCCL/Neutral Wholesaler(s) i) Invoices up to £59,999 ii) Invoices >£60,000	 Associate Director of Procurement Associate Director of Procurement & Deputy Chief Financial Officer – Operational Finance
e) Non-pay Expenditure for new expenditure items, where no specific budget has been set up and are not subject to funding under delegated powers of virement. (Subject to the limits specified in 3a) above)	Chief Financial Officer & Deputy Chief Financial Officer – Operational Finance
f) Orders exceeding 12 month period (subject to limits in 3 a above)	Associate Director of Procurement. **NOTE: Corporate and Healthcare Groups may not commit the Trust to contracts without authorisation from the responsible Executive Director**
g) All contracts for goods & services and subsequent variations to contracts (excluding leases)	
i) Extensions of existing contracts < £1,000,000 (Inclusive of VAT)	Chief Financial Officer with recommendation of Associate Director of Procurement
ii) Extension of existing contracts > £1,000,000 (Inclusive of VAT)	Trust Board with recommendation from originating department As above and to be ratified at the following Trust Board meeting **NOTE: Corporate and Healthcare Groups may not commit the Trust to contracts without authorisation from the responsible Executive Director**
h) Granting, signing and termination of lease (Operating and Finance) i) Up to £99,999 lease lifetime value ii) Between £100,000 and £299,999 lease lifetime value iii) Over £300,000 lease lifetime value	 Deputy Chief Financial Officer – Operational Finance Chief Financial Officer Non-Executive Director with either the Chief Executive or the Chief Financial Officer
i) Compensation under legal obligation (any value)	Chief Executive and Chief Financial Officer and Director responsible for Workforce

j) Legal Advice	
i) Expected value of advice on a single case up to £1,000	Executive Director
ii) Expected value of advice on a single case from £1,000 to £5,000	Executive Director and the Chief Finance Officer or Chief Executive
iii) Expected value of advice on a single case above £5,000	Chief Executive
k) Engagement Consultancy	
i) Contract or expected value up to £50,000	Chief Financial Officer
ii) Contract or expected value over £50,000	Performance & Finance Committee then to NHS Improvement
l) Trust Purchase Cards	
Approve application for Trust Purchase Cards	Chief Financial Officer
Establishing Credit and individual transaction limits	
i) Monthly credit limits up to £2,000	Purchase Card Holders
ii) Monthly credit limits above £2,000	Chief Financial Officer
iii) Transaction Limits up to £250	Purchase Card Holders
iv) Transaction Limits above £250	Chief Financial Officer
4. Capital Schemes	
a) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Chief Financial Officer and Chief Operating Officer
b) Financial monitoring and reporting on all capital scheme expenditure	Chief Financial Officer
c) Responsibility for Projects within Capital Project Budgets	Director of ~~Quality Improvement~~ Strategy
5. Quotation, Tendering & Contract Procedures: Quotes/Tenders should be obtained and opened/approved by (according to value)	
a) **Quotations using Trust's eSourcing system (Inclusive of VAT)**	
~~i) Obtaining two minimum quotations for goods/services up to £7,499~~	~~Level 5~~
i) Obtaining 1 minimum quotations for goods/services up to £499	Level 5
ii) Obtaining 2 minimum quotations for goods/services from £500-£4999	Level 3
iii) Obtaining 3 minimum quotations for goods/services from	

£5000 - £24,999 iv) Obtaining written competitive tenders for goods/services over £25,000 ~~ii) Obtaining three written quotations for goods/services up to from £24,999.~~ ~~£7,500 - £24,999~~ ~~iii) Obtaining written competitive tenders for goods/services over £25,000~~	Level 3 in consultation with Procurement Department Level 3~~/Procurement Buyers~~ Level 3 in consultation with Procurement Department
b) **Waivers of Quotations and Tenders (Inclusive of VAT)** i) Waivers of quotations for goods/services up to £24,999 ii) Waivers of tender from £25,000 to OJEU threshold	 Head of Procurement or Associate Director of Procurement Deputy Chief Financial Officer – Operational Finance
c) **Opening Tenders (Inclusive of VAT)** ~~Paper-based tenders:~~ ~~i) From £25,000 to £249,999~~ ~~ii) From £250,000 to £749,999~~ ~~iii) Over £750,000~~ Electronic tenders d) **Contract Acceptance** OJEU Tenders/Mini-Competition/: Contract over £1,000,000 (Inclusive of VAT) **NOTE: Corporate and Healthcare Groups may not commit the Trust to contracts without authorisation from the responsible Executive Director**	 ~~Two Officers at Band 8 or above~~ ~~Two Executive Directors~~ ~~Chief Executive or Chief Financial Officer and Chair/Non Executive Director~~ Electronic opening through 'time-lock' release via the E-Procurement Portal. Associate Director of Procurement, Budget Holder (in accordance to SFI threshold)& Chief Financial Officer Trust Chairman and one Non-Executive Director to be ratified at following Trust Board meeting
6. **Setting of Fees and Charges** i) Private patients, overseas visitors, income generation and other patient related services	 Chief Financial Officer

ii) Pricing of NHS contracts	Chief Financial Officer
iii) Approval of healthcare contracts and other agreements resulting in income to the Trust	
Up to £40,000,000 and in year variations	Chief Executive and Chief Financial Officer
Over £40,000,000	Trust Board
iv) Approval of non-healthcare contracts and other agreements resulting in income to the Trust	
Up to £10,000,000 and in year variations	Chief Financial Officer
Over £10,000,000	Trust Board
7. **Engagement of Staff Not on the Establishment**	
a) Interim staff or consultancy assignments following completion of the IR35 Review process signed off by the Chief Financial Officer and Director responsible for Workforce	
i) With allocated funding up to £50,000	Responsible Executive Director
ii) Without allocated funding up to £50,000	Chief Executive and Chief Financial Officer
iii) Any Contract over £50,000	Performance & Finance Committee then to NHS Improvement
	NOTE: All interim staff or consultancy assignments are subject to review and approval by a committee established for that purpose.
Subject to limits outlined in section 1 a) Authorisation of Non-Stock Invoices	
Agencies from accredited frameworks must be used. This is in line with NHS Improvement guidance. **Standard HR processes to be followed**	
b) Booking of Bank, Agency and Locum Staff following completion of the IR35 Review process signed off by the Chief Financial Officer and Director of Workforce	Level 6
	NOTE: All use of bank, agency and locum staff is subject to review and approval by a committee established for that purpose.

8. Charitable Funds	
a) Authorisation of Purchase Orders	
i) Up to £1,000 per request	Fund Manager
ii) Over £1,001 but below £10,000	Financial Representative on the Charitable Funds Committee
iii) Over £10,000 per request	Chief Financial Officer and Chair of Charitable Fund Committee (or nominated deputy) after approval by Charitable Fund Committee
b) Authorisation of invoices with Purchase Order	
i) Up to £1,000	Fund Manager
ii) Over £1,001 but below £10,000	Financial Representative on the Charitable Funds Committee
iii) Over £10,000	Chief Financial Officer and Chair of Charitable Fund Committee (or nominated deputy)
c) Review/approve acceptance of restricted funds	Charitable Funds Committee
9. Agreements/Licences re Properties	
a) Preparation of all tenancy agreements/licences for all staff subject to Trust Policy and accommodation for staff	Director of Quality Improvement
b) Extension to existing property leases	Chief Financial Officer
c) Letting of premises to outside organisations	Chief Financial Officer
d) Approval of rent based on professional valuation	Chief Financial Officer
10. Condemning & Disposal	
a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Condemning Decision Condemning Officer and Head of Department with the item to be condemned or disposed of Disposal Condemning Officer and Head of Financial Services
11. Losses, Compensation and Write-offs	

a) Losses and Special Payments (including Compensation) Register	
i) Maintenance of Losses and Special Payments Register	Chief Financial Officer
ii) Review of schedules of Losses, Special Payments and Compensations and make recommendations to the Trust Board	Audit Committee
b) Clinical cases settled by the NHS Resolution	Chief Financial Officer and Chief Nurse or Chief Executive
c) Non-Clinical Cases	
i) Losses and cash due to the Trust, fraud, overpayment and others	Chief Executive and Chief Financial Officer
ii) Fruitless payments	Chief Executive and Chief Financial Officer
iii) Bad debts and claims abandoned	Chief Executive and Chief Financial Officer in line with Trust's Bad Debt Policy
iv) Damages to buildings, fittings, furniture and equipment and loss of property in stores and in use	Chief Executive and Chief Financial Officer
v) Compensation payments made under legal obligation	Chief Executive and Chief Financial Officer and Director responsible for Workforce
vi) Extra Contractual payments to contractors	Chief Executive and Chief Financial Officer
Ex-gratia for Patients Personal Effects (any amount)	Chief Executive and Chief Financial Officer
d) Authorisation to Write-off Debts	
i) Maintenance of a Register of Write-offs and advising the Audit Committee of any write-offs	Chief Financial Officer
ii) Writing off of individual debts	
(i) Up to £249	Head of Financial Services
(ii) Up to £999	Deputy Chief Financial Officer – Operational Finance
(iii) Up to £9,999	Chief Financial Officer
(iv) Up to £49,999	Chief Executive and Chief Financial Officer
(v) Over £50k	Audit Committee
iii) Any debts authorised for write off **MUST** be notified to the Trusts Credit Controller	
12. Reporting of Incidents to the Police	

a) Where a criminal offence is suspected (of any type except fraud) b) Where a fraud is involved	Chief Executive or Chief Operating Officer or Director responsible for Workforce Chief Financial Officer in line with the counter-fraud policy and Local Counter Fraud Specialist
13. Petty Cash Disbursements a) Expenditure up to £25 per item b) Expenditure over £25 per item will only be by exception	Budget Holder (Senior Manager/Nurse) Deputy Chief Financial Officer – Operational Finance
14. Hospitality i) Approve procedures for declaration of hospitality ii) Maintenance of Trust's hospitality register iii) Approval of receipt of both individual and collective hospitality iv) Approval of corporate hospitality including attendance at events (e.g. for receipt of awards)	Trust Board Head of Corporate Affairs Executive Director Executive Team
15. Audit **a) Internal Audit** i) Having an effective Internal Audit Function in place ii) Approval and review of Internal Audit arrangements and service provider iii) Delivery of management actions on Internal Audit Recommendations iv) Follow-up and verification of delivery of management actions v) Devising an annual Internal Audit Plan vi) Approving the annual Internal Audit Plan vii) Receiving the Head of Internal Audit Opinion	Chief Financial Officer Audit Committee Trust Manager identified as Lead Manager for that Internal Audit investigation Internal Audit Service Chief Financial Officer supported by ~~Executive Management Board~~Senior Management Team (or successor body) and Compliance Manager Audit Committee

	Audit Committee and Trust Board
b) External Audit i) Having an effective External Audit Function in place ii) Oversee External Audit arrangements for Trust iii) Oversee External Audit/Independent Review of Charitable Funds iv) Receive letter of representation from the external auditors and agree proposed actions v) Follow-up and verification of delivery of management actions v) Agreeing an annual External Audit Plan	 Audit Committee & Trust Board Audit Committee Charitable Funds Committee & Trust Board Audit Committee & Trust Board External Audit Service Chief Financial Officer
16. Annual Report and Accounts a) Receipt and approval of the Trust's Annual Report & Accounts b) Receipt and approval of the Annual Report and Accounts for the Funds held in Trust. c) Ensure the accounts of the Trust are prepared in line with prevailing guidance d) Produce the narrative for the Trust's Annual Report and Accounts e) Produce the Quality Accounts **f) Receipt and approval of the annual Quality Accounts**	 Chief Financial Officer, Audit Committee and Trust Board Charitable Funds Committee and Trust Board Chief Financial Officer Communications Team ~~Chief Nurse~~ Director of Nursing and Midwifery Audit Committee and Trust Board
17. Investment of Funds (including Charitable Funds)	Charitable Funds Committee & Chief Financial Officer

18. Personnel & Pay	
a) Authority to fill funded post on the establishment with permanent staff	Level 6 subject to review at the weekly challenge meeting
b) Authority to fill unfunded posts on the establishment with permanent staff	
(i) With allocated funding	Associate Chief Medical Officer or responsible Executive with Director responsible for Workforce and Chief Financial Officer
(ii) Without Allocated Funding	Chief Executive
c) Authority to appoint staff not on the formal establishment	
i) With allocated funding	Associate Chief Medical Officer or responsible Executive with Director responsible for Workforce and Chief Financial Officer
ii) Without Allocated Funding	Chief Executive
d) Granting of Additional Increments to Staff	

~~N~~ote: This has to be affordable within the Departmental Establishment Pay budget	Director responsible for Workforce
e) Upgrading & Regrading **Note: All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure and shall only be actioned should the Departmental Establishment pay budget not be exceeded.**	Level 6 in consultation with HR Manager and Finance Manager
f) Pay	
i) Authority to complete standing data forms effecting pay, new starters, variations and leavers	Line Manager
ii) Authority to complete and authorise Salary returns	Line Manager
iii) Authority to authorise overtime	Level 6
iv) Authority to authorise Additional Duty Hours	Chief Medical Officer
v) Authority to authorise travel & subsistence expenses	Level 6
vi) Authority to authorise travel & subsistence expenses in exceptional cases not submitted for over 3 months	Chief Financial Officer
vii) Approval of Executive expenses – (including any transactions made via Trust Purchasing Cards)	Chief Executive (Chief Executive's expenses should be approved by the Trust Chair)
g) Arrears of Pay Where it is established that a member of staff is owed arrears of pay	
(i) Up to £249	Budget Holder
(ii) Up to £999	Head of Human Resources
(iii)Up to £9,999	Director responsible for Workforce
(iv)Up to £49,999	Chief Executive, Chief Financial Officer and Director responsible for Workforce
(v) Over £50k	Executive Team
h) Leave	
Approval of annual leave (over 2 weeks)	
(a) Medical Staff	Chief Medical Officer and Associate Medical Director
(b) Nursing Staff	Chief Nurse and Associate Medical Director
(c) Other Staff	Responsible Executive and Line Manager

Annual leave – No approval to carry any leave forward except in EXCEPTIONAL circumstances.	Line Manager with approval from Associate Chief Medical Officer or responsible Executive
i) Compassionate Leave	Line Manager – in accordance with Trust Policy
j) Special Leave Arrangements	
i) Paternity Leave	Line Manager – in accordance with Trust Policy
ii) Carers Leave	Line Manager – in accordance with Trust Policy
iii) Leave without Pay	Line Manager – in accordance with Trust Policy
iv) Medical Staff Leave of absence (Unpaid)	Associate Chief Medical Officer
v) Maternity Leave – Paid and Unpaid	Automatic approval with guidance
vi) Time off in Lieu	HR Manager
k) Sick Leave	Line Manager – in accordance with Trust Policy
i) Extension of sick leave on half pay up to three months	Level 6 with Director responsible for Workforce
ii) Return to work part-time on full pay to assist recovery	Level 6
iii) Extension of sick leave on full pay	Director responsible for Workforce or Chief Executive
l) **Study Leave**	
Staff study leave (UK)	Chief Executive or Executive Director
All other study leave (UK)	Level 6
Medical Staff Study Leave (UK)	Chief Medical Officer
m) Trust Car and Mobile Phone Users	
i) Post to be designated as Car Users	Director responsible for Workforce
ii) Post to be designated as Mobile phone user	Director responsible for Workforce
n) Grievance Procedure All grievances must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Workforce Officer must be sought as soon as is appropriate and in line with the Grievance Procedure.	Line Manager in conjunction with, and after obtaining advice from, a Workforce Officer

o) Renewal of Fixed Term Contracts	Workforce Department
p) Staff Retirement Policy	Director responsible for Workforce
q) Redundancy	Chief Executive or Remuneration Committee
r) Ill Health Retirement	Director responsible for Workforce
s) Dismissal	Nominated Dismissing Officer
19. Authorisation of Sponsorship	Relevant Authorising Officer
20. Research Projects	
a) Authorisation	Chief Executive and Director responsible for research following proposals made by the Chairman of the Trust's Research Committee. Where appropriate, approval from the Trust's Research Ethics Committee may also be required
b) Authorisation of requisitions/orders relating to research projects i) Up to £1000 per request ii) Over £1,001 but below £5,000 iii) Over £5,000 per request	 Research Manager Chief Financial Officer Trust Research Committee
21. Authorisation of:	
a) **New Drugs**	Chief Pharmacist and Chief Medical Officer, financial implications to be approved by the Chief Financial Officer

b) **New Technologies and Procedures**	Chief Operating Officer, ~~Chief Nurse~~ Director of Nursing and Midwifery and Chief Medical Officer, financial implications to be approved by the Chief Financial Officer
22. Insurance Policies and Risk Management	Chief Financial Officer and ~~Chief Nurse~~ Director of Nursing and Midwifery
23. Contact with Press a) Non-Emergency General Enquiries i) Within Hours ii) Outside Hours b) Emergency i) Within Hours ii) Outside Hours	 ~~Head of~~ Communications team On Call Manager ~~Head of~~ Communications team On Call Manager or Executive Director
24. Infectious Diseases & Notifiable Outbreaks	Chief Operating Officer/Director of Nursing and Midwifery ~~Chief Nurse~~/Chief Medical Officer Director of Estates & Facilities
25. Review of Fire Precautions	Chief Executive
26. Review of statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous, Health Regulations and Major Incidents	Director of Estates & Facilities
27. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	

28. Review of Trust's compliance with the Data Protection Act and The General Data Protection Regulation 2016/679	Chief Financial Officer
29. Review of Trust's compliance with the Access to Records Act	Chief Financial Officer
30. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	Chief Financial Officer
31. Patient's and Relatives Complaints a) Responsibility for ensuring all complaints are dealt with correctly including the completion of a thorough investigation b) Responsibility for handling medical – legal complaints with the NHS RESOLUTION	~~Chief Nurse~~ Director of Nursing and Midwifery ~~Chief Nurse~~ Director of Nursing and Midwifery

32. The keeping of Declarations of Interests	Head of Corporate Affairs
33. Attestation of sealings in accordance with Standing Orders	Chairman/Non-Executive Director & Chief Executive/Executive Director
34. The keeping of a register of sealing	Head of Corporate Affairs or other nominated individual
35. Retention of Corporate Records	Chief Executive/Head of Corporate Affairs
36. Clinical Audit	Chief Medical Officer
37. Review of Medicines Inspectorate Regulations	Chief Pharmacist
38. Monitor Proposal for contractual arrangements between the Trust and outside bodies	Chief Operating Officer
39. Patient Services a) Variation of operating and clinic sessions within existing numbers, including: i) Outpatients ii) Theatres iii) Other	Chief Operating Officer and responsible ~~Associate~~ Chief Medical Officer
b) All proposed changes in bed allocation and use, including: i) Temporary Change	Chief Operating Officer and responsible ~~Associate~~ Chief Medical Officer
40. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, work experience students and apprentices	Director responsible for Workforce

STANDARDS OF BUSINESS CONDUCT

34. INTRODUCTION

34.1 The Princess Alexandra Hospital NHS Trust ("The Trust") aspires to perform to the highest standards of corporate behaviour and responsibility and operates in line with:

~~i. NHS circular HSG(93)5 which sets out the principles for Standards of Business Conduct for NHS staff (1993) – attached for reference at Appendix A~~

~~ii.~~i. The seven principles of public life as enshrined in the Nolan Principles (1995) – attached at Appendix ~~B~~ A

~~iii.~~ii. Professional Standards Authority: Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England – attached for reference at Appendix B ~~C~~

~~iv.~~iii. The NHS Code of Conduct and Accountability in the NHS (second revision July 2004) which sets out the importance of the public service values of Accountability, Probity and Openness

~~v.~~iv. The Code of Conduct for NHS Managers (October 2002).

34.2 It is a long and well-established principle that public sector organisations must be impartial and honest in the conduct of their business and that their staff must remain above suspicion of corruption.

34.3 The aim of the Standards of Business Conduct is to protect the Trust and its staff from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the Trust can provide assurance that its' staff conduct themselves with honesty, integrity and probity.

35. LEGAL CONTEXT AND DEFINITIONS

35.1 Under the Fraud Act 2006 and the Bribery Act 2010, it is an offence for an employee to accept a reward for doing or refraining from doing anything in his/her official capacity or to corruptly show favour or disfavour in the handling of contracts. Any breach of these Acts will render employees liable to disciplinary action and/or prosecution. Moreover, employees in the NHS are expected to ensure that the interests of patients remain paramount, that they are impartial and honest in the conduct of their business and that public funds are utilised to the best advantage of the service. In addition, employees must ensure that they do not abuse their position for personal gain to the benefit of family, friends or their private business interests.

35.2 The Fraud Act 2006 gives a statutory definition of the criminal offence of fraud under three main headings. Those found guilty under the Act are liable for a fine or imprisonment with a maximum sentence of 10 years.

Fraud by False Representation

35.3 This offence is committed by someone dishonestly making a false representation and intending, through this false representation, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. In this context a "representation" is "false" if it is untrue or misleading and if the person making it knows that it is or that it might be, untrue or misleading.

Fraud by Failing to Disclose Information

35.4 This offence is committed by someone dishonestly failing to disclose to another person information which they are under a legal duty to disclose and having the intention, by failing to disclose this information, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss.

Fraud by Abuse of Position

35.5 This offence is committed by someone who occupies a position in which s/he is expected to safeguard, or not to act against, the financial interests of another person. In these circumstances, the person dishonestly abuses this position, and intends, by means of the abuse of that position, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. Further a person may be regarded as having abused their position even though their conduct consisted of an omission rather than an act. The terms "'gain" and "loss" can be applied to money or property and the gain or loss could be temporary or permanent in nature.

Bribery and Corruption

35.6 The Bribery Act 2010 strengthens previous UK anti-bribery legislation through the creation of a new offence which can be committed by organisations which fail to prevent persons associated with them from committing bribery on their behalf. Bribery can take the form of a "financial or other advantage" and the "advantage" does not have to directly benefit the person being influenced and it does not have to be substantial. Furthermore either offering or requesting an advantage both constitute an offence.

35.7 Individuals could be found guilty of the one of the three following offences and face a 10 year prison sentence and unlimited fines:

i. Bribing, or offering to bribe, another person (section 1 of the Act)
ii. Requesting, agreeing to receive, or accepting a bribe (section 2 of the Act)
iii. Bribing, or offering to bribe, a foreign public official (section 6 of the Act).

35.8 The Trust has a responsibility to ensure that all Trust staff are aware of their duties and obligations under the Act otherwise it could be found guilty of failing to prevent bribery (section 7 of the Act).

36. SCOPE

36.1 The Standards of Business Conduct applies to all persons working for the Trust, whether in a clinical or non-clinical capacity. As well as covering all employees of the Trust, this also includes the Trust Chairman and Non-Executive Directors, bank, agency, locum or interim staff engaged by the Trust, students and trainees (including apprentices), staff on honorary contracts and secondees, volunteers, lay Committee members and any other third parties acting on behalf of the Trust under a contract. For the purpose of the Standards of Business Conduct, this group is referred to collectively as "Trust Staff".

36.2 It is the responsibility of all Trust staff to ensure that they:

i. have read and understood the Trust's Standards of Business Conduct ~~including the Standards of Business Conduct for NHS Staff HSG(93)S attached at Appendix A and sign a declaration confirming this on appointment (Appendix B)~~
ii. do not place themselves in a position that risks or appears to risk conflict between any private interests and their Trust duties
iii. are familiar with and adhere at all times to the principles set out on this procedure and any other related documents which may be issued
iv. seek further advice if they are unsure of any aspect of the procedure
v. make declarations as the need arises, not just as part of an annual declarations process
vi. report any known or suspected deviations from the procedure to their manager, the Head of Corporate Affairs or the LCFS
vii. report any suspicions or allegations of bribery to one of the following:
    a) the Trust's Local Counter Fraud Specialist (LCFS)): Gareth Robins 07825 450259 gareth.robins@tiaa.co.ukthe Chief Financial Officer
    b) their Trust's whistleblowing function
    c) NHS Counter Fraud Authority's NHS Fraud and Corruption Reporting Line on 0800 028 40 60.

36.3 In certain circumstances, the acceptance of a Gift, Hospitality, Donation, Sponsorship or other benefit may be authorised and anyone who has the capacity to authorise is known as an "Authorising Officer". An Authorising Officer will be:

i. the Chief Executive
ii. the Chairman for the Non-Executive Directors
iii. an Executive director or Associate Medical Director of a Healthcare group

36.4 In accordance with the Trust's Equality and Diversity policy, this procedure will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, trade union membership, disability, offending background or any other personal characteristic.

37. GENERAL PRINCIPLES - GIFTS, HOSPITALITY, SPONSORSHIP

37.1 As a general rule, Trust staff must not, in their official capacity, receive Gifts, Hospitality, Sponsorship or any other benefits of any kind which might reasonably be regarded as compromising the Trust's position or the individual's judgement and integrity. In short, Trust staff should always behave in such a manner that a fair-minded member of the public, knowing the facts of the matter, would not see anything improper or suspicious in the receipt of the Gift, and/or Hospitality, and/or Sponsorship and/or any other benefit.

37.2 Particularly staff who are in contact with suppliers and contractors (including external consultants), especially those who are authorised to sign purchase requisitions or place contracts for goods and services are expected to adhere to the professional standards set out in the Ethical Code of the Institute of Purchasing and Supply (set out in NHS circular HSG(93)5.

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'
Decision making staff in this organisation are:

- Executive and ~~non-executive~~non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

37.3 Further, to avoid any potential claim of unfair influence, collusion or canvassing, Trust staff should be especially cautious of accepting small items of value, or hospitality from organisations or individuals (potentially) concerned with supplying goods and services to the Trust, particularly during a procurement process.

37.4 Dealing with offers of Gifts, Hospitality, Sponsorship or other benefits is largely a matter of common sense. However, if ever in doubt, about the propriety of accepting them, a polite but firm refusal is the right course of action.

37.5 All offers of Gifts, Hospitality, Sponsorship or any other benefit, whether accepted or declined, must be recorded.

38. GENERAL PRINCIPLES - INTERESTS

38.1 All Trust staff, and in particular Directors, must act at all times with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They must not use their position for personal advantage or seek to gain preferential treatment. Further they must declare any interest, whether direct, or indirect or personal, which may give rise to a conflict of interest or loyalty. They shall do this in the prescribed form (~~see~~ Appendix C~~ces D & E~~):

i. on joining the Trust (howsoever engaged)
ii. as soon as the interest is acquired.

38.2 To assist this process, a standing item on all meetings of the Trust Board and its Committees is "Declarations of Interest". This will be managed by the Head of Corporate Affairs.

38.3 Compliance with these requirements is mandatory to ensure the Trust can identify and manage any current or potential conflicts which may arise between the interests of the Trust and the personal interests, associations and relationships of its Directors and/or staff. Failure to adhere to these arrangements may constitute a criminal offence of fraud or bribery, as an individual could be gaining unfair advantages or financial rewards for themselves or a family member/friend or associate; in the case of a Trust Board member it could result in dismissal from the Trust Board. Any suspicion that a relevant interest may not have been declared should be reported to the Head of Corporate Affairs.

38.4 The Head of Corporate Affairs will maintain registers of interests of Directors and staff and will also ensure that interests of Directors and staff are captured on joining the Trust and as any new interest arises. The register will be available on the Trust's website.

38.5 Relevant interests include:

i. directorships, including Non-Executive directorships, held in private companies or public limited companies (with the exception of dormant companies) or
ii. ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust or
iii. Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
iv. a position of authority in a charity or voluntary organisation in the field of health or social care or
v. any connection with a voluntary or other organisation contracting for NHS or the Trust's services or commissioning NHS or the Trust's services or
~~vi.~~
~~vii.~~vi. any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust. Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation. Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

38.6 Such interests or potential conflicts of interest may arise through a "family interest" which is an interest of a Close Family Member of a Director or member of Trust staff which, if it were the interest of that Director or member of Trust staff, would be regarded as a personal or pecuniary interest. A "Close Family Member" means a person who is related to a Director or member of staff in any of the following ways:

i. spouse or partner (defined as someone who is married to, or has the status of "Civil Partner" to or is a co-habitee of the individual)
ii. parent or parent in law
iii. child, step child or adopted child
iv. sibling
v. grandparent or grandchild
vi. nephew, niece or first cousin
vii. aunt or uncle
viii. spouse or partner of any of above
ix. close family member (as defined above) of the spouse or partner.

38.7 Furthermore there may be circumstances in which Trust staff receive no financial benefit but are influenced by external factors, e.g. by gaining some other intangible benefit, or awarding contracts to friends or personal business contacts.

38.8 In addition, there may be a conflict of loyalties in which Trust staff have competing loyalties between the Trust to which they owe a primary duty and some other person or entity. In this case, such a conflict of interest may present problems in the form of:
i. inhibiting free discussion
ii. resulting in decisions or actions that are not in the interests of the trust
iii. risking the impression that the trust has acted improperly.

38.9 Howsoever the conflict of interest or loyalty arises; it is necessary that it is declared and a decision taken about whether or not the individual should be excluded from discussion or consideration of the matter. In some circumstances, it may be possible to authorise a conflict of interest or loyalty, for example as it would be beneficial for the individual with the conflict to still contribute to discussions. In such circumstances, the individual may be subject to terms and conditions relating to his/her continued attendance and involvement in circumstances where the matter is considered (e.g. through meetings, correspondence or relevant documentation) and shall be obliged to conduct him or herself in accordance with these. Such an authorisation may be revoked or varied at any time. Any authorisation of a conflict of interest or loyalty will be recorded as appropriate in the register of interests including how it was authorised ~~(see Appendix F)~~. The authorisation of a conflict of interest or loyalty will be granted by the forum in which the interest has arisen – e.g. if the conflict of interest or loyalty has arisen during the course of a Trust Board meeting, the Trust Board will authorise, or not, the conflict.

39. GIFTS, DONATIONS AND WILLS/LEGACIES

39.1 Trust staff should not solicit or accept Gifts, although it may be possible to accept unsolicited Gifts or tokens of gratitude of low value where to refuse may cause offence. Trust staff should always refuse Gifts or other benefits which might reasonably be seen to compromise their personal judgement or integrity.
Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):
Gifts of cash and vouchers to individuals should always be declined.
Staff should not ask for any gifts.
Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust and not in a personal capacity. These should be declared by staff.
Modest gifts accepted under a value of £50 do not need to be declared.
A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

39.2 Under no circumstances should staff accept a personal Gift of cash or cash equivalents (e.g. tokens, vouchers, gift cards, lottery tickets or betting slips) regardless of value. Where a cash or cash equivalent gift has been offered to an individual, the donor should be invited to make a donation to the Trust's general charity fund or to a ward-based charity fund, subject to a receipt being issued and the cash banked through the cashier's office. If the donor does not wish to do this, the Gift must be refused.

39.3 Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

39.4 All Trust staff must immediately declare and register any Gifts worth £50 or more, whether accepted or declined, using the form at Appendix ~~ces~~ C ~~D & E~~. The Head of Corporate Affairs will maintain a register of Gifts and Hospitality and ensure that staff are aware of how and when the declaration of Gifts should be made. (~~See appendix G)~~

8.1

39.5 If there is any doubt about the appropriateness of accepting a Gift, staff should either politely decline or consult their line manager or the Head of Corporate Affairs. The Head of Corporate Affairs should be informed immediately if any unreasonably generous Gifts are received.

39.6 Where a member of staff is named as a beneficiary in the will of a patient who has been under their care, the member of staff must inform the Chief Financial Officer and Head of Corporate Affairs so that consideration can be given to whether or not it is appropriate for that member of staff to retain the benefit. It is the responsibility of member of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. Furthermore it is important to avoid subsequent claims by the beneficiaries of the estate of inducement, reward or corruption.

40.0 HOSPITALITY

40.1 "Hospitality" in this context means the provision of meals and refreshments as well as invitations to functions such as award ceremonies, receptions, presentations and conferences as well as invitations to social, cultural and sporting events. Some offers may include overnight accommodation and travel to and from a venue at which an event is being held.

40.2 Trust staff should exercise discretion in accepting offers of hospitality in case it would, or might appear to:

i. place them under any obligation to the individual or organisation making the offer
ii. compromise their impartiality
iii. otherwise be improper.

40.3 This includes hospitality provided by contractors, organisations or individuals concerned with the supply of goods or services, family members or friends, or patients, their relatives, carers or friends.

40.4 Where it is necessary for staff to travel to inspect equipment for possible purchase, the Trust will consider meeting the cost itself to avoid purchasing decisions being compromised. Where contractors meet the cost it must be made clear that this does not create an obligation.

40.5 Where a meeting is funded by the pharmaceutical industry, this must be disclosed in the papers relating to the meeting and in any published minutes or actions. The Department or Directorate organising or hosting the event must ensure that the receipt of funding is approved by the Authorising Officer and recorded in the Sponsorship Register.

40.6 Modest hospitality may be accepted provided that it is normal and reasonable in the circumstances, e.g. lunch provided during the course of a working visits, provided that it does not exceed the scale of hospitality that the Trust would be likely to offer. In case of doubt, advice should be sought from the Head of Corporate Affairs. In all cases, hospitality should always be both appropriate, proportionate and exclude alcohol.

40.7 Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared in the form prescribed by the Head of Corporate Affairs (see Appendix C~~ces D & E~~). The Head of Corporate Affairs will record this in the Gifts and Hospitality Register.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.

A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.

Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:

- offers of business class or first class travel and accommodation (including domestic travel)
- offers of foreign travel and accommodation.

40.8 As well as declaring the acceptance of hospitality in the form prescribed ~~(Appendices D & E)~~, Trust staff are obliged to declare the hospitality on the P11D form as part of an annual tax return to HMRC.

41.0 GIFTS AND HOSPITALITY PROVIDED BY THE TRUST

41.1 Care should also be taken when providing hospitality from Charitable Funds and staff must be aware that Gifts and hospitality provided by the Trust are still sourced from public funding and the public expect these funds to be used for legitimate purposes and demonstrate value for money.

41.2 In exceptional circumstances only, and with the prior approval of the Chief Executive and Chief Financial Officer, it may be appropriate for the Trust to provide a Gift for a member of staff. However this would be highly unusual and subject to consideration on a case by case basis.

41.3 In certain circumstances, it may be acceptable for the Trust to provide modest hospitality in the way of working lunches and/or dinners as long as this is:
i. subject to a genuine business reason, and
ii. with the prior approval of the Chief Executive and Chief Financial Officer.

41.4 As part of its staff recognition and reward initiatives, the Trust may support staff in attending an externally organised event (e.g. an awards ceremony) subject to there being a cap per head of £100 and up to a 20% contribution from each member of staff. In such circumstances, staff are required to declare the hospitality on the on the P11D form as part of an annual tax return to HMRC.

42.0 COMMERCIAL SPONSORSHIP

42.1 Commercial sponsorship refers to all funding from sources external to the NHS. This includes funding of all or part of the cost of a member of staff or project, NHS research, publications, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, hotel and transport costs, and provision of speakers or premises. Any sponsorship over the value of £25 or more must be declared regardless of whether it is declined or accepted.

42.2 Commercial sponsorship may only be accepted in accordance with the **General Principles - Gifts, Hospitality, and Sponsorship.** Commercial sponsorship should not in any way compromise any decisions of the Trust or be dependent on the purchase or supply of goods or services.

42.3 Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event. The Trust will not endorse individual companies or their products as a result of the sponsorship.

42.4 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection legislation. As a general rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

42.5 Trust staff may accept commercial sponsorship subject to:
i. seeking permission from an Authorising Officer in advance using the template at Appendix D ~~H~~
ii. ensuring that purchasing or other relevant decisions will not be compromised in any way.

42.6 The Head of Corporate Affairs will record details of commercial sponsorship in the Sponsorship Register ~~(see Appendix I)~~.

42.7 The Trust will not enter into any arrangements regarding the commercial sponsorship of a post unless it has been made clear to the sponsor that the arrangements will have no effect on purchasing decisions. This must be recorded in writing and kept in the Sponsorship Register by the Head of Corporate Affairs ~~(see Appendix I)~~.

42.8 All pharmaceutical companies entering into sponsorship agreements must comply with the Code of Practice for the Pharmaceutical Industry Second 2012 Edition10. Sponsorship agreements valued in excess of £500 must be approved by the Chief Pharmacist and the Controlled Drugs - Accountable Officer.

42.9 Should there be any doubt about the appropriateness of accepting sponsorship, staff should either politely decline or seek advice from the Chief Financial Officer or Head of Corporate Affairs.

43.0 OUTSIDE EMPLOYMENT OR PRIVATE PRACTICE

43.1 Trust staff are required to seek approval from the Trust if they are engaged in or wish to engage in outside employment in addition to their work with the Trust using the form at Appendices C ~~D & E~~. Staff should declare any existing outside employment on appointment and any new outside employment when it arises.

43.2 Clinical consultants are permitted to carry out private practice subject to national terms and conditions and the terms of their individual contracts of employment. Non-clinical staff may undertake private practice or work provided that it is with the approval of the Trust.

43.3 In either case, outside employment or private practice must neither conflict with nor be detrimental to the NHS work of the Trust staff in question. Examples of outside employment or private practice which may give rise to a conflict of interest includes:

i. employment with another NHS body;
ii. employment with another organisation which might be in a position to supply goods/services to the Trust, and
iii. self-employment, including private practice, in a capacity which might conflict with the work of the Trust or which might be in a position to supply goods/services to the Trust.

43.4 The Trust reserves the right to refuse permission where it believes a conflict will arise.

43.5 The use of Trust equipment or resources for outside employment or private practice is strictly forbidden unless it is agreed in advance and documented in writing.

Initiatives

43.6 In the case of collaborative research between the Trust and any outside body, Trust staff must be fairly rewarded for their input is essential that a written contract is drawn up to cover the collaborative research project which clearly sets out how the input of the Trust and/or its staff will be recognised and/or rewarded.

43.7 Any patents, designs, trademarks or copyright resulting from work done by a member of Trust staff carried out as part of their employment by the Trust (including working on a collaborative research project) shall be the Intellectual Property of the Trust.

43.8 Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work benefits or enhances the Trust's reputation or results in financial gain for the Trust, consideration will be given to rewarding employees subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the ~~Department of Health~~Department of Health and Social Care.

43.9 Before entering into an obligation to undertake external work connected with the business of the Trust, e.g. writing articles for publication or speaking at conferences, approval must be sought from an Authorising Officer.

44.0 SUPPLIERS AND CONTRACTORS

44.1 The Trust has legal duties to uphold under European and UK procurement law. All Trust staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services, are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Procurement ~~Purchasing~~ and Supply as well as the provisions of the Trust's Standing Orders and Standing Financial Instructions.

44.2 All Trust staff must treat prospective contractors or suppliers of services to the Trust equally and in a non-discriminatory way and act in a transparent manner.

44.3 Trust staff involved in the awarding of contracts and tender processes must be excluded

from all stages of the selection process if they have a relevant conflict of interest or loyalty.

Such an interest must be declared to the Head of Corporate Affairs using the form at Appendix C ~~D & E~~ as soon as it becomes apparent.

44.4 No organisation of any sort that bids for Trust work can be given an advantage over competitors. This applies in all cases. All contracts are awarded on merit and in line with the Trust's Standing Orders, Standing Financial Instructions and any other procedural notes linked to specific procurement activity. In addition, no favour can be shown to the business of current or former Trust staff or their relatives or associates.

44.5 Trust staff must not at any time seek to give undue advantage to any private business or other interests in the course of their duties. Equally, Trust staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to officers' and members' benefit schemes offered by the NHS or trade unions.

44.6 Every invitation to tender to a prospective bidder for Trust business must require each bidder to give a written undertaking, not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered. All invitations to potential contractors must include a notice warning of the consequences of engaging in corrupt practices.

44.7 Offers of pro bono work from prospective bidders for Trust business should be refused.

~~45.0~~ PERSONAL CONDUCT

~~45.0~~ Information Governance and Confidentiality

45.1 Trust staff must, at all times, operate in line with the Data Protection Act 1998 and maintain the confidentiality of information of any type, including but not exclusively: patient information, personal information relating to staff, commercial information. This duty of confidence remains after a member of staff (howsoever employed) leaves the Trust and this requirement applies to all individuals. The only exception is where disclosure of confidential information is required by law; in these circumstances, advice should be sought from the Head of Corporate Affairs. Information concerning the Trust which is not in the public domain must not at any time be divulged to any unauthorised person.

45.2 All Trust staff must hold confidential information in the strictest confidence and take all reasonable precautions to prevent anyone else having unauthorised access to it. Further, confidential information should be used solely for the purpose of discharging Trust functions and responsibilities and copies should only be taken or made when strictly necessary.

45.3 Care should be taken that confidentiality is not breached inadvertently by, for instance by:

i. discussing confidential matters in public places, such as whilst travelling by train
ii. leaving patient information (e.g. hand-over notes) in a public place
iii. leaving portable IT equipment containing confidential information where it might easily be stolen, such as on full view in a parked car.

45.4 Disciplinary measures may be taken if the Trust feels that staff have not operated in line with Information Governance principles.

45.5 Trust staff should guard against providing information on the operations of the Trust which might provide a commercial advantage to any type of organisation which supplies/is seeking to supply goods or services to the Trust. In some instances, Trust staff will be required to sign a Non-Disclosure Agreement form, as set out at Appendix E ~~J~~.

Social Networking

45.6 Trust staff must be aware that social networking websites are public forums and should not assume that their entries will remain private. Trust staff communicating via social media

outside work must not:

i. identify themselves as someone who works for the Trust
ii. conduct themselves in a way that brings the Trust into disrepute;
iii. disclose information that is confidential or related in any way to Trust business, staff or patients.

Use of Computers and Information Technology/Information Management

45.7 Trust staff must not run any unauthorised or unlicensed programs, computer games or software on any of the Trust's computers/computer architecture without prior permission. Further no unauthorised equipment should be attached or connected to any of the Trust's computer equipment without express authorisation.

45.8 The Trust's IT department will report all suspicious, inappropriate or fraudulent use of the Trust's IT, internet and/or email provision and HR/Workforce will be informed if there is a concern that a member of Trust staff has breached the Trust's regulations.

Use of Trust Equipment and Resources

45.9 Trust staff are not permitted to use Trust equipment or resources for outside employment, private practice or personal use unless it is agreed in advance and documented in writing.

Gambling

45.10 No member of staff may bet or gamble when on duty or on Trust premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

Trading on Trust Premises

45.11 Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-Trust interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.

8.1

~~**Charitable Collections**~~

~~**45.12** Charitable collections must be authorised in advance by a member of the EMB. With the approval of an Authorising Officer, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday or a new job.~~

Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy/Insolvency

~~45.13~~45.12 Any member of staff who becomes bankrupt, insolvent, has active CCJ, or made individual voluntary arrangements with organisations must inform their line manager and the Workforce Department as soon as possible. Staff who are bankrupt or insolvent cannot be employed in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

Arrest or Conviction

~~45.14~~45.13 A member of staff who is arrested and refused bail or convicted of any criminal offence must inform their line management and the Workforce Department as soon as possible.

Corporate Responsibility

~~45.15~~45.14 All Trust staff, and in particular Directors, have a responsibility to respect and promote the corporate or collective decision of the Trust, even though this may conflict with their personal views. This applies particularly if the Trust has yet to decide on an issue or has decided in a way with which they personally disagree. Directors and staff may comment as they wish as individuals however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of the Trust.

~~45.16~~45.15 When speaking as a member of the Trust, whether to the media, in a public forum or in a private or informal discussion, staff should ensure that they reflect the current policies or view of the Trust. For any public forum or media interview, approval should be sought in advance: from the Chairman and/or Chief Executive (in the case of the Trust Board) or the Communications Team (in the case of all other Trust staff), or their nominated deputies, and Communications Team, but when this is not practicable, they should report their action to the Chairman or Chief Executive, or their nominated deputies, as soon as possible.

~~45.17~~45.16 All staff, and in particular Directors, must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of the Trust.

~~45.18~~45.17 The Trust has guidance for communication with the media which all Trust staff must follow and disciplinary action may be taken if this is not followed.

Freedom of Information

~~45.19~~45.18 All staff will comply with the Trust's Publication Scheme and forward any Freedom of Information requests to the Freedom of Information Officer as soon as practicable. Where an individual member of staff or a Director receives a Freedom of Information request s/he must not reply without forwarding the request to the Freedom of Information Officer and obtaining their advice.

Meeting Etiquette

~~45.20~~45.19 All Trust staff must conduct themselves in a professional manner at all times. When invited to a meeting, they are expected to attend for the full duration of the meeting – unless the invitation is for a single item or part of the meeting only – to arrive on time, having read all the relevant papers, and participate fully in the discussions.

~~45.21~~45.20 Trust staff should be especially aware of how their actions, including non-verbal actions, may be perceived by others (particularly if meetings are held in public) and all activities which may cause a distraction to others (e.g. using mobile devices, laptops, using telephones etc.) should be avoided.

~~45.22~~45.21 When attending meetings, it is important to be tolerant of diverse points of view, avoid giving offence (and be ready to apologise) and avoid taking offence by being open to discussion. It is important that points are made clearly and succinctly and only when they are relevant to the discussion at hand. Challenge should be constructive, not critical, all ideas should be treated with respect and no-one should be isolated when expressing his/her views. In addition, all efforts should be made to help the chairman of the meeting run to time.

~~45.23~~45.22 As set out in the section on Information Governance and Confidentiality, it is important to be mindful of the need for appropriate confidentiality though meetings should be candid and not secretive.

~~45.24~~45.23 Finally time should be set aside at each meeting to review and reflect on the effectiveness of the meeting.

46.0 MANAGEMENT ARRANGEMENTS, REQUIREMENTS AND DUTIES

46.1 The table below sets out the management arrangements, including duties and monitoring requirements, to successfully implement the Trust's Standards of Business Conduct:

MANAGEMENT ARRANGEMENT	DUTY/REQUIREMENT
Chief Executive The Chief Executive has the overall responsibility for funds entrusted to the Trust as the Accountable Officer and that adequate policies and procedures are in place to protect the Trust and the public funds entrusted to it. The Chief Executive shall ensure that arrangements are in place to record and register Interests, Gifts, Hospitality, Sponsorship or other benefits and that these registers are available for public inspection as required. S/he will also ensure that the Trust has appropriate procedures in place to ensure that the Trust staff are "Fit and Proper Persons", impartial, honest and beyond suspicion of corruption in the conduct of their work.	Trust Accountable Officer
~~**Executive Management Board**~~**Senior Management Team Senior Management Team (SMT)** Members of the ~~EMB~~ SMT are required to lead by example and ensure staff are aware of their obligation to comply with the Standards of Business Conduct and make the necessary declarations in line with it. ~~EMB~~ SMT members may also be Authorising Officers in relation to circumstances set out in the Standards of Business Conduct.	Authorising Officer as required
Chief Financial Officer The Chief Financial Officer is the Director responsible for the Trust's overall compliance with the NHS standards in relation to counter fraud, bribery and corruption. To this end, s/he will ensure that the Trust has an LCFS through which adherence to these standards is monitored and any deviation investigated. The Chief Financial Officer will ensure that the Trust takes the required actions to limit and recover losses, apply relevant sanctions and/or manage potential reputational damage – taking advice from and consulting with any members of the EMB as required. The Chief Financial Officer will set the scope and monitor the work of the LCFS. Should a member of Trust staff require to be interviewed or disciplined, s/he, in conjunction with the LCFS, shall consult and take advice from the Director of People ~~Workforce~~. In these circumstances, the employee may be the subject of a separate investigation by the Workforce Department.	Director responsible for Trust's compliance with NHS standards in relation to counter fraud, bribery and corruption Putting in place and managing the LCFS
Workforce Department The Workforce Department will ensure that all Trust staff are aware of their obligations under the Trust's Standards of Business Conduct by ensuring that this is covered at induction and details of how to make the necessary declarations are available to new starters. ~~The Workforce Department will also coordinate an annual return from all Trust staff confirming any outside employment or private practice and produce a report for consideration by EMB.~~ The Workforce Department will also liaise with managers, the Chief Financial Officer and the LCFS, where an employee is suspected of being involved in fraud and/or bribery/corruption. The Workforce Department is responsible for ensuring the appropriate use of any disciplinary procedures operated by the Trust. The Workforce Department manages arrangements for the appointment of	Highlighting Standards of Business Conduct at induction All relevant declarations made by new starters Coordinating annual return from staff concerning outside employment or private practice (EMB) Managing

"Fit and Proper Persons" and any steps to be taken with Trust staff who have been arrested, convicted or have become the subject of an Individual Voluntary Arrangement, CCJ, bankruptcy or insolvency. The Workforce Department oversees the implementation of the Trust's Raising Concerns policy and provides an annual report to the Audit Committee.	arrangements for "Fit & Proper People" – including any changes in circumstances Annual report on whistleblowing
Local Counter Fraud Specialist (LCFS) The LCFS will proactively assist the encouragement of an anti-fraud and bribery culture by undertaking work that will raise fraud and bribery awareness. The LCFS will ensure that all cases of actual or suspected fraud are reported to NHS Counter Fraud Authority before any investigation or referral to the Police takes place. The LCFS will liaise with the NHS Counter Fraud Authority and, in conjunction with the Chief Financial Officer, will decide who will conduct the investigation and when / if referral to the Police is required. The LCFS will, amongst other duties: i. Ensure that the Chief Financial Officer is kept appraised of all cases ii. In consultation with the Chief Financial Officer and the NHS Counter Fraud Authority, report any case to the Police as necessary; iii. Report the outcome of the investigation to the Chief Financial Officer and the NHS Counter Fraud Authority; iv. Ensure that other departments, e.g. HR are informed where necessary. HR will be informed where an employee is a suspect. (LCFS and HR to comply with the relevant protocol between both parties); and v. Ensure that any system weaknesses identified as part of an investigation are followed through with management to implement changes. vi. Manage potential reputational damage. The LCFS shall be responsible, in discussion with the Chief Financial Officer, for informing third parties such as External Audit, NHS Counter Fraud Authority or the Police at the earliest opportunity and as circumstances dictate. The LCFS will provide a regular report about his/her work to the Trust's Audit Committee, including an annual report.	Awareness-raising of fraud, bribery and corruption Investigate suspicions Provide regular reports to Audit Committee including an annual report
Internal and External Audit Through their work, Internal and External Audit will be alert to the risk of fraud and bribery. Through on-going liaison with the LCFS, Internal Audit will seek to assess the control measures in place to manage key fraud and bribery risks where these fall within the scope of their audits. Any incident or suspicion that comes to Internal or External Audit's attention will be passed immediately to the LCFS. The outcome of the investigation may necessitate further work by Internal or External Audit to review systems.	Report any concerns to L~~F~~CF~~S~~
Managers Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. They are required to remind staff of their obligation to comply with the Standards of Business Conduct and make the	Ensure staff complete all declarations required

necessary declarations in line with it, including: i. Informing staff of the Trust's Standards of Business Conduct as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms ii. Ensuring that all employees for whom they are accountable for are made aware of the requirements of the policies iii. Assessing the types of risk involved in the operations for which they are responsible, and iv. Ensuring that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities; supervisory checks; staff rotation, particularly in key posts; separation of duties wherever possible, so that control of a key function is not invested in one individual; and regular reviews. Managers have a duty to instil and encourage an anti-fraud and bribery culture within their teams, be vigilant and alert to the possibility of unusual events or transactions which could be symptoms of fraud and or/bribery and report any concerns to the LCFS. Managers will work with the LCFS to raise awareness about anti-fraud and bribery. All instances of actual or suspected fraud or bribery must be reported immediately either to the LCFS, Chief Finance Officer or via the NHS CFA's reporting line or on-line reporting tool. Under no circumstances should managers attempt to investigate allegations of fraud, bribery or corruption themselves - instead their duty is to refer the concerns to the LCFS or the Chief Financial Officer as soon as possible.	Support LCFS in awareness-raising of fraud, bribery and corruption Report any concerns to the LCFS or Chief Financial Officer
Trust Staff All staff (howsoever engaged by the Trust) are expected to act in accordance with the Standards of Business Conduct as well acting in accordance with the standards laid down by their professional bodies where applicable. Trust staff also have a duty to protect the assets of the Trust, including information and goodwill as well as property. In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses and confidentiality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always: i. Avoid acting in any way which might cause others to allege or suspect them of dishonesty ii. Behave in a way which would not give cause for others to doubt that official matters are dealt with fairly and impartially iii. Be alert to the possibility that others might be attempting to deceive iv. Act with the highest levels of integrity and probity at all times. The Trust's Raising Concerns policy is the appropriate route for staff to raise concerns about conflicts of interest and other financial integrity or business conduct issues that cannot be dealt with satisfactorily through line-management in the first instance. All staff are responsible for reporting suspicions of fraud and/or bribery or corruption using one of the channels set out below: i. the Trust's Local Counter Fraud Specialist (LCFS) Gareth Robins 07825 450259 gareth.robins@tiaa.co.uk ii. the Chief Financial Officer	Declare interests: i. On appointment ii. Annually iii. As a new interest arises Declare any Gifts, Hospitality, Sponsorship or other benefits Outside employment or private practice: i. Seek approval ii. Participate in annual return Report any concerns Complete a Non-Disclosure Agreement as required

iii. their Trust Board's whistleblowing function iv. NHS Counter Fraud Authority's NHS Fraud and Corruption Reporting Line on 0800 028 40 60. Trust staff should be aware that a breach of the Trust's Standards of Business Conduct could render them liable to prosecution as well as leading to the termination of their employment or position with the Trust. Trust staff who fail to disclose any relevant interests, outside employment, private practice or receipt of Gifts, Hospitality, Sponsorship or other benefits as required by the Standards of Business Conduct, or the Trust's Standing Orders or Standing Financial Instructions may be subject to disciplinary action which could, ultimately, result in the termination of their employment or position with the Trust. Breaches of the Standards of Business Conduct will be reported to the Audit Committee. All Trust staff are required to make a declaration of interests on joining the Trust, participate in the annual declaration of interests and provide a new declaration of interest as the need arises.	
Head of Corporate Affairs The Head of Corporate Affairs will be responsible for maintaining the Registers to record interests and also Gifts, Hospitality, Sponsorship and any other benefits. S/he will keep these registers up to date by means of an annual declaration process and by recording any changes which arise in the year. S/he will produce an annual report on the Registers for consideration by the Audit Committee. The Head of Corporate Affairs will also ensure that there is an opportunity to declare interests at key corporate meetings of the Trust. The Head of Corporate Affairs is also responsible for reviewing the implementation of the Standards of Business Conduct and making changes as required.	Manage arrangements and maintain registers for: i. Interests ii. Gifts, Hospitality, Sponsorship, other benefits Coordinate annual returns for the registers and report to the Audit Committee Monitor effectiveness of the Standards of Business Conduct
Procurement Department The Procurement Department is responsible for the Trust upholding its legal duties in relation to European and UK procurement law and operating in line with the professional standards set out in the Code of Ethics of the ~~Chartered Institute of Purchasing and Supply~~ Chartered Institute of Procurement and Supply as well as the provisions of the Trust's Standing Orders and Standing Financial Instructions. The Procurement Department will ensure that no member of staff will be involved in any stage of the selection process for a tender or contract if they have a relevant conflict of interest or loyalty. The Procurement Department will also ensure that all contracts are awarded on merit and in line with the Trust's Standing Orders, Standing Financial Instructions and any other procedural notes linked to specific procurement activity. The Procurement Department will ensure that all invitations to potential contractors must include a notice warning of the consequences of engaging in corrupt practices.	Ensuring the probity of the procurement process Including a warning notice in all invitations to potential contractors of corrupt practice

Audit Committee The Audit Committee will monitor compliance with the Standards of Business Conduct and the Trust's arrangements for raising concerns. It will also receive an annual report on the Registers of Interest, and Gifts, Hospitality, Sponsorship and other benefits. . Breaches of the Standards of Business Conduct will be reported to the Audit Committee.	Receive reports: i. from LCFS ii. Head of Corporate Affairs iii. Workforce Department

~~APPENDIX A~~

January *1993*

Standards of business conduct

for NHS staff

NHS Management Executive

169312

Health Service
Guidelines

NHS Management Executive

Standards of business conduct for NHS staff

HSG(93)5

Standards of Business Conduct for NHS staff

18 January 1993

This replaces HM(62)21 which is cancelled

Addressees

For action:
Regional Health Authorities
District Health Authorities
Special Health Authorities for London Postgraduate Teaching Hospitals
NHS Supplies Authority
NHS Trusts
Directly Managed Units
Family Health Services Authorities
The Central Blood Laboratories Authority
The Dental Practice Board
The Prescription Pricing Authority
The Special Hospitals Service Authority
The Public Health Laboratory Service Board
NHS Training Directorate
Health Education Authority

For information:
Community Health Councils
County Councils
Metropolitan District Councils
London Borough Councils

From:
The NHSME Personnel Directorate
Division HAP2C
Quarry House, Quarry Hill
Leeds LS2 7UE
Tel: 0532–545000 ext 45764

Further copies of this document may be obtained by writing to
DoH Store
Health Publications Unit
No 2 Site
Manchester Road
Heywood Lancs. OL10 2PZ Please quote serial number appearing at the top of this column. Telephone enquiries will not be accepted.

Executive Summary

To assist NHS employers and staff in maintaining strict ethical standards in the conduct of NHS business, the Management Executive has prepared the attached guidance:.

- Brief summary of the main provisions of the Prevention of Corruption Acts 1906 and 1916 - **Part A.**
- General policy guidelines - **Part B.**
  These cover:
  i) the standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
  ii) the steps which NHS employers should take to safeguard themselves and the NHS against conflict of interest.
- Action checklist for NHS Managers - **Part C.**
- Short guide for staff - **Part D.**
- Ethical Code of the Institute of Purchasing and Supply (IPS) (reproduced courtesy of IPS) - **Part E.**

Action

NHS authorities and Trusts should:

- ensure that these guidelines are brought to the attention of all staff, and are effectively implemented;
- develop local conflict of interest policies and the machinery to implement them, in consultation with staff and local staff representatives:
- satisfy themselves that their policies and implementation procedures are regularly reviewed and kept up to date.

8.1

Prevention of Corruption Acts 1906 and 1916 - summary of main provisions

Acceptance of gifts by way of inducements or rewards

1. Under the Prevention of Corruption Acts, 1906 and 1916, it is an offence for employees corruptly to accept any gifts or consideration as an inducement or reward for:

- doing, or refraining from doing, anything in their official capacity; or
- showing favour or disfavour to any person in their official capacity.

2 Under the Prevention of Corruption Act 1916, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

NHS Management Executive (NHSME) - general guidelines

Introduction

1. These guidelines, which are intended by the NHSME to be helpful to all NHS employers (i) and their employees, re-state and reinforce the guiding principles previously set out in Circular HM(62)21 (now cancelled), relating to the conduct of business in the NHS.

Responsibility of NHS employers

2. NHS employers are responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff

3. It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to *all NHS staff,* i.e. those who commit NHS resources directly (e.g by the ordering of goods) or those who do so indirectly (e.g by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business

4. It is a long established principle that public sector bodies, which include the **NHS,** must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts (see PART *A).*

Staff will need to be aware that a breach of the provisions of these **Acts** *renders them liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.*

Principles of conduct in the NHS

5. NHS staff are expected to

- ensure that the interest of patients remains paramount at all times;
- be impartial and honest in the conduct of their official business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

(i) In these guidelines "**NHS** employer" means all "for action' addressees listed on the title page of HSG(93)5.

8.1

6. It is also the responsibility of staff to ensure that they do **not:**

- abuse their official position for personal gain or to benefit their family or friends;
- seek to advantage or further private business or other interests, in the course of their official duties.

Implementing the guiding principles

Casual gifts

7. Casual gifts offered by contractors or others, eg at Christmas time, may not be in any way connected with the performance of duties *so* as to constitute an offence under the Prevention of Corruption Acts. Such gifts should nevertheless be politely but firmly declined. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients *or* their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality

8. Modest hospitality provided it is normal and reasonable in the circumstances, eg lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

9. Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

Declaration of interests

10. NHS employers need to be aware of all cases where an employee, or his or her close relative or associate, has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the employing authority.

11. All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

12. One particular area of potential conflict of interest which may directly affect patients, is when NHS staff hold a self beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.

13. In determining what needs to be declared, employers and employees will wish to be guided by the principles set out in paragraph 5 above; also the more detailed guidance to staff contained in Part D.

14. NHS employers should :

- ensure that staffare aware of their responsibility to declare relevant interests (perhaps by including a clause to this effect in staff contracts)
- consider keeping registers of all such interests and making them available for inspection by the public.
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

Preferential treatment in private transactions

15. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests, on behalf of all staff - for example, NHS staff benefits schemes.)

Contracts

16. All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the Institute of Purchasing and Supply (IPS), reproduced at PART E.

Favouritism in awarding contracts

17. Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

18. NHS employers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

Warnings to potential contractors

19. NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning renderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside *employment*

20. NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell their NHS employing authority if they think they may be risking a conflict of interest in this area: the NHS employer will be responsible for judging whether the interests of patients could be harmed, in line with the principles in paragraph 5 above. NHS employers may wish to consider the preparation of local guidelines on this subject.

***private* practice**

21. Consultants (and associate specialists) employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the handbook "A Guide to the Management of Private Practice in the NHS". (See also PM(79)11). Consultants who have signed new contracts with Trusts will be subject to the terms applying to private practice in those contracts.

22. Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in paragraph 20 above. Ail hospital doctors are entitled to fees for other work outside their NHS contractual duties under "Category 2" (paragraph 37 of the TCS of Hospital Medical and Dental staff), eg. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

Rewards for Initiative

23. NHS employers should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute; eg patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this NHS employers should build appropriate specifications and provisions into the contractual arrangements which they enter into *before* the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

24. With regard to patents and inventions, in certain defined circumstances the Patents Act gives *employees* a *right* to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

25. In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial sponsorship for attendance at courses and conferences

26. Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.

27. On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

Commercial sponsorship of posts - "linked deals"

28. Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for an employing authority. NHS employers should not enter into such arrangements, unless it has been made abundantly dear to the company concerned that the sponsorship will have no effect on purchasing decisions within the authority. Where such sponsorship is accepted, monitoring arrangements should be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

Under no circumstances should employers agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.

"Commercial in-confidence"

29. Staff should be particularly careful of using, or making public, internal information of a "commercial in-confidence" nature, *particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition.* This *principle applies whether private competitors or other NHS providers are concerned,* and whether or not disclosure is prompted by the expectation of personal gain (see paragraphs 16 18 above and Part E).

30. However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

Part C

Action checklist for NHS managers

References are to paragraphs in Part B of "Standards of business conduct for NHS staff" (Annex to HSG(93)5)

You must:

- Ensure that all staff are aware of this guidance (2) and (4);
- Develop a local policy and implement it (2 and 14);
- Show no favouritism in awarding contracts (e.g. to businesses run by employees, ex-employees or their friends or relatives) (17 - 18);
- Include a warning against corruption in all invitations to tender (19);
- Consider requests from staff for permission to undertake additional outside employment (20);
- Apply the terms of PM(79)11 concerning doctors' engagements in private practice (21);
- Receive rewards or royalties in respect of work carried out by employees in the course of their NHS work, and ensure that such employees receive due rewards (24);
- Similarly ensure receipt of rewards for collaborative work with manufacturers, and pass on to participating employees (25);
- Ensure that acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions (26-27);
- Refuse "linked deals" whereby sponsorship of staff posts is linked to the purchase of particular products or supply from particular sources (28);
- Avoid excessive secrecy and abuse of the term "commercial in confidence" (30).

Part D

Short guide for staff

References are to paragraphs in Part B of "Standards of business conduct for NHS staff' (Annex to HSG(93)5):

Do:

- Make sure you understand the guidelines on standards of business conduct, and consult your line managers if you are not sure;
- Make sure you are not in a position where your private interests and NHS duties may conflict (3);
- Declare to your employer any relevant interests (10 - 14). If in doubt, ask yourself:
    i. am I, or might I be, in a position where I (or my family/friends) could gain from the connexion between my private interests and my employment?
    ii. do I have access to information which could influence purchasing decisions?
    iii. could my outside interest be in any way detrimental to the NHS or to patients' interests?
    iv. do I have any other reason to think I may be risking a conflict of interest?

If still unsure - **Declare it!**

- Adhere to the ethical code of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services **(16);**
- Seek your employer's permission before taking on outside **work,** if there is any question of it adversely affecting your NHS duties (20). (Special guidance applies to doctors);
- Obtain your employer's permission before accepting any commercial sponsorship **(26);**

Do not:

- Accept any gifts, inducements or inappropriate hospitality (see **7** - 9);
- Abuse your-past or present official position to obtain preferential rates for private deals (15);
- Unfairly advantage one competitor over another (17) or show favouritism in awarding contracts (18);
- Misuse or make available official "commercial in confidence" information (29).

Part E

Institute of Purchasing and Supply - Ethical Code

(Reproduced by kind permission of IPS)

Introduction

1. The code set out below was approved by the Institute's Council on 26 February 1977 and is binding on IPS members.

Precepts

2 Members shall never use their authority or office for personal gain and shall seek to uphold and enhance the standing of the Purchasing and Supply profession and the Institute by:

a. maintaining an unimpeachable standard of integrity in all their business relationships both inside and outside the organisations in which they are employed;

b. fostering the highest possible standards of professional competence amongst those for whom they are responsible;

c optimising the use of resources for which they are responsible to provide the maximum benefit to their employing organisation;

d. complying both with the letter and the spirit of;

i. the law of the country in which they practise;

ii. such guidance on professional practice as may be issued by the Institute from time to time;

iii. contractual obligations;

e. rejecting any business practice which might reasonably be deemed improper.

Guidance

3. In applying these precepts, members should follow the guidance set out below:

a. Declaration of interest. Any personal interest which may impinge or might reasonably be deemed by others to impinge on a member's impartiality in any matter relevant to his or her duties should be declared.

b. Confidentiality and accuracy of information. The confidentiality of information received in the course of duty should be respected and should never be used for personal gain; information given in the course of duty should be true and fair and never designed to mislead.

c. Competition. While bearing in mind the advantages to the member's employing organisation of maintaining a continuing relationship with a supplier, any relationship which might, in the long term, prevent the effective operation of fair competition, should be avoided.

d. Business Gifts. Business gifts other than items of very small intrinsic value such as business diaries or calendars should not be accepted.

e. Hospitality. Modest hospitality is an accepted courtesy of a business relationship. However, the recipient should not allow him or herself to reach a position whereby he or she might be deemed by others to have been influenced in making a business decision as a consequence of accepting such hospitality; the frequency and scale of hospitality accepted should not be significantly greater than the recipient's employer would be likely to provide in return.

f. when it is not easy to decide between what is and is not acceptable in terms of gifts or hospitality, the offer should be declined or advice sought from the member's superior.

The Princess Alexandra Hospital NHS
NHS Trust

APPENDIX A~~B~~

The Seven Principles of Public Life (the Nolan Principles)

1. Selflessness
Holders of public office should act solely in terms of the public interest.

2. Integrity
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness
Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty
Holders of public office should be truthful.

7. Leadership
Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

APPENDIX BC

professional standards authority

Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

All members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.

Professional Standards Authority
157-197 Buckingham Palace Road, London SW1W 9SP
Telephone: 020 7389 8030 Email: info@professionalstandards.org.uk
Web: www.professionalstandards.org.uk

The Professional Standards Authority for Health and Social Care is the new name for the Council for Healthcare Regulatory Excellence.

Personal behaviour

1. **As a Member[1] I commit to:**

   The values of the NHS Constitution

   Promoting equality

   Promoting human rights

   in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2. **I will apply the following values in my work and relationships with others:**

- **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board[2], including delegated responsibilities, and for the staff and services for which I am responsible
- **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member
- **Openness**: I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
- **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
- **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
- **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all
- **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

1 The term 'Member' is used throughout this document to refer to members of NHS boards and CCG governing bodies in England.
2 The term 'board' is used throughout this document to refer collectively to NHS boards and CCG governing bodies in England.

Standards for members of NHS boards and CCG governing bodies in England

professional standards authority

8.1

Technical competence

3. **As a Member, for myself, my organisation, and the NHS, I will seek:**

   Excellence in clinical care, patient safety, patient experience, and the accessibility of services

   To make sound decisions individually and collectively

   Long term financial stability and the best value for the benefit of patients, service users and the community.

4. **I will do this by:**

- Always putting the safety of patients and service users, the quality of care and patient experience first, and enabling colleagues to do the same
- Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning and continuing professional development
- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates
- Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge
- Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively
- Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board
- Thinking strategically and developmentally
- Seeking and using evidence as the basis for decisions and actions
- Understanding the health needs of the population I serve
- Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same
- Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff
- Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood
- Respecting patients' rights to consent, privacy and confidentiality, and access to information, as enshrined in data protection and freedom of information law and guidance.

Standards for members of NHS boards and CCG governing bodies in England

professional standards authority

Business practices

5. **As a Member, for myself and my organisation, I will seek:**

   To ensure my organisation is fit to serve its patients and service users, and the community

   To be fair, transparent, measured, and thorough in decision-making and in the management of public money

   To be ready to be held publicly to account for my organisation's decisions and for its use of public money.

6. **I will do this by**:

- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, and removing myself from decision-making when they might be perceived to do so
- Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify
- Ensuring that effective complaints and whistleblowing procedures are in place and in use
- Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource, and contract allocation
- Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective and properly used, and that the values in these Standards are put into action in the design and delivery of services
- Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care
- Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

APPENDIX D

STANDARDS OF BUSINESS CONDUCT – DECLARATION FORM

Name:	
Title/Position:	
Department/Section:	

You are required to make the following declarations on appointment and as the need arises throughout the year.

Declaration: Standards of Business Conduct – ALL STAFF AND TRUST BOARD MEMBERS I have read and understand the Trust's Standards of Business Conduct including the NHS circular HSG(93)5 which sets out the principles for Standards of Business Conduct for NHS staff (1993).	
Signature:	
Date:	
Declaration Made: (select one)	**On Appointment:**

Declaration: Nolan Principles – ALL STAFF AND TRUST BOARD MEMBERS I have read, I understand and I agree to uphold the seven principles of public life as detailed by the Nolan Committee.	
Signature:	
Date:	
Declaration Made: (select one)	**On Appointment:**

Declaration: Professional Standards Authority: Standards for Members of NHS Trust Boards and Clinical Commissioning Group Governing Bodies in England – TRUST BOARD MEMBERS ONLY

I understand and am committed to the practice of good governance and to the legal and regulatory frameworks in which the Trust Board operates. I understand both the extent and the limitations of my personal responsibilities.

Signature:	
Date:	
Declaration Made: (select one)	**On Appointment**

Declaration: Interests – ALL STAFF

In line with sections 5.5 – 5.9 inclusive of the Trust's Standards of Business Conduct, I have the following interests which are relevant to the work of the Trust. If you have no interests, state 'nil'.

Nature of Interest in Full:

Office use only:
Authorised ☐ YES DATE: ☐ NO ☐ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised ☐ YES DATE: ☐ NO ☐ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised ☐ YES DATE: ☐ NO ☐ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised ☐ YES DATE: ☐ NO ☐ NOT APPLICABLE

Nature of Interest in Full:		
Office use only: Authorised ☐ YES DATE: ☐ NO ☐ NOT APPLICABLE		
Signature:		
Date:		
Declaration Made: (select one)	On Appointment	

Declaration – Outside Work/Private Practice (ALL STAFF BUT NOT INCLUDING NON-EXECUTIVE DIRECTORS

There should be no conflict of interest between your Trust duties and any other job. If you have another job or undertake private practice and there is no conflict of interest, you must still declare it below (though you will not be prevented from keeping it).

Employer:		
Post/Role:		
Date Employment Commenced:		
Hours and Time Worked:		
Authorisation Status:	Authorised	Not Authorised
Date:		
Declaration Made: (select one)	On Appointment	

Declaration – Gifts, Hospitality, Donation and Other Benefits

All gifts, hospitality, donations or other benefits must be declared, whether accepted or declined.

Details of Gift, Hospitality, Donation or Other Benefit:		
From whom and why: (give as much detail as possible)		
Date Offered:	Value or Estimate:	Accepted or Declined:

	~~(select one and give amount)~~	~~(select one)~~
~~Declaration Made: (circle one)~~	~~On Appointment:~~	
~~Details of Gift, Hospitality, Donation or Other Benefit:~~		
~~From whom and why: (give as much detail as possible)~~		
~~Date Offered:~~	~~Value or Estimate: (select one and give amount)~~	~~Accepted or Declined: (select one)~~
~~Declaration Made: (circle one)~~	~~On Appointment:~~	

APPENDIX C~~E~~

STANDARDS OF BUSINESS CONDUCT – ~~IN YEAR~~ DECLARATION FORM

Name:	
Title/Position:	
Department/Section:	

Declaration: Interests

In line with sections 5.5 – 5.9 inclusive of the Trust's Standards of Business Conduct, I have the following interests which are relevant to the work of the Trust.

Nature of Interest in Full:

Office use only:
Authorised □ YES DATE: □ NO □ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised □ YES DATE: □ NO □ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised □ YES DATE: □ NO □ NOT APPLICABLE

Signature:	
Date:	

8.1

Declaration – Outside Work/Private Practice

There should be no conflict of interest between your Trust duties and any other job. If you have another job or undertake private practice and there is no conflict of interest, you must still declare it below (though you will not be prevented from keeping it).

Employer:		
Post/Role:		
Date Employment Commenced:		
Hours and Time Worked:		
Authorisation Status:	**Authorised**	**Not Authorised**
Date:		

Declaration – Gifts, Hospitality, Donation and Other Benefits

All gifts, hospitality, donations or other benefits must be declared, whether accepted or declined.

Details of Gift, Hospitality, Donation or Other Benefit:		
From whom and why: (give as much detail as possible)		
Date Offered:	**Value or Estimate: (select one and give amount)**	**Accepted or Declined: (select one)**
Details of Gift, Hospitality, Donation or Other Benefit:		
From whom and why: (give as much detail as possible)		
Date Offered:	**Value or Estimate: (select one and give amount)**	**Accepted or Declined: (select one)**
Date:		

APPENDIX F

~~Register of Interests for [Trust Board] or [Staff]~~
~~[date]~~

~~NAME~~	~~DESIGNATION~~	~~INTERESTS DECLARED~~	~~HOW AND WHEN DECLARED~~	~~AUTHORISED √ x N/A~~

APPENDIX G

~~REGISTER OF GIFTS/HOSPITALITY/DONATIONS/OTHER BENEFITS~~

~~NAME~~	~~TITLE/POSITION~~	~~NATURE OF GIFT/ HOSPITALITY/DONATION/ OTHER BENEFIT~~	~~VALUE*~~	~~DATE RECEIVED~~	~~SOURCE~~	~~REASON GIVEN~~	~~ACTION TAKEN** AND REASON WHY~~

~~* Exact value should be provided where known or reasonable estimate provided if unknown~~

**** Record if the Gift/Hospitality/Donation/Other Benefit was accepted or declined**

APPENDIX D

~~H~~ APPLICATION TO SEEK PERMISSION TO ACCEPT COMMERCIAL SPONSORSHIP FORM

Name:	
Title/Position:	
Department/Section:	

Request: To seek Commercial Sponsorship

Section 9.0 of the Trust's Standards of Business Conduct sets out the arrangements for managing commercial sponsorship.

Details of Proposed Sponsorship Opportunity: (give as much detail as possible)		
Details of Proposed Sponsor:		
Background to Offer of Sponsorship (if known):		
Date Offered:	**Value or Estimate: (select one and give amount)**	**Accepted or Declined: (select one)**
Authorising Officer:	**Name:**	**Title:**
Date Commercial Sponsorship Opportunity Authorised or Declined and Reasons Why:		
Signatures:	**Authorising Officer:**	**Trust Staff:**
Dates:	**Authorising Officer:**	**Trust Staff:**

8.1

APPENDIX I

~~REGISTER OF SPONSORSHIP~~

~~NAME~~	~~TITLE/POSITION~~	~~NATURE OF SPONSORSHIP OPPORTUNITY~~	~~VALUE*~~	~~DATE RECEIVED~~	~~SOURCE~~	~~REASON WHY SPONSORSHIP OPPORTUNITY OFFERED~~	~~ACTION TAKEN** AND REASON WHY~~

~~* Exact value should be provided where known or reasonable estimate provided if unknown~~
~~** Record if the Sponsorship Opportunity was accepted or declined; if accepted note the details of the Authorising Officer~~

APPENDIX E ~~J~~

NON-DISCLOSURE AGREEMENT FORM

Name:	
Title/Position:	
Department/Section:	

Declaration: Express Requirement for Confidentiality

You have been requested to be involved in [INSERT DETAILS] (the "Project"). As part of your role in respect of the Project, the Trust, or other parties participating in the Project, may provide you with access to certain confidential information relating the Project at any time before, during or after completion of the Project by any means (eg in writing, by email, verbally, through attendance at meetings), trade secrets including, without limitation, technical data and know-how relating to the Project, information that you may create, develop, receive or obtain in connection with your engagement on the Project, whether or not such information (if in anything other than oral form) is marked confidential (the "Confidential Information").

You are required to:

i. maintain the Confidential Information in the strictest confidence and not divulge any of the Confidential Information to any third party without the prior written permission of the Trust and
ii. not make use of, reproduce, copy, discuss, disclose or distribute the any information other than for use as part of your role in the Project.

By signing this form you agree to comply with these terms.

Signature:	
Date:	

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03/10/19 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Workforce Committee

REPORT FROM: Pam Court – Committee Chair

DATE OF COMMITTEE MEETING: 23/09/019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• The draft nursing establishment review was presented for assurance around the model; financial modelling is underway and will be presented to PAF in October with the full establishment review paper to be presented to Board in November. • Performance against the NHSP contract was reviewed; further discussions will take place at the next meeting and quarterly updates will be received. • The Apprenticeship Strategy was approved. • Workforce Race Equality Standards and Workforce Disability Equality Standards were reviewed and approved for publication (on Board agenda). • Statutory and Mandatory training compliance is 93% and the Trust wide appraisal rate is 87%. WFC will be focussing on HCG's/Corporate areas that are not achieving the target at the next meeting. • BAF risks 2.1 and 2.3 were discussed and WFC agreed the risk scores for 2.1 Nurse Recruitment (16) and Risk 2.3 Inability to recruit, retain and engage our people (12).
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following are highlighted for the Board's awareness and/or assurance:
The committee also received the following reports: Workforce Report (Targets and Performance), Temporary Staffing, Safer Staffing, Training and Education, Progress against People Strategy, Health & Well-being, GMC Survey results, Staff survey and Staff FFT results and a report from the People Board.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The Committee is making good progress against the work plan.

8.2

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 26 September 2019 **AGENDA ITEM NO: 8.2**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 26.09.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• Finance – members reviewed the Financial Recovery Plan. The elements driving the overspend are to be quantified and trajectories for reducing bank and agency spend across HCGs and Trust-wide are to be included. The in-month deficit was £2.6m, £0.1m better than plan and included a £0.5m reduction in temporary staffing costs (M5 - £2.6m). The YTD deficit was £15.2m, £3.1m worse than plan. • The Committee discussed its BAF risks and agreed that scoring on all should remain the same, i.e.: Risk 5.1 (Finance) = 15, Risk 4.2 (ED Target) = 20 and Risk 3.1 (Estate) = 20 and Risk 1.2 EPR = 16. • PAF recommended the Energy Contract to the Board for approval. • The Committee discussed the content of four Health System Led Investment (HSLI) capital bids made by the Trust to NHSE and supported the STP Interoperability HSLI hosting arrangement. • Members approved the updated Cash & Treasury Management Policy for submission to the Trust Policy Group.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, PAF received reports on the following agenda items: Procurement Update, CCG Service Transfers and Allocative Contract, M5 IPR, Data Quality, Coding Update, Annual Report on Emergency Preparedness and Business Continuity Forward Plan.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make good progress against the workplan.

8.2

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: **03/10/2019** **AGENDA ITEM NO:** **8.2**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 26/09/2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
1. The Committee discussed the annual effectiveness review. Members, executive attendees and auditors completed the effectiveness checklist and the committee discussed 3 areas highlighted for consideration from the review: • Has the Committee formally considered how it integrates with other committees that are reviewing risk – for example, risk management and clinical governance: Audit Committee agreed that clinical governance is covered by QSC and the terms of reference should be amended to clearly reflect this duty. The TOR are being amended and will be presented to Board for approval in November. • Has the Committee formally considered how its work integrates with wider performance management and standards compliance: Committee agreed that performance is covered by the audit programme and by way of the composition of the committee's membership with the Chair and NED-AH both members of PAF. • Counterfraud - Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports: Members agreed that implementation of actions following counterfraud reports will be included in LCFS reports going forward. 2. The Committee reviewed and recommended to the Board the Annual Report of the Audit Committee. (appendix 1). 3. The revised Governance Manual was reviewed and recommended to the Board for approval. 4. Internal Audit reports on Complaints Management and safeguarding were received. The Committee has asked QSC to review the information it is receiving in relation to complaints response times. 5. External Audit: The annual audit letter was approved. 6. Reports on Counterfraud and Waivers and Losses were noted. The Committee was informed of the decision to continue with Integra as the preferred finance system. 7. The Committee approved a one year extension of the contract with the Trust's current external auditors.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The AC is making good progress against its annual work plan.

Report of the work of the Audit Committee during 2018/19

1. Role of the Audit Committee

The Audit Committee (the Committee) shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance. QSC provides the Board with assurance on matters relating to clinical governance.

For the purposes of procuring the Trust's External Auditor, the Trust Board has nominated the Audit Committee to acts as its Auditor Panel in line with Schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

2. Meetings and Membership

The Committee has been in place throughout 2018/19 year and held four meetings. (24 May 2018, 5 September 2018, 21 December 2018 and 6 March 2019). Attendance at these meetings is recorded below.

Three independent non-executive directors are members of the Committee; membership changed during 2018/19 as detailed below:

Table: Committee members, appointment to the committee and attendance:

Name	Meeting attendance (out of a possible four)	Committee membership in 2018/19
Stephen Bright - NED and Committee Chair (left the Trust in September 2018)	2/4	Term of appointment as NED ended in September 2018.
Steve Clarke - NED	2/4	Appointed as Trust Chairman in December 2018 and therefore not eligible to be a member of the Committee from that date onwards.
Andrew Holden - NED and interim Chair of Committee from December 2018	4/4	Member of Committee throughout 2018/19 and interim Chair of Committee from December 2018
Helen Howe - Associate NED	2/4	Appointed as a member in September 2018.

The internal and external auditors, local counter fraud service (LCFS) provider, the Chief Finance Officer (CFO) and deputy CFO, Chief Medical Officer as lead executive for risk management and the Head of Corporate Affairs regularly attend meetings to assist the Committee with its duties. Other directors and senior managers are invited to attend to provide assurance on specific items or areas where a limited assurance rating has been assigned by the internal auditors. The Chief Executive attends a minimum of annually, to discuss the annual accounts.

The Committee also held private sessions with both the external auditors and the head of internal audit during the year.

3. Board Governance arrangements

There are three other Board committees: Performance and Finance (PAF), Quality and Safety (QSC) and Workforce all with a monitoring and oversight role. Audit Committee members are familiar with the work of these other committees, attending all of them between them which strengthens the Committee's effectiveness. This is particularly notable when it considers clinical risk issues. QSC oversees all aspects of clinical governance including clinical audit, and provides assurance to the Board on patient safety, quality and experience.

4. Business of the Committee

The Committee has an annual work plan, developed from its terms of reference, to schedule its work throughout the year, and an action log to track actions.

The following provides an overview of the business conducted during the year to help demonstrate how an effective Committee can bring benefits.

5. Risk Management, Assurance and Governance

Effective risk management is essential to the delivery of the Trust's strategic objectives. The Committee has continued to review the ongoing operation and management of the risk and assurance framework.

The Board Assurance Framework (BAF) and risk management process is reviewed annually by the Committee. A review took place at the September 2018 meeting; the Head of Corporate Affairs presented the Board Assurance Framework for assurance on the processes whereby BAF risks are identified, monitored and reviewed. The BAF is reported to Board bi-monthly and individual risks are reported to the respective committees. The Risk Management Strategy was reviewed and approved in August 2018 and the Risk Management Group (RMG) continues to meet monthly to review all risks across the organisation as well as the BAF by exception. The Significant Risk Register (risks above 15) is reviewed bi-monthly at Board and by RMG in line with the workplan.

Preparing the Annual Governance Statement (AGS) is an important part of the governance process. The AGS explains the processes and procedures in place to enable the Trust to carry out its functions effectively. The AGS for 2018/19 was considered by the Committee and recommended for endorsement by the Board at its meeting in May 2019.

The Committee received regular reports on the internal control framework and the internal assurance processes throughout the year. These included:

- Regular reports on finance metrics which included write-off of aged debts, and information on waivers, losses and special payments.
- Progress reports from the Trust's Internal Auditors outlining progress against the Audit workplan for the year and implementation of recommendations made during the audits.

The AGS identified the following significant issues:

- Registered Nurse Vacancy rate
- Operational Performance – A&E Standard
- Financial Sustainability and Strategic Options
- Estate

6. Internal Audit

The Trust's Internal Auditors (TIAA) provided progress reports to the Committee at every meeting. TIAA carried out 11 reviews in year, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's

objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. A summary is set out below.

Financial Reporting and Budget Monitoring	Substantial Assurance
Key Financial Systems	Substantial Assurance
Non-SLA Income	Limited Assurance
Cambio Upgrade Release Testing	Limited Assurance
BAF & Risk Management	Substantial Assurance
Estates Capital Plan	Limited Assurance
Pharmacy Stock Management	Reasonable Assurance
GDPR Compliance	Reasonable Assurance
HR Recruitment and Payroll	Substantial Assurance
Workforce Utilisation - eRostering	Limited Assurance
Back-up	Reasonable Assurance

The Committee reviewed the internal audit annual report for the year including the Head of Internal Audit's (HOIA) opinion. TIAA was satisfied that, for the areas reviewed during the year, The Princess Alexandra Hospital NHS Trust had reasonable and effective risk management, control and governance processes in place. This opinion was included in the AGS.

7. Counter Fraud

TIAA, the LCFS provider, has continued to help strengthen the Trust's anti-fraud and bribery arrangements. The Committee received updates on fraud activities at each meeting and a counter-fraud annual report. These provided on-going assurance on fraud policy work undertaken throughout the year including:

- Engagement and communication to raise awareness of fraud policy.
- Proactive anti-fraud work to prevent and deter emerging fraud risks.
- Investigation and detection of fraud, working with the Trust to ensure appropriate sanction is applied.

8. Other reports

The following reports were also received by the Committee:

- Caldicott Guardian Annual Report
- Legal Services Annual report
- Registers of Interests, Gifts and Hospitality

9. External Audit, Review of Financial Statements and Annual Reports

The external audit service is provided by Ernst & Young. The Committee reviewed and agreed the external audit plan and received regular progress reports and briefings throughout the year. The reports highlighted changes to accounting policy and recommendations for improvements in internal controls. Further details about the plan and the audit fees can be found in the annual report and accounts.

The external auditors completed a full and thorough audit of the financial statements for 2018/19 and the accounts were approved in May 2019. The final audited accounts were given an unqualified opinion, with no weaknesses identified.

The Committee also reviewed both the annual report and quality account. Both provided a narrative on the achievements for the year and on the delivery of the Trust's strategic objectives and quality indicators. The

finding on the quality report included an adverse opinion in relation to incidents and VTE data sampling. The Committee recommended the 2018/19 annual report and accounts to the Board.

10. Evaluation and Briefings

NED Helen Howe, as a new member of the committee attended a training session with both internal auditors and external auditors. The internal and external auditors also provide regular audit, governance and legal briefings for the Committee.

11. Conclusion

The information in this report and the reports provided to the Board throughout 2018/19 demonstrate how the Committee adds value to the overall governance of processes of PAHT. In completing its work it places considerable reliance on the work of both internal and external audit.

12. Recommendation

The Committee recommends this Annual Report of the Audit Committee to the Board for approval.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 3 October 2019 **AGENDA ITEM NO: 8.2**

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

REPORT FROM: John Hogan

DATE OF COMMITTEE MEETING: 27 September 2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Items for escalation to the Board: • The Trust has reported two MRSA bacteraemia. It is likely that the second case is community acquired bacteraemia. Actions are being taken to ensure there is robust adherence to infection control practices across the Trust. • Moderate harm incident figures have shown a steady and sustained rise from February 2019. This has been as a result of an increase in the numbers of post-partum haemorrhages and the changes implemented following the launch of new national pressure ulcer guidance. The trust now declares all hospital acquired and un-stageable category 3 pressure ulcers as moderate harms. • The number of severe harm incidents has increased, some of which is due to a cluster of falls in August. • NHSI have asked the Trust to share its practices on the management of Gram Negative Blood Stream Infections, acknowledging the Trust's strong performance in this area. • QSC discussed the internal audit report on Complaints Management and the timescales for responding to complaints. The matter will be discussed further at the next meeting. • BAF risk 1.1 was reviewed by QSC and members agreed the scoring should remain at 16.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
Other items discussed: QSC also received the following reports: Healthcare Group Quarterly Performance Report – Medicine, an update on the Stent register, Integrated Performance Report (IPR), Mortality Improvement Programme, Safer staffing (Hard Truths), Monthly Quality, Safety & Effectiveness Report, Monthly Report from Patient Safety & Quality Group, Patient Experience Report, Update from Patient Panel, CQC Insight Report.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

	Trust Board – 03 October 2019
Agenda Item:	8.2
Presented by:	Dr Shico Visuvanathan, Consultant Microbiologist and Director of Infection Prevention and Control Jenny Kirsh, Head of Infection Prevention and Control
Prepared by:	Jenny Kirsh, Head of Infection Prevention and Control Dr Shico Visuvanathan, Consultant Microbiologist and Director of Infection Prevention and Control
Date prepared:	July 2019
Subject / Title:	Infection Prevention and Control Annual Report 2018-2019

Purpose:	Approval		Decision		Information	x	Assurance	x

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This report outlines Infection Prevention and Control activity at PAH NHS Trust from 1st April 2018 – 31st March 2019. It includes the Infection Prevention and Control Annual Work Programme, and Audit Programme for the period 1st April 2019- 31st March 2020. A detailed Executive summary is included in the main report.
Recommendation:	The Trust Board is asked to consider and note the attached report.

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

Previously considered by:	QSC.26.07.19
Risk / links with the BAF:	Patient safety is at risk if good infection control practice is not adhered to. Poor practice will lead to an increase in Health Care Associated Infections, putting patients at risk. The Trust is liable for financial penalties if we breach our *C difficile* and MRSA bacteraemia targets.
Legislation, regulatory, equality, diversity and dignity implications:	The Trust has a duty to ensure compliance with the Health and Social Care Act 2008 (updated 2010), which contains Statutory guidance about compliance with Infection Prevention and Control Standards.
Appendices:	Three appendices attached – see contents page

The Princess Alexandra Hospital NHS
NHS Trust

Infection Prevention and Control

Annual Report

1st April 2018 – 31st March 2019

Including the Infection Prevention and Control Annual Work Programme and Audit Programme 1st April 2019- 31st March 2020

Authors:

Dr. Shico Visuvanathan
Director of Infection Prevention and Control/
Consultant Microbiologist

Ms Jenny Kirsh
Head of Infection Prevention and Control

Assisted by:
Ms Magdalena Korejwo
Infection Prevention and Control Information Officer

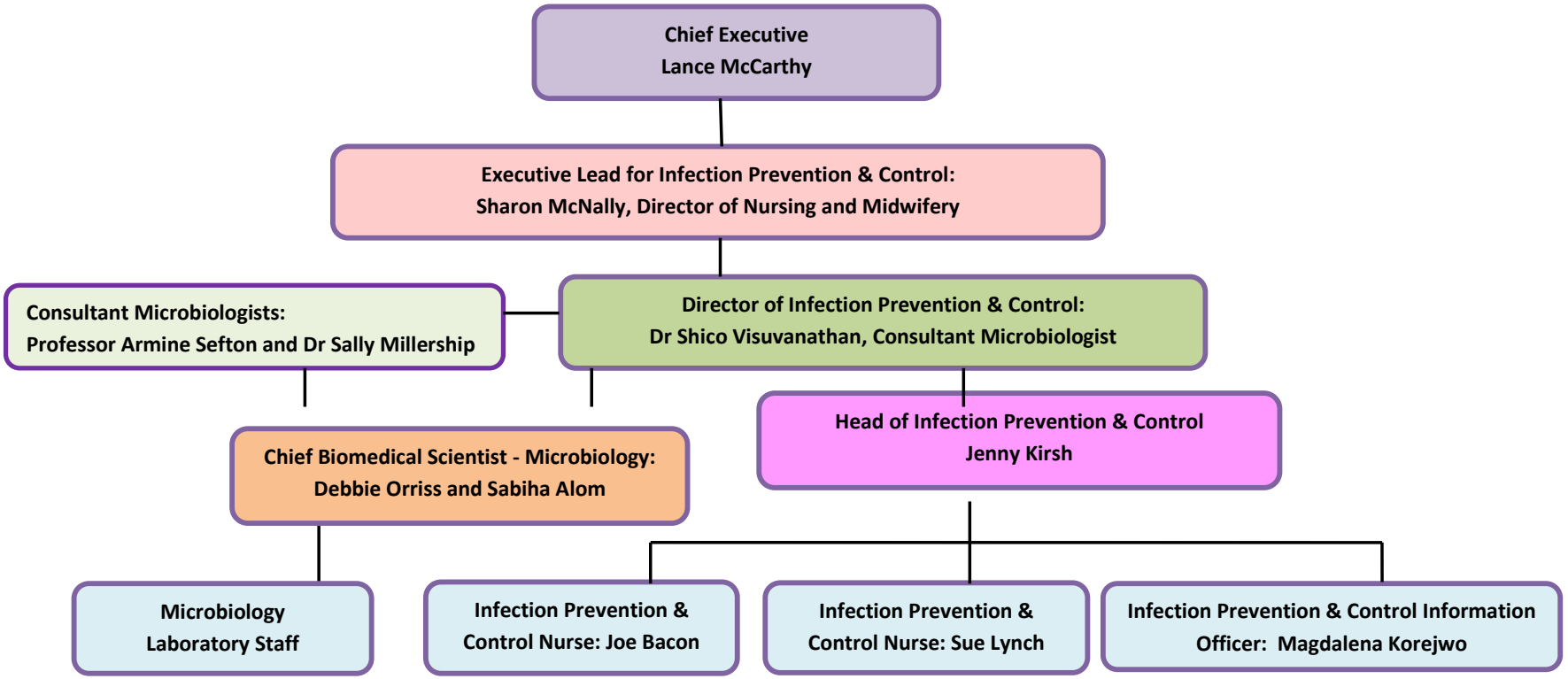
Contents

Abbreviations used in this Document.

ADON	Associate Director of Nursing
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
C.difficile	*Clostridium difficile*
CEO	Chief Executive Officer
CMO	Chief Medical Officer
CPE/CPO	Carbapenemase-producing *Enterobacteriaceae*/organisms
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
DOH	Department of Health
DPH	Director of Public Health
E.coli	*Escherichia Coli*
ED	Emergency Department
ESBL	Extended Spectrum Beta Lactamase producing organisms
GDH	Glutamate Dehydrogenase
HCAI	Health Care Associated Infection
HCG	Health Care Group
HPA	Health Protection Agency. To be replaced with Public Health England
HOIPC	Head of Infection Prevention and Control
HON	Head of Nursing
IPCN(s)	Infection Prevention and Control Nurse(s)
IPCT	Infection Prevention and Control Team
IPC	Infection Prevention and Control
MRSA	Methicillin (or Meticillin) resistant *staphylococcus aureus*
MSSA	Methicillin (or Meticillin) sensitive *staphylococcus aureus*
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NTDA	Nation Health Service Trust Development Authority
PAH	Princess Alexandra Hospital
PCR	Polymerase Chain Reaction
PHE	Public Health England
SSI	Surgical Site Infection
SUI/SI	Serious Untoward Incident/ Serious incident
RCA	Root Cause Analysis
VRE / GRE	Vancomycin Resistant *Enterococci* / Glycopeptide Resistant *Enterococcus*

The Princess Alexandra Hospital NHS
NHS Trust

1.0 Trust Organisational Structure and Reporting of Infection Prevention and Control



2.0 Executive Summary:

2.1 The Trust has a duty to ensure compliance with the Health and Social Care Act 2008 (updated 2010), which contains statutory guidance about compliance with Infection Prevention and Control (IPC) standards. The IPC annual report reflects arrangements in place for management and monitoring IPC at the PAH NHS Trust, and provides an overview of IPC activity in the financial year 2018 /19. There is a separate IPC work programme and audit programme for 2019 /2020.

2.2 There is a trajectory of zero tolerance of MRSA bacteraemia across the NHS. During 2018-19, there were zero cases of MRSA at PAH NHS Trust. PAH has not had a Trust apportioned MRSA bacteraemia case since July 2014.

2.3 In total, there were 13 cases of Trust apportioned *Clostridium difficile* (*C.difficile*) reported in the 2018-19 period. This was against another challenging trajectory assigned to the Trust of just nine cases for the year. However, eight of the 13 cases were successfully appealed at the North Essex Quality Collaborative Serious Incident and Never Event Panel; thus the Trust only had five cases that were 'considered' to be Trust-apportioned in terms of CCG contractual agreements. As a result of this, there will not be any financial penalties imposed on the Trust and would be a cost saving of £10,000 per case over trajectory.

2.4 Trust apportioned cases of Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia have remained low at eight cases for the year. Although more cases than last year (eight), numbers are small and some variation is expected. National benchmarking demonstrates the Trust has continued to control these infections year on year. This has ensured we have remained in the top quarter of best performing Trusts for low rates of MSSA infections.

2.5 National benchmarking shows our health care economy in a favourable position, in the top quarter, for total numbers of Escherichia coli (*E. coli*) blood stream infections (BSI or bacteraemia). During this financial year, 14 of the 133 cases of *E .coli* BSIs were Trust-apportioned, which is 10.5% of cases.

2.6 It is noted that the number of patients presenting with ESBL bacteraemia has reduced in the last year from 18 to seven, due to good antimicrobial stewardship. However, these multi-resistant organisms, like many multi-resistant organisms across the UK, are slowly rising year on year as evidenced by the rising number of urine isolates (356 in 2017/2018 to 414 cases in 2018/2019).

2.7 There is a national gram negative blood stream infection (BSI) ambition (since April 2017), to halve the numbers of healthcare associated Gram-negative BSIs by 2021, now extended to 2024. The focus has been on reducing healthcare associated *E. coli* BSIs, because they represent 55% of all Gram-negative BSIs. Clinical commissioning groups (CCGs) are leading on achieving the Quality Premium from April 2017 for two years, aiming to reduce all *E.coli* BSIs by 10% in Year 1. From April 2017 we also began collecting data for *Klebsiella sp* and *Pseudomonas aeruginosa* cases.

2.8 During 2018-19 we had an outbreak of Vancomycin Resistant *Enterococcus* (VRE) in the critical care setting (ITU / HDU). 17 patients were colonised with VRE during the period

31 December 2018 to 31 March 2019; a further three patients were already colonised with VRE on admission to the unit. Multiple control measures were put in place and are on-going. Five patients were treated with Linezolid as a precaution. One patient had a bacteraemia. There were no patient deaths associated with VRE.

2.9 This year we had nine confirmed cases of Carbapenemase-producing *Enterobacteriaceae* (CPO), seven of these were in the Trust, and two from GP samples. Patients were colonised with CPO and did not have clinical infections. However, more robust screening measures are required to ensure we are detecting all patients with CPO.

2.10 Monthly cross over audit results for hand hygiene compliance over the year shows the Trust average overall compliance to be good. Performance was 95% for the Medicine Health Care Group (HCG), 98% for the Surgery and Critical Care HCG, 99% for the Family and Women HCG, and 99% for the Cancer, Cardiology and Clinical support HCG.

2.11 Norovirus outbreaks at PAH occurred sporadically between April 2018 until March 2019. In total there were six outbreaks (three of which involved multiple wards). The Trust has robust systems in place for the management of outbreaks with daily meetings for the duration.

2.12 Our hospital based Tuberculosis (TB) multi-disciplinary team (MDT) has significantly improved the diagnosis and management of TB across the health care setting. PAH are able to demonstrate that we meet national standards in TB diagnosis and management, including standards outlined in the Collaborative Tuberculosis Strategy for England 2015 to 2020.

2.13 SHAW (Staff Health and Well-being) have led again on the Influenza vaccination programme in the Trust this year, vaccinating staff across the organisation. The target of 75% of staff vaccination was met.

2.14 The Patient Panel Representative attending the ICC since early 2014 provides a lay person's perspective to IPC. The patient representative has been extremely helpful and supportive of the ICC and ICT.

2.15 Since January 2018 there has been no Trust HIV or sexual health Consultant input for in – patients. Staff members who require Post exposure prophylaxis (PEP) for a needle-stick injury receive initial support from ED, and then from SHAW (Staff Health and Wellbeing). However there is no support from a Consultant HIV physician. This is on the risk register for the Medicine Health Care group.

3.0 Introduction

3.1 The purpose of this report is to provide assurance that the Princess Alexandra Hospital (PAH) NHS Trust has safe and robust IPC measures in place which are effective in controlling healthcare associated infections (HCAIs). Additionally, it aims to afford the Trust's compliance against the Code of Practice on the Prevention and Control of Infections (under The Health and Social Care Act 2008), by which it has a duty to provide safe and effective care. This annual report covers the period 1st April 2018 to 31st March 2019 and

reference to the 'year' or '2018/19' refers to these dates. The annual work programme and annual audit programme for 2019/20 are also included as appendices to this report.

3.2 The prevention and control of healthcare-associated infections (HCAIs) is key to the provision of high-quality, safe healthcare. At the PAH, the wider hospital team, together with the IPC team (IPCT) are proud of the robust IPC measures that we have in place to reduce healthcare associated infections (HCAIs). These measures include steps to manage antimicrobial resistance as well as control outbreaks of infection. The prevention and control of infection is an integral part of the Trust's risk management strategy and reduces the risk of harm from HCAIs for our patients, staff and visitors, as well as reducing Trust costs associated with infection. This financial year alone, we have estimated that the Trust has saved at least the equivalent of almost 1.5 M USD using Public Health England (PHE) derived infection costs, especially in relation to gram negative blood stream (bacteraemia) infection (GNBSIs) reduction.

All levels of staff across the organisation are trained and monitored in relation to measures for the prevention and control of infection. The IPC team are supported by the Trust Board in ensuring that effective prevention and control of infection is part of everyday practice and is applied consistently by everyone. There is usually at least weekly contact with the Executive lead for IPC (Director of Nursing). Prevention and control of HCAIs in primary and community care is also supported by the hospital IPCT and Director of Infection prevention and Control (DIPC), ensuring the patient is firmly at the centre of all activities. The NHS Constitution for England, which defines the rights that every patient can expect regarding their care, is supported by the Care Quality Commission (CQC) as an independent regulator ensuring that health and social care is safe. The PAH is monitored by the CQC who take into account compliance with the Code of Practice on the prevention and control of infections, under The Health and Social Care Act 2008 (updated in 2015).

4.0 Trust Performance

We use all NICE quality standards for IPC to improve the structure, process and outcomes of care which includes the following:

- Monitoring HCAIs and other infections of local relevance to drive continuous quality improvement
- Working with local health and social care organisations to manage the risk of infections in hospitals from community incidents
- Staff having objectives and appraisals on IPC linked to board level objectives
- The IPCT are involved in the planning, building, refurbishment and maintenance of hospital facilities
- We share infection related information and associated treatments to help with the care of patients admitted to, discharged from, or transferred between hospitals.

In 2018/19, as in several previous years PAH remains in the top quartile nationally with low case numbers of infection in all key alert organisms measured nationally. As a result the Trust have not incurred any financial penalties in relation to HCAI management. The CQC have commented on our excellence in Trust apportioned MSSA (meticillin sensitive staphylococcus aureus) bacteraemia control, where we remain amongst one of the best performing Trusts in England. For

C difficile control, we remain one of the best in England amongst district general hospitals with a large elderly population. We have had zero cases of Trust apportioned MRSA bacteraemia and have made significant savings in controlling GNBSIs.

5.0 Acknowledgments

5.1 All staff have made great efforts to ensure IPC remains 'everybody's business' at PAH. We thank them all for helping us continually improve and maintain IPC standards across the Trust.

5.2 Additionally the IPCT wish to acknowledge and thank all those that have contributed to the writing of this report, including; Debbie Oriss (Chief BMS, Microbiology Laboratory), Alison Morris (Health and Safety Manager /previously Acting Estates Manager), Julie Matthews (Decontamination Lead), Shayi Shali (Antimicrobial Pharmacist), Chris Goulding (Joint Replacement Nurse), Andy Hare (TB Nurse Specialist), Polly Ridgwell-Cook (Information Department), Alexandra Anyanwu (Head of Core Training and Development) and Kathryn Court (SHAW Nurse).

6.0 Infection Prevention and Control Service and Arrangements

6.1 The IPC department provide a service for the Princess Alexandra Hospital NHS Trust and the out-patient departments of St. Margaret's Hospital in Epping and the Herts and Essex Hospital in Hertfordshire.

6.2 A fully constituted IPCT are in place in the Trust; the team are responsible for the delivery of the infection prevention and control service across the organisation. The function of the team is to provide an advisory service to all members of staff, to provide training and education for clinical and non-clinical staff; to undertake proactive work to reduce the incidence of infection and reactive work in response to incidents and outbreaks. Additionally the team are responsible for the development of the core IPC policies, overseeing and undertaking of audits, surveillance and outbreak management.

6.3 The IPC nursing team establishment is currently funded as:

- 1.0 WTE Head of Infection Prevention and Control (HOIPC)
- 2.0 WTE Infection Prevention and Control Nurses
- 1.0 WTE Infection Prevention and Control Information Officer

6.4 The HOIPC has line management responsibility for the IPC nursing team and the Information Officer. The line management of the HOIPC is with the Associate Director of Nursing (ADON) for Cancer, Cardiology and Clinical Support (CC&CS) and the Director of Nursing as the Executive Lead for IPC. Professionally, the HOIPC is accountable to the DIPC.

6.5 There are two other Consultant Microbiologists, one WTE and one part time, who provide support to the IPC team.

6.6 Additionally, the IPC team have close working relationships with the Microbiology laboratory staff, the Antimicrobial Pharmacist, and Staff Health and Wellbeing (SHAW).

6.7 The IPCT provides an on-call service outside of normal working hours.

7.0 Infection Prevention and Control Team Networks

7.1 The expectation of the Care Quality Commission (CQC) is that the Trust will have effective management systems in place for the prevention and control of HCAI, informed by risk assessments and analysis of infection incidents.

7.2 The IPC networks ensure that the Trust Board and senior staff are kept informed and that surveillance, audit and risk assessments are undertaken and lessons learnt are acted on.

7.3 The HOIPC submits monthly reports detailing activity to the Quality and Safety Committee (Q&SC), Service Performance and Quality Review Group (SPQRG), Trust Integrated Performance Report (IPR), monthly performance reports for each of the four health care groups (HCGs).

8.0 Microbiology Services

8.1 PAH is one of the current NHS pathology providers in the East of England

8.2 Across England, NHS and social care organisations have been encouraged by NHS England and NHSI to work closely together to deliver more effective, joined-up and affordable services that can continue to meet the needs of the population now and in the future. With this in mind Pathology services have initiated talks with our local STP partners with a view to a joint tender of Pathology services

8.3 The Microbiology Department endeavours to provide a modern, relevant microbiological service in an accurate, comprehensive and timely manner. This service includes laboratory diagnosis of, and advice on treatment of infections, advice on immunisation, and the provision of control of infection advice in hospitals. It employs analytical and interpretive skills to aid in the prevention, diagnosis and treatment of disease.

8.4 Services are continually reviewed to ensure the development of services to meet future demands and implementation of new technologies to improve patient safety and efficiencies. The Trust has been supportive in the implementation of these technologies which has enabled us to improve our turnaround times and the quality of results provided. Maintaining an on–site Microbiology service is of great importance in supporting our highly reactive IPC service.

8.5 The laboratory is fully accredited under UKAS standard ISO 15189:2012. Our initial UKAS assessment was in December 2016 has been followed with two further surveillance assessments, the most recent being in March 2019. The UKAS assessors noted the vast improvement in our quality of service over the last 18 months and the benefit of this to our patients.

9.0 Committees and other meetings:

9.1 Infection Control Committee

9.1.1. The Infection Control Committee (ICC) is chaired by the DIPC. The committee usually meets on a bi-monthly basis. It is expected that there is representation from each HCG (medical and nursing), as well as departments such as Facilities and Estates, SHAW and Pharmacy. The Committee is a productive forum, but increased representation from the HCGs and Clinicians is needed. This has been highlighted in previous reports.

Public Health England (PHE) is represented at the ICC; the Consultant in Communicable Disease Control (CCDC) has a dual role and also works at the Trust part time as a Consultant Microbiologist. The IPCT continue to inform and liaise with PHE when there are public health concerns or any communicable diseases to notify.

9.2 Trust Board, Governance and relationships including with other Committees

9.2.1 The HOIPC submits monthly reports to the Q&SC and attends the meeting to present the report. The DIPC attends as required. The HOIPC also submits monthly reports to the SPQRG and will attend as required.

9.3 Meetings with Clinical Commissioning Group (CCG)

9.4 Monthly RCA Scrutiny Panel

9.4.1. The HOIPC meets at least quarterly with the Deputy Director of Nursing for West Essex CCG, who is overseeing IPC within the community, in the absence of an IPCN. Additionally, the HOIPC attends the quarterly East and North Hertfordshire IPC meetings, chaired by the HOIPC for the CCG. Both the Deputy Director for West Essex and the HOIPC for East and North Herts attend the *C.difficile* Appeals Panel review meetings, where a joint decision is made between the two CCGs on the success of the cases.

10.0 Standards

10.1 Regulation 12 of the Health and Social Care Act 2008 *Code of Practice on the prevention and control of infections and related guidance* reviewed 2010 (regulated activities), requires acute Trusts to be compliant with all elements of the regulation; this is monitored by the Care Quality Commissioners (CQC) The Trust is registered with the CQC without conditions.

10.2 The Trust should also demonstrate compliance with best practice guidance such as National Institute of Clinical Excellence (NICE).

11.0 Summary of Infection Prevention and Control Performance 2018-19

11.1 Mandatory surveillance

11.1.1 Mandatory surveillance and monitoring is a requirement for all Trusts on the following:
All bacteraemias caused by:

- Meticillin Resistant *Staphylococcus Aureus* (MRSA)
- Meticillin Sensitive *Staphylococcus Aureus* (MSSA)
- Glycopeptide Resistant *Enterococcus* (GRE) - also referred to as Vancomycin Resistant Enterococcus (VRE)
- *Escherichia Coli* (E-coli)
- *Klebsiella spp.*
- *Pseudomonas aeruginosa*
- *Clostridium difficile* infections in patients over the age of two years old.
  and
- Surgical Site Surveillance - all NHS Trusts where orthopaedic surgery is performed are expected to carry out a minimum of three months surveillance per year (1 April to 31 March) in at least one of the four orthopaedic categories:

  * Hip replacements
  * Knee replacements
  * Repair of neck of femur
  * Reduction of long bone fracture

11.2 MRSA bacteraemia

11.2.1. The Trust is proud to report there have been no MRSA bacteraemia cases since July 2014 and has maintained its position in the top third of best performing Trusts nationally.

11.2.2. Whilst our national position is favourable, it is important that staff do not become complacent. It is therefore essential that there is compliance with IPC standards amongst all staff to reduce the risk of susceptible/colonised patients developing an MRSA bacteraemia.

11.2.3. In the graph below (**Figure 1**) the Trust trajectory of zero for 2018 /2019 is shown in black (a target of zero tolerance has been set by the DoH for all NHS hospitals).

Figure 1: Cumulative data at PAH NHS Trust, for Trust apportioned and non-apportioned MRSA bacteraemia cases in 2018/2019

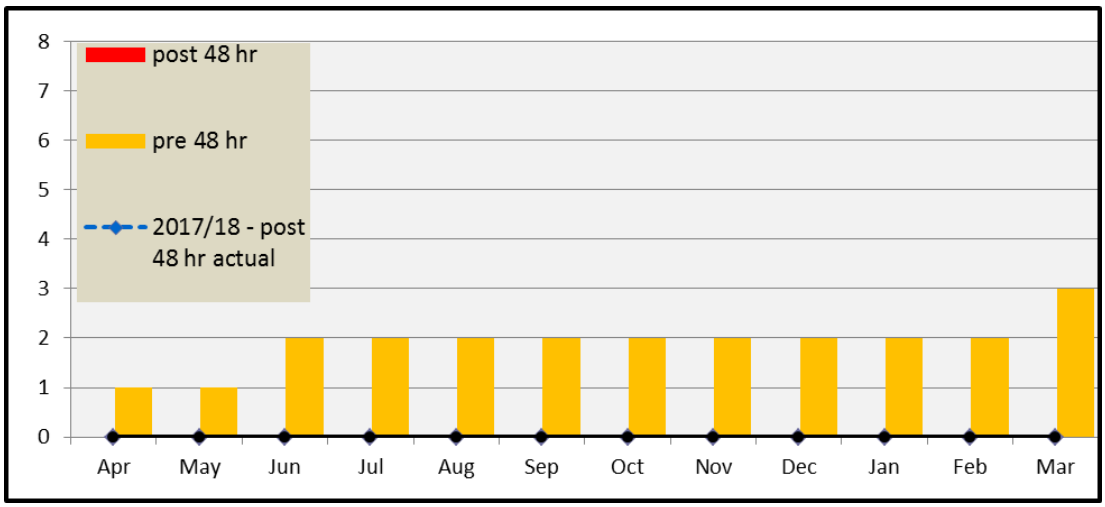

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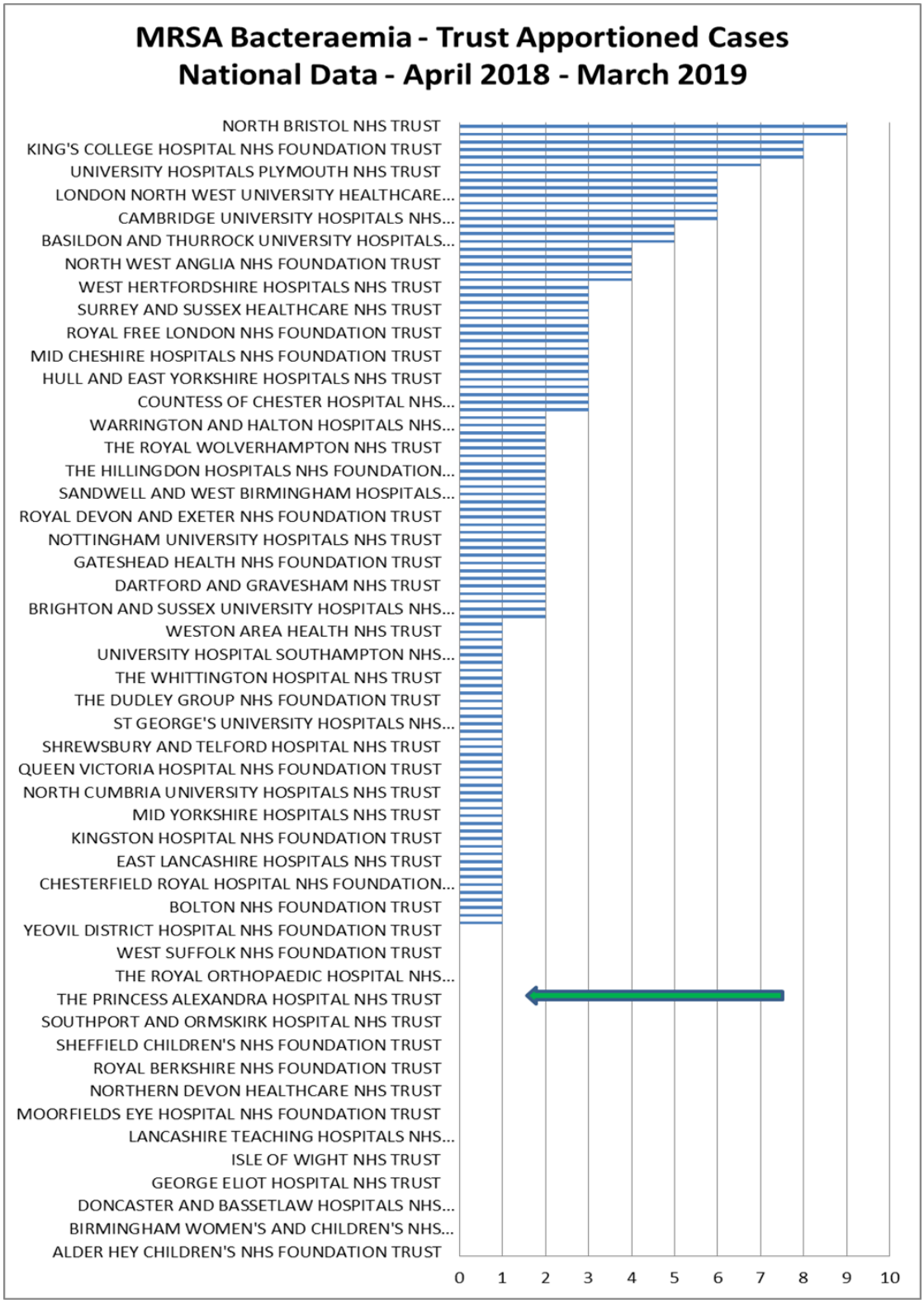
Figure 2: The Trust's position against all acute Trust's in England



11.3 *Clostridium difficile*

11.3.1. The PAH IPC strategy means we have performed extremely well over the years, placing us in the top third of best performing Trusts nationally for 2018-19. We have achieved this through commitment and effort from all staff at the Trust who have remained vigilant and engaged in infection control procedures throughout the year. We have a robust Root Cause Analysis (RCA) process in place which is significant in contributing to shared learning amongst staff. Our success reflects our compliance with IPC and antimicrobial prescribing policies. This is despite the challenges of PAH being an old hospital with many Estates issues and coming through another difficult winter with many elderly patients, a high proportion of which are over the age of 80 years, and norovirus outbreaks.

11.3.2. It should also be noted that PAH had a significantly lower trajectory (just nine cases for the year) than our neighbouring Trusts; this reflects our excellent rates in previous years, but means we face a more challenging trajectory than many others. The trajectories set for PAH have been similar to those assigned to paediatric and specialist hospitals such as orthopaedic and maternity hospitals (where a low rate of *C.difficile* would be expected).

11.3.3. There were 13 cases reported by us for 2018-19 (one less than the previous year and four less than the year before that) on the national HCAI data capture system. However, the CCG (via the West Essex and East and North Herts appeals panel) are in agreement that only five (of the 13) are Trust-apportioned. This is because *C difficile* is recognised as an unfortunate consequence of the use of antibiotics (which often can be life -saving) and there were no lapses in care associated with eight of our 13 cases. These were therefore deemed to be 'unavoidable' cases, hence successful at the appeals panel.

11.3.4. In cases where Trusts go above their trajectory, financial penalties are imposed by the CCG. This therefore means that due to the successfully appealed cases, we are below trajectory; not only is this significant for the Trust's reputation and patient safety, it also means there has been a cost avoidance in penalty fines to the Trust of around £40,000.

11.3.5. Root Cause Analysis (RCA) meetings were held for all cases chaired by the DIPC / Consultant Microbiologist, and included representation from the Consultants (or deputies) caring for the patients, Ward Managers (or Deputy), IPCN(s) and the Antimicrobial Pharmacist.

11.3.6. Key themes identified in the investigations included delays in isolation or unclear documentation relating to this (where appropriate escalation was made, this did not affect success of appeal), some delays in specimen collection and the need for improved communication. Antimicrobial prescribing and hand hygiene were generally good.

11.3.7. The Trust has continued to implement its strategy for the prevention and control of *C.difficile* management which has included;

- Continued use of the SIGHT model (**S**uspect, **I**solate, **G**loves/aprons, **H**and washing, **T**est samples)
- Undertaking of IPC inspections in clinical areas

- Antimicrobial stewardship; the formation of an antimicrobial stewardship group in December 2017, antibiotic ward rounds with Antibiotic Pharmacist/Consultant Microbiologist and the antimicrobial audits
- Teaching and education
- Hydrogen Peroxide Vaporiser for the decontamination of the environment (on discharge of all cases of patients with C.*difficile* and GDH+ve patients)
- Root Cause Analysis of all cases and shared learning
- Appeals process in place for unavoidable cases.

11.3.8. The graph below (**Figure 3**) demonstrates the cumulative total of *C. difficile* from 1st April 2018 – 31 March 2019. All cases, including Trust apportioned cases (shown in red and labelled as post 72 hour cases) and non-Trust attributable (in yellow, referred to as pre 72 hour cases) are shown. The Trust trajectory for 2018-19 is shown in black, and the blue dotted line shows actual Trust-attributable *C. difficile* cases from the previous year, in 2017 -18. The green bars show *C. difficile* toxin *negative* (Glutamate Dehydrogenase) cases which, although being monitored and managed by the IPCT, are not required to be reported to the DoH and PHE. Toxin positivity is required for *C. difficile* disease.

Figure 3: Cumulative data for Trust apportioned and non-apportioned *C difficile* and GDH cases in 2018/2019

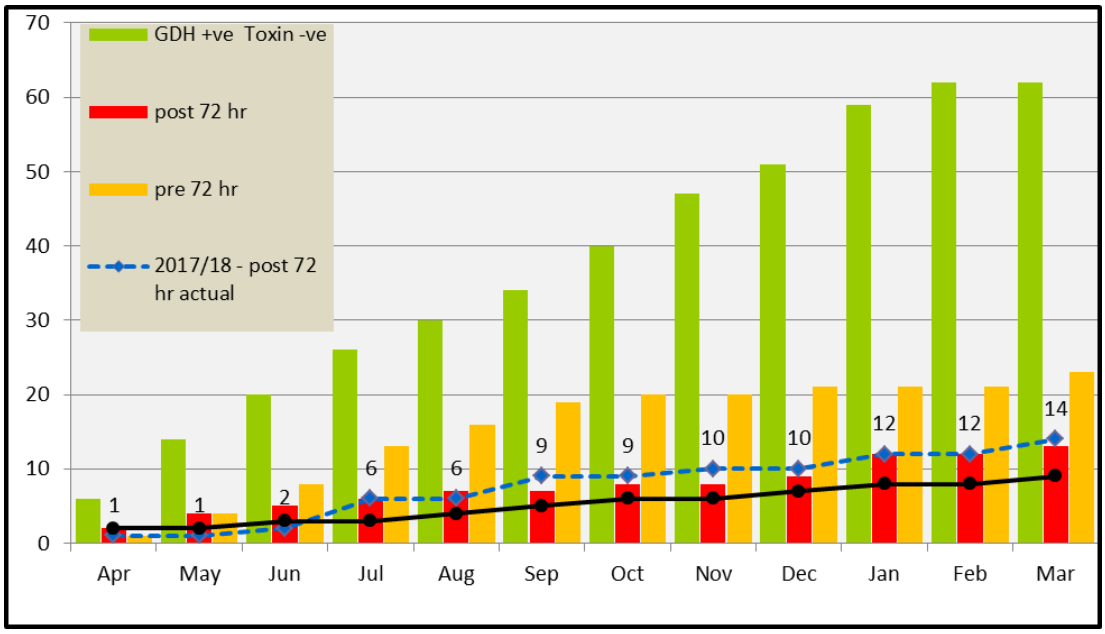
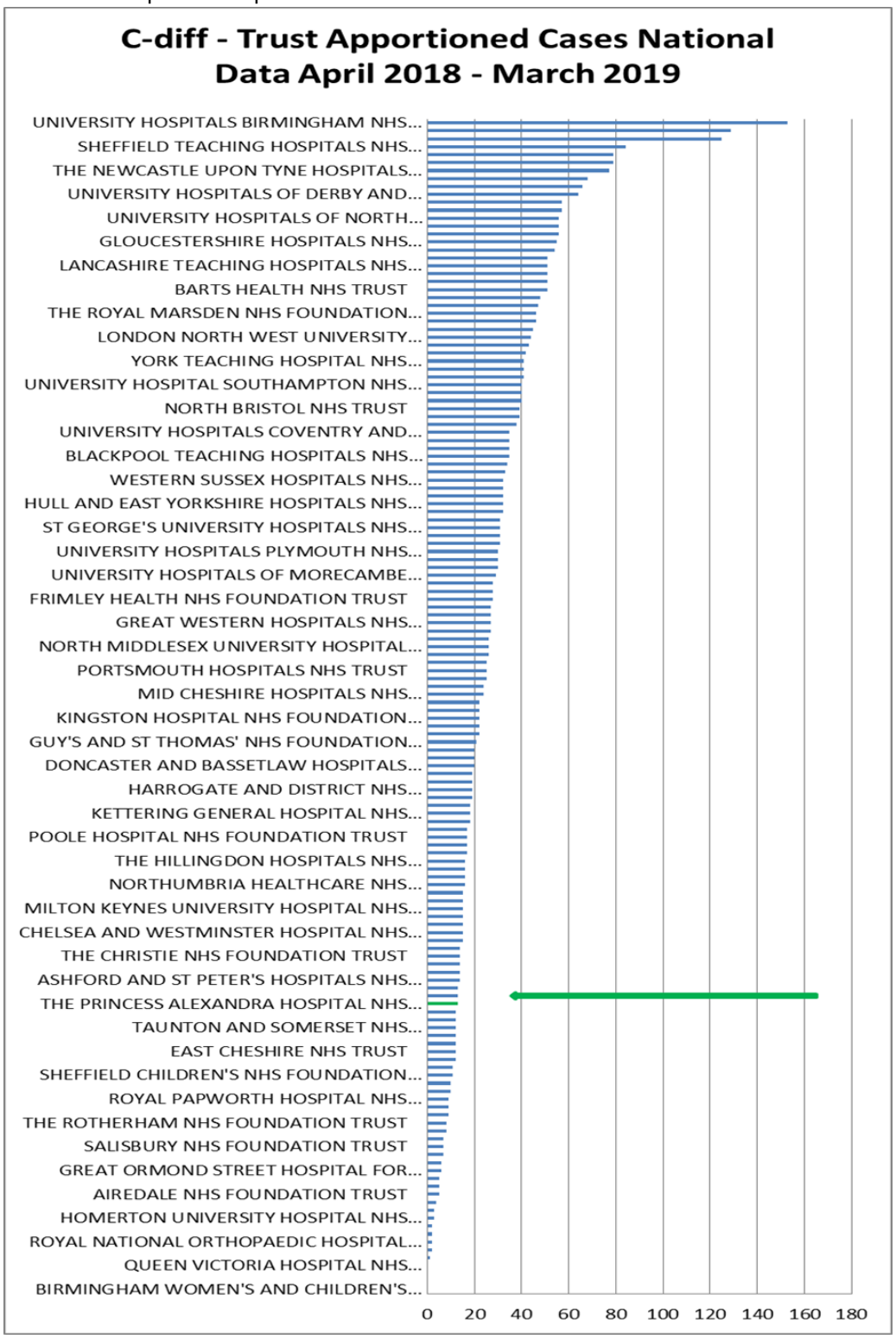
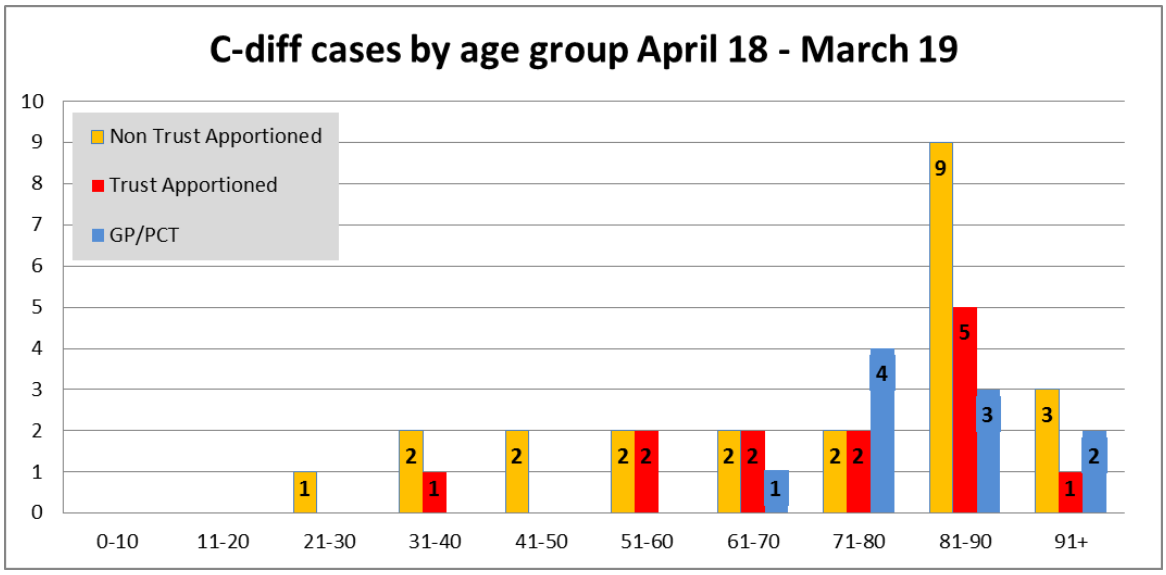


Figure 4: The Princess Alexandra Hospital's position against all acute Trust's in England for *C difficile* for the period of April 2018 – March 2019.



11.3.9. The total number of cases (both Trust apportioned and non-Trust apportioned) categorised by age groups is demonstrated in **Figure 5,** with the highest numbers being in the 81-90 years age group for both Trust-apportioned and non-Trust apportioned cases.

Figure 5: *C.difficile* categorised by age group (all cases)



11.4 Glutamate Dehydrogenase (GDH) Testing

11.4.1. GDH is the first test of a two-step a screening test and was introduced at PAH NHS Trust in July 2012 to comply with the DoH guideline on diagnosis of *C.difficile* infection (Updated Guidance on the Diagnosis and Report of Clostridium Difficile, Department of Health, March 2012). It detects *C. difficile* antigen and is undertaken on all specimens that meet the criteria for *C.difficile* testing. If positive, this would be followed by a test for toxin detection (indicative of *C.difficile* disease). If GDH was negative, the toxin test would not be performed.

11.4.2. All GDH positive, toxin negative cases are managed in the same way as toxin positive cases, in terms of infection control precautions, isolation and environmental decontamination (as patients still carry the *C.difficile* organism and may pose a risk to others). Treatment is considered on an individual basis.

11.5 Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia

11.5.1. MSSA is the normal *staphylococcus aureus* strain that many patients carry in the anterior nares of the nose as part of their 'normal' flora. When MSSA is isolated in the blood stream this is referred to as an 'MSSA bacteraemia' and is potentially a serious condition, which, in some cases, causes mortality. MSSA strains can be treated with Flucloxacillin, a narrow spectrum antibiotic, which cannot be used in *MRSA* treatment, as MRSA is by definition Flucloxacillin resistant.

11.5.2. In the cumulative MSSA graph below (**Figure 6**), there isn't a black trajectory line, as the DoH has not set Trust targets for MSSA. However the IPCT continue to monitor cases and work with clinical teams to reduce Trust-attributable cases.

This year there were eight MSSA bacteraemia cases. As can be seen in **Figure 7**, the Trust remains one of the top performing hospitals in the country, with very few acute (comparable) Trusts with lower numbers than us. Numbers are slightly higher than the previous two years (four cases in 2017/18 and seven in 2016/17); however even with this slight increase, numbers are very low and some variation year on year is expected. Additionally, none of the eight cases were attributable to invasive devices e.g. intravenous lines, indicating the bacteraemia were not due to poor care/practice.

11.5.3. Our success has been multifactorial; aseptic insertion of cannulas, monitoring of phlebitis scores using the 'body map', and by encouraging early removal of cannulas and other invasive devices wherever possible. One measure that we believe to be significant is that all in-patients are provided with an antimicrobial wash to use for the duration of their stay which has been found to reduce the risk of MSSA bacteraemia following a study undertaken in the Trust some years ago. Many measures used to control MRSA also control MSSA. The intravenous (IV) to oral switch of antibiotics also helps control MSSA bacteraemia indirectly by enabling cannulas to be removed early in a large group of patients, as at any one time 25 -30% of hospital patients receive an antibiotic, often intravenously.

Figure 6: Cumulative MSSA Bacteraemia at PAH NHS Trust April 2018 – March 2019

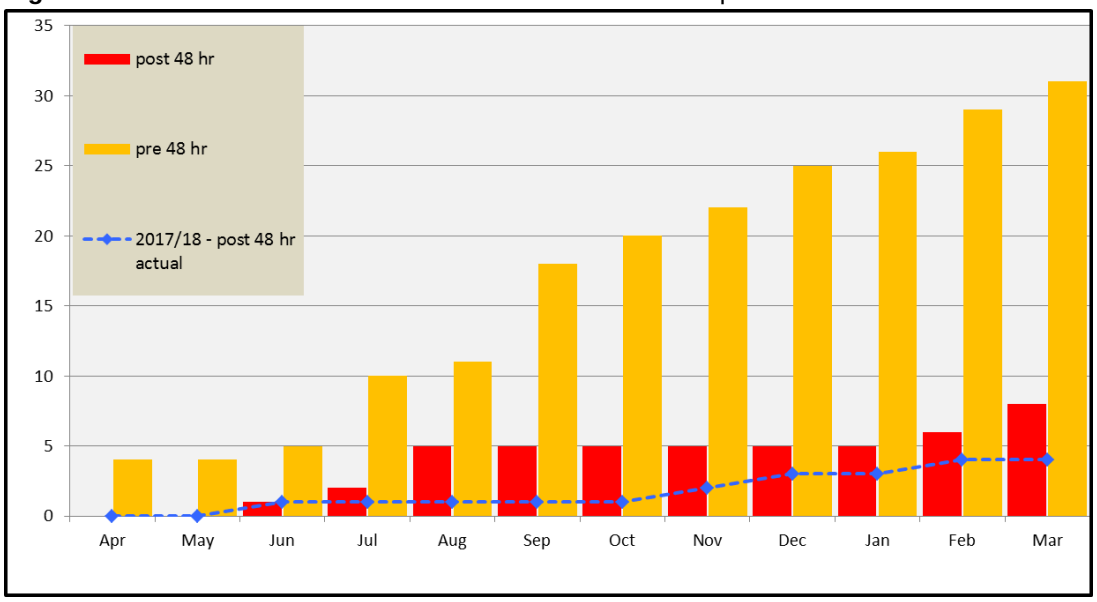
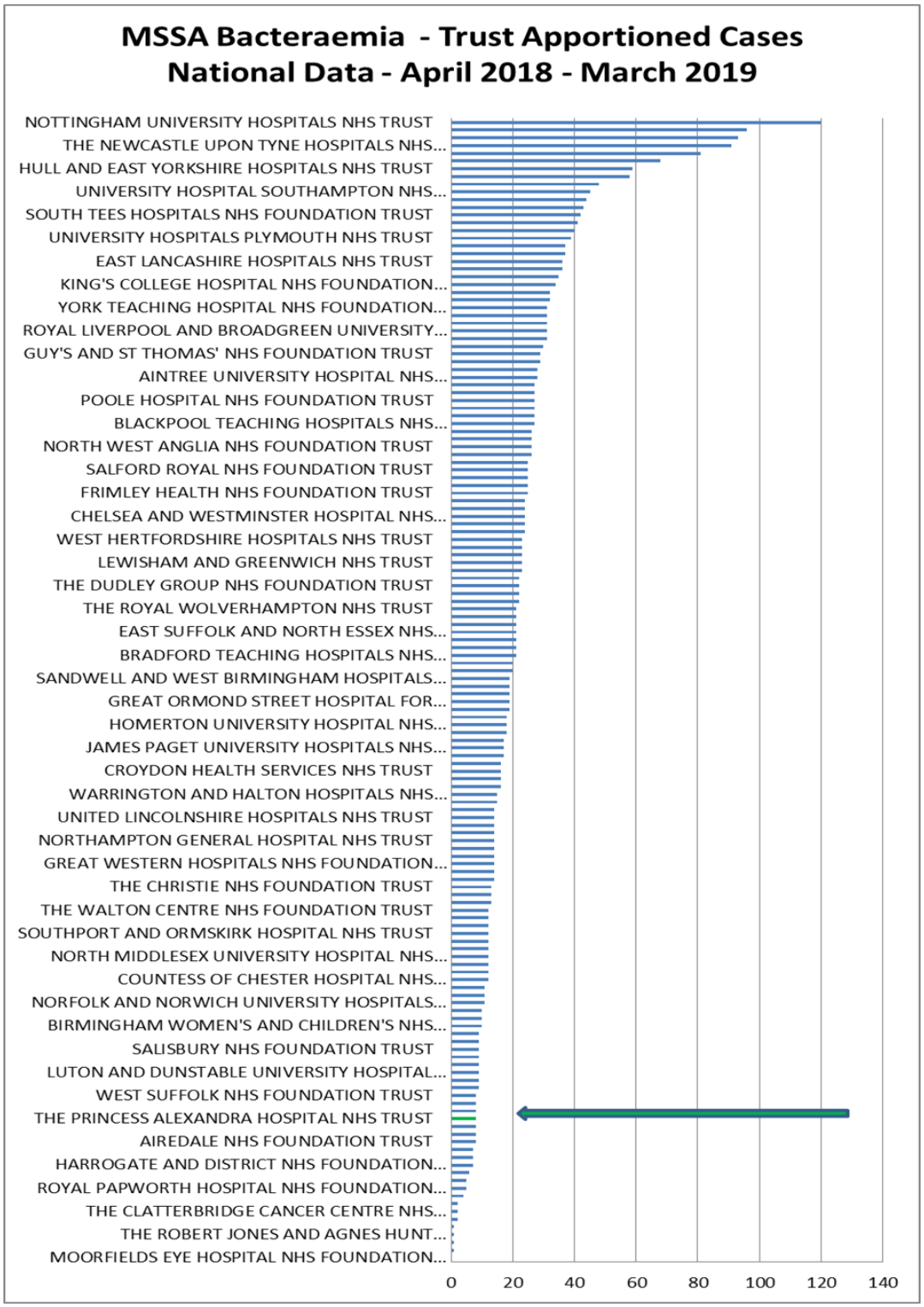


Figure 7: The Princess Alexandra Hospital's position against all acute Trusts in England:



11.6 Gram negative blood stream infections (GNBSIs)

- In England, BSIs caused by Escherichia coli and Klebsiella pneumoniae increased by 15.6% and 20.8% respectively, from 2010 to 2014. These two bacteria also cause the greatest burden of antibiotic resistant infections. Introduction of a national GNBSI target followed to reduce GNBSIs by 50% by 2021 (now extended to 2024), as a whole health care economy, as did mandatory reporting of Klebsiella sp. and Pseudomonas aeruginosa bacteraemia.

- A healthcare associated GNBSI is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who have received healthcare in the community or hospital in the previous 28 days. At PAH NHS Trust we can demonstrate evidence of well-informed leadership, planning and clinical interventions to address this initiative. We have evidence of assessment against the Health and Social Care Act: Code of Practice, we have DIPC / IPCT, senior management and increasing clinical ownership of GNBSIs, and we have a collaborative approach to tackling GNBSIs across the health care economy.

- We understand our local data and review local epidemiology and risk factors for our GNBSI cases, with the source of all GNBSIs documented by the IPCT. We have evidence of collated outcomes of case reviews, for example we undertook a full clinical review for all cases in 2017-2018 of our Trust apportioned Pseudomonas aeruginosa BSIs with clinical leaders involved in the care of the affected patients. This has helped in a reduction in our Trust apportioned Pseudomonas aeruginosa BSI case numbers to one case for the whole of the last financial year 2018-2019, which is a significant achievement.

- Our clinical staff have been trained in antimicrobial use and policies, including information on choice and duration of treatment. We had 17 Consultant Physicians and Surgeons, three Consultant Microbiologists, our antimicrobial pharmacist, two microbiology laboratory managers and five junior doctors contributing to the antimicrobial guidance update by the DIPC last year; we believe this has significantly helped control the primary source of our GNBSI infections. We have specific prescribing actions addressed by the Antimicrobial Stewardship (AMS) group and clinical leaders oversee AMS actions. We have suitable governance arrangements in place, with the action plan being monitored by our Quality and Safety Committee, and an Annual report published for Infection Prevention and control including GNBSIs and AMS.

- Senior clinical leads actively devote time to championing IPC and as mentioned previously, an Executive Lead is responsible for overseeing IPC actions. We have clinical and operational leads working collaboratively to resolve problems, and have Patient safety walkabouts which include review of urinary catheters and device monitoring in the form of a body map, hydration checks, hand hygiene checks, and antibiotic prescribing.

- In November, the IPCT appointed a nurse on a 12 month secondment post to support the Trust in achieving the DoH ambition of a 50% reduction in CAUTI. This role is to support clinical staff training specifically with catheter insertion and management and the post holder has been working closely with the Trust Clinical Nurse Specialist in urinary catheter management. Work is in progress to provide patients who leave hospital with a urinary catheter and those catheterised in the community, with a catheter passport documenting

details of the catheterisation. A new referral system has also been developed for patients with continence issues.

- Collaborative working between CCG and hospital teams is on-going to identify common themes. However more and more surveillance information is being gathered locally and CCG IPC nursing support is required to take this work forward.

- In 2018-19 GNBSI total was 205, of which 23 were Trust apportioned; this is a reduction to the previous year, where there were 239 cases, 38 of these being Trust apportioned.

11.6.1 *Escherichia coli* (*E.coli*) bacteraemia

- During the year 2018/19, there were 133 non Trust apportioned cases and 14 Trust apportioned (post 48 hour) cases. A reduction can be seen when compared to 2017/18; 155 non Trust apportioned cases were isolated and 20 Trust-apportioned (post 48 hours) cases.

- The number of community attributable cases is far higher than hospital attributable, with the majority of positive blood cultures taken within 48 hours of admission, usually in the emergency department. In a significant number of the Trust apportioned cases, it is likely that these were not acquired on admission, but timing of the blood cultures means they are assigned as attributable to the Trust. This cumulative data is displayed in **Figure 8** below.

- The urinary tract is the most common primary source of *E.coli* bacteraemia, accounting for almost two thirds (61%) of all cases in 2018-19; this compares to 60% of cases at PAH NHS Trust in 2017 -18 and 62% nationally in 2016 -2015 being associated with the urinary tract.

- The urinary tract as a primary source is followed by respiratory (16% of cases), hepato-biliary (10% of cases), gastro-intestinal (5% of cases). The primary sources of all cases of *E.coli* bacteraemia can be seen in **Figure 10**.

Of those patients where the urinary tract was the source of gram negative blood stream infection, 18 % had a urinary catheter.

The figures from previous years for percentage of patients with catheters when a urinary source was identified as the cause of the gram negative BSI were: 29% in 2017-18, 26% in 2016-17, 17% in 2015-16, 23% in 2014-15, 43% in 2013-14. These trends will continue to be monitored.

Figure 11 demonstrates the Trust's position for E.coli BSIs, against all acute Trusts in England during the 2018-19 period. PAH is in a favourable position in the top quarter of best performing Trusts nationally.

Cases of ESBL bacteraemia are also monitored by the IPCT, and are discussed in detail in section 11 below. There is currently no national information available to compare our ESBL figures.

Our current recommendation that urine samples be sent to the laboratory from those with clinical treatment failure, frequent or recurrent UTIs or who have a likelihood of a resistant infection continues. The trimethoprim resistance rate of 34% reported nationally and the current recommended first line treatment nitrofurantoin with a resistance rate of 3%, reflects almost exactly our local resistance rates. We have also introduced Pivmecillinam to our

formulary to treat infections due to resistant gram negatives. It will also help meet national CQUIN requirements.

Treating UTIs optimally in General Practice and in hospital have helped control our E.coli and other gram negative BSIs. We have also reduced hospital admissions due to gram negative bacteraemia, saving the Trust and Health care economy over one million pounds.

The Trust also collects data on Klebsiella sp. and Pseudomonas aeruginosa BSIs. This is because nationally, E. coli, Pseudomonas aeruginosa and Klebsiella spp. account for 72% of all Gram-negative BSIs.

11.6.2 Klebsiella sp.

During the year 2018/2019, there were eight Trust apportioned (post 48 hour) cases (in comparison with six the previous year). **Figure 12**

11.6.3 Pseudomonas aeruginosa:

During the year 2018/2019, there was just one Trust apportioned (post 48 hour) cases (in comparison with 10 cases the previous year) **Figure 13** .

The Trust has had spectacular success with regard to control of these Pseudomonas bacteraemias and have moved to being one of the best in the country in terms of Trust apportioned bacteraemia.

The following actions were taken to reduce these infections from last year:

- Detailed root cause analysis by the DIPC and senior clinicians, with follow up actions
- Ward level support provided by the continence team and IPCT to reduce catheter associated urine infections
- writing antimicrobial policies for hospital, CCG, patient at home and palliative care
- compliance with these antimicrobial policies to treat primary source infections

The total number of GNBSIs (*E.Coli, Klebsiella spp* and *Pseudomonas aeruginosa*) are shown in the graph below:

Figure 8: Cumulative total of Gram-negative Bloodstream Bacteraemia for 2018-19

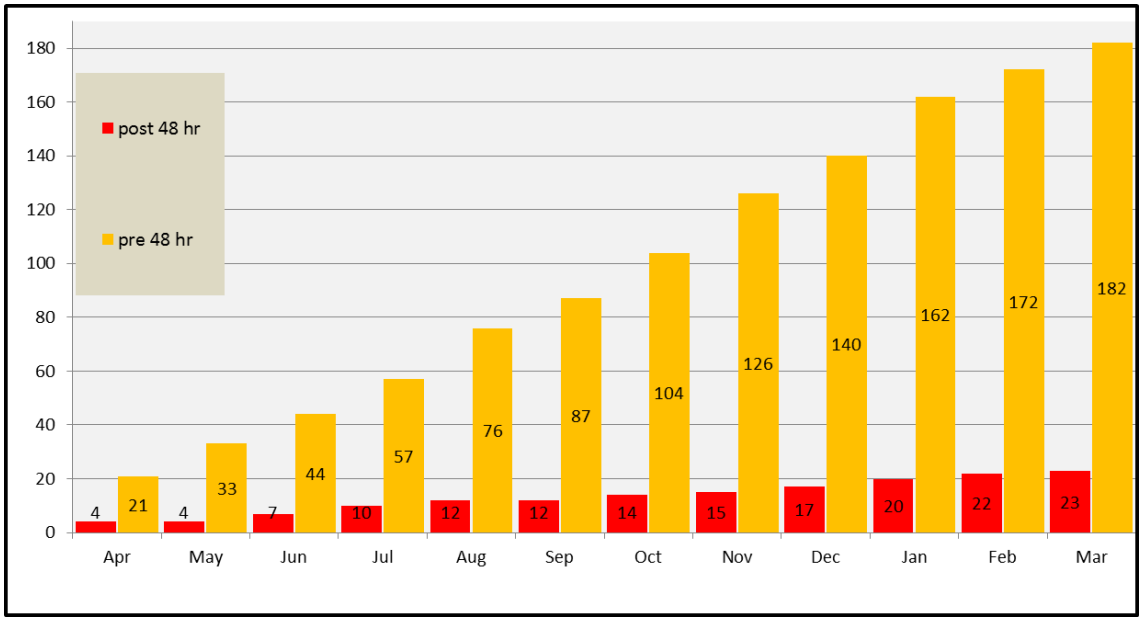


Figure 9: Cumulative *E.coli* Bacteraemia cases 2017 - 2019 at PAH NHS Trust

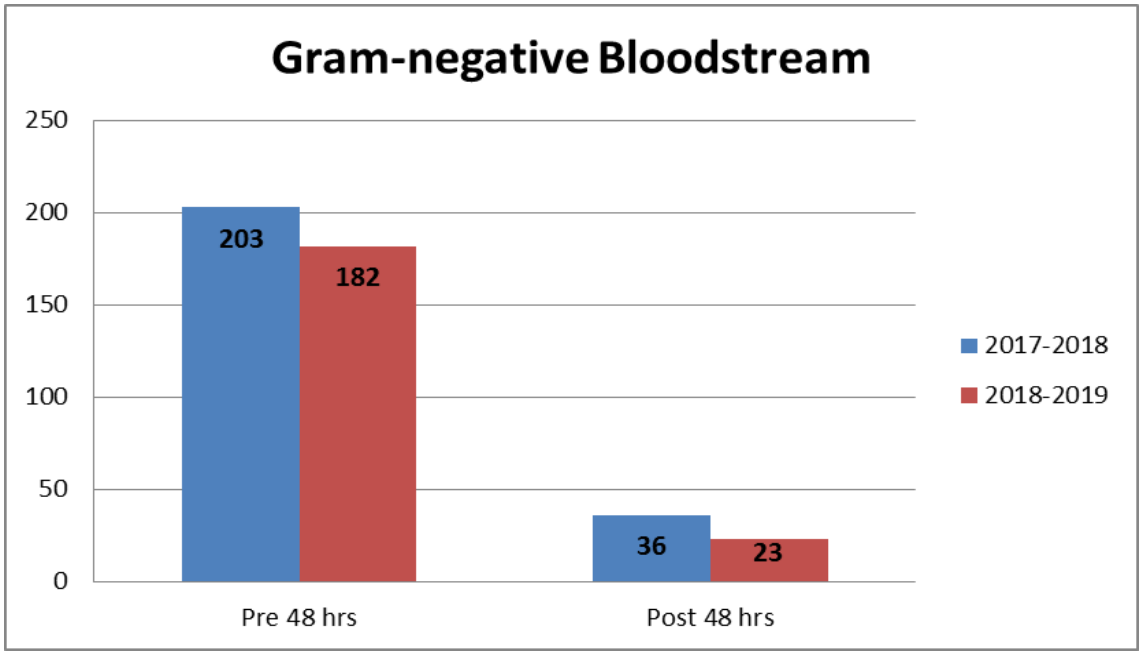
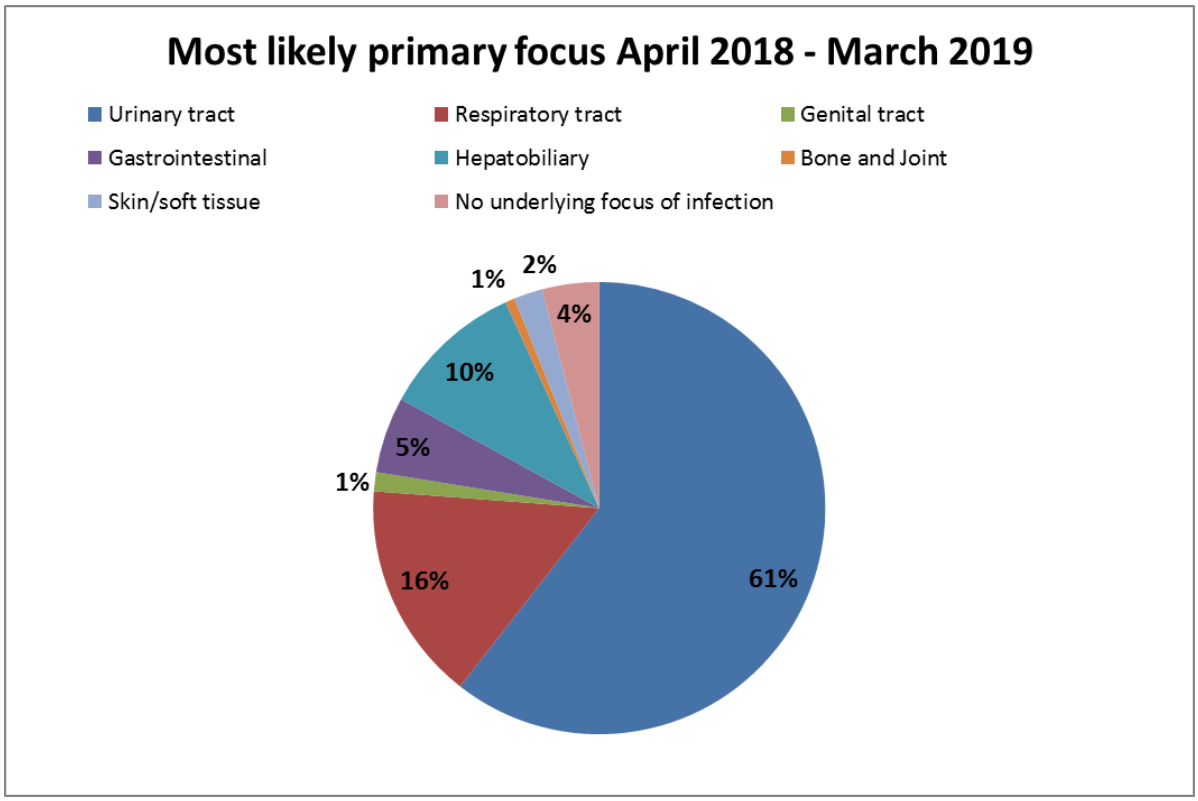


Figure 10: Likely Sources of Primary Infection 2018 – 2019 for cases of *E. coli* bacteraemia at PAH NHS Trust



8.2

Figure 11: The Princess Alexandra Hospital's position against all acute Trusts in England:

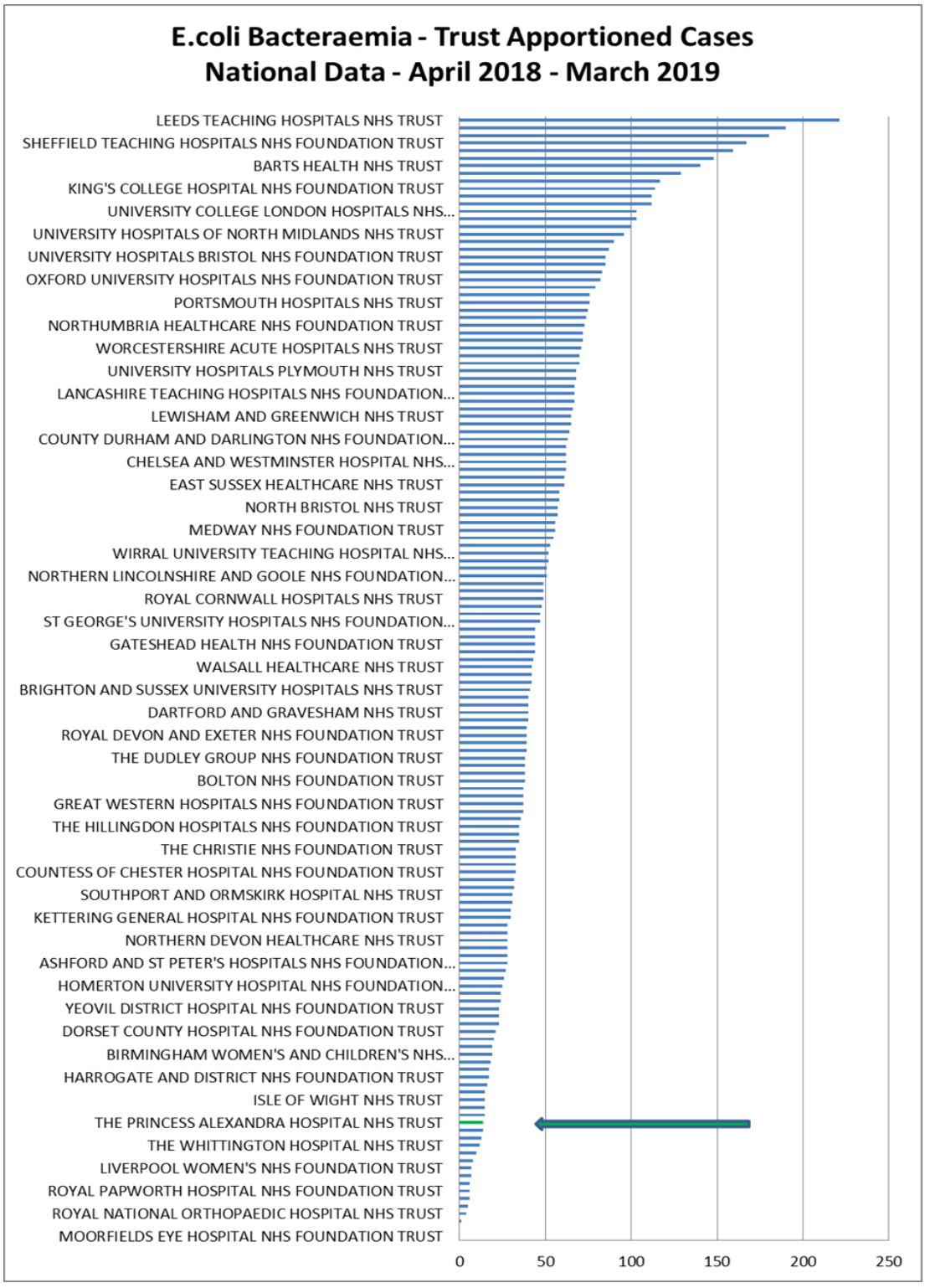


Figure 12: The Princess Alexandra Hospital's position against all acute Trusts in England:

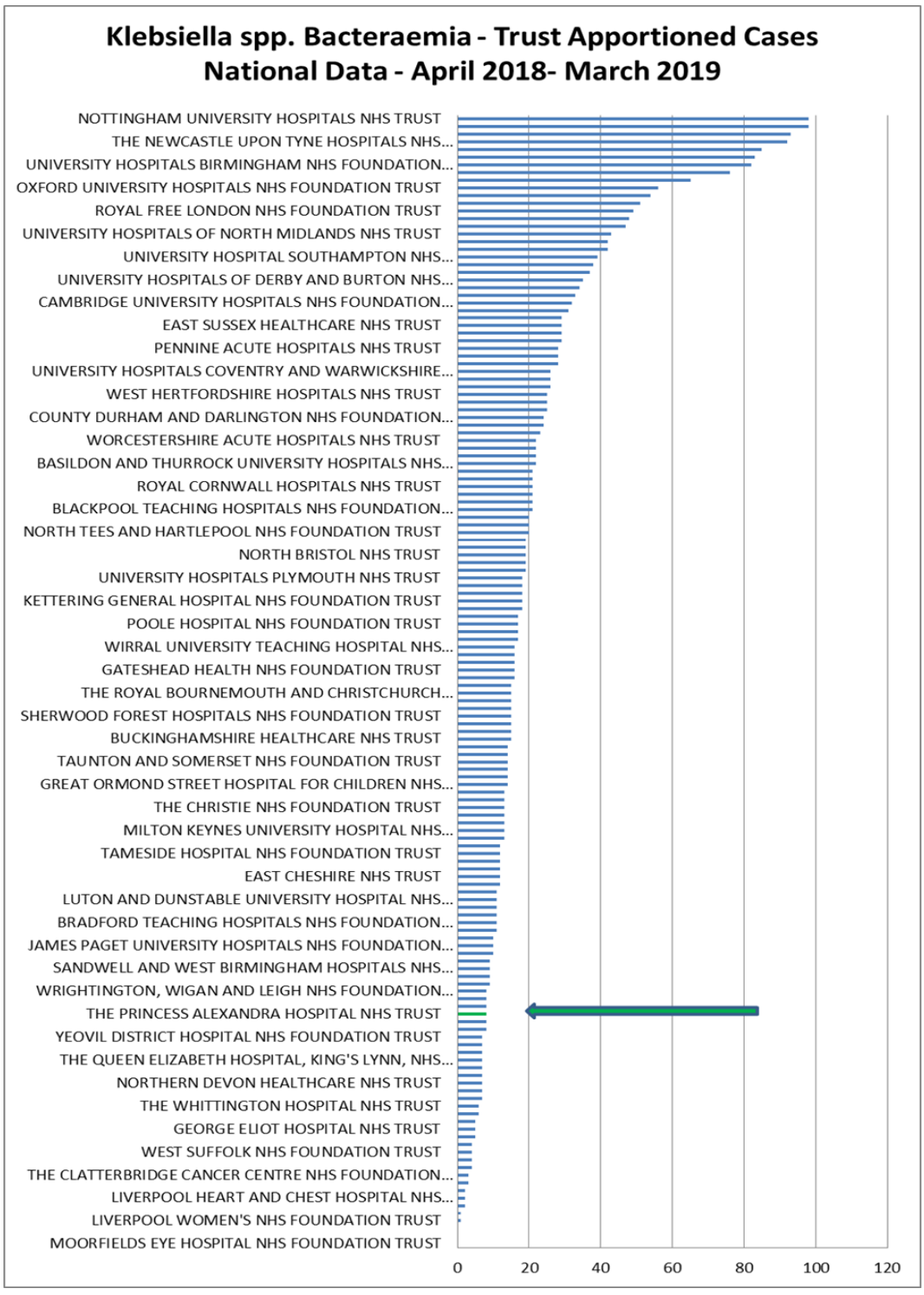
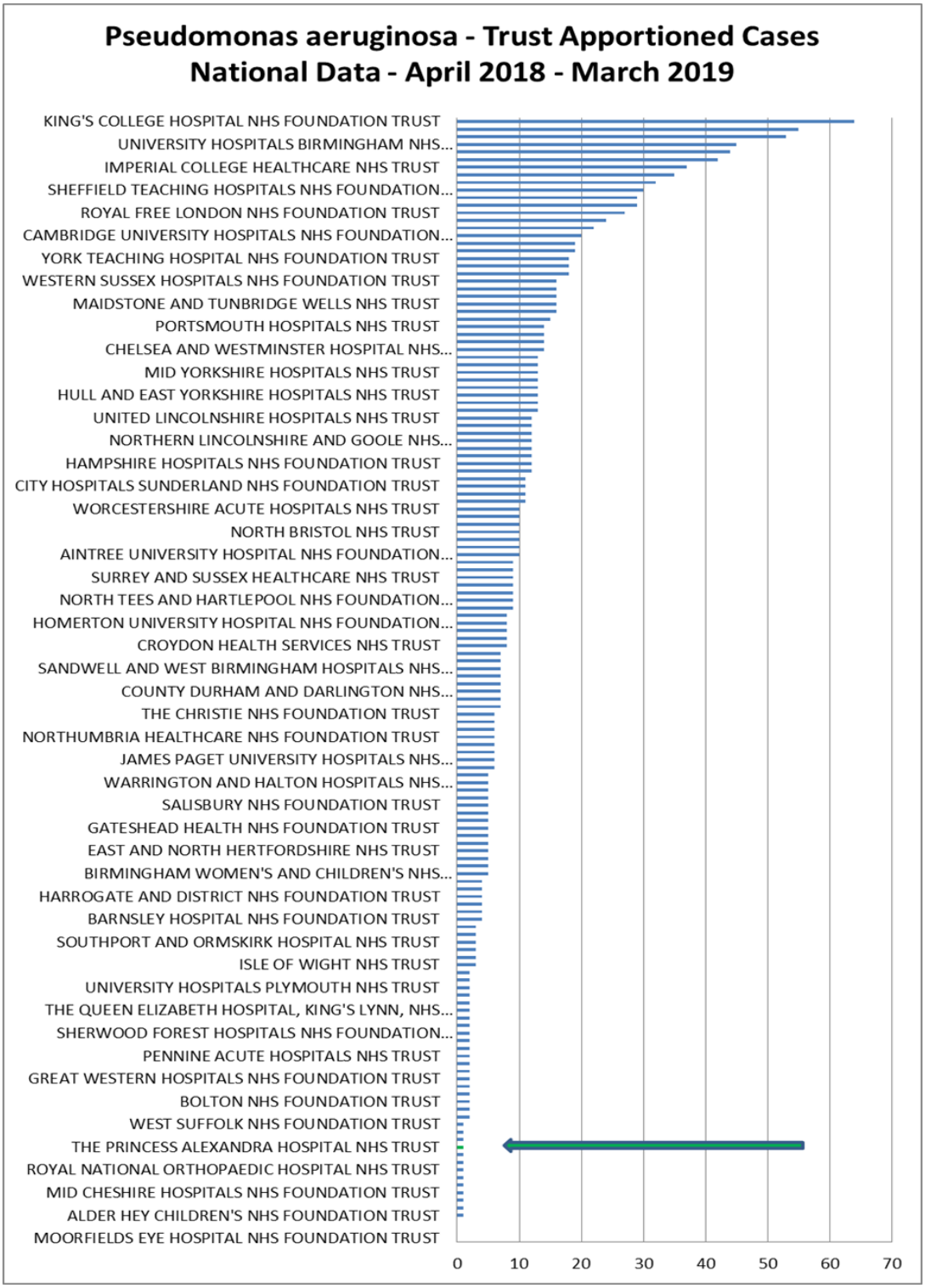


Figure 13: The Princess Alexandra Hospital's position against all acute Trusts in England:



11.7 Glycopeptide (Vancomycin) Resistant *Enterococcus* bacteraemia (GRE / VRE)

11.7.1. It can be seen in **Figure 14** that numbers of VRE isolates (all sites, not just bacteraemia) have been steadily increasing since 2010 to date.

11.7.2. During the year 2018/2019 there were 62 VRE isolates, which is an increase from 41 VRE isolates during the previous year 2017/2018.

17 patients were colonised with VRE during the period 31 December 2018 to 31 March 2019 in the critical care unit; a further three patients were already colonised on admission. VRE screening is currently not undertaken locally or nationally. It was decided however by mid-February 2019 to undertake rectal swab/ stool screening in the critical care unit, as it was an outbreak situation.

Multiple steps were put in place and the multi-disciplinary VRE Incident team chaired by the DIPC met weekly to monitor the situation and help bring the outbreak under control. One patient had a bacteraemia but died of other causes before treatment could be undertaken. In total, five patients were treated with Linezolid as a precaution. There were no patient deaths associated with VRE.
Control measures taken were as follows: Having clear roles and responsibilities, clinical ownership, use of single use items when possible, thorough equipment and environmental cleaning, optimal hand hygiene, review and monitoring of all IPC practices including out of hours audits, using different coloured aprons for each bed space, correct use of PPE, isolation when possible, producing a business case for a further ITU isolation POD, external input from CCG leads, PHE and NHSI, duty of candour letter for patients and relatives, estates involvement including hand wash basin (HWB) design reviews, correct use of HWBs, assurance monitoring jointly done by domestic supervisors with the ITU matron, use of scrubs by all staff, daily review of antimicrobials on ITU and HDU, van A and pulsed field gel electrophoresis analysis of all VRE isolates with on-site microbiology laboratory support for twice weekly VRE screening.

A previous VRE outbreak occurred in critical care three years ago but patient numbers affected were lower and the outbreak lasted for a much shorter time.

Continuing management of the use of broad spectrum and Glycopeptide antibiotics at our Trust will help keep VRE numbers under control. Although the clinical impact wit this organism was not severe as it is usually a colonising organism, VRE is a multi-resistant organism and its control is part of our IPC risk management strategy.

11.7.3. VRE bacteraemia remains unusual in our hospital setting (two cases this year). Most patients are colonised with VRE, rather than infected. The IPCT has noted that VRE has increasingly been isolated from wound swabs as well as urine samples.

11.7.4. Oral vancomycin is used as second line treatment for *C difficile* infection, in accordance with DoH recommendations. It is recognised that low dose oral vancomycin is a risk factor for the development of VRE. The DIPC has reiterated the need to follow Trust antibiotic guidance for the treatment of *C difficile*; metronidazole remains first line treatment for C difficile.

Figure 14: VRE isolates from clinical samples: 2009 and 2019

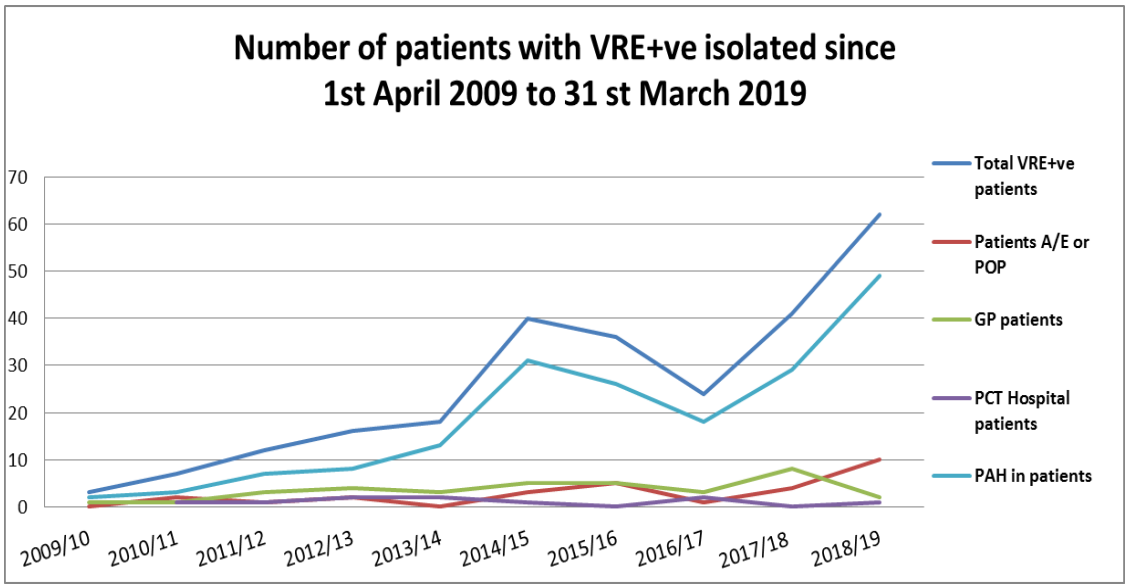
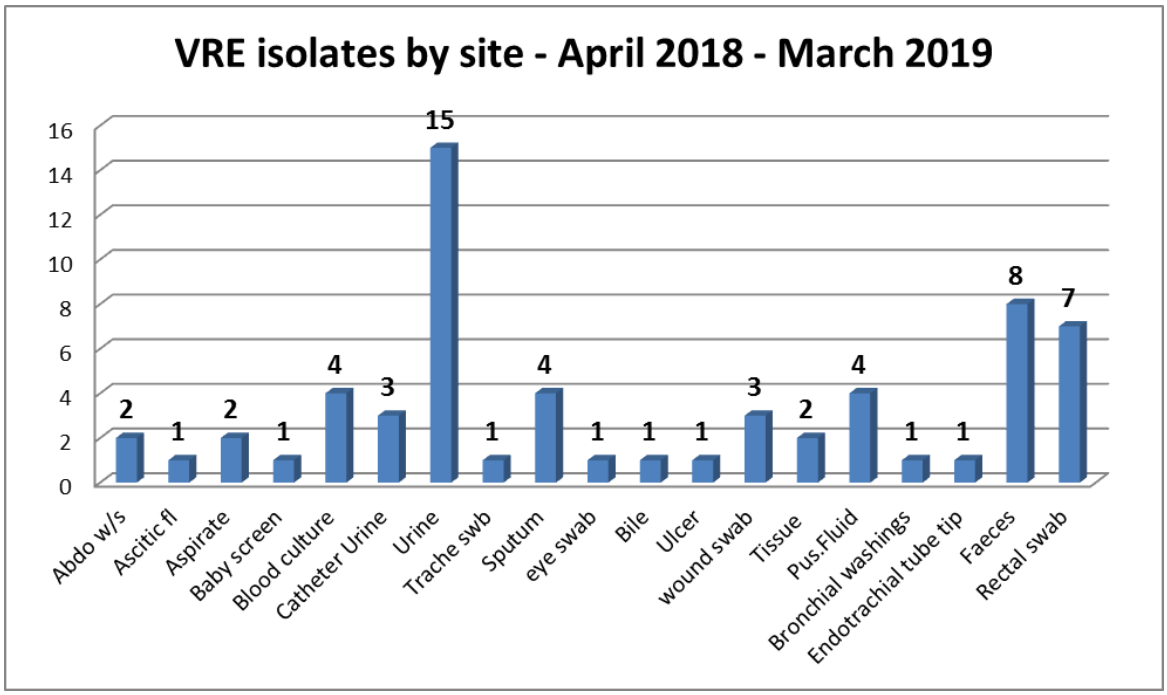


Figure 15: VRE isolates by site – PAH Microbiology Laboratory



12.0 Other Organisms Under Surveillance

12.1 Extended-Spectrum Beta Lactamase producing organisms (ESBL)

12.1.1. The Trust had three Trust-apportioned (post 48 hour) cases of ESBL bacteraemia this year (**Figure 16**). There is a downward trend, however numbers are small.

12.1.2. There were a total of seven patients admitted with ESBL bacteraemia; this compares with 18 patients in 2017-2018, 21 in 2016-17 and 17 in 2015-16. Cases have therefore more than halved this year. This trend has also been seen with sensitive E.coli bacteraemias. It is likely to be due to implementing our new antimicrobial guidelines across the Trust and CCG settings.

12.1.3. Urine specimens continue to account for almost 87% first isolates that are positive for ESBL producing organisms, with wound, blood, respiratory and other isolates all being very small in numbers in comparison (**Figure 17**).

12.1.4. ESBLs are multi-resistant organisms and are entered on the patient's data base under the risk factor section, in the same section as penicillin allergy or MRSA. This is in order that clinicians can use optimal antibiotic treatment (Meropenem) to treat patients who present with serious ESBL infection. Approximately 50% of strains are resistant to Gentamicin and Ciprofloxacin as well as all the beta lactam antibiotics (penicillins and cephalosporins), and Nitrofurantoin resistance is now over 10%.

8.2

Figure 16: Cumulative ESBL Bacteraemia in blood culture

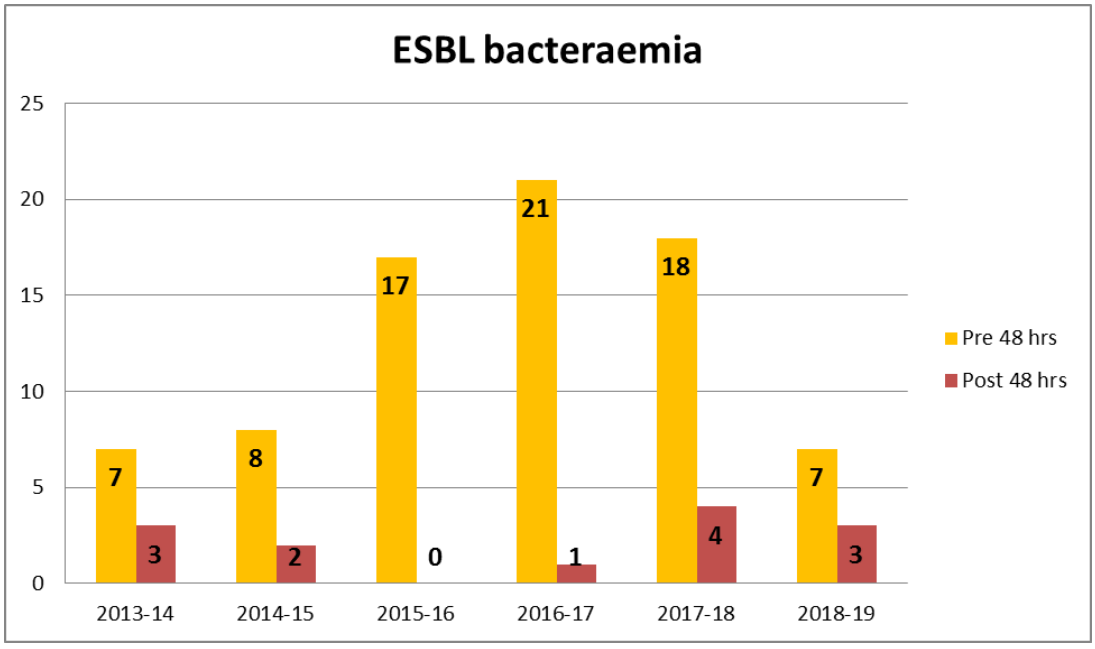
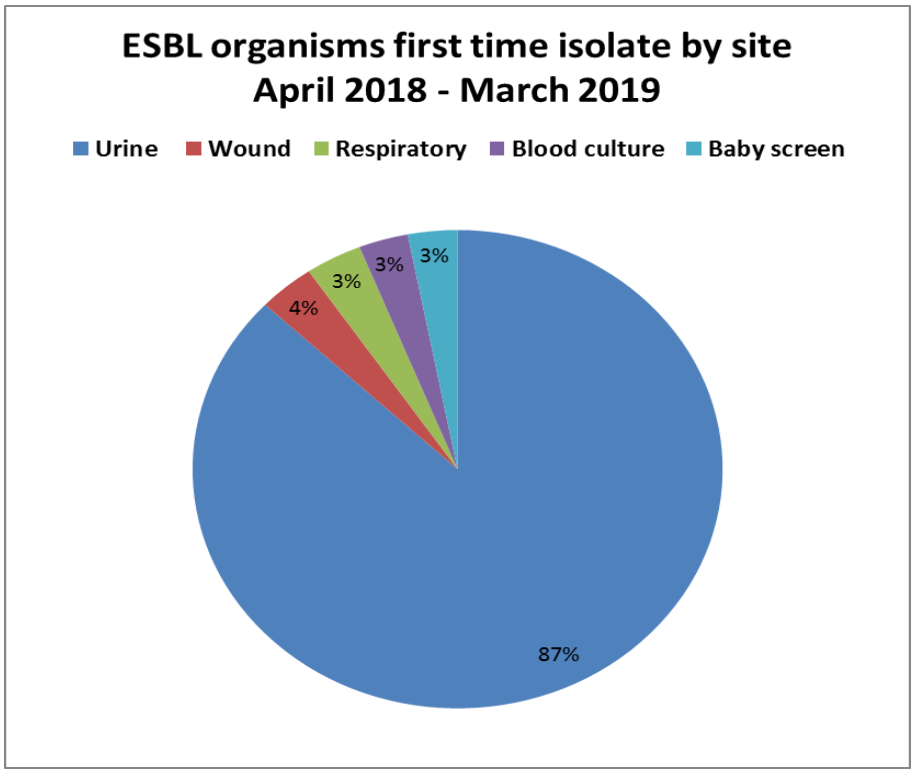


Figure 17: ESBL Isolates by site (first isolate only) – April 2018 – March 2019



12.2 Carbapenemase- Producing Organisms (CPO)

The CPO group of organisms includes CPE (Carbapenemase-producing Enterobacteriaceae) and, Carbapenemase producing *Pseudomonas* sp. and *Acinetobacter* sp.

12.2.1. Carbapenems include Meropenem and Imipenem; these are third line antibiotics for serious infection. Organisms that destroy Carbapenemase have potentially serious consequences.

12.2.2. Carbapenem resistance remains low in blood culture isolates of E. coli and Klebsiella spp. in England. Such resistance is however considered a significant threat to healthcare, as data from other countries, such as Italy, have shown that this type of resistance can increase dramatically over short time periods.

12.2.3. The epidemiology of carbapenem resistance is complex, as it commonly involves both spread of resistant bacterial strains and inter-strain (including inter-species) spread of plasmids containing genes encoding carbapenemases.

12.2.4. Awareness, education, antibiotic control and preventing cross infection are key to controlling CPO. Our normal IPC procedures will control CPO, but they must be implemented at all times.

12.2.5. CPE outbreaks can be controlled by early detection of cases, isolation of patients, patient/staff cohorting and enhanced hygiene measures (hand hygiene and environmental cleaning).
Antimicrobial stewardship may also play an important role in preventing outbreaks of drug-resistant infections (not only CPE).

12.2.6. Most CPE are resistant not only to the carbapenems, but to most other antibiotic classes. Only colistin remained effective against >90% of all CPE. However colistin resistance has started emerging.

12.2.7. A local Trust policy for CPO has been written and updated. This includes rectal screening of high risk patients (e.g. those that fit the DoH definitions of higher risk), as screening is the most common method of detecting CPO.

12.2.8. During 2018-19, we have nine confirmed CPO positive cases (two from GP samples). This compares with three cases the previous year. Although an increase, numbers remain low. However, following an audit of CPO screening, we are aware that not all patients meeting the criteria for admission screening are being screened, and more work to increase compliance is needed. Reassuringly, we are not seeing CPO infections, which would suggest our numbers are still low.

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13.0 Mandatory Surveillance

13.1 Orthopaedic Surgical Site Infections (SSI) 2018-2019

At Princess Alexandra we began an orthopaedic surveillance programme in 2005 reporting only on knee replacement for the mandatory one quarter annually. However, since the last quarter in 2012, we have been reporting for the whole year on both hip and knee replacements. Whilst this category of surgery is mandatory, it is not mandatory to undertake the surveillance for all four quarters of the year, but the Trust have opted to do this. The data is submitted to PHE and quarterly reports are produced from this.

This data enables the Trust to understand its infection rates year to year, provides scope to benchmark accurately against other hospitals that participate in the surgical site surveillance programme. All data is collated by the Joint Replacement Nurse Practitioner and reported to the ICC.

The report supplied by the Joint Specialist Nurse, who undertakes this surveillance, will be submitting this as a late addendum to this paper. However, the Surgery and Critical Care team have provided assurance of no deep infections since 2017.

14.0 MRSA Screening and Transmissions

14.1 Non Elective Screening

14.1.1. In 2014, the DoH published guidance (Implementation of modified admission MRSA screening guidance for NHS (2014) Department of Health expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection), recommending Trust's should consider reverting to the previous risk assessment based screening. However, following a review of the document and consultation with medical and nursing colleagues PAH made a decision to continue to screen all patients. The Trust has an excellent record for control of MRSA bacteraemia and we were concerned risk-based screening may compromise this.

14.1.2. The Information Team are responsible for collecting the data and reporting on compliance. The target for screening patients with MRSA is 95%. Those patients that are attending the Emergency Department and having treatment, but not being admitted i.e. zero day's length of stay (LOS) are excluded.

14.1.3. Each month, validation of the short stay wards is required as a number of patients are recorded as 'not swabbed'. Following this, some are able to be excluded if these patients have been in less than 24 hours

14.2 Elective Screening

14.2.1. All elective patients must be screened as part of the pre-assessment process, with the exception of the exclusion categories outlined in the 2010 DoH publication; MRSA screening - operational guidance 3. Additionally, whilst not mandatory, the Trust has taken the decision to screen patients attending oncology and haematology as day cases; this is because of the potential serious consequences of developing an MRSA infection in this group of patients and because of shared learning from other Trusts.

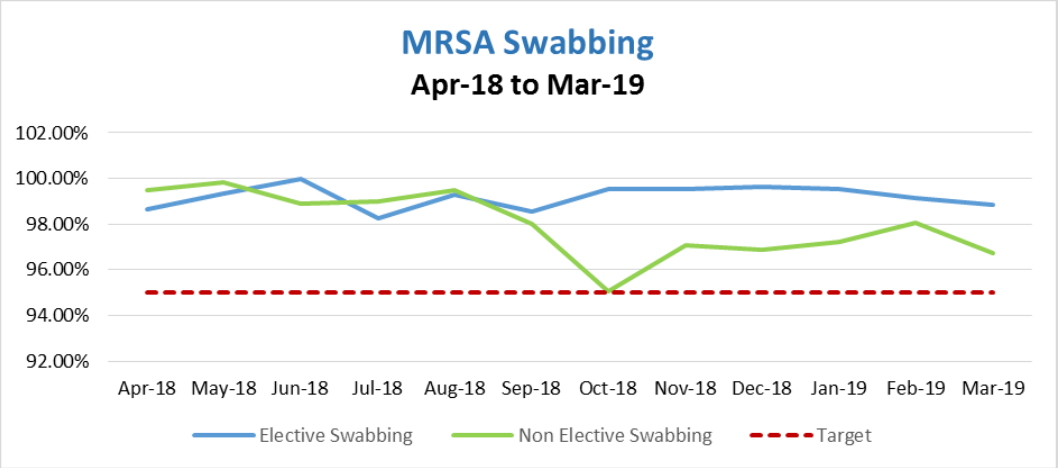
14.2.2. Data is reported on a monthly basis via the Information Team to the ADONs/Matrons, Senior Managers and the IPCT**.** Each month, a preliminary compliance figure is calculated, but usually includes data on a number of patients with missing screens; therefore the compliance rate at this point is lower. Nominated individuals within each HCG follow up on, and validate patients with missing screens. Once this information is received, the Information Team provide a final figure after adjustments are made.

14.2.3. A review of the procedures to exclude was also undertaken to ensure accurate and up to date.

14.2.4. Performance for both elective and non-elective swabbing has remained above the target for majority of year.

14.2.5. Going forward - A more in depth view of oncology MRSA screening is planned as some inconsistencies remain with excluded procedures.

Figure 18: Elective and Non-Elective MRSA Swabbing: April 2018 – April 2019 (provided by Informatics Team).



14.3 MRSA: New Cases, Colonisation and Transmission

14.3.1. The IPCT monitor new cases of MRSA colonisation and transmission and are responsible for communicating results to the clinical areas.

14.3.2. All patients admitted to the hospital (regardless of their MRSA status) are commenced on decolonisation treatment (a wash preparation); this is to reduce the risk of both colonisation and transmission of MRSA (and MSSA), which could potentially lead to a bacteraemia developing in susceptible patients.

14.3.3. There were 298 new isolates this year, compared with 267 the previous year. Although actual case numbers was slightly higher this year, the actual number of transmissions was the same for the last two years at 12%. See **Figure 19** for case numbers and transmissions by month in 2018-19.

14.3.4. The Trust continues to screen in-patients for MRSA on a weekly basis. This is not a national requirement, but the Trust made this decision locally as it was felt this was beneficial to the control of MRSA and therefore optimises patient safety.

14.3.5. A process is in place for monitoring transmission cases which includes a review with the Ward Manager; factors that may have contributed to the transmission, for example, other patients on the ward with MRSA, risk factors, hand hygiene and environmental audit results are addressed. The Information Officer undertakes ward mapping to establish whether there has been any commonalities or links with other patients on the ward who may have had MRSA. If there are deemed to be particular areas of concern, or multiple cases, a meeting will be held with the wider team including Matron/HoN/ADON and ward Consultant.

14.3.6. During 2018-19, there was a period of increased incidence (PII) of MRSA transmission on one of the medical wards. For clarification, this was termed 'PII' because there were no cases of infection during this period; all cases were colonisation.

14.3.7. There were a total of 18 cases of transmission between 31/3/18 – 2/11/18. Patient MRSA swabs were sent to the reference laboratory for typing. At least 11 strains were the same; EMRSA -15, PFGE (pulsed field gel electrophoresis) variant B3. Cross transmission is likely to have occurred, given the unusually high numbers. However, as this strain is a prevalent strain in the UK, individual acquisition cannot be absolutely ruled out.

14.3.8. An incident team was formed and met on a weekly basis to ensure all control measures were in place and regularly reviewed. Control measures included:

- Increased environmental cleaning and assurance of full terminal cleans after discharge of all patients. Additionally enhanced cleaning on the ward and fogging of side rooms that were occupied by patients with MRSA.
- Increased cleaning of shared patient equipment and the purchasing of equipment specifically for side rooms
- Plan for Estates issues to completed
- Daily hand hygiene audits
- Increased senior presence on the ward
- Observations of practice out of hours/nights
- Antimicrobial stewardship
- Staff allocation of specific staff to care for patients in isolation wherever possible
- All patients with MRSA to be allocated a side room
- Increase patient MRSA screening to twice per week

14.3.9. Staff screening was an additional measure undertaken. The decision to screen staff was taken after careful consideration and consultation with the Executive Team, HR and SHaW). This was at the point where all additional measures were in place, but new transmissions were still occurring. The HoIPC provided sessions on the ward for all staff to attend to understand the rationale and implications for staff screening. The screening itself was managed by SHaW and communication of results carried out in the strictest confidence. Staff screening identified two cases, but these were different strains.

14.3.10. In line with our commitment to transparency, the Trust informed the senior IPC lead for NHSI of the PII with an invitation to visit the Trust to review the measures implemented to date from an external perspective. The NHSI lead was in agreement with all measures implemented. During the visit (in November), some observations were made, particularly in relation to cleaning and estates issues and there was a recommendation to strengthen processes around this. This was commenced with immediate effect, although it was recognised that some of the estates/environmental work would need to be part of longer term plans to refurbish the ward.

14.3.11. The PII was formally declared over when 28 days had passed since the last positive case. This definition was agreed by the incident team and in line with the PHE definition and NHSI advice

Figure 19: New MRSA Isolates and Possible MRSA Transmissions by Month (all wards).

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
New MRSA isolates	25	18	23	29	31	27	30	22	32	18	19	24
Possible transmissions	4	3	3	5	6	4	2	2	1	0	4	2
% of possible transmissions from new isolates	16%	17%	13%	17%	19%	15%	7%	9%	3%	0%	21%	8%

15.0 Tuberculosis (TB)

The incidence of tuberculosis in England is higher than most other Western European countries, and more than four times as high as in the US. TB has been identified as a priority, and indicators of TB incidence and TB treatment outcomes are included in the Public Health Outcomes Framework.

Public Health England (PHE) and NHS England believe that action, supported by national expertise, can reduce the suffering and harm caused by TB, meet the WHO End TB Strategy milestone of reducing TB incidence by 50% by 2025, and contribute eventually to the elimination of TB.

8.2

15.1 The TB Nursing Service

The TB nursing service is an essential part of the diagnosis and management of TB. The TB specialist nurses work closely with the Chest Physicians to provide the clinical TB service managing patients and their contacts. Only very few patients with TB are in-patients at PAH, most patients are managed as out-patients.
The TB specialist nurses are employed and managed by Essex Partnership University Trust (EPUT). The Service has been commissioned 19 hours per week. The Royal College of Nursing (RCN) recommends 1 WTE for 40 standard TB cases and 1 WTE for 20 enhanced management TB cases. The lead for PAH is Andrew Hare.

15.2 TB cases in Harlow

15.2.1. TB patients in and outside hospital are managed by the TB MDT, comprising the TB specialist nurses (EPUT), the Trust chest physicians, the DIPC / Consultant Microbiologist, Chief Biomedical scientist Microbiology, the Consultant in Communicable Disease Control who is the TB Lead Public Health England (Anglia & Essex) based at the Essex Health Protection unit, a public health nurse, and a Consultant Radiologist (Chest), with input from the IPCN staff as required. The MDT meets once a month.

Hospital teams must remain vigilant and refer any suspected cases early to the nominated Consultant Chest Physician who is the Lead for TB in the Trust.

15.2.2. In 2018 (January to December) there were 13 active cases of TB and 47 latent cases of TB.

Measures were put in place at the PAH NHS Trust in 2014 to improve the clinical, radiological and microbiological diagnosis of TB. Standardised protocols were used for all patients, and all suspected or proven TB cases were discussed at the MDT. The results of a comprehensive clinical audit carried out by the MDT (TB) are presented below. The team reviewed clinic letters, pathology, biochemistry and radiology using the 'SystmOne' Electronic record system held by the TB nurse specialists. Medical notes and laboratory results were also reviewed.

Table 1:

PAH	2016	2017	2018
Total TB notifications	14	26	13
Culture confirmed	7	10	4
Clinically probable	7	16	13
Diagnosed incorrectly and notified as active TB (but were actually latent TB)	0	0	0
Not TB – diagnosed incorrectly	0	0	0
Diagnosed outside PAH			3

Table 2:

	National standard PHE, 2015	PAH 2016	PAH 2017	PAH 2018
Proportion of culture confirmed TB cases	58-61%	58% (2 WERE EXCLUDED AS DIAGNOSED OVERSEAS)	48% (5 excluded as diagnosed outside PAH)	57% (4 of 7) (3 excluded as diagnosed outside PAH/3 excluded as sent for Histology only
Culture confirmed Pulmonary TB cases	72%	75%	50% (9 from 18 cases)	60% (3 of 5)
Culture confirmed Extra-pulmonary cases	47%	25%	33% (1 from 3 cases)	50% (1 of 2)

15.3 TB Audit Report

The PAH TB audit for 2018 shows a decrease in TB notifications from the previous year. This is due in part, to 2017 showing an unusually high upturn in cases owing to one case generating a further 9 cases. The notification rate for 2018 shows parity with 2014-2016.

Three cases were excluded from the Microbiology review as these samples were processed elsewhere. These cases were commenced on treatment at a different hospital and later transferred to PAH.

Three cases were excluded as the samples were not sent for culture but Histology only. In two of these cases Histology was highly suggestive for MTB. In the remaining case the Histology was sent for PCR and was reported as MTB with no Rifampicin resistance.

In the seven samples sent for culture (5 PTB/2NPTB) four grew MTB in the lab (3PTB/1NPTB). Of the four MTB cultures; 2 were fully sensitive, one Isoniazid resistant and one MDRTB.

All TB diagnoses were considered robust and based on:
1. MTB culture
2. Histology – highly suggestive of MTB
3. Positive IGRA.
4. Symptoms

All notifications have been reported to PHE, discussed in PAH TB MDT and reviewed at Cohort Review.

16.0 SHAW (Staff Health and Well Being)

16.1 Staff Influenza Vaccination Programme

The vaccination programme for staff began in September 2018 and all staff were required to have a face to face consultation with a member of the Flu team. The programme was planned in order to control the risk of flu transmission in the event of a local or national outbreak.

Regular communication during the campaign and the Trust's 'InTouch' magazine was used as a means of communication, and to advertise the campaign and update on progress via screen savers.

Final PAH figures showed that 2325 of Healthcare workers were vaccinated who has a direct contact with patients.

The table below **Table 3** provides information on the numbers of vaccinations administered to different staff groups between September 2018 and March 2019.

Flu champions on the ward areas are commended for their support and continuing with vaccination during difficult times.

Influenza Vaccines administered September 2018 – March 2019

Table 3: the numbers of vaccinations administered to different staff groups between September 2018 and March 2019.

Staff Group	Number of vaccines administered
Doctors - Anaesthetists, all grades of Doctors, Medical Students	**250 out of 404 =61.8%**
Nurses/Midwives - Ward Managers, Matrons, Specialist Nurses	**642 out of 885 =72.5%**
Support staff- Health care Assistant, Maternity Care Assistants, Operating Department Practitioners, Trainees, pre-registered Nurses, Nursery Nurses, Students, Assistants, Domestics, Porters, Ward clerks	**604 out of 640 =94.3%**
Allied Healthcare Professionals - Audiology, Technicians, Pharmacy Pathology, Radiology, ATO's, IM&T, Physiotherapy, EBME, Scientists, In Patient Therapies	**221 out of 302 =73.1%**
Target was set to have 75% of healthcare workers vaccinated for PAH From the total number of 2231 staff	**Achieved**

8.2

16.2 **Sharps injuries/ body splashed Injuries**

The report on inoculation injuries for March 2018- End of February 2019 shows that in total 91 injuries and body fluid splashes occur in that time and out of 91 ,75 sharps injuries were noted.

Table 4: Where these Occurred

Cardiac Cancer and Diagnostics Health Group	19
Family and Women's service	20
Medical health group	29
Surgical Health Group	23

Table 5: Staff Designation

Consultant	7
Junior Doctor	22
HCA	9
Nurses	21
Phlebotomist	5
Student	1
Technician	4
Domestic	5
Midwife	14
Other	3

Table 6: Equipment involved in the Injury

Blood gas syringe with needle	1
Cannulation Inducer	6
Disposable syringe with needle	5
Hollow needle	21
Scalpel	7
Suture needle	13
Insulin Needle	12
Vacutainer needle	10
Other	16

17.0 Infection Control Incidents and Outbreaks

17.1 Norovirus Outbreaks

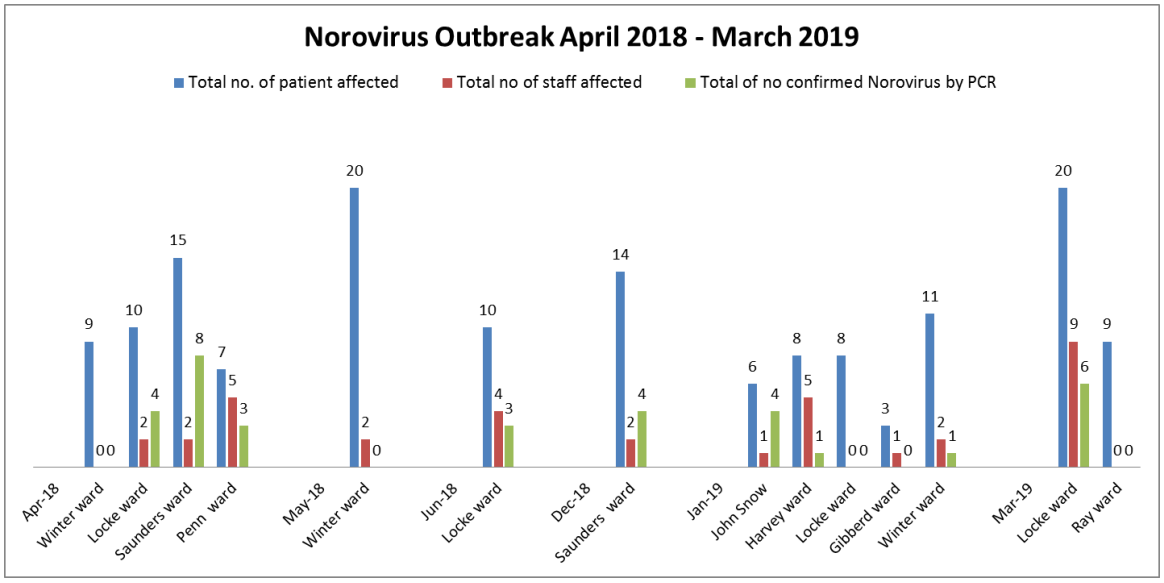
17.1.1. In 2018-19 there were six outbreaks, three of which involved multiple wards and three that were single ward outbreaks. Norovirus PCR confirmed cases in five of the outbreaks. See **Figure 20** below for affected wards; the green bars indicate PCR positive results.

14 wards were affected (some more than once). There were just over 150 patients (34 confirmed norovirus cases), around 35 staff members affected and more than 400 bed days lost.

17.1.2. Our infection control management and associated processes have demonstrated that we have been able to ensure that the affected wards became fully operational as soon as possible (after closure or partial closure), by taking necessary steps such as managing wards bay by bay, isolating and co-horting within the ward (as per national norovirus guidelines).

17.1.3. Outbreak meetings were held daily, led by the IPCT. On occasions, the Deputy Director of Nursing from West Essex CCG the meetings to offer support to the Trust.

Figure 20: Norovirus Outbreaks April 2018 – March 2019



8.2

18.0 Deaths Associated with HCAI

All deaths relating to HCAI should initiate a discussion between the DIPC or a Consultant Microbiologist, and the clinical teams. This provides assurance that deaths due to HCAI are accurately recorded on death certificates. It also enables the impact of HCAI associated mortality to be monitored.

18.1 There were no deaths this year where MRSA were cited on death certificates.
There was only two deaths associated with *C difficile* in 2018-19 on the death certificate;

one as Part 1a (a Trust apportioned case) and the other was Part 2 (a non-Trust apportioned case).

19.0 Audits

19.1 Audit Programme 2018-19

19.1.1 Audits have been undertaken throughout the year; a variety of clinical areas were involved in the audit programme. The audits undertaken in this period were:

- Hand hygiene compliance (cross over monthly validation audits)
- Surgical site infection (*Saving Lives* audit)
- Ventilated associated pneumonia (*Saving Lives* audit)
- Peripheral line insertion (*Saving Lives* audit)
- Peripheral line on-going care (*Saving Lives* audit)
- Urinary catheter insertion (*Saving Lives* audit)
- Urinary catheter on-going care (*Saving Lives* audit)
- Unannounced Clinical and Environmental audits
- Isolation Policy compliance audit
- CPO Policy and screening log
- Invasive devices audit
- Antimicrobial compliance

19.2 Hand Hygiene Compliance Audits

19.2.1. As the single most effective method of preventing infection, training and education on hand hygiene remains a core part of all teaching sessions provided by the IPCT for all groups of staff.

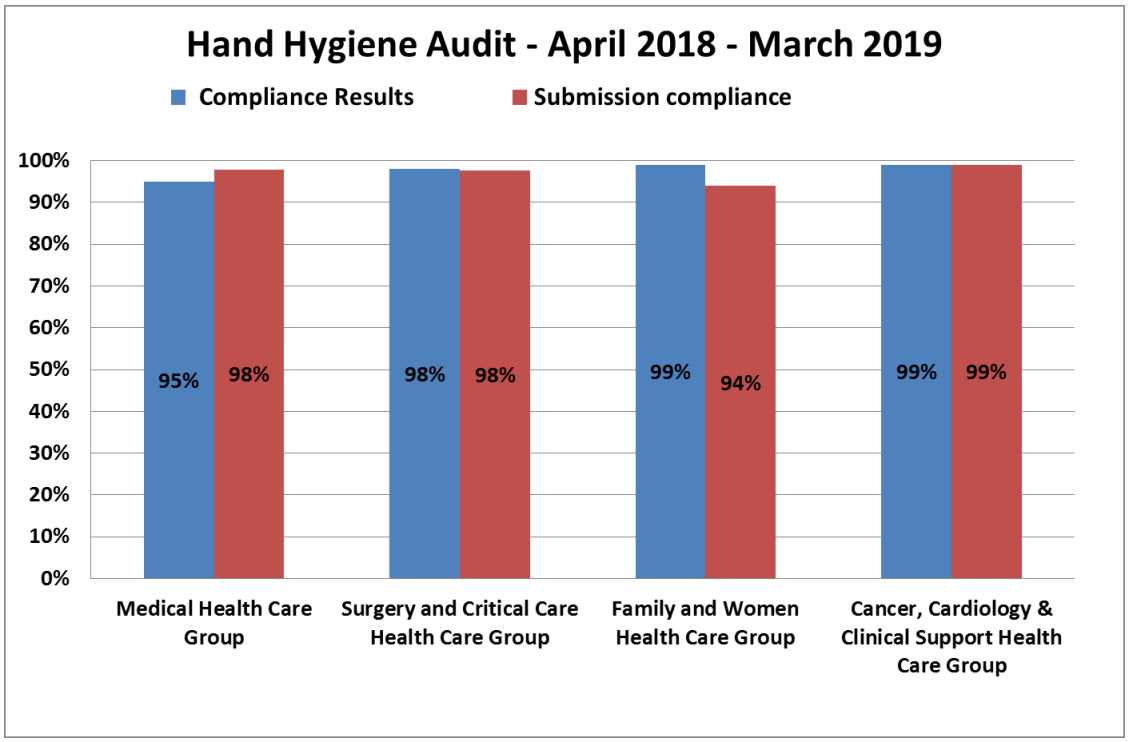
19.2.2. Compliance with hand hygiene is monitored through the monthly hand hygiene audits which are a mandatory requirement for all clinical areas. The purpose of the audit is to capture staff compliance with hand hygiene before and after direct contact with patients' and with their environment. Additionally it monitors compliance with the Trust dress/uniform code.

19.2.3. Clinical wards/departments undertake 'cross over' (peer review) audit rather than auditing their own area. The expectation is for each clinical area to observe 20 opportunities for hand hygiene each month and the expected standard of compliance is 95%.

19.2.4. The results of the audits are collated by the IPC Information Officer and widely distributed each month in several reports. The results are also discussed as a standing agenda at the ICC meetings and Quality and Safety Committee meetings. Additionally it is the expectation that these are discussed, and the appropriate actions implemented, in the local Health Group PS&Q meetings.

19.2.5. An average score (by Health Care Group) for the year in terms of both submission of audits and performance can be seen in **Figure 21** and the individual monthly breakdown by ward/department is shown in **Table 7**.

Figure 21: Hand hygiene audit compliance by Health Group – 2018 - 2019



8.2

The Princess Alexandra Hospital NHS
NHS Trust

Table 7: Hand hygiene audits – monthly by ward/department – 2018 - 2019

Area	Monthly average	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E	88%	95%	96%	86%	96%	96%	81%	96%	64%	Not audited by Fleming	91%	74%	93%
Fleming/MAU	91%	86%	81%	98%	97%	69%	100%	93%	89%	95%	100%	98%	83%
Harvey	100%	100%	100%	100%	100%	100%	Not audited by Endoscopy	100%	100%	100%	100%	100%	100%
Tye Green	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gibberd ward	93%	98%	86%	85%	100%	99%	81%	93%	88%	98%	99%	93%	95%
Winter Ward	88%	79%	93%	89%	79%	88%	93%	95%	88%	90%	90%	83%	94%
Ray	97%	90%	100%	100%	97%	99%	76%	100%	100%	100%	100%	100%	99%
Lister	94%	97%	79%	91%	97%	100%	97%	100%	86%	91%	100%	94%	93%
Locke	95%	93%	96%	93%	95%	96%	91%	95%	100%	85%	96%	96%	100%
Harold ward	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saunders	91%	98%	91%	100%	88%	100%	85%	90%	80%	Not audited by Gibberd	95%	83%	90%
Endoscopy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Penn ward	96%	95%	100%	100%	99%	94%	Not audited by ITU/HDU	99%	98%	85%	93%	100%	98%
Henry Moore	98%	100%	100%	100%	81%	100%	100%	100%	Not audited by Tye Green	100%	100%	100%	100%
ICU/HDU	99%	100%	100%	95%	100%	100%	99%	100%	91%	99%	100%	100%	100%
Charnley ward	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%
PACU	94%	100%	85%	Not audited by Theatres	89%	84%	89%	98%	100%	100%	100%	91%	96%
Main Theatres	100%	99%	100%	100%	98%	99%	100%	100%	100%	100%	100%	100%	100%
Alexandra Day Stay Unit	98%	99%	90%	98%	98%	95%	100%	99%	96%	100%	100%	100%	100%
Eye Unit	99%	99%	100%	96%	97%	97%	100%	100%	100%	100%	100%	100%	100%
Oak Unit	99%	100%	96%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%
Nightingale	99%	100%	98%	100%	99%	99%	99%	97%	96%	99%	99%	100%	100%
Melvin ward	100%	Not audited	Not audited	Not audited	Not audited	Not audited	100%	100%	100%	100%	100%	99%	99%
A&E/Paeds	96%	99%	83%	90%	100%	100%	94%	96%	96%	95%	100%	100%	100%
Dolphin	96%	95%	81%	100%	99%	92%	91%	100%	100%	100%	95%	100%	98%
NICU	100%	98%	100%	100%	100%	Not audited by Chamberlain	Not audited by Chamberlain	100%	100%	100%	Not audited by Chamberlain	100%	100%
Samson	98%	98%	86%	100%	100%	99%	96%	100%	99%	95%	100%	100%	99%
Chamberlain	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Labour ward	100%	100%	100%	100%	100%	100%	100%	Not audited	100%	100%	Not audited	100%	100%
Birth Unit	99%	100%	100%	96%	100%	100%	Not audited	100%	100%	100%	100%	99%	99%
MFAU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ANC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Kingsmoor/CCU	99%	95%	89%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cardiac Angiography	99%	96%	98%	100%	100%	99%	98%	100%	100%	100%	100%	100%	100%
OPD PAH	98%	100%	100%	100%	100%	100%	99%	100%	90%	95%	93%	100%	99%
Williams Day Unit	100%	100%	100%	100%	100%	100%	98%	100%	99%	100%	100%	99%	100%
Radiology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Bevan Ward	99%	100%	100%	100%	100%	99%	98%	99%	100%	95%	100%	98%	Not audited by WDU
OPD H&E	99%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	95%	99%
OPD SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

19.3 High Impact Intervention Audits

19.3.1. The High Impact Interventions (HIIs) were introduced as part of the 'Saving Lives: reducing infection, delivering clean and safe care' programme (DoH 2007). The purpose is to incorporate care bundles based on best practice and care process / actions associated with quality patient care. They are used as a tool to help address particular practice or care process issues. By auditing HII there is a constant review, and process for improvement of care. The tool reinforces the actions that are required on a continuous basis to reduce infection and to reduce unwarranted variation in care delivery. Each element of the audit is evidence based and has been proven to have a benefit in reducing health care associated Infections.

19.3.2. The HII audits undertaken in 2018-19 were:

- Preventing peripheral line infection (insertion)
- Preventing peripheral line infection (on-going care)
- Preventing urinary catheter infection (insertion)
- Preventing urinary catheter infection (on-going care)
- Ventilated Associated Pneumonia (VAP-ITU)
- Surgical Site Infection (SSIs – Theatres)

19.3.3. All clinical areas involved in the care of patients with peripheral lines or urinary catheters, are expected to undertake the audits on a monthly basis. As with the hand hygiene audits, the HII audits are reported on monthly by the IPCT in the HCG Performance reports and at the Quality and Safety Committee. Results should also be discussed in the local HCG PS&Q forums, with actions taken by the ward/department manager as appropriate.

19.3.4. **Table 8** shows the monthly performance scores

Table 8: Compliance of HII audits (SSI and VAP) for 2018-19

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
The Ventilated Associated Pneumonia (VAP)	n/s	80%	n/s	100%	100%	100%	87%	100%	100%	100%	100%	100%
Preventing Surgical Site Infection SSI	n/s	n/s	91%	96%	100%	100%	100%	96%	100%	100%	93%	91%

Table 9: Average Compliance for Submission and Performance for 2018-2019

	Preventing Peripheral Lines Infection - Insertion Performance%	Preventing Peripheral Lines Infection - Insertion Compliance%	Preventing Peripheral Lines Infection - Ongoing Care Performance%	Preventing Peripheral Lines Infection - Ongoing Care Compliance%	Preventing Urinary Catheter Infection - Insertion Performance%	Preventing Urinary Catheter Infection - Insertion Compliance%	Preventing Urinary Catheter Infection - Ongoing Care Performance%	Preventing Urinary Catheter Infection - Ongoing Care Compliance%
Medical Health Care Group	**99**	**93**	**87**	**96**	**100**	**96**	**99**	**98**
Surgery and Critical Care Health Group	**98**	**90**	**86**	**98**	**99**	**95**	**97**	**98**
Women and Family Health Group	**99**	**92**	**91**	**99**	**92**	**88**	**100**	**100**
Cancer, Cardiology & Clinical Support Services Health Group	**100**	**96**	**92**	**100**	**100**	**96**	**100**	**96**

20.0 Antimicrobial Prescribing Compliance

20.1 Current evidence clearly demonstrates that the inappropriate use of broad-spectrum antibiotics is associated with the selection of antibiotic resistant bacteria such as Extended - Spectrum Beta-Lactamase (ESBL) - producing Gram negative bacteria as well as the specific acquisition of MRSA and the induction of Clostridium difficile infection. In particular, it has been recommended that the use of broad spectrum antibiotics such as cephalosporins, quinolones and broad-spectrum penicillins (including co-amoxiclav) and clindamycin should be avoided unless there are clear clinical indications for their use.

20.2 Antimicrobial prescribing has remained an important focus for the Trust this year, and considerable work has been implemented to improve all aspects of prescribing with microbiology, pharmacy and clinical teams working together to achieve this; examples include microbiology reports being issued following the principles of responsible antibiotic use, education of junior and senior medical staff about use of antibiotics, and antimicrobial ward rounds being undertaken by microbiology consultants and the antimicrobial pharmacist, to directly improve infection management for individual patients and influence prescribing practice.

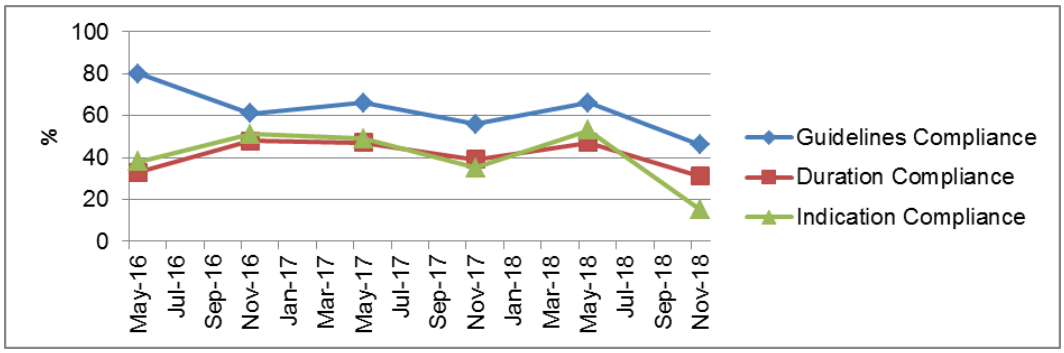
20.3 From historic data collections it is known that at least one third or more of inpatients at PAH are receiving one or more antimicrobials at any point in time. In line with the "Start Smart – Then Focus" document, published by the Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) in November 2011, the guidelines stipulate that indication and intended duration of treatment and a review date should be clearly documented on the drug chart and in the medical notes at the time of prescribing.

20.4 Over the years, several initiatives have been attempted to improve antimicrobial prescribing, including regular feedback to prescribers, pharmacy interventions and documentation in patients' notes. Despite these initiatives, although compliance with the antibiotic policy is good, audit results for prescribing of indication and duration of antibiotics has remained poor.

20.5 Antibiotic Audits

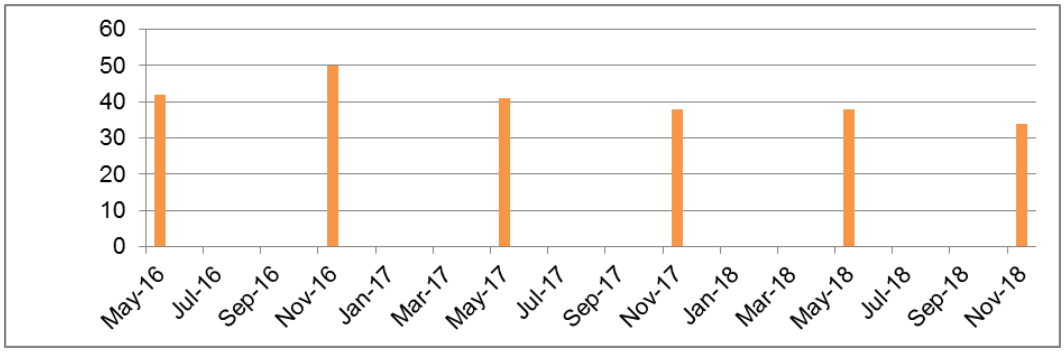
20.5.1. A six-monthly major audit of antimicrobial prescribing standards and usage is undertaken by the antimicrobial pharmacist twice a year; last audit was carried out in November 2018. All patients on antibiotics were included over a period of one week. Compliance to PAH guidelines has decreased to 46% since the last audit in May 2018. Documentation of indication and duration on drug charts (JAC) has significantly decreased from 53% and 47% to 15% and 31% respectively as shown in **Table 10.**

Table 10: Trust adherence to prescribing requirements over 2016-2018



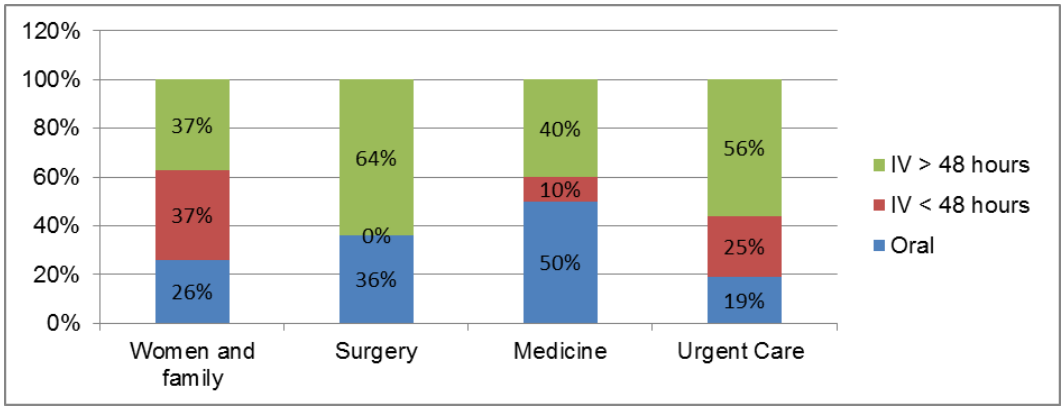
The overall percentage of patients receiving antimicrobials was slightly reduces compared to previous audits as shown below in **Table 11.**

Table 11: Trust percentage of patients on antimicrobials over 2016-2018



In November 2018 the overall proportion of patients receiving their prescribed antibiotics intravenously was 60%, and the proportion remaining on them for longer than 48 hours was consistent at 49% (48% in May 2018). See **Table 12** below for the proportions within individual HCGs.

Table 12: Prescribed route of antibiotics by Healthcare Group

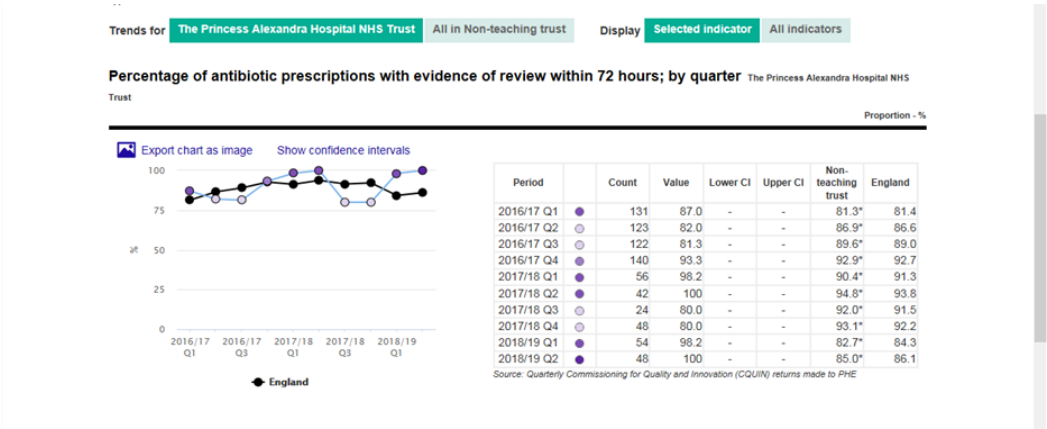


20.6 **AMR CQUIN 2018/19**

20.6.1. The 2018/19 CQUIN is focused on reducing the impact of serious infections, in particular, antimicrobial resistance and sepsis. Antibiotic consumption and stewardship indicators for the 2018/19 CQUIN are as follows:

A. Increasing the proportion of antibiotic prescription review by a senior clinician (within 72 hours) for patients with documented sepsis. All reviews must be clearly documented in patient notes.In 2018/19 Q2 100% of patients at PAH with documented sepsis had their antibiotics reviewed by a clinician within 72 hours (see **Table 13** below)

Table 13: Percentage of antibiotic prescriptions with evidence of review within 72 hours at PAH compared to England**.**



Period		Count	Value	Lower CI	Upper CI	Non-teaching trust	England
2016/17 Q1		131	87.0	-	-	81.3*	81.4
2016/17 Q2		123	82.0	-	-	86.9*	86.6
2016/17 Q3		122	81.3	-	-	89.6*	89.0
2016/17 Q4		140	93.3	-	-	92.9*	92.7
2017/18 Q1		56	98.2	-	-	90.4*	91.3
2017/18 Q2		42	100	-	-	94.8*	93.8
2017/18 Q3		24	80.0	-	-	92.0*	91.5
2017/18 Q4		48	80.0	-	-	93.1*	92.2
2018/19 Q1		54	98.2	-	-	82.7*	84.3
2018/19 Q2		48	100	-	-	85.0*	86.1

Source: Quarterly Commissioning for Quality and Innovation (CQUIN) returns made to PHE

Table 14: Percentage of antibiotic prescriptions with evidence of review within 72 hours at PAH compared to England.

B. Reduction in antibiotic consumption (DDDs per 1,000 admissions). Figure 5 below illustrates a modest reduction in overall antibiotic consumption within the trust since February 2016.It illustrates also that many other trusts have increased their antibiotic consumption (DDDs per 1,000 admissions) over the same period, thus demonstrating the challenge presented.

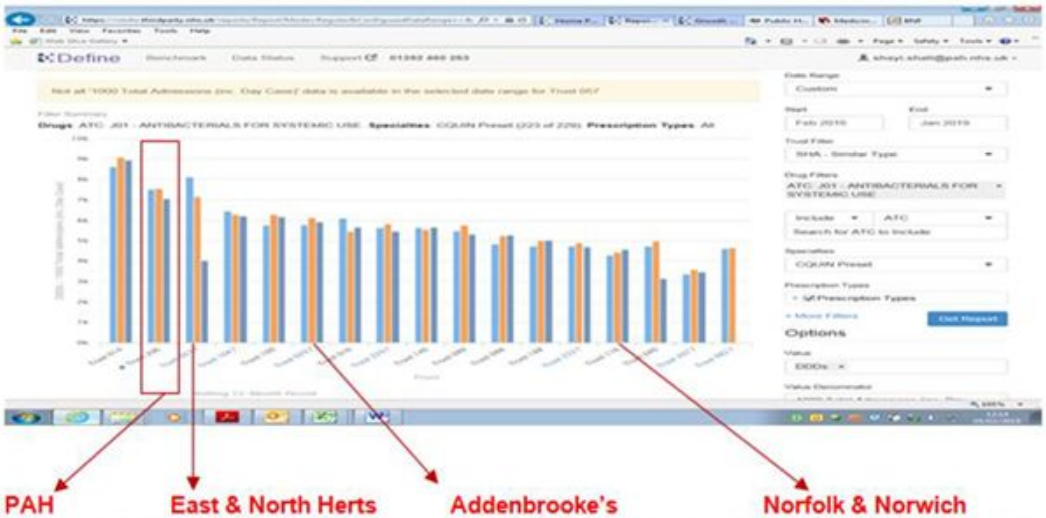


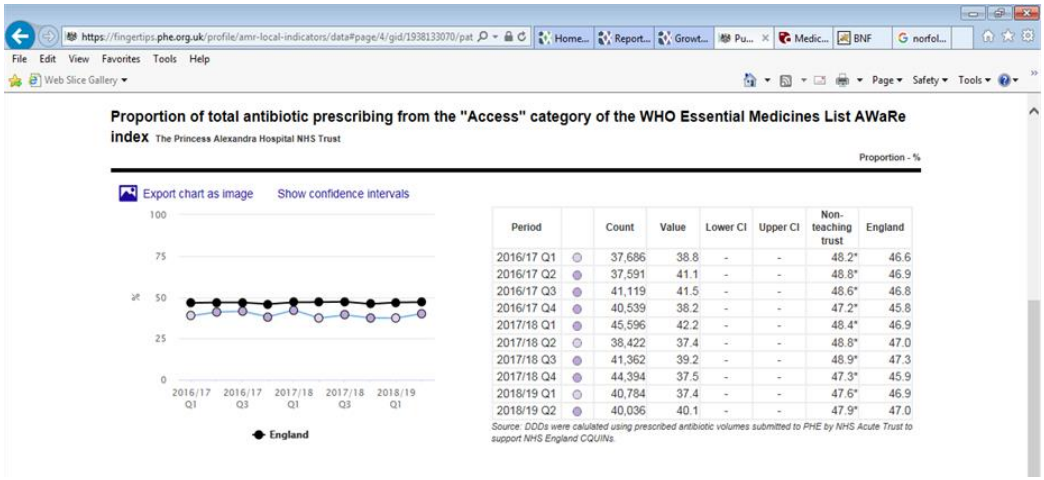
Figure 5: Total Antibiotic Consumption in DDD/1000 Admissions February 2016- January 2019 at PAH compared to hospitals with similar bed size.

C. Increasing the proportion of antibiotic usage (for both in-patients and out-patients) within the "Access" group of the AWaRe* category, thus decreasing the use of broad spectrum antibiotics. The "Access" group includes the following antibiotics:

- Phenoxymethylpenicillin
- Nitrofurantoin
- Metronidazole
- Gentamicin
- Flucloxacillin
- Doxycycline
- Co-trimoxazole
- Amoxicillin
- Ampicillin
- Benzylpenicillin
- Benzathine Benzylpenicillin & Procaine Benzylpenicillin
- Oral Fosfomycin
- Fusidic Acid
- Pivmecillinam
- Tetracycline
- Trimethoprim

Table 16: (below) shows the proportion of "Access" group antibiotic use in the Trust to be 40.1% compared to a national average of 47%.

Table 16: Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe at PAH compared to England



Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index The Princess Alexandra Hospital NHS Trust

Proportion - %

Export chart as image Show confidence intervals

Period		Count	Value	Lower CI	Upper CI	Non-teaching trust	England
2016/17 Q1		37,686	38.8	-	-	48.2*	46.6
2016/17 Q2		37,591	41.1	-	-	48.8*	46.9
2016/17 Q3		41,119	41.5	-	-	48.6*	46.8
2016/17 Q4		40,539	38.2	-	-	47.2*	45.8
2017/18 Q1		45,596	42.2	-	-	48.4*	46.9
2017/18 Q2		38,422	37.4	-	-	48.8*	47.0
2017/18 Q3		41,362	39.2	-	-	48.9*	47.3
2017/18 Q4		44,394	37.5	-	-	47.3*	45.9
2018/19 Q1		40,784	37.4	-	-	47.6*	46.9
2018/19 Q2		40,036	40.1	-	-	47.9*	47.0

Source: DDDs were calulated using prescribed antibiotic volumes submitted to PHE by NHS Acute Trust to support NHS England CQUINs.

20.7 Implications and Risks

Antimicrobial Stewardship must become integrated in clinical management. If teams fail to appropriately manage antibiotics and follow AMS guidance the following risks will remain and potentially worsen:

- Failure to meet Antimicrobial Stewardship Standards (NICE guidelines NG15).
- Increased antibiotic resistance
- Increased cost for the Trust

20.8 Recommendations

- Education is delivered to doctors of all grades from FY1 to consultant, highlighting good antimicrobial prescribing practice, including the importance of 72 hours review, IV-oral switch, appropriate course lengths, and choice of empiric antimicrobials.

- Utilising the electronic prescribing system intended course lengths of 3, 5 or 7 days should be assigned to all antibiotics at the point of prescribing. It is still possible for a prescriber to amend the course length, if required, at a later time.

- Monthly data on overall, carbapenem and piperacillin-tazobactam usage by each clinical area, is used to target AMS activity e.g. ward rounds. This data is extracted from the pharmacy system.

- The Antimicrobial Stewardship Committee uses the expertise and resources of a multidisciplinary team to coordinate its activities. AMS programs need sustained effort to remain effective; otherwise, antimicrobial prescribing patterns and consumption can rapidly change.

21.0 Infection Prevention and Control Training and Education

21.1 Level 1 & 2 Infection Prevention and Control Training is provided to all staff at Induction and Update days either via eLearning or face to face classroom training. Clinical staff complete Level 2 training and complete this training face-to-face as part of their Clinical Skills induction programme. This teaching session is delivered by a member of the Infection Prevention and Control team.

21.2 The eLearning course designed by the IPC team is specific to the Trust and meets the training requirements of the UK Core Skills Training Framework which includes assessment questions and compliance monitored monthly.

21.3 As part of the mandatory updates, all staff are required to complete the Infection Prevention and Control Level 1 e-learning programme or via the Core Training Booklet. The course includes Hand Hygiene and an assessment questions refreshed every 3 years. In addition, all clinical staff are required to complete the Infection Prevention and Control Level 2 every year and have the option to either complete this by e-learning programme, including the assessment questions or attend a classroom session.

21.4 Attendance in all mandatory training is monitored and records are maintained by the Training Department on ESR. Compliance to Training is reported to all service leads monthly.

21.5 Other training carried out by the infection control team includes participation in delivery of the, newly qualified nurse training, overseas nurse training, the induction of student nurses and doctors, and provide sessions on the Emergency Department (ED) and Neonatal 'away days'. The team are also committed to provide teaching at local level to the wards when requested.

Table17: Trust compliance as at end March 2019

Name of Course	Trust Target		Trust Position
Infection Control Level 1	**90%**		97%
Infection Control Level 2	**90%**		86%

Table 18:

Competence Name	Assignment Count	Required	Achieved	Compliance %
Infection Prevention & Control - Level 2|Core	1958	1958	1676	86%
Infection Prevention & Control Level 1 - 3 yrs|Core	1215	1215	1175	97%

21.6 Level 2 Training compliance has been increasing on a month by month basis and plans to further improve compliance rates before the end of this year is supported by the newly introduced Agenda for Change Pay Progression with emphasis on 100% compliance with Core Training at Appraisal before any pay progression is agreed.

Table 19: Compliance by Staff Group

Compliance by Staff Group	Add Prof Scientific & Technic	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates &Ancillary	Healthcare Scientists	Medical & Dental	Nursing & Midwifery Registered
	96%	**95%**	**98%**	**96%**	**93%**	**98%**	**75%**	95%
Infection Control Level 1	100%	100%	98%	100%	94%	100%	81%	90%
Infection Control Level 2	90%	89%	94%	95%	95%	83%	63%	92%

22.0 Cleanliness and the Environment

22.1 Monitoring of Cleaning Standards

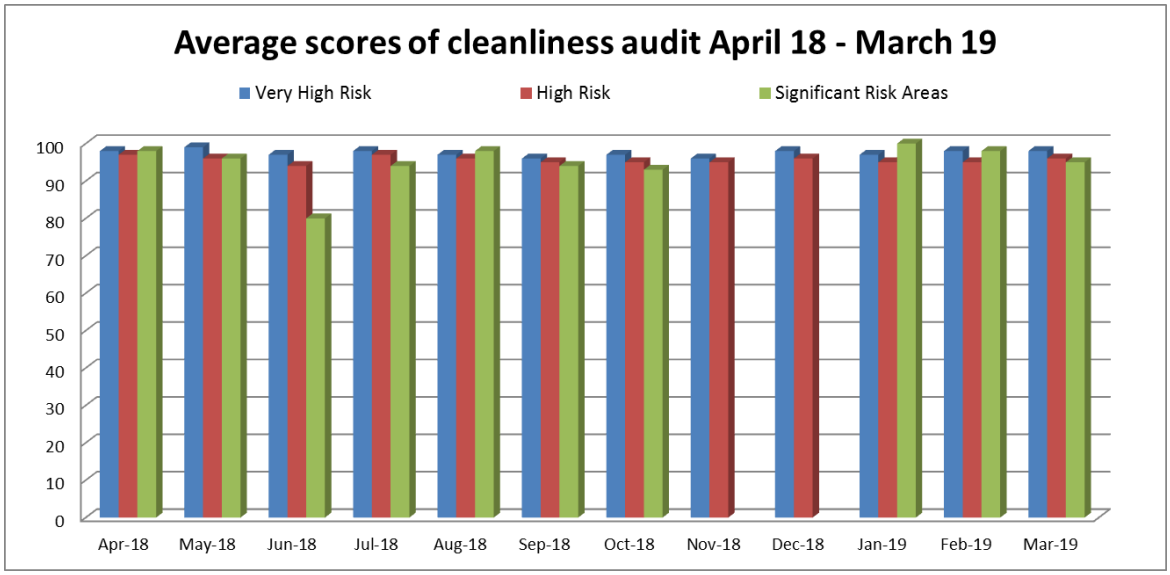
22.1.1. In addition to good hand hygiene, prompt isolation and antimicrobial control measures, the cleanliness and condition of the patient environment and estate is an integral part of the control and reduction of infection.

22.1.2. The Facilities Team undertake environmental hygiene audits on a regular basis and the Domestic Supervisors have responsibility for these. As with the previous year, staff shortages in the Facilities Team has resulted in some areas not being audited monthly; however, where any non-compliances have been identified, the Facilities Team have provided assurance that action plans were implemented immediately and the areas re-audited.

22.1.3. The 'pass' marks for the audits are:

- Very High Risk areas – 98%
- High Risk areas – 95%
- Significant Risk areas – now 90%

Figure 22: Environmental Hygiene Audit Scores – 2018-2019



22.2 Deep Cleaning and Hydrogen Peroxide Vaporiser (HPV) Decontamination

22.2.1. Deep cleans are undertaken in clinical areas in situations where a more intense level of cleaning is required, for example after an outbreak situation. Hydrogen Peroxide Vaporiser (HPV) decontamination is an additional measure which can be used after an area has been deep cleaned. All side rooms occupied by patients with *C.difficile* and GDH+ve must be decontaminated with HPV following discharge. To facilitate this process, the IPCT work closely with the Clinical Site Team and Facilities Teams on a daily basis, communicating rooms which will require HPV decontamination via the isolation list.

22.2.2. Areas of the main ward requiring HPV decontamination must be unoccupied (from all personnel) and sealed off for a number of hours. This does have limitations as capacity in the Trust is usually running at a high level and there is not a 'decant' area available. Meticulous planning is therefore required to enable decanting of these wards to other areas in order to facilitate the deep cleaning and HPV decontamination.

22.3 Clinical and Environmental Inspections

22.3.1. The purpose of undertaking Clinical and Environmental Inspections is to undertake unannounced 'spot checks' of the clinical environment and IPC activity. The focus is to ensure clinical areas meet the requirements of the Hygiene Code, and are compliant with IPC standards, and where not compliant, make recommendations. Clinical practice, cleaning standards and estates/environment issues are all included in the audits.

22.3.2. This year the IPCT applied for funding from the 'Chairman's Fund' and were successful in securing money which enabled them to purchase an electronic audit tool as part of the 'Perfect Ward' package. The tool was designed by the IPCT and therefore contains the relevant questions required for this audit. This has also meant audits are objective, quicker

to undertake and has the ability to produce reports for the wards/departments and Estates/Facilities with scores and photographs, assisting them in generating an action plan.

22.3.3. Following the inspections, a report is collated by the IPCT and circulated to the relevant staff. Ward Managers, Estates and Facilities are expected to take immediate action at the time of the inspection if appropriate, and to implement an action plan for issues that will require longer term planning.

22.3.4. If there are significant concerns following an inspection, a re-visit of the area will take place.

22.3.5. Going forward in 2019/20, the IPCT will have membership to the D'omestics and housekeeping Quality Improvement and Transformation Group' which is part of a Trust wide quality improvement and transformation programme, focussed on improving the quality of care and experiences that we provide our patients and our people.

Purpose:
The purpose of this Group is to improve the safety, quality of care and experiences of our patients through the provision of effective, safe and efficient domestic and housekeeping services. It will:

- develop a quality improvement and transformation plan than ensures the achievement of the national cleaning standards first time, every time, efficiently & effectively
- develop a quality improvement and transformation plan to ensure the delivery of a high quality housekeeping service at ward level
- ensure quality is put first in everything that we do

23.0 Water Services Management (report from Estates)

23.1 **Estates Activities**

During this time period the Estates department provided a reactive and proactive maintenance service across the Trust to include issues relating to infection prevention and control. This includes:

- Ventilation maintenance and monitoring
- Water quality monitoring
- Minor repairs to fabric of buildings.

23.2 **Water Safety Management**

23.2.1. The 2018/19 contract has been awarded to David Harper, Harper Legionella to carry out Authorising Engineer services as set out in Health Technical Memorandum 04:01. There was no appointed Authorised Person for Water in 2018/19, the roles were being undertaken by the Head of Estates. The Deputy RP role was being filled by the Health, Safety and Governance Manager

23.2.2. Annual audits of the water safety management systems are undertaken by the AE (W) and a report detailing major and minor non-compliances is sent to the Responsible person. All audits are reviewed by the Water management team (as above) and a suitable and

sufficient action plan is produced. The actions required are risk assessed, controls implemented, or uncontrolled risks entered on the HCG risk register with timely actions planned.

23.2.3. The water safety management structure is reviewed annually.

23.2.4. Water Safety Group meetings were been reinstated from June 2018. This has ensured there is a water safety action plan going forward that is monitored via the Group.

23.2.5. The Water safety Policy and Water Safety Plan (WSP) was ratified in February 2019 and is now in place. Monitoring will be carried out (as described in the procedural documents) to ensure compliance going forward.

23.2.6. The water risk assessment for the Trust is due to be reviewed by an external company in June 2019. To date, the Estates maintenance team have completed all high and medium risk works highlighted.

23.2.7. Temperature monitoring and sampling is being carried out across site along with periodic chlorination of tanks and systems.

23.2.8. The Planned Preventative Maintenance Schedule is to be reviewed in 2019/20.

23.3 Adverse Water Quality Results

23.3.1. In 2018/19 there has been no significant increase in the number of adverse water quality results notified to the Trust. High risk organisms such as Legionella, Pseudomonas, E.coli and coliforms have been detected in isolated areas largely due to the age of outlets, scale build-up or poor flushing regimes.

23.3.2. In order to reduce the risk, a full descale of all water outlets was commissioned by a contracting company and the PAH Estates team. Where scale was considerable, outlets were replaced. A communication exercise was carried out across the Trust with regard to tap flushing. Education was provided where required along with templates and the guidance documents contained within the Water Safety Plan for the Trust. Tap flushing is now monitored and reported on monthly by the Water Safety Engineer, which is slowing an improvement in most areas. Areas that remain non-compliant are escalated via the Health and Safety Committee.

23.3.3. The only area in which there was a systemic issue identified was MRI. The risk assessment carried out following identification of Legionella in significant numbers, and revealed failures in the mini water boilers installed at all sinks/outlets. The system was designed in such a way so as not to penetrate the walls with pipework due to the nature and use of the area. The water boilers are now scheduled to be replaced as part of the capital plan for 2019/20, before the MRI unit is reopened.

23.4 Projects involving water systems

23.4.1. This period saw the implementation of suitable and sufficient water system drawings, which were approved by relevant persons, prior to the building works commencing. This ensured that the correct sinks, taps and fixings were specified from project conception, therefore

designing out the risks. The issue of sampling water systems that has occurred in previous years has now been remedied by ensuring suitable and sufficient time scales are planned so testing is carried out and clear results received prior to reoccupation of an area (especially in augmented care units).

23.5 **Plans for 2019-20**

23.5.1. Review planned preventative maintenance regime for water safety management.

23.5.2. Design and approve documentation to ensure areas that are taken out of use, or closed for a period of more than 2 days are adequately maintained to provide assurances on water quality and safety.

23.5.3. Commission the 3 year review of the site wide water risk assessment

23.5.4. Ensure suitable and sufficient assurances are provided from landlords with regard to water safety management in leased buildings occupied by the Trust.

24.0 Decontamination (report from Decontamination Lead)

24.1 Decontamination Management Structure

24.1.1. Annual audits of the Endoscopy and sterile services departments are undertaken by the AE. All audits are reviewed by the Decontamination management team (as above) and a suitable and sufficient action plan is produced. The actions required are risk assessed, controls implemented, or uncontrolled risks entered on the HCG risk register with timely action plans. The Decontamination management structure is reviewed annually.

24.1.2. Decontamination Group meetings have been reinstated from March 2019. This will ensure there is a Decontamination action plan going forward that is monitored via the Decontamination Group.

24.1.3. The Decontamination policy will be reviewed at the May Decontamination group with a view to approve and send out for peer review. All comments will be than be collated at the June meeting and submitted to the Trust Policy Group for ratification.

24.2 **Theatres**

24.2.1. Following a full condition inspection by the Health and Safety and Infection Prevention and Control Team, a comprehensive report was provided to the S&CC HCG detailing gaps in compliance with regard to theatre cleanliness and equipment condition.

24.2.2. The report highlighted areas of concern, risk rated with an action plan for prioritisation of remedial works.

24.2.3. A full deep clean of all theatre areas was undertaken, equipment was replaced and urgent defects that may present difficulties in cleaning, or a risk of shedding were repaired. Further works will be required in FY 2019/20 to ensure the risks of contamination are reduced as far as is reasonably practicable.

24.2.4. Following this inspection, it was recommended that theatres 8 and 9 were no longer used as operating theatres due to the degradation of the temporary building.

24.2.5. FY 2019/20 will see an increase in audits of 'clean' areas in consultation with the Health and Safety Team, Infection Prevention and Control Team and Estates and Facilities.

24.2.6. A full review of domestic services and cleaning provision is being carried out by the Estates and Facilities department. The review will also consider the specialist cleaning requirements of the operating theatre environment.

24.3 Decontamination of Medical Equipment

24.3.1. The IP&C team carry out regular audits in clinical areas to assess the effectiveness and efficacy of the decontamination of medical equipment.

24.3.2. Following a compliance audit carried out in Feb 2019 in the EBME department, it has been noted that medical equipment is not being adequately contaminated prior to being sent to or collected by the EBME department. The EBME management team will be reviewing their processes and procedures, in line with Trust decontamination procedures to ensure this risk is addressed and adequately controlled.

24.4 Sterile services (CSSD)

24.4.1. The sterile services department have been subject to an annual audit of their decontamination management system in line with HTM01:01. The audit revealed no major non-compliances, and referred only to areas that required minor improvements.

24.4.2. The sterile services department have a robust monitoring regime in place to ensure their equipment and water quality remains conducive to the activities being carried out. Where machine failures have occurred, the correct testing and monitoring regimes have been undertaken to prove the system fit for use i.e. steam quality and water quality testing.

24.4.3. The ventilation system within CSSD is nearing end of life and has been added to the Air Handling Unit replacement programme for Capital funding in FY 20/21. In the interim, increased maintenance and inspection regimes will be put in place by the Estates department to ensure any potential failures are acted upon and prevented.

24.4.4. There has been no adverse patient safety incidents linked to CSSD in the FY 18/19.

24.5 Endoscopy

24.5.1. The audit carried out by the AE (D) in endoscopy revealed some major non-compliance around the management of monitoring systems. The non-compliances were reviewed by the newly formed decontamination management team, and the AP (D) was asked to monitor Endoscopy going forward, as well as CSSD.

24.5.2. The action plan revealed gaps in compliance with guidance relating to microbiological monitoring and servicing. All microbiological monitoring results are now sent directly to the AP(D) for review and actions, and a service schedule in line with HTM 01:01 is now in place.

24.5.3. The Endoscopy washers were at the end of their useable life and breaking down daily. This lead to the need to cancel lists, increased overtime, increased workload on colposcopy machines and an increased risk of the introduction of microbial contamination into the system.

24.5.4. The Medicine HCG put together a proposal for funding of 2 new washers and the redesign of the decontamination area to meet statutory regulations such as COSHH and PUWER. The works have begun and are scheduled for completion by June 2019.

24.6 Colposcopy

24.6.1. Planned refurbishments including a new scope washer and redesign of the contamination area to make it compliant were completed in 2019/10.

24.6.2. Colposcopy washers are used to back up the Endoscopy washers, especially during the refurbishment works planned.

24.7 Cleaning and disinfection (Trust wide)

24.7.1. A review of the cleaning schedules, processes and systems began in FY 2018/19 and will be concluded in 2019/20. The review will identify where performance can be increased, and infection rates decreased. The review will also highlight areas that are not in line with the 'model hospital' and can therefore be changed or upgraded to enable our domestic staff to clean in a safer environment with greater productivity.

24.7.2. The IP&C team communicate directly with the Estates and facilities team following an outbreak or adverse microbiological results to ensure areas have been suitable decontaminated prior to reoccupation. This includes the use of HPV technology.

24.7.3. Regular monitoring of cleaning standards is carried out by the IP&C tram in consultation with the Estates and Facilities team. This ensures areas of concern are identified, and remedial actions put in place immediately to prevent incidents and increase compliance.

24.8 Critical Ventilation Plant

24.8.1. All critical ventilation plant has had an annual inspection and reverification as per HTM 03:01.

24.8.2. The Endoscopy unit should have a specialist ventilation system in line with the requirements set out in HTM 03:01 to ensure suitable air changes and pressures are achieved. The annual inspection of this areas revealed that the air handling is not suitable or sufficient, and does not meet the requirements of HTM 03:01. There is currently no supply air, limited extraction and no pressure differentials achieved between the decontamination area and the theatres.

24.8.3. This major non-compliance has been escalated the Estates and Facilities team and is currently being considered for funding in the 2019/20 capital plan. The Medicine HCG have been informed and are planning to schedule these works as part of the Endoscopy upgrade scheduled for 2019/20.

24.8.4. There are non-compliances across the critical ventilation systems throughout the Trust, which is not unexpected due to the age and complexity of the systems. All required remedial works are scheduled by the Estates team, and major works are designed and planned by the Capital projects team.

24.9 Critical Pressure systems

24.9.1. Pressure systems are used throughout the Trust for decontamination purposes in the form of autoclaves, steam generators and boilers.

24.9.2. All pressure systems are subject to an annual inspection as required by the Pressure Equipment (Safety) Regulations 2016. Pressure systems are also inspected and serviced in line with the requirements of the regulations and manufactures instructions.

24.9.3. There have been no adverse incidents leading to decontamination incidents in FY 2018/19.

25.0 Conclusion

PAH NHS Trust has again maintained another good year in terms of control of HCAIs. Excluding norovirus, there were two PII / outbreaks; the MRSA transmissions and the VRE outbreak in critical care. Neither of the outbreaks have had serious clinical consequences due to immediate and sustained control measures.

There was no outbreak of Influenza this year at PAH NHS Trust. SHAW received support from the wider hospital team and the Trust achieved high rates of staff vaccination for Influenza.

We have reduced most of our Trust apportioned HCAI case numbers year on year. This is largely attributable to us having in place a strategy that describes actions over time to support the prevention, recognition and management of infections, a suitably resourced Infection Prevention and Control Team (IPCT) and good clinical engagement. As an organisation we have developed and own a board-approved HCAI reduction plan and progress is reported against this. Antimicrobial stewardship (AMS) is included and we contribute to whole economy decision making on HCAI reduction.

The local (Essex) Health Protection Unit have offered support for public health matters. Teaching and training in IPC including microteaching, has been on going throughout the year and the IPC Audit programme has been actively supported. The Executive Team, Consultants and Matrons continue to ensure IPC is an essential quality standard, and part of our Trust safety culture.

Trust clinicians, pharmacists, facilities staff and the entire hospital team remain committed to *C difficile* control. The continuing low numbers of C difficile is a real achievement year on year at the Trust. Our in-house Facilities Team continue to play a vital role in maintaining high standards of cleanliness and use hydrogen peroxide vapour to further decontaminate ward environments, including providing out of hours support.

In 2019-20 assignment of *C.difficile* cases will be changing. Although guidance for testing and reporting CDI cases remains unchanged, the focus will now be on a system-wide approach for delivery of objectives, with CCGs having responsibility or accountability for delivery of reductions in the total number of cases assigned to them. A total trajectory for the four new categories of assignment will be applied, as opposed to having Trust and no Trust-apportioned trajectories.

Introduction of the GNBSI target in 2017 with mandatory reporting of E.coli, Klebsiella sp. and Pseudomonas aeruginosa bacteraemia has meant information being gathered locally is increasing. Collaborative working between CCG and hospital teams is required to identify common themes. CCG IPC nursing support is required to take this work forward.

A Trust wide programme to reduce catheter associated urinary tract infections has been agreed locally as another step towards reducing GNBSIs and this is being supported by our seconded post holder.

An NHS objective is to improve population health through reduced antimicrobial resistance (AMR). Good antimicrobial stewardship has been strengthened due to the establishment of an antimicrobial stewardship committee in the Trust in November 2017. This has been one of the most significant developments in the Trust this year. This committee has received support from senior Consultants and junior doctors, and has established strong relationships with the Microbiology team, anti-microbial pharmacy team and ward pharmacists. The Trust antibiotic policy has been updated taking into consideration local resistance patterns, and ensures the antibiotic management of infection and sepsis is optimal.

Resistance to antibiotics in gram negatives is increasing in our Trust, and reflects national trends closely. For example, for E.coli in blood cultures, the resistance rate in 2017 was just over 14% for gentamicin, one of our broad spectrum antibiotics. Some other hospitals have needed to change to the antibiotic Amikacin due to increasing gentamicin resistance. This may need to be considered at PAH NHS Trust in the next few years if gentamicin resistance continues.

Carbapenemase producing Enterobacteriaceae (CPE) continue to be monitored, although this organism group have so far not caused concerns at PAH NHS Trust. Rectal screening in patients who present to PAH from hospitals where CPE is common is still not well established. This will require more education and training of front line staff.

The on-site Microbiology laboratory team report antimicrobial resistance as real time information to the IPCT, who then take the necessary actions. We have an active surveillance programme of antibiotic resistance as well as antibiotic use. Our audits still shows a high consumption of antibiotics, including some broad spectrum antibiotics. As there is good understanding across the Trust about AMR and a willingness to use antibiotics correctly, it may be that antibiotics are duplicated often, such as co-amoxiclav and metronidazole for anaerobe cover. Education and training will continue to address these issues. The Microbiology team also supports the Patient at home service, as many patients are treated for infection by this service.

Authors:
Dr Shico Visuvanathan (DIPC/Consultant Microbiologist) and Ms Jenny Kirsh (Head of IPC)
June 2019

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The Princess Alexandra Hospital NHS
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Appendix 1

Infection Prevention and Control Strategy and Annual Programme of Work (including Audit Programme)

1st April 2019 – 31st March 2020

The Princess Alexandra Hospital NHS
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Introduction

This document details the Infection Prevention and Control Team (IPCT) Objectives and Programme of Work, including the Audit Programme, for 2019-20:

- Corporate and Organisational
- Service Development
- Policies, Procedures and Guidelines
- Surveillance of Healthcare Associated Infection
- Infection Prevention and Control Audit Programme
- Infection Prevention and Control Education Programme
- Infection Control Link Professionals
- Team Development.

- The primary role of the IPCT is to plan, implement and evaluate initiatives and strategies to prevent and reduce the risks associated with, and incidence of healthcare associated infection. The IPCT perform a vital function in providing advice, teaching and education, advising on clinical laboratory results, auditing clinical areas and ensuring HCAIs continue to reduce . In addition, we have an important role in setting standards for best practice through the writing and monitoring of polices. We also have a duty to ensure we comply with Department of Health guidance and legislation and meet the requirements of the Hygiene Code (The Health and Social care Act 2008)
- The IPCT is led by the Director of Infection Prevention Control (Consultant Microbiologist) and the Head of Infection Prevention Control and consists of a team of Nurses, an Information Officer and Consultant Microbiologists. The team has a variety of roles within Princess Alexandra Hospital, but our primary objective is patient safety.
- The IPCT work closely with all staff, clinical and non-clinical and this includes the Executive Team who are fully engaged with IPC.
- The progress against IPCT objectives will be monitored by the Infection Prevention and Control Committee (IPCC)
- This Programme of Work should be read in conjunction with other IPC documents. Each Health Care Group (HCG) is responsible for undertaking and monitoring their IPC related activities/objectives. These should be reported on by each HCG at the IPCC.

The Princess Alexandra Hospital NHS
NHS Trust

The Infection Prevention and Control Service is provided by:

Name	Title
Dr Shico Visuvanathan	Director of Infection Prevention and Control / Consultant Microbiologist
Jenny Kirsh	Head of Infection Prevention and Control
Sue Lynch	Infection Prevention and Control Nurse
Joe Bacon	Infection Prevention and Control Nurse
Kimberley Cabiles	Associate Infection Prevention and Control and Continence Nurse (Secondment)
Magdalena Korejwo	Infection Prevention and Control Information Officer
Michelle Grove	Infection Prevention and Control / Microbiology Secretary
Professor Armine Sefton	Consultant Microbiologist
Dr Sally Millership	Consultant Microbiologist / PHE
Shayi Shali	Antimicrobial Pharmacist

Activity / Objective	Actions Required	Designated IPCT Responsible Person/s/Lead	Timescale / Progress
1. Corporate and Organisational			
1.Hygiene Code Compliance: The Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (updated 2010 and 2015)	1.Maintain registration with the Care Quality Commission and ensure compliance with all infection prevention and control/ healthcare associated infection components 2.Review and complete Gap Analysis - to be presented at IPCC and Q&SC 3.Ensure that IPC risks are identified and updated on the IPC and HCG risk registers	1.DIPC / HoIPC 2.HoIPC (input from ADoNs) 3.DIPC/HoIPC/ADoNs/ Heads of Departments/ Service Leads/ PSQ Facilitators/ Matrons	1.N/A 2.Bi-annually (Sep 19 and March 20) 3.Monthly
1.2 Reporting to external organisations	1.Undertake reporting as required. Oversee recovery plans and provide assurance to the organisation on progress	1.DIPC / HoIPC	1.As required
1.3 Assurance Role of the IPCT	Continue to further develop the role of the IPCT in supporting HCGs to provide assurance of Trust wide compliance and progress of infection prevention and control	1.HoIPC and IPCT	1.On-going
1.4 Infection Prevention and Control Committee	Continue to develop assurance and monitoring functions of the IPCC	1.DIPC / HoIPC	Bi-monthly* (April, May, July, August, October, December 2019 and February 2020) *some variations due t room availability/cancellation
1.5 Infection Prevention and Control Annual Report	Compile Infection Prevention and Control Annual Report for the Trust Board and the public	1.DIPC / HoIPC	July 2019 IPCC and Q&SC January 2020
1.6 Infection Prevention and Control Team Objectives and	1.Compile and implement following approval from the IPCC who will also monitor progress throughout	1.DIPC / HoIPC and IPCT	July 2019 IPCC

Programme of Work	the year		
1.7 Attend HCG Patient Safety and Quality meetings	1.Ensure that all relevant IPC matters are discussed and owned by individual HCGs and action plans implemented as required.	1.HoIPC, IPCT, ADoNs and PSQ Facilitators.	Monthly (or as determined by frequency of HCG meeting)
1.8 Other Initiatives	Initiatives relating to • Antimicrobial stewardship • Sepsis awareness • Hand hygiene campaign • Catheter associated urinary tract infection • Clinical Consumable Review Group • IV and Invasive Devices Management Group • Water Safety Group • Transformation Programme for Domestics and Housekeeping staff	IPCT IPCT IPCT Associate IPC and Continence Nurse IPCT IPCT IPCT IPCT IPCT	As required
Success Criteria	We will know there has been success regarding this section when the above corporate and organisational directives and initiatives are undertaken, embedded and sustained. Verification will be via the Trust's performance management systems and processes		

2. Service Development				
2.1 Provision and delivery of an effective IPC service to ensure safe patient care and reduce the risk of incidents and outbreaks	1.Delivery of a proactive and reactive infection control advisory service, accessible to all clinical and non-clinical staff across the Trust to minimise health care associated infections and deliver safe patient care. 2.The provision of a proactive/reactive IPC nursing team service Monday to Friday, and an on call service out of hours. 3.Clinical Microbiology advice	1.DIPC/IPCT 2.IPCT 3.Consultant Microbiologists	1.4.19 – 31.3.20 1.4.19 – 31.3.20 1.4.19 –31.3.20	

	available from the Microbiology Consultants in normal working hours and via the on call Microbiologist Consultant outside of working hours/weekends/Public Holidays. 4.Incidents and outbreaks of significance will be reported through the correct channels and these are discussed in team meetings, reported on at committees (IPCC, Quality Safety Committee, Health Group PSQ forums, Senior Practitioner Forums, Band 6/7 Forums, Link Practitioner Meetings), Executive Team and communicated to the commissioners, NHSI and PHE as required. 5.Monthly performance reports submitted to Q&SC and SPQRG, detailing IPC activity and any incidents/outbreaks of importance. 6. Root Cause Analysis investigations (RCAs) are undertaken for significant incidents and the lessons learned are shared with clinical teams. 7.The IPC nursing team have allocated areas that they are responsible for providing expert support and advice to.	4.DIPC/HOIPC 5. HOIPC 6..DIPC/HOIPC 7. HOIPC / IPCT	-Weekly/monthly IPCT meetings -Monthly committees/ forums -Monthly reports to QSC, IPR SPQRG and each HCG. Notify Executive Team (in particular CMO / Chief Nurse) when significant outbreak / incident occurs. Monthly Within 14 days of incidents occurring Daily	
2.2 Outbreak of Infection Management	1.Continue to develop the management of outbreaks of infection. Compile and analyse data and produce summary reports	1.IPCT / IPC Information Officer	Seasonal / ahead of peak times and during outbreaks	

2.3 Seasonal Influenza	1. Membership of Influenza Planning Group to develop and implement a co-ordinated response to the increase in cases of influenza over the winter months (effective choice of vaccination, bed management, diagnosis and treatment) Provide infection prevention and control input into the Seasonal Influenza Vaccination Planning Group	1.Lead Nurse for OPD / SHaW / IPCT	From June 2019	
2.4 Written Information for Patients, Relatives and the Public	Develop and revise the current range of patient information. Devise information that achieves a good depth of equality and diversity	IPCT	As per review dates	
2.5 MRSA Screening Continue to achieve screening compliance for elective and emergency admissions	1. Work with Information Analyst to review monthly screening data and with the clinical areas that have non-compliances in MRSA screening 2. Undertake sample screening checks across in- patient areas to gain assurance of compliance with weekly screens.	Information Analyst for CC&CS Head of IPC supported by ADONs /HCG Dept/Service Leads IPC Information officer	1.4.18 - 31.3.19 - monthly Monthly	
2.6 Provision of Education and Training to all grades of clinical and non-clinical staff	1. The IPCT will continue to be responsible for delivery of infection prevention and control training for all grades of staff across the organisation. This will be in the form of structured	IPCT IPCT	1.4.19 – 31.3.20 Review quarterly	

	sessions and ad hoc events 2. The IPCT will continue to update and review presentations 3. Focus on developing and strengthening the role of the IP&C Link Practitioner (IPCLP) and the educational programme, to improve communication and engagement. 4. IPC to facilitate an Annual IP&C Conference	 PCT (with support from Ward Managers) IPCT IPCT/Continence	 Quarterly The In's and Out's of Catheters Conference - June 2020	
2.7 New Builds and Refurbishments	Each new build or refurbishment to have input from the IPCT including signing off of the final plans. It is the responsibility of the Estates/Capital Project Lead to make contact with the IPCT	Estates/IPCT	As required	
2.8 Standards of Cleanliness and Environmental Hygiene	Participate in providing assurance to the organisation with regards to standards of cleanliness and identify any issues of concern Support the Facilities Team and provide infection prevention and control direction Provide membership to the domestics and housekeeping Quality Improvement and Transformation Group is part of a Trust wide quality improvement and transformation programme	DIPC / IPCT DIPC /IPCT HOIPC	1.4.19 – 31.3.20 First meeting July 2020 – every two weeks thereafter As required	

	Participate in audits, initiatives, working groups and activities, for example, regular audits, PLACE Assessments Provide support in decant /deep clean programmes		As required	
2.9 Decontamination	Continue to provide support and guidance to the Trust Decontamination Lead (Chair of the decontamination meeting)	IPCT	Attend all Decontamination meetings	
2.10 Procurement Activities	Provide infection prevention and control input and support to Procurement colleagues into procurement activities, for example hand hygiene products, invasive devices, and all related products and equipment	IPCT	Monthly meetings	
2.11 Infection Prevention and Control social Media Initiatives and Intranet site	Strengthen and improve intranet site, ensure site is well maintained and up to date and liaise with the Communications Team as necessary. Utilise social media to promote IPC	IPCT	Review monthly	
Success Criteria	We will know there has been success regarding this section when the above infection prevention and control service development initiatives are undertaken, embedded and sustained. Verification will be via the Trust's performance management systems and processes			
	3. Development and Review of Policies, Procedures and Guidelines			
3.1 Existing Infection Prevention and Control Policies	Maintain the agreed reviewing process for updating of existing policies and ensure they are put through the appropriate processes.	IPCT	As per Health Assure dates	

	Policies/guidelines due this year include: 1. Prevention and Management of Chickenpox and Shingles Guideline 2. Control of Viral Haemorrhagic Fevers Policy 3. Management of *Clostridium difficile* 4. Management of Invasive Devices Policy			1. May 20 (Reviewed and going to August TPG) 2. August 20 (under review) 3. July 20 (out for comments/peer review) 4. July 20 (out for comments)	
3.2 New Policies, Procedures and Guidance	Provide assurance that IPC policies are in line with The Health and Social Care Act (2008). Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance		IPCT	Review Quarterly	
Success Criteria	We will know there has been success regarding this section when the above policy activities are undertaken, embedded and sustained. Verification will be via the Trust's performance management systems and processes				
	4. Surveillance and Reduction of Healthcare Associated Infection				
4.1 Reporting of Mandatory Data	Input required data to achieve compliance		DIPC / IPCT Information Officer	As per mandatory requirements	
4.2 Surveillance Reports	Produce monthly/ bi-monthly HCG specific surveillance reports		IPCT / Information officer	Each month for HCGs, bi-monthly for IPCC and annually.	
4.3 MRSA Bacteraemia	DoH Trajectory for 2019-20 - zero tolerance		1.DIPC/IPC Information Officer	1.4.19– 31.3.20	

	1. Report monthly to PHE via HCAI Data Capture System 2. Local RCA to be undertaken and develop delivery plans for any case of Trust apportioned MRSA bacteraemia (The Trust is not required to undertake a PIR this year due to our good performance) 3. Disseminate dashboard to Managers and Clinicians (includes CCG) at least weekly		2.DIPC/Microbiologist/IPCT with relevant Consultant/Medical Team and Ward Manager or Nursing Team member, Matron/ADON and DoN/Deputy DoN Ownership: HCG 3.IPC Information Officer	2.As cases occur 3.As cases occur	
4.4 *Clostridium difficile:*	DoH Trajectory for 2019-20 = 27 (New definitions/assignment of *C.difficile* cases introduced this year to include acute and community cases in one trajectory 1. Report monthly to PHE via HCAI Data Capture System 2. RCA undertaken for all Trust apportioned cases RCA Scrutiny Panel meetings (now chaired by NHS Herts Valleys CCG and NHS East & North Hertfordshire CCG and West Essex CCG))		1.DIPC/IPC Information Officer 2.CCGs,DIPC/Microbiologist/IPCT with relevant Consultant/Medical Team and Ward Manager or Nursing Team member and Matron/ADON and Antibiotic Pharmacist Ownership: Health Group 3.IPC Information Officer 4.IPCT	1.4.19– 31.3.20 (as cases occur) 2.RCA and Appeals Panel now to be held as a combined meeting with CCG present on a monthly basis (may be less frequent if no cases have occurred). 3.Minimim weekly or more frequently if cases occur	

	3. Disseminate dashboard for all cases of *C.difficile* to Managers and Clinicians (including CCG) at least weekly 4. Appraise and implement *C.difficile* infection objectives for NHS organisations for guidance on sanction implementation			1.4.19 – 31.3.20	
4.5 Gram Negative Blood Stream Infections (GNBSI):	DoH ambition (came into effect from 1.4.17): Reduce the numbers of healthcare associated Gram-negative bloodstream infections (BSIs) by 50% by the year 2021 (now increased to 2024) 1. Report monthly to PHE via HCAI Data Capture System 2. RCA undertaken for Trust apportioned cases . 3. Continue with Catheter-associated UTI (CAUTI) working group to support the Trust with the DoH ambition – key member supporting and driving this is seconded associate IPC/Continence Nurse and focussing on project		1.DIPC/IPC Information Officer 2.Consultant Microbiologist /IPCT 3.Consultant Microbiologist IPCT / Bladder and Bowel Nurse Specialist 4. Quality First Project manager/Continence nurse/IPCT/DIPC 5. DIPC and Antimicrobial pharmacist 6. IPC Information Officer	1.4.19 – 31.3.20	

	work. 4. Update Trust antibiotic guidance to control urinary and other infections as required, thereby preventing onset of various bacteraemia; use of antibiotics is monitored by the Antimicrobial stewardship group. 5. Disseminate dashboard to Manager and Clinicians (including CCG) at least weekly to provide feedback				
4.6 Vancomycin / Glycopeptide Resistant Enterococcus (VRE/GRE) Positive Blood Cultures	No DoH trajectory has been set 1. Report quarterly to PHE via HCAI Data Capture System 2. Continue to monitor trends in both blood cultures and isolates, and raise awareness amongst clinicians		DIPC/IPCT/Lead BMS/Microbiology	1.4.19-31.3.20	
4.7 Carbapenemase Producing Organisms (CPO)	1. Continue to promote policy; raise awareness and educate clinical staff 2. Continue to work with the		DIPC / IPCT / Antimicrobial pharmacist	1.4.19 – 31.3.20	

	Emergency Department/ward staff to implement screening of patients that fulfil the criteria as set out in the policy 3. Raise awareness of standard infection control precautions (hand hygiene, environmental hygiene) 4. Monitor adherence to antimicrobial policy 5. Initiate management plan and contact tracing actions as per CPO policy/algorithm if cases occur 6. Audit screening log to determine compliance.			6.December 2019	
4.8 Surgical Site Infection Surveillance	1.Provide the specialist knowledge and expertise to enable Clinicians to collect data 2.Review categories of surveillance with a plan to implement a new category		DIPC /IPCT S&CC and FAWs HCG IPCT	As requested August 20 (initial review meeting)	
Success Criteria	We will know there has been success regarding this section when the above surveillance activities are undertaken, embedded and sustained. Verification will be via the Trust's performance management systems and processes				
	5.Antibiotic Stewardship				
5.1 Promote good Antimicrobial Stewardship	1. Monitor compliance with antimicrobial policy bi-annually. Audits to be	1.DIPC, Antimicrobial Pharmacist and Consultant Microbiologists		July 2019 and Jan 2020	

	disseminated to Clinical Leads, Executive team and to ICC. Use of antibiotics is monitored by the Antimicrobial Stewardship Committee which was started in November 2017. 2. To promote responsible use of antibiotics across the Trust and health care setting 3. Provide telephone and ward support for prescribers in choice and use of antibiotics; choices need to be compliant with Start Smart then Focus 2011 (DoH) ,the UK 5 Year Antimicrobial Resistance Strategy 2013 – 2018 and updated Trust antibiotic guidance 4. To progress Antibiotic CQUIN (2019 - 2020): a.The CCG1a (Pay levels 60-90%) focuses on improving the diagnosis and management of lower UTIs in older people. The PHE document should be used to guide	2.Consultant Microbiologists and all ward pharmacists Consultant Microbiologists Antimicrobial pharmacist /DIPC CQUIN Trust lead (Deputy Chief Nurse), and Contracts Manager responsible for CQUIN	On-going Quarterly returns with progression for maximal compliance by 31 March 2020

	the appropriate diagnosis of lower UTIs in older people in the hospital. NICE guidelines do not cover diagnosis; it is being used to guide treatment instead of local hospital guidelines. NICE guidelines provide the most up-to-date evidence-based treatment of lower UTIs. b. The CCG1b (Pay levels 60-90%) focuses on antibiotic prophylaxis in colorectal surgery. There is one lower and upper threshold for each indicator. Payment is determined by reference to these thresholds. Where the upper threshold is reached by the Trust, 100% of payment will be earned; where it drops below the lower threshold, 0% would be earned. Payment by the CCG is graduated between the two thresholds evenly.		

Appendix 2 : Infection Prevention & Control Annual Audit Programme 1st April 2019 – 31st March 2020

	Audits	Monitoring / Audit method	Lead	Responsible Person	Audit Frequency	Proposed Date(s)	Date of Completion	To which committee was outcome and action plans reported to (inc date)	Audit Registration Number
1	CPO Policy and screening log	Internal audit tool	Head of IPC	IPC Nurses	Annual	9th December 2019			TBC
2	Isolation Policy Compliance	Internal audit tool	Head of IPC	IPC Nurses	Annual (but also included in annual ward and department environmental audit)	10th January 2020			TBC
3	Invasive Devices Audit	Internal audit tool	Head of IPC	IPC Nurses	Annual	18th June – 19th July 2019			TBC
4	MRSA Weekly Screening	Internal audit tool	Head of IPC	IPC Information Officer	Monthly	1st August 2019 – 31st March 2020	Report quarterly throughout 2019-2020	ICC July '19, Dec '19, March '20.	N/A
5	Hand Hygiene Policy	Internal audit tool (Peer review 'cross over' audits)	Head of IPC	Ward Managers	Monthly	1st April 2019 – 31st March 2020			N/A
6	Environmental and IPC ward/Departmental	Internal audit tool (based on the Infection	Head of IPC	IPC Nurses with support from Estates	Annually in every clinical department	1st April 2019 – 31st March 2020 separate			N/A

	Audits	Monitoring / Audit method	Lead	Responsible Person	Audit Frequency	Proposed Date(s)	Date of Completion	To which committee was outcome and action plans reported to (inc date)	Audit Registration Number
	Annual Audit	Prevention and Control Society Improvement Tools)		and Facilities		programme of dates			
7	Antimicrobial Prescribing Compliance Audits	Internal audit tool	Antimicrobial Pharmacist	Antimicrobial Pharmacist	Bi Annually	July 2019 – Jan 2020	Ongoing	PS&Q MMIC	3659
8	Sharps Safety (External company)	Sharps Smart audit tool	Head of IPC	Sharps Smart	Monthly	Monthly			N/A
9	Hand Hygiene Compliance (External company)	Deb Cutan audit tool	Head of IPC	Deb Cutan Rep	Annual	TBC			N/A
Saving Lives High Impact Intervention									
10	Prevention of Ventilated Associated Pneumonia (VAP)	Saving Lives audit tool	Intensive Care Unit Manger	Intensive Care Unit Nurses	Monthly	1st April 2019 – 31st March 2020			N/A
11	Surgical Site Infection (SSI)	Saving Lives audit tool	Theatre Matron	Theatre Nurses	Monthly	1st April 2019 – 31st March 2020			N/A

	Audits	Monitoring / Audit method	Lead	Responsible Person	Audit Frequency	Proposed Date(s)	Date of Completion	To which committee was outcome and action plans reported to (inc date)	Audit Registration Number
12	Peripheral Line Insertion and Continuing Care	Saving Lives audit tool	Head of IPC	Ward/Department Managers (all relevant clinical areas – see Scorecard)	Monthly	1st April 2019 – 31st March 2020			N/A
13	Urinary Catheter Insertion and Continuing Care	Saving Lives audit tool	Head of IPC	Ward Managers	Monthly	1st April 2019 – 31st March 2020			N/A
14	Central Venous Access Device Insertion and Continuing Care	Saving Lives audit tool	Head of IPC	Ward Managers	Monthly	TBC			N/A

Duties:

The quality improvement and transformation plans developed by the Group will include, as a minimum:

- Investment required in new cleaning equipment
- Timeframe for microfibre and steam/cleaning equipment implementation across the site
- Introduction of an electronic meal ordering solution
- Review of the meal preparation support
- Electronic monitoring facility of national cleaning standards
- Clarity on a fit for purpose structure for the domestic services team

- Rota pattern changes required to ensure the demand for services can be met
- Review of staffing establishment

The Group will also:

- Develop, track and monitor a risk log for the programme and agree and implement relevant mitigation
- Work within current financial resources and Standard Financial Instructions
- Escalate any conflicts with other quality improvement and transformation programmes to the Senior Responsible Officer
- Facilitate the transformational change required to drive the radical redesign of services
- Champion the programme both internally and externally to the benefit of stakeholders

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03.10.19 **AGENDA ITEM NO: 8.3**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATES OF MEETINGS (Fortnightly): 3 and 17 September 2019.

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

SMT meetings took place on 3 and 17 September 2019.

The following items were discussed at the meetings:

3 September 2019:

- Internal Audit Update - updated received from the Trust's Internal Auditors on progress against the Internal Audit workplan.
- CQC update
- Short Notice Clinic Cancellations
- Deep dive presentation received on SLR Haematology
- Mortality Improvement: a revised framework was presented including the implementation of a patient safety and mortality facilitator and a nursing lead for quality and governance to substantiate robust learning and alignment with the Trusts current SI framework.
- Talent management - introducing the first pilot cohort of an externally supported Talent Management (TM) Programme in September 2019,

17 September 2019:

- CQC High Level Improvement Plan - the paper explained the new process to address the recommendations from the 2019 inspection. The mock PIR data collection process was already underway.
- The Senior Nurse Lead & Clinical Safety Officer for Information Technology demonstrated Nervecentre capability in the Trust via the live system.
- STP Regional Updates and ICP & Partnership Board noted.
- Month 4 finance results discussed; £3.2m adrift from plan and key drivers were highlighted and discussed.
- STP Falls Pathway - presented by the Falls Practitioner and Physiotherapist (FP/P) and it was noted the STP are devising unified pathways across the patch.