## Board of Directors
### Public AGENDA

**Date:** Tuesday 18 December 2018  
**Time:** 0830hrs – 1100hrs  
**Venue:** Boardroom, Level D, Rotherham Hospital

<table>
<thead>
<tr>
<th>Time</th>
<th>Item no.</th>
<th>Description</th>
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<tbody>
<tr>
<td>0830</td>
<td>475/18</td>
<td>Chairman’s welcome and apologies for absence</td>
<td>Verbal - For noting</td>
<td>Martin Havenhand, Chairman</td>
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<tr>
<td></td>
<td>476/18</td>
<td>Declaration of Conflicts of Interest</td>
<td>Verbal - For noting</td>
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#### Quality and Safety

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<tr>
<td>0835</td>
<td>477/18</td>
<td>Patient Story</td>
<td>Verbal - -</td>
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#### Procedural Items

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<td>Enc. 3 For approval</td>
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<td></td>
<td>479/18</td>
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<td>Action Log</td>
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#### Strategy and Strategic Planning

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<td>0900</td>
<td>481/18</td>
<td>Public Report from the Chairman</td>
<td>Enc. 17 For noting</td>
<td>Martin Havenhand, Chairman</td>
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<td>Report from the Chief Executive</td>
<td>Verbal - For noting</td>
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<td>483/18</td>
<td>Progress Report on Quarter 2 Operational Plan</td>
<td>Enc. 23 For noting</td>
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#### Board Governance

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<td>484/18</td>
<td>Matters Reserved to the Board</td>
<td>Enc. 34 For approval</td>
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<td>Standing Financial Instructions, and Scheme of Delegation</td>
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<td>488/18</td>
<td>Review of Risk Management Report</td>
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#### Operational Performance
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<tr>
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<tr>
<td>1000</td>
<td>489/18</td>
<td>Integrated Performance Report</td>
<td>Enc.</td>
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<tr>
<td>489/18(a)</td>
<td>Quality Report</td>
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<td>Angela Wood, Chief Nurse</td>
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<td>Dr Callum Gardner, Interim Medical Director</td>
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<td>489/18(b)</td>
<td>Operational Performance Report</td>
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<td>Workforce Report</td>
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<td>489/18(d)</td>
<td>Finance Report</td>
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<td>300</td>
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<td>Simon Sheppard, Director of Finance</td>
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<td>490/18</td>
<td>Data Quality Report</td>
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<tr>
<td>491/18</td>
<td>Strategy and Transformation Report</td>
<td>Enc.</td>
<td>311</td>
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<td>Chris Holt, Deputy Chief Executive</td>
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<tr>
<td>1045</td>
<td>492/18</td>
<td>Governance Report</td>
<td>Enc.</td>
<td>315</td>
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<tr>
<td>493/18</td>
<td>How we Learn from Deaths Report</td>
<td>To follow</td>
<td>320</td>
<td>For noting</td>
<td>Dr Callum Gardner, Interim Medical Director</td>
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<tr>
<td>494/18</td>
<td>Any other business</td>
<td>-</td>
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<td>For approval</td>
<td>Martin Havenhand, Chairman</td>
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<tr>
<td>1100</td>
<td>495/18</td>
<td>Date of next meeting: Tuesday 29 January 2019</td>
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<td>For noting</td>
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**Assurance Framework**

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To ensure smooth transaction of business, the Chairman will invite questions from the public at the end of the meeting only.

In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting.
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON TUESDAY 27 NOVEMBER 2018 IN THE BOARDROOM, LEVEL D

Present: Mr M Havenhand, Chairman
Mrs G Atmarow, Non-Executive Director
Mrs L Barnett, Chief Executive
Mr G Briggs, Chief Operating Officer
Mrs H Craven, Non-Executive Director
Mr M Edgell, Non-Executive Director
Mr P Ferrie, Acting Director of Workforce
Dr C Gardner, Interim Medical Director
Ms L Hagger, Non-Executive Director
Mr C Holt, Deputy Chief Executive
Mr B Mellor, Non-Executive Director
Mr S Sheppard, Director of Finance
Ms A Wood, Interim Chief Nurse

Apologies: Mr J Barnes, Non-Executive Director
Dr D Hannah, Non-Executive Director
Dr C Wareham, Medical Director

In attendance: Ms A Milanec, Director of Corporate Affairs / Company Secretary
Miss D Stewart, Corporate Governance Manager (minutes)

Observers: There were no observers to the meeting

422/18 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed those present to the meeting with any apologies having been received and noted.

Mr Havenhand reported that, following interviews held on 23 November 2018, a recommendation to the Nominations Committee would be made that Ms Wood, currently interim Chief Nurse, should be substantively appointed to the role.

It was noted that the Nominations Committee would be meeting later in the day to discuss the recommendation.

423/18 DECLARATIONS OF CONFLICTS OF INTERESTS

There were no declarations of any conflict of interest. Colleagues were asked that should any become apparent during discussions that they be highlighted.
QUALITY AND SAFETY

424/18 PATIENT STORY

The Board of Directors received the patient story presented by the Interim Chief Nurse.

The story related to a young mother who had developed a congenital heart condition, who would potentially require a heart transplant in the near future, and the support she had been given by Rotherham local NHS services.

In noting the patient story, Mr Havenhand reported that the Council of Governors had sought provision of such patient stories for their formal meetings, and suggested that the presentation would be very fitting.

**ACTION – Interim Chief Nurse**

PROCEDURAL ITEMS

425/18 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 30 October 2018 were agreed as a correct record.

426/18 MATTERS ARISING FROM THE PREVIOUS MEETING

There were no matters arising from the meeting, which were not either covered by the action log or agenda items to be considered.

427/18 ACTION LOG

The Board of Directors considered and discussed the Board action log, with a number agreed that should be formally closed, and others that would continue to be monitored.

The following were specifically noted:

i. Log 89 – Ms Wood confirmed that, following conclusion of the serious incident (SI) investigation, expected to be in December, the learning as to why a complaint had led to a SI, would be shared with the Board once the SI process was completed.

Dr Gardner additionally commented that, whilst it was not unusual for complaints to lead to an SI investigation, the revised SI process would include a new requirement to explain why an SI had not been identified prior to the Trust receiving a formal complaint. It was anticipated that this approach would improve learning opportunities.

ii. Log 91 – confirmation had been received that the internal audit recommendations following the business continuity review had been factored into the Emergency Preparedness, Resilience and Response (EPRR) annual self-assessment of compliance process.

As such, the delegated authority to approve the self-assessment document had been enacted, and the action closed.
STRATEGY AND STRATEGIC PLANNING

428/18 REPORT FROM THE CHAIRMAN

The Board of Directors received the report from the Chairman, which provided an update on the South Yorkshire and Bassetlaw Integrated Care System, the Trust’s Proud Week celebrations and the Boards concern of our failure to achieve the 4-hour access standard.

With regard to the Proud Week celebrations, Mr Havenhand indicated that Dr Alison Cooper, the recipient of the Chairman’s Award, would be joining the Board later in the meeting. This was to facilitate receipt of her certificate and trophy, as she had been unable to attend the ceremony on the day.

Also detailed within the report were meetings attended by the Chairman. One of which included the routine meeting with the Lead Governor, also attended by Ms Hagger. The deputy Lead Governor would be invited to attend in the future.

Additionally, the Board was informed that the Council of Governors had undertaken a finance training session facilitated by the Director of Finance, as part of their Forum session. Feedback had been complimentary on what could be a difficult subject matter for a lay person.

The Board of Directors noted the Chairman’s Report.

429/18 REPORT FROM THE CHIEF EXECUTIVE

The Board of Directors received the report from the Chief Executive which outlined key strategic issues, operational issues and stakeholder engagement.

Mrs Barnett reported that work continued in development of the Five Year Plan and one-year Operational Plan.

Appended to the report was information which detailed progress against the 2018/19 operational objectives.

In terms of this appendix, members commented that there should be further review and refinement of the process supporting the reporting of progress against the operational objectives. Additionally, the content of the template could be enhanced in order to provide further information and therefore assurance to the Board. This was to provide a more comprehensive overview to the board to supplement the information and discussions about the individual elements, which took place at the board assurance committees. Mrs Barnett confirmed that she was happy to receive further feedback and would look again at the process for 2019/20.

ACTION – Chief Executive

As the Trust continued to actively engage with the Getting It Right First Time (GIRFT) programme of work, it was agreed that the Quality Assurance Committee should receive further information on the areas participating in the scheme.

ACTION - Interim Medical Director
The Board of Directors noted the report from the Chief Executive.

**STRATEGY AND TRANSFORMATION REPORT**

The Board of Directors received the report presented by the Deputy Chief Executive which provided an update across the transformation programme, and digital and estates agenda.

Mr Holt informed the Board that a number of the ward refurbishments, including Ward B1 and the Acute Medical Unit, were either nearing completion or were well underway.

The memorandum of understanding pertaining to the capital allocation to support the work on Ward B1 and the Acute Medical Unit, stated that the costs had be incurred by the end of the 2018/19 financial year. However, Mr Sheppard was requested to seek clarification from NHS Improvement to ensure there were no misunderstanding of the requirement which could result in any risk for the Trust. **ACTION – Director of Finance**

Whilst it was considered that the transformation programme was progressing favourably, it was questioned if the Trust was sufficiently robust and systematic in articulating the impact from the programmes on such as the performance indicators and the corporate objectives. Mrs Barnett indicated that in this respect there was clarity of the anticipated benefits to be gained from the transformation programme, citing the surgical admissions unit as an example. However, she concurred that there may be opportunities to share and articulate the wider intentions and aspirations from the transformation programmes to the Board more systematically, through this report, and to highlight the interdependency between programmes to develop new models of care, and the digital and estates work streams.

Mr Havenhand concluded the discussion by confirming that additional evidence needed to be provided to the Board, as part of the governance arrangements, when considering the transformation programme and any supporting business cases. This included measurable outcomes from the allocation of additional resources, and how performance would be improved. **ACTION – Deputy Chief Executive**

It was noted that the Strategic Workforce Committee had discussed the Rotherham Equipment and Wheelchair Services transfer to a new provider as a number of concerns had been raised regarding the slow responsiveness in a number of areas from both Rotherham Clinical Commissioning Group (CCG) and the new Provider. It was noted that a meeting had been held with colleagues from the service, the new provider and the CCG to discuss the issues which had been raised. A number of contractual and estates issues remained to be resolved. It was agreed that an update on the position would be provided to the Finance and Performance Committee next month. **ACTION – Deputy Chief Executive / Director of Finance**

The Board of Directors noted the report.
The Board of Directors received and noted the monthly Integrated Performance Report (IPR) introduced by the Chief Executive.

Mrs Barnett highlighted the areas of top achievement and most improved performance which included cancer 62 day and the number of cancelled operations. Whilst there had been some positive signs of improvement, one of the areas of key concern continued to be the 4-hour access standard.

The Board noted that the position with regard to the percentage of looked after children receiving initial health assessment within 20 days and delayed transfer of care were both being addressed with the relevant external partner agencies. It was agreed that this would be discussed in more detail during the next item.

The Board of Directors noted the Integrated Performance Report, with detailed information on a number of matters contained within subsequent reports.

431/18(a) QUALITY REPORT

The Board of Directors received the Quality Report presented by the Interim Chief Nurse and Interim Medical Director.

Ms Wood highlighted a number of areas including harm free care, complaints response times, hospital acquired infections, nurse staffing levels and the CQUIN (Commissioning for Quality and Innovation) programme.

With regard to initial health assessments for looked after children, whilst the number of assessments undertaken had increased to 50%, there remained challenges outside the Trust’s control. As such, discussions continued with both the Local Authority and Rotherham Clinical Commissioning Group (CCG) to implement alternative models of care.

The Board acknowledged that although there had been some improvements, it had not been significant nor sustained. As this standard related to looked after children, and given the potential reputational implications to the Rotherham health economy, the Board agreed that the matter should be raised at the highest level with the CCG and the new Director of Children’s Services at Rotherham MBC. **ACTION – Interim Chief Nurse**

Additionally, Mrs Barnett agreed to discuss the matter with the Chief Executive of Rotherham Metropolitan Borough Council. **ACTION – Chief Executive**

Dr Gardner reported that the mortality position stood at 104 for HMSR (Hospital Standardised Mortality Ratio). However, as a consequence of improvements across the sector, the national position had been rebased to 98.8 from 100. Therefore, the review of the Trust’s mortality process, as described in a later report, would be essential to further improve the Trust’s own position.
The Board was advised that the dementia and delirium assessment calculation, which at previous meetings had been reported as having reached 90%, was in fact circa 70 - 75%. There had been a requirement for a recalculation due to inaccuracies in the data collection. A rebase for the previous two years had been requested, with the findings to be reported to the Quality Assurance Committee and Board. **ACTION – Interim Chief Nurse**

The nurse staffing report, which formed one of the appendices, was discussed, with Ms Wood confirming that a full establishment review was scheduled for December 2018. This review could result in a requirement for business cases for additional resources or a reconfiguration of current staff. It would also support the development of five-year training plans.

It was noted that the Strategic Workforce Committee would utilise the review findings, in addition to the medical workforce requirements, at their workshop planned to take place in January 2019. As the workforce had direct links to quality of services and the finances it may be appropriate to consider widening the invitation to other Board members.

The Board of Directors noted the Quality Report.

### 431/18(b) OPERATIONAL PERFORMANCE REPORT

The Board of Directors received the Operational Performance Report, which was presented by the Chief Operating Officer.

Mr Briggs focussed the Board’s discussion on a number of key performance standards, starting with the 4-hour access target.

Although signs of improvement were being seen, with a number of days seeing performance at above 95%, in–month performance stood at 88.7% against the agreed local trajectory of 91%. The year to date position was 88.1%.

Pre noon discharges were not at the required levels and there continued to be breaches in a number of specialities. However, the primary care support in the Urgent and Emergency Care Centre had significantly improved, with shift fill rates now averaging 90%.

In other areas, the winter team had been established with a number of specific actions to take forward; the Improvement Academy had commenced their initial work; and annual leave templates, which provided the opportunity to assess the position a month in advance, had been developed and shared with the Finance and Performance Committee. Additionally, the site room had been redesigned with the support of the emergency care intensive support team.

Mrs Craven commented that when performance against this standard had been discussed by the Finance and Performance Committee, it had been questioned as to whether the local trajectory had been set too high and whether it was achievable. Mrs Barnett confirmed that although a local target was in place, the Trust continued to work to achieve the national and constitutional target.
It was anticipated that the reconfiguration of the front of the hospital, as detailed in the Strategy and Transformation Report, would support delivery of the target. It remained essential that ownership of the target was given by all teams and departments, with service leaders driving the required changes.

With regard to cancer the quarter two target had been achieved. The performance currently stood at 85.2%. Focus remained on quarter three performance, which, Mr Briggs advised, would be more challenging.

As raised at the previous meeting as part of the Governance Report (minute 396/18) Mr Briggs confirmed that the duty of care requirements had been individually conveyed to non-medical staff within the Emergency Department.

It was commented that in signing off the operational plan with the regulator, commitment had been given to ensuring that the total number of 18 week RTT incomplete waits at the end of the financial year, would not exceed the number as at the end of 2017/18. The Board was advised that currently, the number was significantly above where it needed to be and may require additional resources to ensure the Trust was within the required parameters, but that this remained a risk. The Board requested that the position be clarified in the next report, with any proposed next steps. **ACTION – Chief Operating Officer**

With regard to one of the most deteriorated areas as detailed in the IPR, Mr Briggs indicated that as a consequence of a number of local hospitals ceasing their sleep study services, there had been an increase in referrals to Rotherham. This had resulted in breaches in the 6 week waiting standard. However, it was anticipated that the 6-week diagnostic standard would continue to be achieved. The service was looking to remodel in order to provide additional capacity as there was an opportunity for additional income in this area and primarily to ensure further resilience in terms of service delivery

The Board of Directors noted the Operational Report.

**431/18(c) WORKFORCE REPORT**

The Board of Directors received the Workforce Report presented by the Acting Director of Workforce.

Mr Ferrie reported that sickness absence rates had increased in October to 4.33%, against the 3.95% target. He added that seasonal variation was to be expected, with both short and long term absence having increased in month.

Mandatory and Statutory Training (MaST) and Personal Development Review compliance rates remained above plan, with the interim Medical Director looking at performance in specific medical groups.

In relation to Information Governance training, specific focus was being given to support achievement of the required 95% compliance rate.
Whilst historically new starters had not been included in the calculation of MaST compliance until they had been in post for three months, recent changes to the induction process would suggest that it would now be appropriate for them to be included in the data presented to the Board.

Appended to the report was the Workforce Report which was an enabler to support the Five Year Plan. This report had been discussed by the Strategic Workforce Committee and would form the basis for a workshop discussion in January 2019. Mrs Atmarow confirmed that other members of the Board were welcome to attend.

Mr Ferrie commented that as documented in this Workforce Report, there were a number of areas including nursing and midwifery, where there was a higher number of part time, compared to full time, employees. As such, there may be opportunities to fill staffing gaps from within the existing staff base.

With regard to the flu campaign, to date 63% of staff had been vaccinated. It was anticipated that the Commissioning for Quality and Innovation (CQUIN) target of 75% would be achieved within the month.

The Board of Directors noted the Workforce Report.

431/18(d) FINANCE REPORT

The Board of Directors received and noted the month seven Finance Report presented by the Director of Finance.

Mr Sheppard reported that at the end of October 2018 the Trust was performing better than planned by £200k. The deficit being £12.69m against the plan of £12.90m.

In terms of the cost improvement programme (CIP), it was ahead of the year to date trajectory by £900K, with £5.1m of schemes having been delivered. Additionally, schemes to the value of £10.2m had been identified against the in-year target of £9.7m. Although a number of Divisions were not currently meeting their trajectory, the year-end CIP forecast remained delivery in excess of the plan.

The overall year end forecast was that the £20.3m deficit plan would be delivered.

The Board of Directors noted the Finance Report.

432/18 JOB PLANNING

The Board of Directors received the report presented by the interim Medical Director which provided an update on progress of e-job plan implementation.
Dr Gardner reported that in accepting that there was a requirement for completed and signed job plans, it was also important that they were fit for purpose for the individual and each speciality.

A number of Non-Executive Directors indicated that whilst the new approach was supported, the matter of the pace in completing job plans had been an escalation to the Board on numerous occasions. Once again the Board was seeking assurance that job plans would be in place for 2019/20.

Dr Gardner explained that the aspiration was to have 95% of job plans completed, which would be supported by the GMC who were suggesting that as part of the appraisal/revalidation process, there was a requirement to demonstrate engagement in job planning. Dr Gardner also advised that he was liaising with the GMC regarding other methods of encouraging the timely completion of job plans, including consideration of this requirement as one of the eligibility criteria for Clinical Excellence Awards.

The Board of Directors noted the report, with a further report on progress to be provided in February 2019.

**ACTION – Interim Medical Director**

**ASSURANCE FRAMEWORK**

**433/18 BOARD ASSURANCE FRAMEWORK**

The Board of Directors received the report presented by the Director of Corporate Affairs/Company Secretary which detailed the quarter two review of the Board Assurance Framework (BAF).

Ms Milanec confirmed that each of the twelve BAF risks had been considered by the relevant Board Assurance Committee. Proposed changes to the risk scores for B1, B2 and B4 and B9 were detailed in the report for consideration by the Board. It was proposed that the remaining BAF risk scores would remain unchanged.

Mr Sheppard questioned the proposed increase of the likelihood score from 4 to 5 in relation to B4 (the Trust cannot deliver the range of services and / or Trust plans it is commissioned to deliver due to insufficient workforce capability and/or capacity) following discussion by the Strategic Workforce Committee.

It was agreed that B4 would be further discussed with Mr Ferrie outside the meeting. Any further revision to the score would be considered at the January 2019 Board Assurance Committee and Board of Directors meetings.

**ACTION – Acting Director of Workforce**

The Board of Directors approved the quarter two BAF risk scores as detailed within the report.

**434/18 RISK MANAGEMENT REPORT**

The Board of Directors received the Risk Management Report, including the
risk register for those scoring 15 and above, presented by the interim Chief Nurse.

Ms Wood outlined the current position with regard to agreement of risk assessments, development of the corporate risk register, the Risk Analysis Group and the role of individual Divisions.

Mr Havenhand indicated that there was a requirement for the Trust’s approach to risk management to be discussed at the December Board seminar as there were a number of different approaches being suggested. Following that discussion, the proposed way forward would be outlined at the December 2018 Board of Directors meeting. **ACTION – interim Chief Nurse**

The Board of Directors noted the report.

**435/18 GOVERNANCE REPORT**

The Board of Directors received the Governance Report presented by the Director of Corporate Affairs/Company Secretary.

Ms Milanec reported that NHS Improvement’s consultation on the subject of wholly owned subsidiaries had closed on 16 November, with the Trust response appended to the report. Updated guidance was expected from NHS Improvement before the end of December 2018.

Also appended to the report was the list of statutory, regulatory and in-house positions held by Trust officers.

Due to the timings of the Board Assurance Committees and Board meeting in December, and as deadlines may be contrary to individual terms of reference, the Board of Directors approved the revised deadlines for submission of reports and circulation of meeting papers.

The Board of Directors noted the report.

**436/18 MORTALITY**

The Board of Directors received the report presented by the interim Medical Director which provided an update on the Trust’s Mortality Review Process, current performance, and information on planned next steps.

Dr Gardner reported that whilst progress had been made in the previous twelve months, there remained areas which could be further strengthened to facilitate additional month-on-month improvement.

Areas of focus included a stage 1 and stage 2 approach to reviews, consideration of adopting the national Improvement Academy’s Structured Judgement Review process, and a review of the membership and role of the Mortality Review Group.
In response to a query regarding potential correlation between the Division of Medicine’s divisional HSMR rate and not all deaths being reviewed, Dr Gardner agreed that there was some links. However, he stressed that identification of patients at the end of life could potentially be more appropriately managed, which would in itself, improve the mortality position.

Mr Edgell, as Chair of the Quality Assurance Committee, welcomed and was supportive of the work being undertaken. He added that it remained important that mortality reviews were undertaken in a timely manner, were of sufficient quality and subject to peer oversight.

The Board of Directors noted the report.

437/18 CQC MONTHLY REPORT

The Board of Directors received the monthly Care Quality Commission (CQC) report presented by the interim Chief Nurse.

Ms Wood indicated that the report summarised the current position following the CQC inspections. It also detailed the action plans developed based upon the initial feedback from the various visits.

The Board was informed that the draft CQC report was expected in early December, with a short period of time to complete the factual accuracy checks.

With regard to the Section 31 letter and application of conditions on the registration, it was indicated that the normal process would be that any condition would not be removed until a re-inspection had taken place. However, the exact timeframe had yet to be confirmed.

The Quality Assurance Committee was requested to continue to monitor the position and implementation of the action plans, specifically seeking assurance that the actions would support delivery of the required outcomes and that they were being implemented with sufficient pace. ACTION – Interim Chief Nurse

The Board of Directors noted the report.

438/18 PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT REPORT

The Board of Directors received, for information, the report presented by the interim Chief Nurse, which highlighted the findings of the Patient Led Assessment of the Care Environment (PLACE).

439/19 NATIONAL STAFF FLU CAMPAIGN EXECUTIVE SUMMARY REPORT

The Board of Directors received the report presented by the interim Chief Nurse which outlined the executive summary of the staff flu plan, the Trust’s response to the letter to Chief Executives from NHS England and the healthcare worker flu vaccination best practice management checklist.
Ms Wood confirmed that the CQUIN target was for 75% of colleagues to be vaccinated with efforts continuing to increase take up rates even further.

Should there be a high rate of reported flu cases amongst patients, a risk assessment would be undertaken to help inform any decision to redeploy colleagues who had chosen not to be vaccinated.

The Board of Directors noted the current position.

**BOARD GOVERNANCE**

440/18 **REVIEW: AUDIT COMMITTEE TERMS OF REFERENCE**

The Board of Directors received the proposed revisions to the Audit Committee Terms of Reference presented by the Director of Corporate Affairs/Company Secretary in the absence of the Chair of the Audit Committee.

It was noted that the Audit Committee, having considered the revisions at their 16 November 2018 meeting, recommended approval of the updates.

The Board approved the revised Audit Committee Terms of Reference.

In considering the terms of reference it was questioned as to the Committee(s) which had oversight of the statutory and regulatory submissions. Ms Milanec clarified that the Standing Orders, which would be considered at the December 2018 Board meeting, included a requirement for a log of e-signatures appended to such submissions, to be routinely provided to the Board.

However, as commented by the Executive Directors, there was a considerable number of operational submissions required throughout the business year to the regulators. Mr Holt agreed to provide clarity on the types of submissions in due course.

**ACTION – Deputy Chief Executive**

441/18 **ANY OTHER BUSINESS**

There were no items of any other business.

442/18 **DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on Tuesday, 18 December 2018.

Martin Havenhand
Chairman
<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting Date</th>
<th>Report/Agsenda title</th>
<th>Minute Ref</th>
<th>Agenda Item and Action</th>
<th>Lead Officer</th>
<th>Timescale/Deadline</th>
<th>Comment/Feedback from Lead Officer(s)</th>
<th>Open / Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>25-Jul-17</td>
<td>Escalations from Governors</td>
<td>269/17</td>
<td>To be added to action log: 3 staff governor vacancies out of 5 remain vacant. Execs to consider options available to co-op colleagues to ensure they are engaged and represented through CoG.</td>
<td>Co Sec</td>
<td>30/09/2018 (re constitution)</td>
<td>Update from November meeting: Item to be left open until 5 staff co-opted / Governors are in place.</td>
<td>Open</td>
</tr>
<tr>
<td>86</td>
<td>30-Oct-18</td>
<td>Chairman’s report</td>
<td>391/18</td>
<td>Write to Pride of Britain Fundraiser of the Year regional award winner to express congratulations on behalf of the Board</td>
<td>Chair</td>
<td>30/11/2018</td>
<td>Completed</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>87</td>
<td>30-Oct-18</td>
<td>CEO Report</td>
<td>392/18</td>
<td>SYB ICS response to the NHS Long Term Plan (appendix 1, item 2.6) to be circulated to board members</td>
<td>CEO</td>
<td>30/11/2018</td>
<td>Will be sent out as soon as received,</td>
<td>Open</td>
</tr>
<tr>
<td>88</td>
<td>30-Oct-18</td>
<td>Five Year Strategy Refresh</td>
<td>393/18</td>
<td>Strategy to be updated as per Board feedback, approved with delegated authority to Chairman, CEO and Vice Chair, and final copy circulated to Board.</td>
<td>CEO</td>
<td>18/12/2018</td>
<td>Will be sent out as soon as received,</td>
<td>Open</td>
</tr>
<tr>
<td>89</td>
<td>30-Oct-18</td>
<td>Quality Report</td>
<td>395/18</td>
<td>Learnings to be shared with the Board following an investigation of the complaint / SI.</td>
<td>CEO</td>
<td>27/11/2018</td>
<td>November board update: Investigation not yet complete - bring back to Board in January 2019.</td>
<td>Open</td>
</tr>
<tr>
<td>92</td>
<td>27-Nov-18</td>
<td>Patient Story</td>
<td>424/18</td>
<td>Patient Story to be presented at next Council of Governors meeting</td>
<td>CEO</td>
<td>15/01/2019</td>
<td>Item on Council of Governors’ January 2019 agenda</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>93</td>
<td>27-Nov-18</td>
<td>CEO Report</td>
<td>429/18</td>
<td>Process for tracking progress on operational objectives to be reviewed for 2019/20</td>
<td>CEO</td>
<td>31/03/2019</td>
<td>Item on January QAC agenda</td>
<td>Open</td>
</tr>
<tr>
<td>94</td>
<td>27-Nov-18</td>
<td>CEO Report</td>
<td>429/18</td>
<td>QAC to receive more information regarding which clinical services are included in GIRFT</td>
<td>IMD</td>
<td>15-Jan-19</td>
<td>Item on January QAC agenda</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>95</td>
<td>27-Nov-18</td>
<td>Strategy and Transformation Report</td>
<td>430/18</td>
<td>Clarify with NHSI as to requirements regarding funding for capital for assessment floor</td>
<td>DoF</td>
<td>18/12/2018</td>
<td>MOU presented to FPC and additional board members</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>Log No</td>
<td>Meeting</td>
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<tr>
<td>96</td>
<td>27-Nov-18</td>
<td>Strategy and Transformation Report</td>
<td>430/18</td>
<td>When considering transformation projects and business cases, to include measurable outcomes.</td>
<td>DCEO</td>
<td></td>
<td>Going forwards, this will become business as usual.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>97</td>
<td>27-Nov-18</td>
<td>Strategy and Transformation Report</td>
<td>430/18</td>
<td>FPC to receive an update on progress with the REWs transfer.</td>
<td>COO</td>
<td>18/12/2018</td>
<td>Item included on the December FPC agenda, item 304/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>95</td>
<td>27-Nov-18</td>
<td>Quality Report</td>
<td>431a/18</td>
<td>Issues relating to Looked After Child services, to be taken to highest level with CCG and new Director of Children's Services</td>
<td>IMD</td>
<td>18/12/2018</td>
<td>Verbal update will be provided at the meeting</td>
<td>Open</td>
</tr>
<tr>
<td>96</td>
<td>27-Nov-18</td>
<td>Quality Report</td>
<td>431a/18</td>
<td>CEO to raise Looked After Child services with RMBC CEO</td>
<td>CEO</td>
<td>18/12/2018</td>
<td>Complete</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>97</td>
<td>27-Nov-18</td>
<td>Quality Report</td>
<td>431a/18</td>
<td>Outcome of the review of dementia and delirium assessment performance figures from last two years to be provided to QAC and Board</td>
<td>ChN</td>
<td>18/12/2018</td>
<td>On January 2019 QAC agenda On board planner for January 2019</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>98</td>
<td>27-Nov-18</td>
<td>Operational Report</td>
<td>431b/18</td>
<td>Further detail relating to cancer position to be reported to next board, confirming position of whether the quarter will be achieved, and any proposed actions</td>
<td>COO</td>
<td>18/12/2018</td>
<td>Included as part of agenda item 489/18 (b)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>99</td>
<td>27-Nov-18</td>
<td>Job Planning</td>
<td>432/18</td>
<td>Further report on progress to be brought to Board</td>
<td>IMD</td>
<td>26/02/2018</td>
<td>Moved to board planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>100</td>
<td>27-Nov-18</td>
<td>BAF</td>
<td>433/18</td>
<td>Clarification sought on wording on B4 on the BAF, and whether a revised score would be required.</td>
<td>Co Sec / ADW</td>
<td>29/01/2019</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>101</td>
<td>27-Nov-18</td>
<td>Risk Management Report</td>
<td>434/18</td>
<td>Board to discuss future risk management processes in the Trust as part of December Board Seminar and Board meeting</td>
<td>ChN</td>
<td>18/12/2018</td>
<td>Agenda item 488/18</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>102</td>
<td>27-Nov-18</td>
<td>CQC Monthly Report</td>
<td>437/18</td>
<td>QAC to continue to monitor implementation of action plans, at sufficient pace</td>
<td>ChN</td>
<td>18/12/2018</td>
<td>Regular item on QAC agendas</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>103</td>
<td>27-Nov-18</td>
<td>Audit Committee ToR</td>
<td>440/18</td>
<td>Clarity on the type and number of operational submissions made to regulators, not seen by the Board, to be provided</td>
<td>DCEO</td>
<td>18/12/2018</td>
<td>Details emails to board members</td>
<td>Recommend to close</td>
</tr>
</tbody>
</table>
### Agenda item 481/18

#### Report

**Public Report from the Chairman**

**Executive Lead**

Presenter: Martin Havenhand, Chairman

**Link with the BAF**

The Chairman’s report reflects various elements of the BAF

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
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</thead>
</table>

**Executive Summary**

(including reason for the report, background, key issues and risks)

South Yorkshire and Bassetlaw Integrated Care System colleagues met again this month, where the Hospital Services Review and system wide governance structures, continued to be the focus of discussion.

The Rotherham Ambition Board is progressing with its plans to positively promote the Borough of Rotherham.

The Board remains concerned at the lack of consistency in accomplishing the 4-hour access standard.

Barry Mellor, attended the North of England Organ Donation conference in Manchester on the 6 December, which provided a national update on related matters.

**Recommendations**

It is recommended that:

The Board note this report.

**Appendices**

Appendix 1: Park Rehabilitation Centre volunteers (Press Release)

Appendix 2: What is Good about Rotherham Maternity Services
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 27 November 2018.

2.0 South Yorkshire and Bassetlaw Integrated Care System (ICS)

2.1 The Chairs and Chief Executives of the Acute Trusts met on 3 December 2018, and it was agreed that from February 2019 onwards, the meeting would take place on a bi-monthly basis.

2.2 Discussions continue regarding the ICS governance structure, and particularly with regard to the need for clarity regarding the ‘holding to account’ structure and processes.

2.3 Work relating to the Hospital Services Review continues, with more work to be completed in identifying what the proposed format of level 1, level 2 and level 3 Networks. It is still anticipated that the hosted networks will become operational from 1 April 2019.

3.0 Rotherham Ambition Rotherham Board

3.1 The Ambition Rotherham Board is part of the Rotherham Together Partnership and is a collaboration of business leaders and public sector organisations that make up the Board, are striving to build the ‘Rotherham Brand’ by promoting positive local assets and attributes, as well as taking pride in the Borough’s history and vibrant past. In order to progress this work, a delivery plan has been created, with a whole range of activities due to commence in the New Year, which will support continued development of this enterprise.

3.2 I chaired the meeting taking place on 4 December where much of the discussions were based on the proposed Rotherham Ambition delivery plan.

4.0 4 Hour Access Standard Performance

4.1 The Board remains concerned about our non-achievement of the 95% target against the 4-hour access standard. As reported previously, a new winter team has been established with responsibility to improve performance in this area.

5.0 Organ Donation Committee

5.1 Barry Mellor, as Chair of our Organ Donation Committee, attended the North of England Organ Donation Conference in Manchester on the 6th December.

5.2 This provided a national update including progress on the Donation Opt Out Legislation which is currently going through Parliament and is hoped will be approved in April 2019 for implementation a year later. Studies in Wales have shown a 10% increase in donations since they introduced similar legislation.

5.3 In addition, case studies were presented on Upper Limb Donation and transplantation, Neonatal Donation and Liver donation and transplantation.
6.0 Chairman's other activities since the last Board Meeting

- 30 November: Meeting with the Chair of Sheffield Teaching Hospitals NHS Foundation Trust

- 4 December: Odgers Berndtson, Berwick Partners seminar on Diversity of Boards

- 10 December: Chairing the Joint Appointments Panel for our new Director of Workforce, jointly with Barnsley Hospital NHS Foundation Trust

- 11 December: Supporting colleagues from Park Rehabilitation Centre in their assessment of a Queens Award for Voluntary Service. A press release about the assessment can be found at Appendix 1.

- 11 December: Meeting our midwives who won the Innovation Award at our recent Proud Awards ceremony. During the meeting, our enthusiastic colleagues were keen to promote the excellent work that they do and the facilities and services that they provide. Details of ‘What is good about Rotherham Maternity Services’ can be found at Appendix 2.

Martin Havenhand
Chairman
December 2018
Park Rehabilitation Centre volunteers (PRESS RELEASE)

On Tuesday, volunteers and colleagues at Park Rehabilitation Centre welcomed two of the Deputy Lieutenants for South Yorkshire; Janet Wheatley and Hock-Ann Chia who were visiting as part of an assessment for a Queen’s Award for Voluntary Service.

The award is the highest given to volunteer groups in the UK. Following a written nomination, local assessment panels look at all the nominations and decide which ones to send to the National Award Committee. The committee makes recommendations to the Department for Digital, Culture, Media and Sport which sends a final list to the Queen for her approval. Winners are announced in the London Gazette on 2 June.

During the visit, the Deputy Lieutenants met volunteers Chris and Sheila, as well as a number of patients who regularly use the café area which they run. Discussions took place around the role of the volunteers, the service they provide and the impact it has on the patients. The patients praised the work of the volunteers and talked about how the café had become a social space for them around their treatments. One talked about how her condition had made her feel isolated and not wanting to socialise; the volunteers had introduced her to other patients through the café which allowed her to discuss and ‘normalise’ the condition, giving her the confidence to go out into the world.

Clare Laybourne, Operational Support Manager for Park Rehabilitation Centre who submitted the original nomination, said: “The volunteers support the patients by listening and talking through fears and issues people may have prior to, or following, treatment and this is all done whilst having a hot drink and a biscuit. They help people to integrate with others and it helps them become part of a bigger family and make friends. They engage with people with physical and mental disabilities and communication barriers due to medical conditions. The ladies really do care about what they do, which is fantastic to see.”

The nomination was accompanied by letters of support provided by patients which sung the praises of the volunteers. One patient wrote: “They join in and laugh with us at happy times and comfort us at sad times, they are not just the volunteers who are there to give us tea and coffee they are part of our group and we are lucky to have them.”

Martin Havenhand, Chairman of the Trust, said: “The volunteers at Park Rehabilitation Centre perform an invaluable role in helping to care for our patients. From talking to patients, it is clear how much the volunteers are valued and how they have created a calm, safe and social atmosphere during what may be tough and stressful times for those using the Centre.

“I believe the volunteers deserve to be recognised for their efforts and I hope they are successful in receiving a Queen’s Award for Voluntary Service.”

The café is run entirely by volunteers and is open 9.30am-1pm Monday and Tuesday each week. Donations made go towards the Rotherham Hospital and Community Charity’s Purple Butterfly Appeal.
What is Good about Rotherham Maternity Services

- Weekend / Evening Booking Clinics - allowing easier access to services for working families.
- Nationally recognised Smoking Cessation support service - led by a Midwife, offering targeted 'Stop Smoking' in pregnancy advice.
- Community Hubs - developing increasing services, providing a more community based, accessible way of accessing Maternity Care.
- Birth Workshops - A friendly and informative way of presenting information to groups of parents.
- Breastfeeding Workshops - Specific breastfeeding information classes run by our Infant Feeding Co-ordinator Debbie Ellis.
- Use of the Perinatal Institutes GAP/GROW personalised growth charts - to allow good quality monitoring and care planning for individual pregnancies.
- A Team of Specialist and friendly Consultant Obstetricians - Clinicians with areas of specialist interests who can provide individual care planning and support for more complex pregnancies.
- The use of Accupins for Hyperemesis - Led by Ruth Roddison (Acute Pain Team), the use of simple accupins has significantly reduced hospital admissions in early pregnancy for severe vomiting.
- Use of the 'Perineal Protection Technique' at birth - this has led to Rotherham having one of the lowest extensive tear (3rd/4th degree) rates within our region.
- We achieve a 67% normal birth rate.
- We have a Team of midwives offering aromatherapy treatment to aid pain relief and analgesia in the antenatal/labour and postnatal period.
- We have launched an Outpatient Induction of Labour service - this treatment utilises catheter balloons to induce labour, which allows women to go home safely to await labour.
- Birthing pool - allowing us to offer water births for those who chose them. We have water proof electrical monitoring allowing the foetal heart rate to be monitored in the pool if required. This allows a wider range of women to utilise the pool as close monitoring is still achievable.
- Partners stay on the ward 24/7 if they wish to - allowing families to stay together and for women to have the support from their partners as and when required.
- We have a team of friendly Nursery Nurses who provide families with support day and night with baby care, performing baby observations and any extra treatment that baby might require.
- We have Peer Support Workers who offer 1:1 support with breastfeeding. They have the knowledge and time required to give families that extra support they may need to establish their breastfeeding.
- We have a weekly Breastfeeding Drop-In every Thursday in Megs Room which is open to all. It is staffed by experienced staff to provide and extra support needed at whatever stage baby is at. No need to book, women can just drop in if they need support.
- We have an internal referral pathway for Tongue Tie division. If a tongue tie is noted in a baby they can be referred to our own ENT surgeons rather than having to be referred to another unit.
We have an 'Enhanced recovery' pathway for women who have a planned caesarean section operation. This pathway allows these women to be recovered and discharged 24hrs following their operation, reducing extended ward stays if they are not required.

We have excellent tools for assessing the VTE risk of pregnant and postnatal women - all staff are well trained in this area and women are risk assessed at several points in their pregnancy to ensure they are on the correct treatment to significantly reduce the risk of VTE.

We have excellent Mental Health support for our women with our Perinatal Mental Health Team, who have had regional recognition for the very successful Drop In Support Group that they run.

We conduct Multi-Disciplinary Training for all members of the clinical team to update and work together as an annual requirement. We have a state of the art 'SIM Mom' which allows use to run emergency drills and practice and develop our skills and human factors awareness together all as one effective Team.
Agenda item | 483/18
---|---
Report | Progress Report on Quarter 2 Operational Plan
Executive Lead | Chris Holt, Deputy Chief Executive / Director of Strategy & Transformation
Link with the BAF | B11 & B8: This report provides an update on a number of the Place Plan initiatives with partner organisations. Where appropriate it also reports on the digital agenda and potential resilience in delivery
Purpose | Decision ☐ To note ✓ Approval ☐ For information ☐

Executive Summary (including reason for the report, background, key issues and risks)

The purpose of this paper is to present to the Board a review of progress against the operational plan for Q2 2018/19. It summarises progress against each of the operational objectives, enablers and headline milestones within the plan and gives an overall assessment of progress to date.

In total, 31 milestones or outcomes were due to be achieved during Q2, and a summary of progress is as follows:
- 14 milestones / outcomes were delivered or remain on track
- 10 milestones / outcomes were not achieved to plan, but remedial plans were put in place to recover delivery during 2018/19.
- 3 milestones / outcomes were not achieved or delivered. For each of these, remedial plans are in place, but these will not now deliver as planned in 2018/19.
- 4 milestones are classed as On Hold or Not Rated, primarily due to a change in circumstances or approach.

Key focus during Q2 was the management of the CQC planned and unplanned inspections (and subsequent actions) as well as achieving performance against the 4-hour access target.

Work has continued into Q3, and strong progress continues to be made. However, the challenges from Q2 are largely consistent and this has remained a key focus of the executive and divisional teams.

Recommendations | To note
Appendices | Appendix A: Milestone Summary for Q2
1.0 Introduction

1.1. Following on from the update in Q1 and the monthly updates to Trust Board, progress has continued on delivering the Operational Objectives, Enablers and key priorities within the overall 2018/19 plan.

1.2. The governance and monitoring of the overall plan continues to be reviewed with further updates throughout Q2 on how progress is presented to not only Trust Board but also to the assurance committees. This has seen revisions made to the format of reports being presented to assurance committees and highlight reports against key areas being prepared. Whilst this has brought a degree of standardisation, further work is required to enhance and embed the approach and this has continued through Q2. Furthermore, the approach is being reviewed for 2019/20.

1.3. Overall progress also needs to be read in conjunction with the Integrated Performance Report (IPR) as well as the individual reports from Executive Directors. However, reviewing progress against the milestones laid out in the operational plan does ensure a degree of challenge and visibility on the progress being made.

2.0 Overall progress against Operational Objectives in Q2

2.1 Overall, progress has remained positive across a number of key areas. However, there have also been a number of key challenges throughout Q2, particularly in responding to and managing the CQC planned and unplanned inspections and also in maintaining and delivering the quality of care, particularly across the emergency care pathway, with extended delays being experienced for a number of our patients.

2.2 With regards to the operational plan, the Trust has continued to deliver against a number of the priorities and milestones, and this has been demonstrated with some positive operational performance; 18 week RTT, Cancer 62 Day and 6-week wait diagnostics all achieved national standards within Q2, as well as compliance with the overall financial plan. Work has also continued against the quality priorities, demonstrating positive progress across a number of key areas.

2.3 In total, 31 milestones or outcomes were due to be achieved during Q2, and a summary of progress is as follows:

- 14 milestones / outcomes were delivered or remain on track
- 10 milestones / outcomes were not achieved to plan, but remedial plans were put in place to recover delivery during 2018/19.
- 3 milestones / outcomes were not achieved or delivered. For each of these, remedial plans are in place, but these will not now deliver as planned in 2018/19.
- 4 milestones are classed as On Hold or Not Rated, primarily due to a change in circumstances or approach.

2.4 A summary of all 31 milestones for Q2 is contained in Appendix 1, and all of the ratings and progress updates have been shared and agreed with the appropriate assurance committees.

2.5 In order to provide further narrative and context to each of the sections, further information is provided in the sections that follow:
2.5.1 Operational Objectives
- **CQC preparation**: As part of the preparation for the CQC inspections through September, a report on progress since the last inspection, and proposed recommended actions, was completed.
- **Financial Plan**: We continue to deliver against the financial plan and the planned Cost Improvement Plans.
- **WOS**: The business case to support the Wholly Owned Subsidiary was a major piece of work within Q2, but due to changes in regulatory guidance, this was put on hold prior to presentation to the Trust Board.
- **Clinical Services Review**: The work to support the CSR’s was undertaken largely in Q2, and this was presented to the Board in November, so whilst not achieved in Q2, this output has subsequently been delivered.

2.5.2 Enablers
- **Service Improvement**: training has been undertaken with the Board and the next cohort of individuals has been identified. We have also engaged with NHSI and the QSIR College.
- **RCHC**: work has been ongoing with Rotherham CCG and partners around the use of RCHC, and an initial outline proposal is available and a firm plan will be presented now in March 2019.
- **Replacement of IT Infrastructure**: over 250 new laptops and workstations have been replaced across wards and community teams, along with over 150 desktops also replaced. Delays to the original plan are now logistical.

2.5.3 Patients
- **4hr access standard**: The significant challenge across the Patients theme through Q2 has been delivery against the 4hr access standard. The requirement to achieve 90% in September 2018 was not achieved and we remain behind our monthly trajectory.
- **Mortality (HSMR)**: whilst above 100, has been improving through Q2, and the actions taken continue to be embedded and further improvements are anticipated.

2.5.4 Colleagues
- **NHS National Survey**: the requirement to have an improved engagement score was re-set from Sept’18 to Feb’19 due to the timing of the staff survey.
- **Sickness Absence**: following strong performance (against the rolling sickness absence) the last month of Q2 saw an increase above the 3.95%. Work continues with divisions to address this and recover the standard.
- **PDR / MAST**: overall, following a difficult Q1, performance against both PDR’s and MAST has improved and met the planned outcomes, with the exception of Information Governance training, where actions are in place. The challenge remains compliance in key staff groups.

2.5.5 Finance
- **Cash profile**: As outlined above, we continue to deliver against the financial plan and this also includes meeting the planned cash profile through Q2.
2.5.6 **Governance, Partners & Estates**
- There were no Governance or Estates specific milestones due in Q2 and the ‘Partner’ milestones are addressed within the transformation programme

2.5.7 **Digital**
- **EPR Replacement**: A paper was originally planned to go to board in Q2 on the EPR replacement proposal, and this is now scheduled to go to Board in Dec’18. It will still meet the requirements of the overall replacement timeline.
- **Coded Spells**: the requirement to code 90% of spells within 5 days of discharge is being achieved, as planned
- **Call centre**: the business case for the upgrade of the TRFT call centre was rescheduled due to competing priorities (including securing external funding for other schemes) and is now due in Jan’19

2.5.8 **Transformation Programme**
- **Across the Trust**: the focus in Q2 has remained on the development of the SAU and GAU, with business cases agreed in Q3. The ambulatory and frailty pathways are operational and the service model is being updated and will be available in Q4.
- **Across the Place**: the key milestones have been revised service models for newly integrated teams (Integrated Rapid Response and Single Point of Access). Revised dates have been agreed which do not impact the operational performance. The Integrated Discharge Team joint role was achieved.
- **Across the ICS**: As outlined in Operational Objectives, the CSR’s have been completed.

3.0 **Focus for Q3**

11.1. Focus for delivery has continued within Q3, with a number of key Estates and Place milestones due as well as key milestones across the Governance theme. Overall, priorities and focus remains largely as they were within Q2 with good progress being made overall.

4.0 **Conclusion**

12.1. Overall progress against the milestones within the plan remains positive, with the majority of milestones achieved and / or delivered (14 of 27 – less those On-Hold). A further 10 milestones have agreed, revised dates and further positive progress will be seen in Q3.

Chris Holt  
**Deputy Chief Executive / Director of Strategy & Transformation**  
November 2018
## Operational Objectives: Milestones for Q2

<table>
<thead>
<tr>
<th>Operational Objectives and Milestone Plan</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1: Implement the 9 quality priorities for 2018/19</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Produce report on progress since last CQC inspection report and recommended new key actions</td>
<td>Jun-18</td>
<td>Aug-18</td>
<td>CN</td>
<td>Delivered</td>
</tr>
<tr>
<td><strong>Objective 2: Deliver the financial plan and the contract</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Operate within the agreed expenditure budgets</td>
<td>Monthly</td>
<td></td>
<td>DoF</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Objective 3: Implement year 1 of the Transformation &amp; Efficiency Programme</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Business case presented to Trust Board to determine whether to proceed with the Wholly Owned Subsidiary</td>
<td>Jul-18</td>
<td>Sep-18</td>
<td>DoST</td>
<td>On Hold</td>
</tr>
<tr>
<td><strong>Objective 5: Review our clinical strategy in light of the Hospital Services Review</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Complete clinical service review and strategy refresh</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>MD</td>
<td>Delivered</td>
</tr>
</tbody>
</table>

Delivered: Delivered
Green: On track
Amber: Off track but remedial plan in place
Red: Will not deliver as planned
# Enablers: Milestones for Q2

<table>
<thead>
<tr>
<th>Enablers and Milestone Plan</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enabler 3: Train key people across the organization in service improvement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Undertake service improvement training for all Trust Board members</td>
<td>Jul-18</td>
<td></td>
<td>CN</td>
<td>Delivered</td>
</tr>
<tr>
<td>3.3 Complete training for wave 2 and identify wave 3 cohort</td>
<td>Sep-18</td>
<td></td>
<td>CN</td>
<td>Delivered</td>
</tr>
<tr>
<td><strong>Enabler 4: Optimise the Corporate Estate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Review and present proposal to Trust Board for future use of RCHC</td>
<td>Jul-18</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td><strong>Enabler 5: Replace the core IT Infrastructure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Community laptop replacement programme complete</td>
<td>Jun-18</td>
<td>Jul-18</td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>5.2 All Workstation-On-Wheels (WOW's) in inpatient areas replaced</td>
<td>Jul-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>5.3 Business case for data and WiFi upgrade agreed</td>
<td>Sep-18</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
</tbody>
</table>

**Legend:**
- **Delivered**
- **Green** On track
- **Amber** Off track but remedial plan in place
- **Red** Will not deliver as planned

28
### Strategic Theme – Patients: Milestones in Q2

#### Strategic Theme - Patients: Excellence in Healthcare

<table>
<thead>
<tr>
<th>Topic</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Operational Standards</td>
<td>To deliver all quality performance standards across the Integrated Performance Report</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Not rated</td>
</tr>
<tr>
<td>4 Hour Access</td>
<td>Achieve month-on-month performance improvement</td>
<td>Monthly</td>
<td></td>
<td>COO</td>
<td>Red</td>
</tr>
<tr>
<td></td>
<td>Achieve 90% 4 hour access performance</td>
<td>Sept'18</td>
<td></td>
<td>COO</td>
<td>Red</td>
</tr>
<tr>
<td>Mortality (HSMR)</td>
<td>To maintain HSMR below 100</td>
<td>Monthly</td>
<td></td>
<td>MD</td>
<td>Red</td>
</tr>
</tbody>
</table>

*Delivered* Delivered  
*Green* On track  
*Amber* Off track but remedial plan in place  
*Red* Will not deliver as planned
<table>
<thead>
<tr>
<th>Topic</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS National Survey</td>
<td>Improve overall engagement score by 5%</td>
<td>Sep-18</td>
<td>Feb-19</td>
<td>DoW</td>
<td>Red</td>
</tr>
<tr>
<td>Sickness Absence</td>
<td>To have sickness absence levels of no greater than 3.95% of total workforce.</td>
<td>Monthly</td>
<td></td>
<td>DoW</td>
<td>Amber</td>
</tr>
<tr>
<td>PDR / Appraisal</td>
<td>PDR / Appraisal target of 90%</td>
<td>Jul-18</td>
<td>DoW</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Band 7 and above – compliance by end Q1</td>
<td>Sep-18</td>
<td>DoW</td>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- All other colleagues – compliance by end Q2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAST</td>
<td>MAST Training levels to be:</td>
<td>Monthly</td>
<td></td>
<td>DoW</td>
<td>Green</td>
</tr>
<tr>
<td></td>
<td>- 85% for MAST</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 95% for Information Governance</td>
<td>Monthly</td>
<td></td>
<td>DoW</td>
<td>Amber</td>
</tr>
<tr>
<td>Leadership Programme</td>
<td>Develop and introduce a Medical Leadership programme</td>
<td>Jul - 18</td>
<td>Jan-19</td>
<td>DoW</td>
<td>On Hold</td>
</tr>
</tbody>
</table>
### Strategic Theme – Finance: Milestones in Q2

#### Strategic Theme - Finance: Strong Financial Foundations

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>3)</td>
<td>Deliver against the cash flow profile by delivering the I&amp;E plan and managing debtors and creditors</td>
<td>Monthly</td>
<td></td>
<td>DoF</td>
<td>Green</td>
</tr>
</tbody>
</table>

- **Delivered** - Delivered
- **Green** - On track
- **Amber** - Off track but remedial plan in place
- **Red** - Will not deliver as planned
## Digital: Milestones in Q2

<table>
<thead>
<tr>
<th>Estates</th>
<th>Headline Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Clinical Backbone</td>
<td>1.2 - Paper on recommendation for post-March’19 Electronic Patient Record contract</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>3) Information Management</td>
<td>3.1 - 90% of spells coded within 5 days</td>
<td>Jul-18</td>
<td></td>
<td>DoST</td>
<td>Delivered</td>
</tr>
<tr>
<td>4) Infrastructure</td>
<td>4.2 - TRFT call centre upgrade business case completed and agreed</td>
<td>Sep-18</td>
<td>Jan-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
</tbody>
</table>

**Legend:**
- **Delivered**
- **Green** On track
- **Amber** Off track but remedial plan in place
- **Red** Will not deliver as planned
## Transformation Programme: Milestones in Q2

<table>
<thead>
<tr>
<th>Transformation Programme - Trust</th>
<th>Key Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of Assessment facilities</td>
<td>Business case for SAU, GAU and revised AMU agreed</td>
<td>Jul-18</td>
<td>Oct-18</td>
<td>COO</td>
<td>Delivered</td>
</tr>
<tr>
<td>Implementation of AEC and Frailty pathways</td>
<td>Ambulatory service model defined and agreed</td>
<td>Jul-18</td>
<td>Jan-19</td>
<td>COO</td>
<td>Amber</td>
</tr>
<tr>
<td>Review of a Wholly Owned Subsidiary</td>
<td>Business Case and recommendation presented to Trust Board</td>
<td>Jul-18</td>
<td>Sep-18</td>
<td>DoST</td>
<td>On Hold</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transformation Programme - Place</th>
<th>Key Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Single Point of Access</td>
<td>Service model for Integrated SPA agreed with ICP Board</td>
<td>Sep-18</td>
<td>Mar-19</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>Integrated Rapid Response</td>
<td>Service model for Integrated Rapid Response agreed with ICP Board</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>DoST</td>
<td>Amber</td>
</tr>
<tr>
<td>Integrated Discharge Team (IDT)</td>
<td>IDT joint provider post in place</td>
<td>Aug-18</td>
<td>Oct-18</td>
<td>DoST</td>
<td>Delivered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transformation Programme - ICS</th>
<th>Key Milestone</th>
<th>Due</th>
<th>Revised Due</th>
<th>Exec Sponsor</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Across the ICS</td>
<td>Clinical specialty and strategy reviews Complete clinical service review and strategy refresh</td>
<td>Sep-18</td>
<td>Dec-18</td>
<td>MD</td>
<td>Delivered</td>
</tr>
</tbody>
</table>

*Delivered* | *Delivered* | *Green* | *On track* | *Amber* | *Off track but remedial plan in place* | *Red* | *Will not deliver as planned*
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>484/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Matters Reserved to the Board</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Presenter: Anna Milanec, Director of Corporate Affairs, Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>Direct linkage to the Board Assurance Framework</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [ ] Approval ✔ For information [ ]</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>The revised Matters Reserved to the Board (appendix 1) were first presented to the Audit Committee in August 2018, again in November 2018 and were recommended for approval by the Board at the Audit Committee meeting on 12 December 2018. The document has undergone a change of format, now including regulatory and statutory references where applicable and follows a best practice template provided for NHS Trusts, by The Institute of Chartered Secretaries and Administrators.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that: The Matters Reserved to the Board be approved by the Board.</td>
</tr>
<tr>
<td>Appendices</td>
<td>1. Draft, Matters Reserved to the Board, document</td>
</tr>
</tbody>
</table>
DRAFT

MATTERS RESERVED TO THE BOARD

December 2018
The NHS Foundation Trust Code of Governance, which is recognised by the Trust as a method of promoting best practice, requires the Board of Directors (“the Board”) to determine those matters on which decisions are reserved unto itself. These reserved matters are set out below.

<table>
<thead>
<tr>
<th>Matters reserved for the board</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General enabling provisions</strong></td>
<td></td>
</tr>
<tr>
<td>The statutory powers of the Trust shall be exercised by the Board of Directors.</td>
<td>NHS FT principles A.1.c, A.1.f, NHSA s47</td>
</tr>
<tr>
<td>The Board may determine any matter it wishes in full session within its statutory powers, i.e. the Trust may do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, its purpose.</td>
<td></td>
</tr>
<tr>
<td>An NHS Foundation Trust must exercise its functions effectively, efficiently and economically.</td>
<td>NHSA s63, NHS FT supporting principle A.1.h</td>
</tr>
<tr>
<td>The Constitution must provide for all the powers of the Trust to be exercisable by the Board of Directors on its behalf</td>
<td>HSCA 2003 Schedule 1, NHSA Schedule 7</td>
</tr>
<tr>
<td><strong>Strategy and Management</strong></td>
<td></td>
</tr>
<tr>
<td>Approval of the Trust’s Five Year Plan</td>
<td>NHS FT supporting principles A.1.e, A.1.f</td>
</tr>
<tr>
<td>Approval of the Trust’s annual operating plan (subject to feedback from the Council of Governors)</td>
<td></td>
</tr>
<tr>
<td>Responsibility for the overall management of the foundation trust, in compliance with its licence, constitution, legislation, regulatory guidance and contractual obligations</td>
<td>NHS FT supporting principle A.1.d, MCC 26</td>
</tr>
<tr>
<td>Approval of the Trust’s business plans (operational and financial), and overall budgets.</td>
<td>NHS FT supporting principles A.1.e, A.1.f</td>
</tr>
<tr>
<td>Approval of the annual operating and capital expenditure budgets and any material changes to them.</td>
<td></td>
</tr>
<tr>
<td>Oversight of the Trust’s operations, ensuring:</td>
<td>NHS FT principle C.2.1.</td>
</tr>
<tr>
<td>• Competent and prudent management</td>
<td></td>
</tr>
<tr>
<td>• Sound planning</td>
<td></td>
</tr>
<tr>
<td>• An adequate system of internal control</td>
<td></td>
</tr>
<tr>
<td>• Adequate accounting and other pertinent records</td>
<td></td>
</tr>
<tr>
<td>• Compliance with statutory and regulatory obligations</td>
<td></td>
</tr>
<tr>
<td>Responsibility for ensuring the quality and safety of health care services, education, training and research delivered by the Trust.</td>
<td>NHS FT supporting principle A.1.g</td>
</tr>
<tr>
<td>Review of performance in the light of the Trust’s overall strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken.</td>
<td>NHS FT principle A.1.4, supporting principle A.4.b</td>
</tr>
<tr>
<td>Review of the Trust’s activities into new operational or geographic areas</td>
<td>NHSA s45 – 47</td>
</tr>
<tr>
<td>Approval of any decision to cease to operate all or any material part of the Trust’s business or services</td>
<td>NHSA s45-46</td>
</tr>
<tr>
<td>Approval of business cases with a value in excess of £250K</td>
<td>SFIs</td>
</tr>
<tr>
<td>Approval of single requisitions with a value in excess of £1m</td>
<td>SFIs</td>
</tr>
<tr>
<td>Authorization of the waiver of Non Competitive Action in excess of £250k</td>
<td>SFIs</td>
</tr>
<tr>
<td>Approval of increases by 5% or more of the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, subject to approval by the Council of Governors</td>
<td>HSCA 2012 164 (3D)</td>
</tr>
<tr>
<td>Responsibility for ensuring effective dialogue between the Board of Directors and Council of Governors, and how Governors will undertake their role.</td>
<td>NHS FT code provision A.5.d</td>
</tr>
<tr>
<td>Approval of the Trust’s Vision, Mission and Values.</td>
<td>NHS FT code provision A.1.e</td>
</tr>
</tbody>
</table>

### Delegation of Authority

Subject to any directions to the contrary by Monitor, NHSI or the Trust itself, any of the powers of the Board of Directors may be delegated to the Chief Executive, or to another Executive Director, or to a committee of the Executive Directors.  
NHS FT code provision B.1.e
Standing Order 5.0

- Appoint and dissolve (non-statutory) committees which are directly accountable to the board.  
Standing Order 6.1.b, 6.1.i

- Approval of terms of reference of Board Committees  
NHS FT code provision A.2.1
Standing Order 5.2.b.

- Receiving reports from the Board Committees on their activities, as required by the Board  
NHS FT code provision A.2.1

- Approving arrangements for the periodic formal evaluation of the performance of Board Committees  
NHS FT code provision B.6.a

- Confirming or rejecting the recommendations of the Board Committees where the Committees have exceeded their delegated powers, or do not have delegated executive powers  
Standing Order 6.1.e

- Approving membership and Chairmanship of Board Committees  
Standing Order 6.1.b, 6.1.i

- Where formal documents are signed on behalf of the Trust using electronic signatures, a register of such details shall be maintained and presented to the Board for ratification on a bi-annual basis.  
Standing Order 11.d

### Structure and capital

- Approval of any changes to the Trust as a stand-alone Foundation Trust
- Approval of changes relating to the Trust’s capital structure including reduction of capital
- Approval of changes to the Trust’s corporate structure
- Approval of changes to the Trust’s management and control structure

Any establishment of subsidiary companies, joint ventures, partnerships or arrangements (subject to Council of Governors’ approvals required under significant transactions as defined in the Constitution)  
NHSA s46(5)

Approval of any proposal to merge, acquire, dissolve or separate (subject to Council of Governors’ approvals required under significant transactions as defined in the Trust’s Constitution)  
NHSA s56A, s56B, s56 (1A), s57A

### Financial reporting and controls

Approval of the annual report and accounts, including quality report  
HSCA 2003 s27, NHSA s27

Approval of any significant changes in accounting policies or practices  
Audit Committee
### Internal controls

Ensuring maintenance of a sound system of internal control and risk management, including (but not limited to):

- Receiving reports on, and reviewing the effectiveness of, the Trust’s risk and control processes to support its strategy and objectives;
- Undertaking an annual assessment of these processes;
- Approving an appropriate statement (AGS) for inclusion in the annual report;
- Approving internal and external audit arrangements (save that Council of Governors appoint and / or remove the External Auditors);
- Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking into account, the advice of the Audit Committee;
- Receipt of Annual Audit Committee report;
- Approval of the BAF, the Trust Risk Register (risks scoring 15 and above) including the Corporate Risk Register.

### Contracts

Approval of major capital projects:

Approval of contracts which are material strategically or by reason of size, entered into by the Trust or any subsidiary, in the ordinary course of business, for example, acquisitions or disposal of fixed assets above £500K, or single tenders above £250K or any commercial loan.

Contracts of the Trust (or any subsidiary) not in the ordinary course of business, for example loans and repayments above £1m and acquisitions or disposals above £500K.

Approval of financial investments in excess of £250K.

### Communication

Approval of resolutions to be put forward to members at a general meeting.

### Board membership and other appointments

Changes to the structure, size and composition (including diversity) of the Board of Directors, following recommendations from the Nominations Committee.

Ensuring adequate succession planning for the Board of Directors and senior management (to be defined).

Appointment and removal of the Chief Executive (Approval also required from the Council of Governors for appointment).

Appointment and removal of executive directors.

Appointment of the Senior Independent Director (with Council of Governors approval).
<table>
<thead>
<tr>
<th>Appointment of the Vice Chair</th>
<th>NHS FT code provision B.2.6.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuation in office of any director at any time, including the suspension or termination of service of an executive director as an employee of the Trust.</td>
<td>Nomination Committee</td>
</tr>
<tr>
<td>Approval of the appointment of the Deputy Chief Executive</td>
<td></td>
</tr>
<tr>
<td>Appointments to the boards of subsidiaries</td>
<td></td>
</tr>
<tr>
<td><strong>Remuneration</strong></td>
<td></td>
</tr>
<tr>
<td>Determine the remuneration policy for the executive directors</td>
<td>NHS FT supporting principle A.1.m,</td>
</tr>
<tr>
<td><strong>Corporate governance matters</strong></td>
<td></td>
</tr>
<tr>
<td>Undertake a formal and rigorous annual review of its own performance, and that of its committees, and individual directors (PDRs)</td>
<td>NHS FT code provision B.6.a</td>
</tr>
<tr>
<td>Determine the independence of directors</td>
<td>NHS FT code provision B.1.1</td>
</tr>
<tr>
<td>Review of the Trust’s overall corporate governance arrangements</td>
<td></td>
</tr>
<tr>
<td>Receiving reports on the views of the Trust’s Governors, members and patients</td>
<td></td>
</tr>
<tr>
<td>Approving the use of the Trust’s seal and receiving and approving reports detailing use of the Trust’s seal</td>
<td>Standing Order 10.0</td>
</tr>
<tr>
<td>Receiving declarations of interests from Officers which may conflict with those of the Trust and determining the extent to which such Officers may remain involved with the matter under consideration.</td>
<td>Standing Order 7.0</td>
</tr>
<tr>
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<td>Approve the opening, and signatories to bank and / or investment accounts in the Trust’s name</td>
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In addition, the Board of Directors will receive reports and recommendations from time to time, on any matter which it considers significant to the Trust.
## Policies

Approval of policies, including:
- Standing Financial Instructions
- Scheme of Delegation
- Standing Orders
- Standards of Business Conduct and Conflicts of Interest Policy
- Board Code of Conduct
- Whistle Blowing Policy (Raising Concerns Policy)
- Counter Fraud, Bribery and Corruption Policy
- Health and Safety Policy
- Corporate Responsibility Policy
- Disciplinary Policy
- Risk Management Policy
- Management of Complaints and Concerns Policy
- Policy for Safeguarding Children Supervision

(This is not an exhaustive list, and the Board of Directors may approve any policy, at any time, which it deems appropriate)

## Strategies / Plans

Approval of strategies, including:
- ICS Strategy
- Rotherham Place Plan
- The Trust’s Strategy
- The Trust’s Five Year Plan
- The Trust’s Annual Operational Plan
- The Trust’s Quality Account
- Digital Strategy / Plan
- Health and Safety Strategy
- Workforce Strategy / Plan
- Estates Strategy / Plan
- Procurement Strategy / Plan
- Equality and Diversity Strategy / Plan
- Annual Oversight and Delivery Plan
- Annual Financial Plan

(This is not an exhaustive list, and the Board of Directors may approve any Strategy or Plan, at any time, which it deems appropriate)

## Other

Approval of the appointment of the Trust's principal advisors / consultants (excluding statutorily required appointments, e.g. external auditors) with appropriate approvals sought from NHSI, for any consultancies in excess of £50,000

Approval of prosecution, defence or settlement of litigation [involving amounts above £5 million or being otherwise material to the interests of the Trust]

Approval of the overall levels of insurance including directors’ and officers’ liability insurance (and indemnification of directors)

Approval of this schedule of Matters Reserved for the Board

Approval of the suspension of the Standing Orders, and / or variation or amendment of the Standing Orders
| Being informed of any instances of non-compliance with the Standing Orders, ratifying or requiring actions in accordance with the Standing Orders | Standing Orders 5.4 |
| Approving changes to the Trust’s Constitution, subject to approval by the Council of Governors | HSCA 2012 161 |
| The Board of Directors should maintain a schedule of the specific third party bodies in relation to which the Trust has a duty to co-operate. | NHS FT code provision E.2.1 |
| Approving arrangements relating to the discharge of the Trust’s responsibilities as a corporate trustee for funds held on charitable or other trusts | Standing Order 2.8 |

Key to cited legislation and regulations:

CCA 2004 – Civil Contingencies Act 2004

EA(SD) = The Equality Act 2010 (Specific Duties) Regulations 2011.

HA 2009 = Health Act 2009

HSCA 2003 = Health and Social Care Act 2003

HSCA 2012 = Health and Social Care Act 2012

MPR 2013 = Medical Professional (responsible Officers) (Amendment) Regulations 2013

NHS 2006 = NHS Act 2006

NHS 2017 = National Health Service (Quality Accounts) (Amendment) Regulations 2017, par 7.8

NHS FT = The NHS Foundation Trust Code of Governance (2014)

NQB 2017 = National Quality Board 2017 (guidance)

PSED = Public Sector Duty of the Equality Act 2010
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**Executive Summary (including reason for the report, background, key issues and risks)**

The revised Standing Orders (appendix 1) were first presented to the Audit Committee in August 2018, again in November 2018 and were recommended for approval by the Board at the Audit Committee meeting on 12 December 2018.

The document has been updated to recognise the Trust’s new ways of collaborative working through structures such as the Integrated Care System, and to recognise extended responsibilities, such as Freedoms to Speak up.

All updates are provided in red text for ease of reference.

**Recommendations**

It is recommended that:

The Standing Orders are approved by the Board.

**Appendices**

1. Draft, Standing Orders, document
Standing Orders

For the regulation of proceedings and business of the Board of Directors
Foreword

Within the Terms of Authorisation issued by NHS Improvement, the Independent Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003.

Standing Orders (SOs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. These documents, together with Standing Financial Instructions, Standards of Business Conduct, Scheme of Delegation, the Fraud and Corruption Policy, and the Trust's Constitution provide a 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 Standing Orders, Standing Financial Instructions, Standards of Business Conduct, Scheme of Delegation and provide a comprehensive business framework that is to be applied to all activities, including those of the Charitable Foundation. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents.
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Introduction

Statutory Framework
The Rotherham NHS Foundation Trust (the Trust) is a statutory body, which came into existence on 1 June 2005 pursuant to authorisation of Monitor under pursuant to Section 6 of the Health and Social Care (Community Health Standards) Act 2003, and was formerly the Rotherham General Hospitals NHS Trust.

The principal place of business of the Trust is:
Rotherham General Hospital
Moorgate Road
Rotherham S60 2UD

For administrative purposes, Rotherham Hospital is the Trust Headquarters.


The functions of the Trust are conferred by this legislation and the authorisation.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Trust must adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals.

NHS Governance Framework
The Code of Governance requires that, inter alia, Boards of Directors draw up a schedule of decisions reserved to that Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated appropriately.

The Code also requires the establishment of an Audit Committee and a Remuneration Committee, with formally agreed terms of reference.

The Code of Practice on Openness in the NHS’ set out the requirements of public access to information on the NHS, subject to, for example, the Freedom of Information Act 2012.

Delegation of Powers
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 (SO5),
the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a Trust committee, sub-committee or joint committee appointed by virtue of Standing Order 6 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or in accordance with the Constitution and the terms of the authorisation.

Collaboration with others

Foundation Trust Boards of Directors are encouraged to move away from silo governance and develop internal integrated governance that will support authorised decision making which is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance.

However, this is being furthered with the introduction of new systems of health and social care, with many different types of organisations becoming a part of a single system.

A number of organisations in South Yorkshire and Bassetlaw (‘SY&B’), have come together and established an Integrated Care System (‘ICS’). These organisations include clinical commissioning groups, local authorities, voluntary organisations, regulatory authorities and others, including:

The Rotherham NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Sheffield Children’s Hospital NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

In parallel, Accountable Care Partnerships have been established across SY&B ‘Place’ localities, including those in Rotherham, Bassetlaw, Barnsley, Doncaster and Sheffield.

Collectively, the new structures will share obligations, set out in Memoranda of Understanding. National legislation is not yet in place to support collaborative governance and decision making arrangements, therefore the Trust retains legal and regulatory obligations as a stand-alone entity, at the time of writing. Appropriate amendments and updates will be made to these Standing Orders to reflect the progress made re the legal structures.
1.0 Interpretation

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Company Secretary).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this interpretation and in addition:

"Accounting Officer" means the Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Chief Executive.

"Authorisation" means the authorisation of the Trust by Monitor, now under the umbrella organisation, NHS Improvement, the Independent Regulator of NHS Foundation Trusts

"Board of Directors" means the Chair, Non-Executive Directors and the Executive Directors appointed in accordance with the Trust's Constitution.

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

“Budget Holder” means the director or employee with delegated authority to manage finances for a specific area of the organisation.

"Chair" is the person appointed in accordance with the Constitution to lead the Board of Directors and the Council of Governors. The expression “the Chair” shall be deemed to include the Vice Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust.

"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 appointed by the Board of Directors.

“Committee in Common” means the collective group or representation from NHS organisations established to perform a particular function or duty.

"Committee members" mean persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Constitution" means the Constitution of the Trust as approved from time to time by NHS Improvement, the Independent Regulator of NHS Foundation Trusts.

"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.

“Council of Governors” means the persons, elected and appointed, to fulfil the functions as laid out in the Constitution.

"Finance Director" means the Director of Finance who is the chief finance officer of the Trust.

"Executive Director" means a director who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document, “director” shall not include an employee whose job title incorporates the word director but who has not been appointed in this manner.

"Funds held on Trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Sch 2 Part II para 16.1c NHS & Community Care Act 1990. Such funds may or may not be charitable.

“ICS” means Integrated Care System


“Memorandum of Understanding” (MoU) means a bilateral or multilateral agreement between two or more parties expressing an intended will and/or common line of action between the parties.

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

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

"Non-Executive Director" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution or under the previous appointment system. This includes the Chair of the Trust.

"Officer" means an employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or Non-Executive Director of the Trust.

“Secretary” means the Company Secretary unless otherwise defined

"SFI’s" means Standing Financial Instructions.

"SO’s" mean Standing Orders.

“SY&B” means South Yorkshire and Bassetlaw, where a collaboration between the South Yorkshire and Bassetlaw NHS providers, and others, is established to deliver the objectives of the South Yorkshire and Bassetlaw ICS.
"Trust" means The Rotherham NHS Foundation Trust.

"Vice Chair" means the Non-Executive Director appointed by the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.
2.0 The Trust
   a. All business shall be conducted in the name of the Trust.
   b. The responsibilities of the Board of Directors are set out in the Constitution.
   c. The powers of the Trust established under statute shall be exercised by the Board of Directors except as otherwise provided for in SO5.
   d. Directors acting on behalf of the Trust as Corporate Trustee of The Rotherham Hospital and Community Charity Charitable Funds are accountable for charitable funds held on trust to the Charity Commission.
   e. The Board of Directors has resolved that certain powers and decisions may only be exercised or made by that Board in formal session. These powers and decisions are set out in the Matters Reserved.

2.1 Composition of the Board of Directors
   a. In accordance with the Trust’s Constitution, the composition of the Board of Directors shall comprise both Executive and Non-Executive Directors.
   b. The Board of Directors shall comprise:
      1) A Non-Executive Chair
      2) No fewer than five other Non-Executive Directors
      3) No fewer than five Executive Directors including:
         • Chief Executive (and Accounting Officer)
         • Director of Finance
         • Registered Medical Practitioner or Registered Dentist (within the meaning of the Dentists Act 1984)
         • Registered Nurse or a Registered Midwife
   c. The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

2.2 Appointment and removal of the Chair and Non-Executive Directors
   a. The Chair and Non-Executive directors are appointed and may be removed by the Council of Governors in accordance with the procedure set out in the Constitution.
   b. Non-Executive Directors (including the Chair) are to be appointed by the Council of Governors using the procedure set out in the Constitution.

2.3 Terms of Office of the Chair and Non-Executive Directors
   a. The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Constitution. The terms and conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment of Vice Chair of the Board of Directors
   a. For the purpose of enabling the proceedings of Governors of the Trust to be
conducted in the absence of the Chair, the Council of Governors will appoint a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify. Provision 3.6 of these Standing Orders sets out the provision if the Chair and Vice Chair are absent.

b. Any Non-Executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair in accordance with the Constitution.

2.5 Powers of the Vice Chair
a. Where the Chair of the Trust has ceased to hold office, or has been unable to perform duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include reference to the Vice Chair.

2.6 Appointment of Senior Independent Director
a. The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director, using the procedure set out in the Constitution.

2.7 Role of Board of Directors
a. The Board will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.8 Corporate role of the Board
a. All business conducted by the Trust shall be conducted in the name of the Trust unless otherwise resolved by the Directors.

b. All funds received in trust shall be held in the name of the Trust as corporate trustee.

c. The powers of the Trust established under statute shall be exercised by the Board in session except as directed by a resolution of the Board.

2.9 Lead Roles for Board Members
a. The Chair will ensure that the designation of Lead roles or appointments of Board members as required or as set out in any statutory or other guidance, will be made in accordance with the guidance or statutory requirement.

b. Additional ‘champion’ roles may also be allocated to Non-Executive Directors.
2.10 **Statement of Matters Reserved**

a. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the statement of Matters Reserved to the Board and shall have effect as if incorporated into these Standing Orders.
3. Meetings of the Board of Directors

3.1 Admission of the Public and Press
a. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the Board resolving as follows:

b. ‘That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’ (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

c. The Chair shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

d. ‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public’ (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

e. Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the Board.

f. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked ‘in confidence’ or minutes and papers headed ‘private’ outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

g. Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.2 Observers at Board Meetings
a. The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust’s Board meetings, and will change, alter or vary these terms and conditions as it deems fit.

3.3 Calling Meetings
a. Ordinary meetings of the Board of Directors shall be held at such times and places as that Board may determine.

b. Meetings of the Board of Directors may be called by the Secretary, or by the Chair.
c. Meetings of the Board of Directors may be called by at least one-third of directors who give written notice to the Secretary specifying the business to be carried out.

d. The Secretary should send a written notice to all directors within seven days after receipt of such a request. If the Chair, or Secretary, refuses to call a meeting following a requisition, such one-third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings
a. Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every director, or sent electronically or by post to the agreed address of such director, so as to be available at least three clear days before the meeting.

b. A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any director shall not affect the validity of a meeting.

c. In the case of a meeting called by directors in default of the Chair, those directors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

d. Agendas will be sent to directors no less than three clear days before the meeting and supporting papers shall accompany the agenda, save in emergency.

3.5 Setting the Agenda
a. The Board of Directors may determine that certain matters shall appear on every agenda for a meeting. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

b. A director who requires an item to be included on the agenda should advise the Secretary of the Board prior to the agenda being agreed with the Chair and no less than 7 working days before a meeting.

c. When a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

3.6 Chair of Meeting
a. At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice Chair shall preside. If the Chair and Vice Chair are absent, such Non-Executive Director as the directors present shall choose, shall preside.

b. If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the directors present shall choose shall preside.
3.7 **Annual Members’ Meeting**  
a. The Trust will publicise and hold an annual members meeting, in accordance with the terms of the Constitution.

3.8 **Notices of Motion**  
a. A director wishing to move or amend a motion should advise the Secretary prior to the agenda being agreed with the Chair and no less than 7 clear days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.9 **Emergency Motion**  
a. Subject to the agreement of the Chair, and subject to the provision of SO 3.8, a director of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda up to one hour before the time fixed for the meeting.

b. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair’s decision is final.

3.10 **Withdrawal of Motion or Amendments**  
a. 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 Chair.

3.11 **Motion to Rescind a Resolution**  
a. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors.

b. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within 6 months. However, the Chair may do so if he/she considers it appropriate.

3.12 **Motions**  
a. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

b. When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:  
- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceeds to the next business.
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put.
• A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).
• No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.13 **Chair’s Ruling**
a. Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity, and any other matters, shall be observed at the meeting.

3.14 **Voting**
a. Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

b. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

c. If at least four of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

d. If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

e. Under no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

f. In exceptional circumstances (to be defined by the Chairman), with prior agreement of the Chairman and Chief Executive, any Director (with the exception of the Chair) may participate in a Board of Directors meeting by telephone, video or computer link. If prior agreement has been given, participation, and voting, shall be allowed, in accordance with SO 3.19.f.

g. An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director.

h. An officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer’s status when attending a meeting shall be recorded in the minutes.

i. The Directors of Clinical Services attending Board of Directors’ meetings, will have no formal voting rights on a decision nor the personal accountabilities associated with
Board membership.

j. No resolution shall be passed if it is opposed by all the Non-Executive Directors present, or by all of the Executive Directors present.

3.15 Minutes
a. The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

b. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

c. Where providing a record of the meeting, a set of minutes from the meeting shall be made available to the public (required by Code of Practice on Openness in the NHS and the Freedom of Information Act) and circulated to the Council of Governors. A record of items discussed in private will be maintained and approved by the Board of Directors.

3.16 Suspension of Standing Orders
a. Except where this would contravene any statutory provision or any provision of the authorisation or of the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

b. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

c. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

d. No formal business may be transacted while Standing Orders are suspended.

e. The Audit Committee shall review every decision to suspend Standing Orders.

3.17 Variation and Amendment of Standing Orders
a. These Standing Orders shall be amended only if:
   • a notice of motion under Standing Order 3.8 has been given; and
   • no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of amendment; 
   • at least two-thirds of the Directors are present; and
   • the variation proposed does not contravene a statutory provision or provision of the authorisation or of the Constitution.

3.18 Record of Attendance
a. The names of the Chair and directors present at the meeting shall be recorded in the minutes.

b. The Secretary shall keep and maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors. The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link as per SO 3.14.e. Participation where agreed shall be deemed to constitute presence in person at the meeting.

3.19 Quorum

a. No business shall be transacted at a meeting of the Board of Directors unless at least one-third members of the whole number of the Directors are present (including at least one Executive Director and one Non-Executive Director).

b. An officer in attendance for an Executive Director but without formal acting up status, may not count towards the quorum.

c. If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7) they shall no longer count towards the quorum.

d. 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.

e. The meeting must then proceed to the next business. The above requirement for one Executive Director to form part of the quorum, shall not apply where the Executive Director is excluded from a meeting.

f. In exceptional circumstances, any Director may participate in Board of Directors’ meetings by telephone, video or computer link in accordance with SO 3.14.e. With prior agreement of the Chairman, which shall be noted in the minutes, the Director may form part of the quorum. However, a majority of quorum members (not including the Chair) must be present in person.

3.20 Frequency

a. The Trust shall hold meetings of the Board of Directors on a generally monthly basis, and at least ten times in each calendar year.

b. The Board of Directors shall determine the dates of the board meetings in advance.
4.0 Meetings of the Council of Governors

4.1 Admission of the Public and Press

a. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Governors resolving as follows:

b. ‘That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’ (Section 1(2) Public Bodies (Admission to Meetings) Act 1960.)

c. The Chair (or Vice Chair) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors’ business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows:

‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Governors to complete business without the presence of the public’ (Section 1(8) Public Bodies (Admission to Meetings) Act 1960.)

d. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

4.2 Calling Meetings

a. General Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

4.3 Notice of Meetings

a. Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted by it, shall be delivered to every Governor, or sent by post to the usual residence of such Governor, so as to be available to him/her at least three clear days before the meeting.

b. Lack of service of the notice on any Governor shall not affect the validity of the meeting.

c. Meetings of the Council of Governors may be called by seven Governors (including at least one elected Governor and one appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send out a written notice to all Governors as soon as possible after receipt of such a request.

d. Agendas will be sent to Governors three clear days before the meeting, and supporting papers, whenever possible, shall accompany the agenda. Papers may be
sent by electronic means.

e. A notice shall be presumed to have been served one day after posting.

4.4 Chair of Meeting
a. At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, one of the other Non-Executive Directors will be nominated by the Council of Governors to preside.

b. If the person presiding at the meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, the Vice Chair (or nominated Chair) will chair that part of the meeting.

4.5 Notices of Motion
a. A Governor desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Secretary, who shall insert in the agenda for the meeting, all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned in the agenda.

4.6 Withdrawal of Motion or Amendments
a. 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 Chair.

4.7 Motions
a. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment of the Chair.

b. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:
   - An amendment to the motion
   - The adjournment of the discussion
   - That the meeting proceeds to the next business
   - The appointment of an ad hoc committee to deal with a specific item of business
   - A motion under section 1 of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public (including the press)

c. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.8 Chair's Ruling
a. Statements of Governors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevance, regularity and any other matter shall be observed at the meeting.

4.9 Voting
a. Every question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the person presiding at or chairing the meeting shall have a casting vote.

b. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands.

c. If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

d. If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

e. Under no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.10 Minutes
a. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

b. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

c. Where providing a record of a public meeting the Council of Governors’ minutes shall be made available to the public as required by the Code of Practice on Openness in the NHS.

4.11 Record of Attendance
a. The names of the Governors present at the meeting shall be recorded in the minutes, and shall be reported in the Trust's annual report.

4.12 Quorum
a. For Council of Governors meetings, the quorum is as set out in the Constitution.

b. If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO7) he shall not 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.

4.13 Frequency of Council of Governor meetings
a. The Council of Governors shall hold meetings at least four times a year in each calendar year.
5.0 Arrangements for the exercise of functions by delegation

a. Subject to a provision in the authorisation or the Constitution, the Board of Directors may make arrangements for the exercise, on its behalf of any of its functions by
   • a committee or sub-committee of the Board;
   • appointed by virtue of SO5.c below; or
   • by an Executive Director.

b. The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by a Committee, which it has formally constituted. The constitution and terms of reference of these Committees and their specific executive powers, shall be approved by the Board.

c. Each case will be subject to such restrictions and conditions as the Board of Directors thinks fit.

d. Standard exceptions to this requirement are:
   a) Approval of single tenders: Where, in the best interests of the Trust, single tendering arrangements need to be completed before the next Audit Committee meeting, the request may be considered by the Chief Executive and the Director of Finance acting jointly. Where the request is approved, the decision of the Chief Executive and Director of Finance will be reported in writing to the next Audit Committee meeting for formal acknowledgement and, if appropriate, approval.

   b) Use of the Trust’s seal: Where, in the best interests of the Trust, the sealing of documents needs to be completed before the next Board meeting, the sealing may be undertaken by any two of the following acting jointly: Chairman, Chief Executive and / or Director of Finance.

5.1 Emergency Powers

a. The powers which the Board of Directors has retained to itself within these Standing Orders may, in emergency be exercised by the Chair, after having consulted at least two Non-Executive Directors and an Executive Director. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

5.2 Delegation to Committees

a. The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted.

b. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

5.3 Delegation to Officers

a. Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to officers to undertake.
b. The Chief Executive shall prepare a Scheme of Delegation (which is set out in the Standing Financial Instructions) identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

c. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors or the Director of Finance or other executive director. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

d. The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.4 **Overriding Standing Orders**

a. 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 Audit Committee.

b. All members of the Board of Directors, Council of Governors and colleagues have a duty to disclose any non-compliance with these Standing Orders to the Chairman as soon as possible.
6.0 Committees

6.1 Appointment of Committees

a. Subject to the authorisation and the Constitution, the Board of Directors may appoint committees of the Trust, consisting wholly or partly of the Chair and Executive or Non-Executive Directors of the Trust, or wholly of persons who are not Executive or Non-Executive Directors of the Trust.

b. A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Independent Regulator of the Trust, and in accordance with the Constitution, appoint sub-committees consisting wholly or partly of directors of the committee or joint committee (whether or not they are directors of the Trust); or wholly of persons who are not directors of the Trust or the committee of the Trust.

c. The Scheme of Delegation does not discharge accountability to Non-Executive Directors to provide information and advise the Board of Directors in accordance with any statutory requirements.

d. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “director” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold any meetings of committees established by the Trust, in public.)

e. Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation.

f. Such terms of reference shall have effect as if incorporated into the Standing Orders.

g. Where Trust committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

h. Committees, sub-committees, or other groups, will not use the designation ‘Board’ in its name.

i. The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, those persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the authorisation and the Constitution.

j. The committees and sub-committees established by the Trust are:
   - Audit Committee
   - Remuneration Committee
   - Nomination Committee (made up of majority Non-Executive Directors and relating to the appointment / removal of Executive Directors);
   - Finance and Performance Committee
• Quality Assurance Committee
• Strategic Workforce Committee
• Strategy and Transformation Committee
• The Rotherham NHS Foundation Trust Committee in Common

k. Membership of the Trust's Committee in Common is defined by its Terms of Reference, as agreed by all the parties. The Board of Directors, together with other SYB ICS partners, has agreed not to delegate any of its statutory functions to the Committee in Common.

l. Such other committees may be established, as required, to discharge the Board's responsibilities.

m. The committee established by the Council of Governors is the Nomination Committee, made up of Governors, save for the Committee Chair, being the Trust Chairman. Travelling and other allowances for Non-Executive Directors shall be determined by the Committee.

n. A Charitable Funds Committee has been established by the Corporate Trustee of The Rotherham Hospital and Community Charity.

6.2 Confidentiality

a. 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 Board of Directors or shall otherwise have concluded on that matter.

b. A Director of the Trust, a member of a committee or attendee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if that committee shall resolve that it is confidential.

c. The Board of Directors may facilitate the attendance of up to two Governors at certain Board Committee meetings. The purpose of Governors attending the Committees is to allow them to observe the Non-Executive Directors. This provides Governors the opportunity of fulfilling their duty of holding Non-Executive Directors to account for the performance of the Board, and to participate in Non-Executive annual appraisals. To ensure the integrity of Board Committee governance, Governors will not participate in the meetings, unless directly invited to so by the committee Chairman. No actions shall arise as a result of Governors’ invited participation. Attending Governors shall acknowledge their duty of confidentiality of matters discussed, by providing a signed declaration to this effect.


7.0 Declarations of Interests

7.1 Members of the Board of Directors

a. Pursuant to Section 20 of the Schedule 7 of the National Health Service Act 2006, a register of Director’s interests must be kept by each NHS Foundation Trust.

b. All Directors (including for the purposes of the standing order, Non-Executive Directors) should declare relevant and material interests to the NHS Board of which they are a member. This should take place on appointment.

c. Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as ‘relevant and material’ and which, for the avoidance of doubt, should be included in the register are:

(a) Any directorship of a company;
(b) Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 5% of the total issued share capital, or the value of such shareholding does not exceed £25,000) or position in any firm or company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;
(c) Any interest in an organisation providing health and social care services to the National Health Service; or
(d) Position of authority in a charity or voluntary organisation in the field of health and social care;
(e) Any affiliation to a special interest group campaigning on health or social care issues (this includes political parties).
(f) To the extent not covered above, any connection with an organisation, entity or company considering entering into, or having entered into financial arrangement with The Rotherham NHS Foundation Trust, including but not limited to, lenders or banks.

d. Reference should also be made to the Monitor NHS Foundation Trust Code of Governance and the Trust’s Constitution in determining whether other circumstances or relationships are likely to affect, or could appear to affect, the director’s judgement.

e. Each Board agenda will contain at the beginning, an agenda item relating to declaration of interests. During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should 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 vote will resolve the issue with the Chair having the casting vote.

f. At the time that interests are declared, they should be recorded in the Board of Director’s minutes. Any changes in interests that should arise between Board meetings, should be advised to the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest.

g. It is the responsibility of the director to inform the Secretary of changes in their interests, within the appropriate timelines.
h. A register of directors’ interests shall be maintained and held by the Secretary and presented bi-annually to the Board of Directors. This will be formally recorded in the minutes. Any changes in interests should be officially declared to the Secretary where an appropriate amendment is required.

i. There is no requirement for the interests of directors’ spouses or partners to be declared; however, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly advisable (as are declaring the interests of other immediate family members and co-business partners).

j. If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or Secretary.

k. For the avoidance of doubt, any remuneration, compensation or allowances payable to the Chair or a Non-Executive Director in accordance with the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

l. The Register of Directors’ Interests will be available for inspection by the public free of charge. Copies or extracts of the Registers must be provided to Members of the NHS Foundation Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-Members for copies or extracts of the register.
8.0 Standards of Business Conduct

8.1 Policy
a. The Trust’s Standards of Business Conduct provides guidance for all colleagues in the Trust who may or may not be Members of the Board of Directors, and who may have conflicts of interest that should be declared.

b. There is an obligation on the Trust, through its incorporation with the NHS Standard Contract pursuant to General Condition 27, that ‘Managing Conflicts of Interest in the NHS’ statutory guidance (publications gateway reference 06419) and superseding the Standards of Business Conduct for NHS staff (HSG(93)5), is complied with by all colleagues.

c. All Trust colleagues should familiarise themselves with the contents of the Standards of Business Conduct policy, and should seek advice if in doubt as to whether a potential interest should be declared.

8.2 Canvassing of, and Recommendations by, Directors in Relation to Appointments
a. Canvassing of Directors of the Trust, or members of any Committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate for such appointment.

b. A Director shall not solicit for any person any appointment under the Trust, or recommend any person for such appointment, but this paragraph of this Standing order shall not preclude a Director from giving written testimonial of a candidate’s ability, experience or character for submission to the Trust.

c. Informal discussions outside appointment panels or committees, whether solicited or unsolicited, will be declared to the panel or committee.
9.0 Compliance with Fit and Proper Persons Regulations

a. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all NHS Trusts to ensure that all Executive and Non-Executive Director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations ('FPPR'). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at Board meetings.

b. The regulations stipulate that Trusts must not appoint or have in place an Executive Director or a Non-Executive Director unless they meet the standards set out in the Regulations.

c. Guidance issued by the CQC in January 2018 places ultimate responsibility on the Trust Chair to discharge the requirements of the FPPR.

d. The Chair must assure themselves that new applicants and existing post holders meet the fitness checks and do not meet any of the unfit criteria. Responsibility also falls on the Chair to decide whether an investigation is necessary and, at the end of the investigation, to consider whether the director in question remains fit and proper.

e. The Chair will be notified by the CQC of any non-compliance with the FPPR, and holds responsibility for making any decisions regarding action that needs to be taken.
10.0 Custody of Seal and Sealing of Documents

10.1 Custody of Seal
a. The Trust’s Seal shall be kept by the Chief Executive, or officer appointed by them, in a secure place.

10.2 Sealing of Documents
a. The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or where the Board of Directors has delegated its powers.

b. The affixing of the Seal shall be attested and signed by the Chief Executive Director (or officer nominated by them) together with one other Executive Director.

c. Before any building, engineering, property or capital document is sealed, it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them).

d. For contracts, other than building and engineering, contract management teams and Departmental Heads are required to consider the enforceability of rights which may accrue by virtue of breaches of such contracts.

e. Where the contract management team or Departmental Head believes that the contract should be entered into under seal, that contract should be submitted to the Director of Finance for review. If the Director of Finance agrees that the contract should be completed under Seal then appropriate processes set out in the SFI’s for building and engineering contracts, should be followed.

10.3 Register of Sealing
An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least bi-annually. (The report shall contain details of the seal number, the description of the document and date of sealing). The book will be held by the Secretary.
11. **Signature of documents**
   
a. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

b. For the purpose of defence documents in legal proceedings, the Secretary or in their absence, any Executive Director, shall be authorised to sign the necessary documentation on behalf of the Trust.

c. The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

d. Where electronic documents have been ‘signed’ with electronic signatures, details pertaining to the document, shall be maintained in a register and presented to the Board of Directors, for ratification where necessary, on a bi-annual basis.
12. Freedom to Speak Up

a. In accordance with the Public Interest Disclosure Act 1998, the Board of Directors is required to prepare and update, as necessary, procedures for receiving and investigating disclosures, internally or externally, as well as illegal acts or omissions at work.

b. The Board of Directors is responsible for ensuring that all senior leaders, are knowledgeable about Freedom to Speak Up (FTSU), and can readily articulate the Trust's FTSU requirements and policy.

c. The Chief Executive is responsible for appointing the FTSU Guardian and ultimately, for ensuring that FTSU arrangements meet the needs of colleagues.

d. The Chief Executive and Chair are responsible for ensuring the annual report contains information about FTSU and that the Trust is engaged with both the regional Guardian network and the National Guardian's Office.
13. Miscellaneous

13.1 Standing Orders to be given to Directors and Officers
a. It is the duty of the Chief Executive to ensure that existing directors and officers are notified of and understand their responsibilities within Standing Orders and SFIs.

b. Updated copies shall be issued to staff in e-mail format through the Trust’s Colleague Bulletin.

c. New designated officers shall be informed in writing and shall receive e-copies where appropriate of Standing Orders.

13.2 Documents having the standing of Standing Orders
a. Standing Financial Instructions and the Scheme of Delegation shall have effect as if incorporated into Standing Orders.

13.3 Review of Standing Orders
a. Standing Orders, and all documents having effect as if incorporated in Standing Orders, shall be reviewed bi-annually by the Audit Committee on behalf of the Board of Directors.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>486/18</th>
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<tbody>
<tr>
<td>Report</td>
<td>Standing Financial Instructions and Scheme of Delegation</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Simon Sheppard, Director of Finance</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B6, B9, and B10</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ☐ Approval √ For Information ☐ (Tick only one box)</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>The revised Standing Financial Instructions and Scheme of Delegation (appendix 2) have been updated since the last review and recommended for approval by the Audit Committee. The document has been updated to recognise changes to portfolios, updates to the Matters reserved for the Board of Directors and changes to decision making committees such as the Business Investment Committee The full document is provided as appendix 2, with appendix 1 highlighting the amendments and changes from the previous approved document</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that the Standing Financial Instructions and Scheme of Delegation is approved by the Board of Directors</td>
</tr>
<tr>
<td>Appendices</td>
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## Appendix 1 – Changes to the Previously Approved SFI’s and Scheme of Delegation

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<th>Proposed Text</th>
<th>Impact of Changes</th>
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<td>2.3.2</td>
<td>INTRODUCTION – Responsibilities and Delegation</td>
<td>Insertion of list of specific financial powers reserved to the Board…</td>
<td>(a) Acquisition, disposal or changing of use of land and/or buildings.</td>
<td>Provide greater clarity and details for the specific financial powers reserved to the Board.</td>
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<td></td>
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<td>(b) Introduction or discontinuation of any significant activity or operation.</td>
<td>Any activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any net off) in excess of £250,000 - and views of the Governors will be taken into account (see Section 7 and Appendix 4).</td>
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<td>(c) Approval of spending in excess of budget of more than £100,000 (see Paragraph 4.5).</td>
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<td>(d) Approval of business cases with a value greater than £250,000 (see Appendix 4).</td>
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<td>(e) Approval of single requisitions in excess of £1,000,000 (see Paragraph 10.2.5 (e) and Appendices 1 and 2).</td>
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<td>(i) Approve increases by 5% or more of the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, subject to approval by the Council of Governors.</td>
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<td>(j) Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it requires from directors, committees and officers of the Trust to continually assess the Trust’s going concern status (see Paragraphs 4.4 and 4.5).</td>
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<td></td>
<td></td>
<td>(k) Consideration and approval of the Trust’s Annual Report including the annual accounts (in accordance with Standing Order 3.1.36) and annual quality report (see Section 5).</td>
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<tr>
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<td></td>
<td>(l) Annual approval of the extent of delegation to budget holders and other officers (see Appendices 1 to 7).</td>
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<td>4.2.2</td>
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<td>Reflects revised governance arrangements.</td>
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### Appendix 1 – Changes to the Previously Approved SFI’s and Scheme of Delegation

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<td>Transfer of responsibilities between the Directors of Finance and Workforce respectively, now that management of the Payroll function has transferred to the latter director.</td>
<td>Recognising changes in responsibilities at executive director level.</td>
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<td>10.2.2</td>
<td>NON-PAY EXPENDITURE - Procedures for Obtaining Goods and Services</td>
<td>Insert additional reference to patient bespoke Orthotics procurement as an additional exception.</td>
<td>To reflect the reality of the current arrangements.</td>
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<tr>
<td>11.2.1</td>
<td>TENDERING AND CONTRACTING FOR NON PAY EXPENDITURE – Procedure for Procurement of Non-Payroll Items</td>
<td>Insert additional reference to patient bespoke Orthotics procurement as an additional exception.</td>
<td>To reflect the reality of the current arrangements.</td>
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<tr>
<td>11.2.6</td>
<td>TENDERING AND CONTRACTING FOR NON PAY EXPENDITURE – Procedure for Procurement of Non-Pay Items</td>
<td>Amending the lower limit for quotations from £5,000 to £25,000.</td>
<td>In line with proposals across the local health economy as part of the Working Together Programme.</td>
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<td>12.1.2</td>
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<td>No longer relevant and a revised Treasury Management Policy drafted to reflect changed circumstances.</td>
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<td>Appendix 1</td>
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<td>References updated.</td>
<td>To ensure consistency within the document.</td>
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<td>In line with proposals across the local health economy as part of the Working Together Programme.</td>
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STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

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</tr>
<tr>
<td>Date Approved</td>
<td></td>
</tr>
<tr>
<td>Title of Author:</td>
<td>Mark Bloy, Deputy Director of Finance</td>
</tr>
<tr>
<td>Title of Responsible Committee/Individual:</td>
<td>Audit Committee</td>
</tr>
<tr>
<td>Date Issued:</td>
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<td>Review Date:</td>
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<tr>
<td>Target Audience:</td>
<td>All Colleagues, Contractors, Volunteers, etc.</td>
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## Document History Summary

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<thead>
<tr>
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<td>Deputy Director of Finance</td>
<td>New policy</td>
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<td>Amendments to approval limits and process for business case approval and increasing the quotation threshold for procurement. Other minor changes also incorporated.</td>
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1. **FOREWORD**

1.1 References to the “Board” in these Standing Financial Instructions apply to the Board of Directors of the Rotherham NHS Foundation Trust, in respect of exchequer funds. Funds held on trust are managed within the arrangements set out in this document, where the Board acts in its capacity as Corporate Trustee.

1.2 The Board operates within a statutory framework within which it is required to adopt standing orders. The “Directions on Financial Management in England” issued under HSG (96)12 in 1996 state that each board must adopt standing financial instructions setting out the responsibilities of individuals. These Directions are mandatory for health organisations but not for NHS foundation trusts. The Board has adopted these Directions as a key component of its financial governance arrangements.

1.3 The Code of Accountability for NHS Boards (published by the Department of Health in April 1994, EL(94)40 requires boards to draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions. The Code also requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, boards will have drawn up locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules, which all employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1.4 The purpose of this document is to provide clarity about the financial framework in which the Trust provides patient services. Once these Standing Financial Instructions have been adopted by the Board, they are mandatory for all employees of the Trust and any contractors or consultants engaged by the Trust.
2. INTRODUCTION

2.1 General

2.1.1 These Standing Financial Instructions are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each trust shall agree standing financial instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Trust’s Standing Orders.

2.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Statement of Powers Reserved to the Board adopted by the Trust.

2.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust, including trading units. They do not provide detailed procedural advice. These statements should therefore, be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

2.1.4 Should any difficulties arise regarding the interpretation or application of any of these Standing Financial Instructions, then the advice of the Director of Finance MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust’s Standing Orders and Statement of Powers Reserved to the Board.

2.1.5 FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

2.2 Terminology

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

(a) “Authorised Signatory” means an employee with delegated authority to commit expenditure on behalf of the Trust/Charity from within approved budgets.

(b) “Board” means the Board of Directors.
(c) “Budget” means a resource, expressed in financial terms, sanctioned by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(d) “Budget Holder” means an employee with delegated authority to manage finances (income and expenditure) for a specific area of the Trust with a delegated transactional financial limit of £10,000. Authorised signatories may commit expenditure on behalf of the budget holder for transactions above £10,000.

(e) “Chief Executive” means the chief officer of the Trust who is designated as the Accounting Officer under The National Health Service Act 2006.

(f) “Corporate Trustee” means a corporation that has been appointed to act as trustee of a charity. A corporation is a collection of persons, which, in the eyes of the law, has its own legal existence (and rights and duties) separate from those of the persons who form it from time to time. The Board is the corporate trustee for the Rotherham Health Foundation and Related Charities.

(g) “Delegated Transactional Financial Limit” is the maximum amount of expenditure that any authorised signatory can commit in one transaction.

(h) “Division” refers to a number of service units that are managed and controlled collectively and reported upon as a single entity to the Board.

(i) “Funds Held on Trust” means those funds which the Trust held as at 1st April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Section 90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

(j) “Legal Adviser” means the properly qualified person appointed by the Trust to provide legal advice.

(k) “NHS Improvement” means the body responsible for overseeing foundation trusts, NHS trusts and independent providers.

(l) “Service Unit” refers to a number of budgets that are managed and controlled collectively and reported upon as a single entity.

(m) “Trust” means the Rotherham NHS Foundation Trust.

2.2.2 Wherever the title Chief Executive, Director of Finance or other nominated officer is used in these instructions, it shall be deemed to include such other employee who has been duly authorised to represent them.
2.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2.3 Responsibilities and Delegation

2.3.1 The Board exercises financial supervision and control by:

(a) Formulating the financial strategy.

(b) Requiring the submission and approval of budgets within overall income.

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

(d) Defining specific responsibilities placed on employees as indicated in the Scheme of Delegation (see Appendices 1 to 8).

2.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the “Statement of Powers Reserved to the Board” document. Specifically, these include:

(a) Acquisition, disposal or changing of use of land and/or buildings.

(b) Introduction or discontinuation of any significant activity or operation. Any activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any net off) in excess of £250,000 - and views of the Governors will be taken into account (see Section 7 and Appendix 4).

(c) Approval of spending in excess of budget of more than £100,000 (see Paragraph 4.5).

(d) Approval of business cases with a value greater than £250,000 (see Appendix 4).

(e) Approval of single requisitions in excess of £1,000,000 (see Paragraph 10.2.5 (e) and Appendices 1 and 2).

(f) Approval of financial losses and special payments (excluding payments that require HM Treasury approval) above £10,000 (see Appendix 7).

(g) Authorisation of the waiver of non-competitive action above £250,000 (see Appendix 6).

(h) Approval to commence significant litigation on behalf of the Trust. In cases judged by the Chief Executive to be urgent, then he or she may exercise this power pending the next meeting of the Board, in accordance with Standing Order 10).
(i) Approve increases by 5% or more of the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, subject to approval by the Council of Governors.

(j) Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it requires from directors, committees and officers of the Trust to continually assess the Trust's going concern status (see Paragraphs 4.4 and 4.5).

(k) Consideration and approval of the Trust's Annual Report including the annual accounts (in accordance with Standing Order 3.1.36) and annual quality report (see Section 5).

(l) Annual approval of the extent of delegation to budget holders and other officers (see Appendices 1 to 7).

2.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by the Trust (see Appendices 1 to 8).

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

2.3.5 The general and specific responsibilities of the Chief Executive as the Accounting Officer for the Trust are outlined in more detail in the NHS Foundation Trust Accounting Officer Memorandum published by NHS Improvement and available on its website.

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

2.3.7 It is a duty of the Chief Executive to ensure that existing employees and all new appointees are notified of and understand their responsibilities within these Standing Financial Instructions.

2.3.8 The **Director of Finance** 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 check
are prepared, documented, maintained and disseminated to supplement these Standing Financial Instructions. Appropriate registers of these procedures will be maintained.

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

And, without prejudice to any other functions of employees of the Trust, the duties of the Director of Finance include:

(d) The provision of financial advice to the Trust and its employees.

(e) The design, implementation and supervision of systems of internal financial control.

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

Additionally, the Director of Finance should ensure that all necessary requirements are fulfilled, as necessary, to enable the Trust's external auditors to be able to comply with the Audit Code for NHS Foundation Trusts, published by NHS Improvement, which prescribes the way in which auditors are to carry out their functions as set out in the National Health Service Act 2006.

2.3.9 All employees, severally and collectively, are responsible for:

(a) Security of the property of the Trust in accordance with NHS guidelines.

(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, Scheme of Delegation and Statement of Powers Reserved to the Board.

(e) Notifying the Director of Finance of any known instances of non-compliance with Standing Financial Instructions.

2.3.10 Under no circumstances should any contractor or employee of a contractor be empowered by the Trust to commit it to expenditure or authorised to obtain income on its behalf, unless explicitly agreed by the Director of Finance. If so authorised, they will similarly be covered by these instructions and it will be the responsibility of the Director of Finance to
ensure that such persons are made aware of this. The only exception to this is where the contractor is an interim Chief Executive where by virtue of the fact that the post holder is Accounting Officer they are deemed to have authority to commit expenditure and obtain income in accordance with the Scheme of Delegation. In addition where the Director of Finance is an interim, similarly by virtue of the office, they will be deemed to have authority to commit expenditure and obtain income in accordance with the Scheme of Delegation.

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

2.4 Escalation Procedures for Non-Compliance

2.4.1 Any instance of non-compliance with Standing Financial Instructions must be notified to the Director of Finance as soon as it has been identified.

2.4.2 The Director of Finance will investigate all significant instances and report the detailed circumstances of each to Audit Committee at its next meeting.

2.4.3 The Director of Finance will determine what disciplinary or other action, if any, is necessary, having sought appropriate advice from the Director of Workforce.

2.4.4 If the Director of Finance is suspected of breaching Standing Financial Instructions, then this should be notified to the Chief Executive who will similarly take action identified above.

2.4.5 Any potential breaches of Standing Financial Instructions by executive directors will be escalated to the Chair of the Audit Committee, who will advise on further actions to be instigated in accordance with the approved Governance and Compliance Framework. Any such breaches not involving the Director of Finance will also be reported to the Director of Finance.
3. **AUDIT AND ASSURANCE**

3.1 **Audit Committee**

3.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference, consistent with the NHS Foundation Trust Code of Governance. Specifically this will include:

(a) Monitoring the integrity of the financial statements and any formal announcements relating to the Trust’s financial performance, reviewing significant financial reporting judgements contained therein.

(b) Reviewing the internal financial controls.

(c) Reviewing the internal control and risk management systems.

(d) Monitoring and reviewing the effectiveness of the internal audit function.

(e) Reviewing and monitoring the external auditors’ independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

(f) Developing and implementing policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external firm.

Additionally, the Audit Committee will be responsible for:

(g) Monitoring compliance with Standing Orders and Standing Financial Instructions.

(h) Reviewing schedules of losses and compensations and making recommendations to the Board.

3.1.2 The Audit Committee shall meet quarterly.

3.1.3 Where the Audit Committee considers that there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that it wishes to raise, the chairman of Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS Improvement (to the Director of Finance in the first instance or the Chief Executive, if the matter involves the Director of Finance).
3.1.4 Similarly, the Audit Committee shall report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken in accordance with NHS Improvement’s Code of Governance.

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

3.2 **Fraud and Corruption**

3.2.1 In line with their responsibilities as originally set out in HSG(96)12, the Chief Executive and Director of Finance shall monitor and ensure compliance with NHS Protect Standards for Providers on fraud, bribery and corruption as well as other best practice and guidance.

3.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as required by NHS Protect Standards for Providers on fraud, bribery and corruption.

3.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with NHS Protect staff in accordance with the NHS Anti-Fraud Manual and in compliance with NHS Protect Standards for Providers on fraud, bribery and corruption.

3.2.4 The Local Counter Fraud Specialist shall develop a work plan that includes the range of areas of counter fraud activity required by NHS Protect Standards for Providers on fraud, bribery and corruption. This work plan shall be agreed with the Audit Committee at the beginning of each financial year, with progress against the plan being reported quarterly.

3.2.5 The Trust must maintain an Anti-Fraud, Bribery and Corruption Policy.

3.3 **Security Management**

3.3.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State on NHS security management.

3.3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist as specified by the Secretary of State in guidance on NHS security management.

3.3.3 The Trust shall nominate a non-executive director to be responsible to the Board for NHS security management.

3.3.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security
3.4 **Director of Finance**

3.4.1 The Director of Finance is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function and will normally attend Audit Committee meetings.

(b) Ensuring that the internal audit is adequate and meets the NHS Internal Audit standards.

(c) Deciding at what stage to involve the police in cases of misappropriation, and other irregularities.

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee, as a minimum covering:

   (i) A clear statement on the effectiveness of internal control.
   (ii) Major internal financial control weaknesses discovered.
   (iii) Progress on the implementation of internal audit recommendations.
   (iv) Details of actual performance against plan.

(e) Ensuring that regular and timely reports are prepared for the consideration of the Audit Committee, covering:

   (i) Progress against plan over the previous year.
   (ii) A detailed plan for the coming year.

3.4.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice (although this will usually be given unless circumstances warrant otherwise) to require and receive:

(a) Access to all records (including patient 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 employee of the Trust.

(c) The production of any cash, stores or other property of the Trust under an employee's control.

(d) Explanations concerning any matter under investigation.
3.5 **Role of Internal Audit**

3.5.1 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 and inefficient administration.
(iii) Poor value for money or other causes.

3.5.2 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 (of or pertaining to money), the Director of Finance must be notified immediately.

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

3.5.4 The Head of Internal Audit shall be accountable to the Director of Finance, where internal audit services are provided internally. Where internal audit services are provided by a third party organisation it will be the responsibility of the Director of Finance to manage the contract between the two organisations and agree a nominated individual to fulfil the role of Head of Internal Audit. At all times the Head of Internal Audit and internal audit services must remain independent and objective and must not be compromised by the role of the Director of Finance.

3.5.5 The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. This agreement shall be in writing and shall comply with the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years or whenever a new internal audit provider is appointed.

3.6 **External Audit**

3.6.1 The external auditor is appointed by the Council of Governors and paid for by the Trust.
3.6.2 In accordance with NHSI’s Code of Governance:-

(a) The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.

(b) Audit Committee shall:

(i) Make a report to the Council of Governors in relation to the performance of the external auditor, including detail such as the quality and value of the work, and the timeliness of reporting and fees, to enable the Council of Governors to consider whether or not to re-appoint them.

(ii) Make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

(c) If the Council of Governors does not accept the recommendations from Audit Committee, the Board should include in the annual report a statement from the latter explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.

3.6.3 The Audit Committee must ensure a cost-efficient service by periodically seeking competitive tenders for the Trust’s external audit service. Cost efficiency must not be used as a reason to compromise the quality of the external audit service and compliance with NHS Improvement’s Audit Code.

3.6.4 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed. The results of the tendering exercise should be reported to the Board.

3.6.5 Should there appear to be a problem with the external audit service being provided, then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Audit Committee.

3.6.6 If requested by the external auditor, during part of one Audit Committee meeting each financial year, executive directors and others normally in attendance will be excluded from the meeting in order to allow private discussions between Audit Committee, non-executive members and the external auditor.
3.6.7 The External Audit Engagement Lead and/or the Audit Manager will normally attend Audit Committee meetings.
4. BUSINESS PLANNING, BUDGETS AND BUDGETARY CONTROL AND MONITORING

4.1 Preparation and Approval of Business Plans and Budgets

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

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

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

The plan must take into account the views of the Council of Governors in accordance with the Trust constitution and be submitted to NHS Improvement in line with required deadlines.

4.1.2 The Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. This will normally happen prior to the start of the financial year or in exceptional circumstances as soon as possible after the start of the financial year, but only in agreement with the Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual business plan and also meet the necessary requirements within the Trust’s terms of authorisation granted by NHS Improvement.

(b) Accord with workload and manpower plans.

(c) Be produced following discussion with appropriate budget holders.

(d) Be prepared within the limits of available income, unless agreed otherwise by the Board and approved by NHS Improvement.

(e) Identify potential risks.

4.1.3 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board on a monthly basis.

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

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

4.2.1 With the exception of budget transfers and virement (see Appendix 3) there will be no changes to budgets in year unless duly authorised. Only expenditure which has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

4.2.2 The only corporate bodies with the authority to commit additional (net) expenditure on behalf of the Trust are:

(a) Business Investment Committee;

(b) Trust Management Committee, via Executive Directors

and

(c) The Board;

in accordance with limits detailed in Appendix 4.

4.2.3 Where a workforce re-structure is proposed this must follow the establishment change process and only where additional costs are incurred would the above process need to be followed.

4.2.4 Where additional expenditure has already been approved in accordance with either Paragraphs 4.2.2 or 4.2.3 above and there is a likelihood that this resource will be insufficient to fulfil the objectives of the original business case then the budget holder must ensure that:

(a) This is brought to the attention of the Director of Finance as soon as is practicably possible;

(b) No additional expenditure is incurred beyond that already approved in the first instance;

(c) A revised business case is submitted in accordance with limits detailed in Appendix 4 for the additional expenditure to be incurred.

4.2.5 These requirements apply equally to both income and expenditure (see also Paragraph 7.2.4 below) and capital budgets.

4.3 Retrospective Approval for In Year Changes to Budgets

4.3.1 Under normal circumstances, all in year changes to budgets need to be approved prospectively in accordance with Section 4.2 above before any additional expenditure is committed or incurred.
4.3.2 In exceptional circumstances, approval can be sought and granted retrospectively, but only with the approval of the Director of Finance who will be responsible for ensuring that the necessary governance arrangements are then followed in accordance with the limits detailed in Appendix 4.

4.3.3 Should the Director of Finance come to a view that the expenditure thus committed and or incurred, prior to retrospective approval being granted, cannot be legitimately justified and supported via arrangements contained in Section 4.2 above, then he or she must:

(a) Consider the necessary actions required to expedite the cancellation of any existing and/or contractual commitments with a view to limiting the amount of any further unapproved expenditure to be incurred in the future;

(b) Escalate the matter in accordance with Section 2.4 above, for non-compliance.

4.3.4 Legitimate justification and support referred to in Paragraph 4.3.3 above, is a matter of subjectivity, but is intended to prevent any authorised signatories making decisions which cannot be substantiated appropriately via consideration of a proper business case.

4.3.5 If the Director of Finance is unclear, in his or her opinion, whether a business case can be legitimately justified and supported, then the business case should follow the requirements described in Section 4.2 above and it will be left to Business Investment Committee or the Board to determine the position. Should either of these corporate bodies subsequently not support the business case then the Director of Finance will be required to instigate actions as referred to in Paragraph 4.3.3 above.

4.4 **Budgetary Delegation**

4.4.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation will be in accordance with the business plan and the Scheme of Delegation, both approved by the Board.

4.4.2 The Director of Finance is responsible for maintaining the lists of authorised signatories and their delegated transactional financial limits. Managers are responsible for advising the Director of Finance of all changes in accordance with agreed procedures.

4.4.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.
4.4.4 The Board, as advised by the Finance & Performance Committee, will
determine what action is necessary where budgetary totals are being
exceeded.

4.4.5 Any budgeted funds not required for their designated purpose(s) must be
declared to the Director of Finance who will determine what action, if any is
to be taken.

4.4.6 Non-recurring budgets should not be used to finance recurring expenditure
without the authority in writing of the Director of Finance.

4.5 **Budgetary Control and Reporting**

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

(a) Financial reports to the Board, in a form approved by Finance &
Performance Committee on behalf of the Board, containing:

(i) Monthly income and expenditure to date showing trends
and, from the second quarter of the year, forecast year-end
position.

(ii) Monthly movements in working capital, including cash,
where significant.

(iii) Capital scheme spend and forecast year-end position.

(iv) Explanations of any material variances from plan.

(v) Details of any corrective action where necessary and the
Director of Finance’s view of whether such actions are
sufficient to correct the situation.

(vi) Details of the financial risk ratings and indicators of forward
financial risk as set out in NHS Improvement’s Compliance
Framework.

(b) The issue of timely, accurate and comprehensible advice and
financial reports to each budget holder, covering the areas for which
they are responsible. These will be produced monthly and will be
made available to budget holders and authorised signatories in a
format agreed by the Director of Finance.

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

(d) Monitoring of management action to correct variances.
(e) Arrangements for the authorisation of budget transfers and virement.

4.5.2 Each budget holder is responsible for ensuring that:

(a) Any likely overspend or reduction of income, which cannot be met by virement, is not incurred without the formal approval of the Board. This will be achieved via the Board’s acceptance of the monthly finance report produced by the Director of Finance.

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

(c) Permanent employees are appointed in accordance with the Establishment Control Policy, provided for in the budgeted establishment as approved by the Board, and reviewed, as a minimum on an annual basis.

(d) Their use of temporary staff complies with Trust policies.

4.5.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual business plan to deliver a balanced position against budget as a minimum.

4.6 Capital Expenditure

4.6.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in Section 13.

4.7 Monitoring Returns

4.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHS Improvement and any other requisite monitoring organisations. These returns must be accurate and timely and key financial returns will be subject to review by the Director of Finance prior to submission.
5. **ANNUAL ACCOUNTS AND REPORTS**

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

(a) Prepare annual accounts in accordance with International Financial Reporting Standards, as adjusted from time to time with accounting policies and guidance issued by NHS Improvement, the Trust’s own accounting policies and generally accepted accounting practice, as appropriate.

(b) Prepare and submit annual financial reports to NHS Improvement certified in accordance with current guidelines.

(c) Submit financial returns to NHS Improvement for each financial year in accordance with the prescribed timetable.

5.2 The annual accounts must be approved by the Board, although this may be delegated to the Audit Committee, which will then make recommendations to the Board, as appropriate.

5.3 The Trust’s audited annual accounts must be presented to a public meeting within six months of the end of the financial year to which they relate. It is acceptable that these accounts can be in summary form although the full set of accounts must be made available on request.

5.4 The Trust will publish an annual report in accordance with its Constitution and in compliance with NHS Improvement’s NHS Foundation Trust Annual Reporting Manual.

5.5 The annual report will be presented to the Council of Governors at a general meeting and similarly presented to the same public meeting as the annual accounts.
6. **BANKING AND GOVERNMENT BANKING SERVICES**

6.1 **General**

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

6.1.2 The Board, via Audit Committee, shall approve the banking arrangements.

6.2 **Bank and Government Banking Services Accounts**

6.2.1 The Director of Finance is responsible for:

(a) Bank accounts and Government Banking Services accounts.

(b) Establishing separate bank accounts for funds held on trust on behalf of the Corporate Trustee.

(c) Ensuring payments made from bank or Government Banking Services accounts do not exceed the amount credited to the account except where arrangements have been made i.e. accounts should not become overdrawn without explicit prior approval.

(d) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 **Banking Procedures**

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and Government Banking Services accounts, which must include:

(a) The conditions under which each account is to be operated.

(b) The limit to be applied to any overdraft.

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

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated. This will normally be achieved through the list of authorised signatories supplied to the bank.

6.3.3 All funds shall be held in the name of the Trust.
6.3.4 No employee other than the Director of Finance shall open any bank account in the Trust’s name. For the Trust’s main commercial bank and Government Banking Services, the Director of Finance has discretion to open the number and type of accounts as necessary to expedite normal day to day business activities. For accounts to be used for investment of surplus cash these must be in accordance with requirements of the Treasury Management Policy.

6.4 **Tendering and Review**

6.4.1 The Director of Finance 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.

6.4.2 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed. The results of the tendering exercise should be reported to the Board.

6.5 **Electronic Transfer of Funds**

6.5.1 All electronic transfers of funds must only be made under secure arrangements approved by the Director of Finance.
7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

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

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

7.2 Fees and Charges

7.2.1 The Trust shall follow guidance issued by the Department of Health for the pricing of its patient related services with commissioners, supplemented by any additional guidance provided by NHS Improvement.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by statute. Independent professional advice on matters of valuation shall be taken as necessary. This should be incorporated into and documented in the business planning process to ensure that this happens annually as a minimum.

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. This must be via prompt and regular presentation of cash transactions for banking or through the formal debt recovery process for credit income.

7.2.4 The Director of Finance, shall approve business cases for schemes where potential gross income generation exceeds £10,000 per annum, in order to ensure profitability of such schemes to the Trust overall. It will be at the discretion of the Director of Finance to determine whether such schemes need to be considered by Business Investment Committee in line with limits referred to in Appendix 4. Schemes with gross income above £100,000 will need to be approved, similar to business cases, in accordance with the limits referred to in Appendix 4.

7.2.5 The requirements outlined in paragraph 7.2.4 above equally apply to a discontinuation of, or disinvestment in a service or operation.

7.2.6 All contracts and/or service level agreements must be agreed by the Head of Contracts and Marketing who will then sign contracts under £100,000 and pass contracts over £100,000 for signing by the Director of Finance. All such contracts must be retained and stored securely by the Head of Contracts &
Marketing.

7.3 **Tendering for Services**

7.3.1 A decision to submit a bid for services tendered by another organisation must be approved by the Chief Executive who will consult with other relevant executive directors before reaching a decision.

7.3.2 Once a decision has been made to submit a bid for services so tendered, the bid will be co-ordinated, prepared and presented in a form determined by the tender specification and process.

7.3.3 The financial elements of the tender bid must have been agreed by the Director of Finance.

7.3.4 The final tender bid must be approved prospectively in accordance with the financial limits contained in Appendix 4 or retrospectively, where following this approval process would delay the tender bid beyond the required submission date. In such instances the Director of Finance must have approved the final tender bid document. A register of all submitted tenders will be maintained.

7.4 **Debt Recovery**

7.4.1 The Director of Finance is responsible for the appropriate recovery action for all outstanding debts. This will include the use of external debt recovery services, where appropriate.

7.4.2 Income not received should be dealt with in accordance with losses procedures described in Section 15.2 and delegated financial limits detailed in Appendix 7.

7.4.3 Overpayments should be detected (or preferably prevented) wherever is reasonably possible and recovery initiated.

7.5 **Security of Cash, Cheques and Other Negotiable Instruments**

7.5.1 The Director of Finance is responsible for:

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

(b) Ordering and securely controlling any such stationery.

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

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

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

7.5.3 All cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received under any circumstances.

7.5.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes under any circumstances.

7.5.5 The opening of post shall be undertaken by two employees together and all cash, cheques and other forms of payment shall be entered in an approved register before handing to the Director of Finance.

7.5.6 The opening of cash tills, telephones and other coin operated machines and the counting and recording of takings shall be recorded by two officers together. Both shall sign the records and the keys shall be held by a separate nominated officer.
8. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

8.1 The Chief Executive is responsible for negotiating legal contracts with commissioners for the provision of services to patients in accordance with the business plan, and for establishing the arrangements for providing non-contract activity treatment services in accordance with the guidance contained in “Who Pays? Establishing the Responsible Commissioner” published by the Department of Health and any other best practice guidance. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) Costing and pricing of services.
(b) Payment terms and conditions.
(c) Amendments to contracts.
(d) Non-contract activity arrangements.
(e) Provision of contract data.
(f) Any other financial matters.

8.2 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.

8.3 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices shall comply with guidance issued by the Department of Health and NHS Improvement.

8.4 The Director of Finance shall produce regular reports detailing actual and forecast contract income linked to patient activity with a detailed assessment of the impact of the variable elements of income. These will be presented monthly for review to the Trust Management Committee, Finance & Performance Committee and the Board.

8.5 Any pricing of contracts at marginal cost must be approved by the Director of Finance and reported to the Board if material. Materiality is deemed to be when such contracts have a financial impact in excess of £100,000 in this instance.

8.6 The Chief Executive is responsible for ensuring procedures are in place to ensure all patient related activity is recorded appropriately and that flex and freeze dates for agreeing actual levels of activity against contracts are strictly adhered to in order to maximise the level of income received by the Trust.

8.7 Where the Trust wants to procure healthcare services from a third party organisation in order to deliver its contractual obligations with one or more of
its commissioners, then this will be undertaken by the Procurement Department, consistent with the requirements contained in Section 11.

8.8 Where Trust employees are involved in the direct delivery of healthcare services on behalf of a third party organisation, each employee must have declared that interest to the Trust and confirm that there has been no conflict of interest arising which has led to the procurement of the same healthcare services. Such declarations must be signed by each employee and in a format agreed by the Chief Executive.

8.9 Submission of bids for services tendered by another organisation must be undertaken in accordance with the requirements of Section 7.3.
9. TERMS OF SERVICE AND PAYMENT OF ALL STAFF

9.1 Remuneration and Terms of Service

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

9.1.2 The Trust’s Remuneration Committee will:

(a) Review the ongoing appropriateness and relevance of the Trust’s Remuneration Policy.

(b) Agree the appropriate remuneration and terms of service for the Chief Executive and other executive directors, including:

   (i) All aspects of salary (including any performance-related elements/bonuses).
   
   (ii) Provisions for other benefits, including pensions and cars.
   
   (iii) Arrangements for termination of employment and other contractual terms.

(c) Monitor the evaluation of the performance of individual executive directors.

(d) Advise on and oversee appropriate contractual arrangements for executive directors including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) Approve remuneration or other awards made to executive directors outside of contractual obligations only with the approval of HM Treasury, where applicable.

(f) Monitor compliance with IR35: Countering Avoidance in the Provision of Personal Services for off-payroll arrangements.

(g) Monitor redundancy and capitalised pension costs for all staff groups and to approve any such individual arrangements in excess of £100,000.

The Remuneration Committee will take into account the principles contained in NHS Improvement’s Code of Governance when exercising its responsibilities.
9.1.3 There shall be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration of individual executive directors. No executive director should be involved in deciding his or her own remuneration.

9.1.4 Whilst the Board may delegate decision making about remuneration to the Remuneration Committee it remains accountable for taking decisions on the remuneration and terms of service of executive directors.

9.1.5 The Trust will remunerate the Chairman and non-executive directors in accordance with instructions issued by the Council of Governors.

9.2 **Funded Establishment**

9.2.1 The manpower plans incorporated within the annual business plan and budgets will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive, in accordance with the requirements of the Establishment Control Policy.

9.2.3 Increases to funded establishments can only be approved in accordance with Section 4.2 and financial limits contained in Appendix 4.

9.2.4 The funded establishment of any department may not be exceeded without the prior approval of the Director of Finance and subject to authorised powers of virement contained in Appendix 3.

9.3 **Staff Appointments**

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

(a) Unless authorised to do so by the Chief Executive, in accordance with the requirements of the Establishment Control Policy; and

(b) Within the limit of his/her approved budget and funded establishment.

9.3.2 The arrangements for securing the services of temporary (agency) staffing are outlined in Section 11.3.

9.3.3 The Board will approve procedures presented by the Director of Workforce and Director of Finance for the determination of pay rates, condition of service, etc. for groups of staff not linked to national terms and conditions whose period of employment has not yet commenced. This relates to the
9.3.4 When appointing staff, authorised signatories must ensure that:

(a) The recruitment, selection and contracting processes are consistent with Trust policies.

(b) Any offer of employment complies with the appropriate terms and conditions of employment for that category of staff.

(c) Appropriate documentation is completed prior to the offer of employment being made and immediately on commencement of duty with the Trust.

9.3.5 Where a budget holder requires to deviate from national terms and conditions, or locally agreed terms and conditions where these exist, for an individual member of staff, this will need to be prospectively approved jointly by the Director of Finance and the Director of Workforce prior to an offer of employment being made.

9.4 Changes to Rates of Pay

9.4.1 Proposals to pay individual members of existing staff other than in accordance with national terms and conditions, or locally agreed terms and conditions where these exist, will need to be prospectively approved jointly by the Director of Finance and the Director of Workforce.

9.4.2 Proposals to pay groups of existing staff other than in accordance with national terms and conditions, or locally agreed terms and conditions where these exist (e.g. changes in rates of pay for bank staff, local on call arrangements, etc.) should be approved in the form of a business case and in accordance with the financial limits contained in Appendix 4. There is provision for retrospective approval to support operational and clinical decision making in exceptional circumstances (See Section 4.3 above).

9.4.3 Where proposals outlined in Paragraph 9.4.2 are approved, a post implementation review should be carried out and reported to the Director of Finance and Director of Workforce, with the outcome presented to the Finance & Performance Committee.

9.5 Processing of Payroll

9.5.1 The Director of Workforce is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other notifications.
(b) The final determination of pay, jointly with the Director of Finance.
(c) Making payment on agreed dates.
(d) Agreeing the method(s) of payment.

9.5.2 The Director of Workforce will issue instructions, having taken appropriate advice from the Director of Finance, regarding:

(a) Verification and documentation of data.
(b) The timetable for receipt and preparation of payroll data and the payment of employees.
(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 the completed payroll before and after payment.
(f) Authority to release payroll data under the provisions of the Data Protection Act.
(g) The payment of pay awards and arrears.
(h) Procedures for the change of bank account details by staff.

9.5.3 The Director of Finance will issue instructions regarding:

(a) Methods of payment available to various categories of employee.
(b) Procedures for payment by cheque or bank credits to employees.
(c) Procedures for the recall of cheques and bank credits.
(d) Pay advances and their recovery.
(e) Maintenance of regular and independent reconciliation of pay control accounts.
(f) Separation of duties between the preparation of records and the handling of cash and other types of payment.
(g) A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.
(h) The secure operation of the system for payments by BACS.

9.5.3 Budget holders 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 instructions and in the form prescribed by the Director of Workforce.

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee’s resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Workforce must be informed immediately and prompt action taken as necessary to prevent any over-payments arising.

This must be consistent with the requirements of the Establishment Control Policy and transactional financial limits detailed in Appendices 1 and 2, as appropriate.

9.5.4 Regardless of the arrangements for providing the payroll service, the Director of Workforce, having taken appropriate advice from the Director of Finance, shall ensure that payments made by the payroll function are supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures where appropriate.

9.5.5 The Director of Finance will ensure that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.6 Contracts of Employment

9.6.1 All contracts of employment shall be in a format agreed by the Director of Workforce, in conjunction with the Remuneration Committee, as appropriate.

9.6.2 The Board shall delegate responsibility to a budget holder for:

(a) Ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation (see also Paragraphs 9.3.3 and 9.3.4); and

(b) Dealing with variations to, or termination of, contracts of employment (save for instances arising from clause 9.4); in accordance with the requirements of the Establishment Control Policy.
9.6.3 Where termination of employment involves redundancy (voluntary or compulsory) agreements or any other form of contractual payments, this shall require formal and prospective approval from the Director of Finance or the Remuneration Committee if individually in excess of £100K as per Paragraph 9.1.2 (g) above. He or she will seek appropriate advice, as necessary, from the Director of Workforce before making any such decision.

9.6.4 All payments outside contractual obligations (e.g. compromise agreements, etc.) require formal and prospective approval from the Remuneration Committee to approve a submission to HM Treasury. All payments outside contractual obligations require prospective HM Treasury approval, irrespective of value.
10. **NON-PAYROLL EXPENDITURE**

10.1 **Delegation of Authority**

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

10.1.2 No employee shall commit or authorise expenditure unless they have delegated authority to do so.

10.1.3 As part of the approval of annual budgets, as set out in section 4, the Board will approve non-pay budgets.

10.1.4 Authorised signatories have delegated authority to commit or authorise non-pay expenditure up to the budget, for the purpose of the budget, subject to the transactional financial limits set out in Appendices 1 and 2.

10.1.5 Virement of budget is permissible within the Trust's approved rules and limits (See Appendix 3).

10.1.6 **Requisitions and Orders:** In line with best practice, most goods or services will be ordered through the Procurement Department (via web-based requisitioning) following a requisition raised by an authorised signatory. A list of goods and services where an official purchase order may not be required will be agreed, maintained and held by the Director of Finance and made available via the intranet.

A single requisition may involve, for example, the requisition of a contract involving a number of annual payments; these payments are added together to determine the transactional financial limit.

Requisitions may not be split or otherwise placed in a manner devised so as to avoid the transactional financial limits.

Requisitions should be placed prior to any goods or services being received and must not be used as a means to retrospectively comply with these instructions.

10.1.7 **Signing of Contracts or Licences:** An order for goods or service may result in a contract or license to be signed by both the Trust and the supplier. All contracts must be agreed by the Head of Procurement who will then sign contracts under £100,000 and pass contracts over £100,000 for signing by the Director of Finance. All such contracts must be retained and stored securely by the Head of Procurement.

10.1.8 **Authorisation of Invoices:** Most invoices relating to goods requisitioned and purchased via an order issued by the Trust do not require authorisation.
The Finance Department will match the Goods Received Note to the invoice and invoice value, and resolve any differences, seeking assistance from authorised signatories with this if necessary.

Invoices not matched in the way described above require authorisation before payment in accordance with delegated transactional financial limits.

10.2 **Procedures for Obtaining Goods and Services**

10.2.1 In choosing the item to be supplied (or the service to be performed) the advice of the Procurement Department shall be sought in order to obtain value for money and, as far as possible, meet the sustainability obligations of the Trust.

10.2.2 The only exceptions to the above are the Pharmacy Department which is permitted to procure drugs without seeking the advice of Procurement and patient bespoke Orthotics procurement.

10.2.3 Where the advice of Procurement is not accepted by an authorised signatory, the Director of Finance (and/or the Chief Executive) shall be consulted and may approve procurement contrary to the advice received, as long as the Trust complies with UK and European law.

10.2.4 Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

10.2.5 The procedure that the Trust shall follow to raise official orders and the authorised signatory’s role in this is set out in Section 11. All orders must:

(a) Be consecutively numbered in batches, as controlled by the Head of Procurement, unless automatically system generated.

(b) Be in a form approved by the Director of Finance.

(c) State the Trust’s terms and conditions of trade.

(d) Only be generated based on the delegated authority of the appropriate signatory as detailed in Appendices 1 and 2.

(e) Be authorised in accordance with procedures determined by the Director of Finance. All orders in excess of £1,000,000 must have already been approved by the Board.

10.2.6 No order shall be issued for any item or items to any firm which has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, or conventional hospitality such as lunches in the course of working visits to suppliers.
10.2.7 All contracts for example; leases, tenancy agreements and other commitments which may result in a liability shall be notified to the Director of Finance.

10.2.8 These Standing Financial Instructions apply equally to goods or services relating to funds held on trust, see Appendix 8 for delegated financial limits.

10.2.9 No verbal instructions, without an official order number, are to be given to suppliers of goods and services.

10.2.10 No orders are to be raised after goods and services have already been supplied unless in accordance with agreed procedures approved by the Director of Finance.

10.2.11 No orders to be raised with suppliers of goods and services where the authorised signatory is related to an individual who will directly benefit from that order or, the authorised signatory has a financial interest with that supplier. The Trust’s Standards of Business Conduct provide further information regarding personal and business integrity and instances where a close family or personal relationship may give rise to a conflict of interest or the perception of such.

10.3  **Confirmation of Receipt for Goods and Services**

10.3.1 The system for receipt of goods and services shall provide for:

   (a) Details of employees authorised to certify invoices (see Paragraph 4.3.2).

   (b) Certification that goods have been duly received, examined and are in accordance with specification and the prices are correct.

   (c) Certification that 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.

   (d) 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.

   (e) Where appropriate, that the expenditure is in accordance with regulations and all necessary authorisations have been obtained.
(f) The account is arithmetically correct.
(g) The account is in order for payment.
(h) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.4 Payment for Goods and Services

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

10.4.2 The Director of Finance is responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

10.4.3 The Director of Finance is responsible for designing and maintaining procedures regarding the use and control of purchasing cards.

10.4.4 The Director of Finance is responsible for ensuring that payment for goods and services is only made once the goods and services are received unless in line with contractual terms and conditions imposed by the supplier, subject to the provisions contained in Paragraph 10.4.5.

10.4.5 Pre-payments, other than those specified by contractual terms and conditions imposed by the supplier, are only permitted where exceptional circumstances apply. In all such instances the advice of both the Director of Finance and the Head of Procurement should be sought before entering into any contractual arrangements. In such instances:

(a) The budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments. Any proposals must be discussed with the Head of Procurement before submitting a request to the Director of Finance.

(b) The Director of Finance may approve the prepayment arrangement to progress if:

(i) The proposed arrangements takes into account the European Union public procurement rules where the contract is above a stipulated financial threshold;

and

(ii) The financial advantage outweighs the disadvantages.
(c) The budget holder is responsible for ensuring that all items due under a pre-payment contract are received and they must immediately advise the appropriate Director or Chief Executive if problems are encountered.

10.5 Petty Cash

10.5.1 Purchases from petty cash are restricted in value and by type of purchase as detailed in Appendix 5 and must be supported by receipt(s) and certified by an authorised signatory within their delegated limit.

10.5.2 The Director of Finance will determine record keeping and other instructions relating to petty cash.
11. TENDERING AND CONTRACTING FOR NON-PAYROLL EXPENDITURE

11.1 Duty to Comply with Standing Financial Instructions and Standing Orders

11.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions as well as Standing Orders, as appropriate.

11.1.2 All tendering and contracting must be carried out by the Procurement Department with the exception of Pharmacy. However, the Procurement Department should still be involved to provide guidance and support, as appropriate, to ensure procurement in these areas is undertaken in accordance with the requirements of these Standing Financial Instructions.

11.1.3 No employee is to enter into commercial discussions with potential or actual suppliers without the full agreement and involvement of the Procurement Department.

11.1.4 All contracts will:

(a) Be within the Trust's powers as delegated by the Secretary of State.

(b) Comply with relevant Department of Health guidance as advised by the Head of Procurement.

(c) Incorporate the Standard NHS terms and conditions.

(d) Endeavour to obtain best value for money.

(e) Be compliant with the latest government guidance and policy regarding transparency within procurement.

11.1.5 Standing Financial Instructions and Standing Orders also apply to where the Trust elects to invite tenders for the supply of health care services.

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

11.2 Procedure for Procurement of Non-Payroll Items

11.2.1 Paragraph 10.2.2 provides for the procurement of drugs to be undertaken through the Pharmacy Department, where the Chief Pharmacist will follow similar procurement procedures to those set out below. Relevant paragraphs below equally apply to patient bespoke Orthotics procurement.
11.2.2 Authorised signatories will requisition the required goods or services. All requisitioners will be required to follow the ordering procedures set by the Procurement Department.

11.2.3 The Procurement Department will follow the processes outlined for the procurement of goods and services in accordance with the financial limits detailed in Appendix 6.

11.2.4 Formal tendering is not required if goods and services are obtained via a framework contract put in place by a recognised body and which is open for the Trust to utilise. However, this work will still be undertaken by the Procurement Department.

11.2.5 **Obtain Best Value:** The Procurement Department will use their knowledge base and compiled catalogues of suppliers and prices to obtain best value for money. Value for money is described in the Public Contracts Directive 2004/18/EC as:

“...obtaining the maximum benefit with the resources available. It is getting the right balance between quality and cost. Value for money is about achieving the right balance between economy, efficiency and effectiveness - the 3Es - spending less, spending well and spending wisely. This means that value for money not only measures the cost of goods and services but also takes account of the mix of cost with quality, resource use, fitness for purpose and timeliness to judge whether or not, together, they constitute good value.”

11.2.6 **Quotations – Goods or Services:** A minimum of three written quotations are required where the contract value is expected to be between £25,000 and £50,000 unless using an already competitively tendered contract (excluding works). For spend below £25,000 then a value for money check must be completed by the budget holder along with Procurement input. Any contract entered into by the Trust regardless of value must be completed by Procurement and signed as per Paragraph 10.1.7 even those below the thresholds identified in this section. Competitive quotations should be:

(a) Obtained based on specifications or terms of reference prepared by, or on behalf of, the budget holder.

(b) Obtained in writing and published via an e-tendering platform, which includes sending the opportunity through to Contracts Finder for publication.

(c) Treated as confidential and should be retained for inspection.

(d) Evaluated by the Procurement Department in conjunction with the budget holder or delegated officer to select the quotation giving the best value for money. If this is not the lowest quotation, if payment is
to be made by the Trust; or the highest, if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record. The Procurement Department will advise on which quotation should be accepted.

11.2.7 **Formal Tendering – Goods or Services and Works:** Where the likely contract value exceeds £50,000 for goods or services, and £200,000 for works, formal tendering will be undertaken.

Where a requirement for goods or services likely to cost in excess of £50,000 and requisitions for works in excess of £200,000 is known, the budget holder will work with the Procurement Department on a formal tender process unless a framework can be used as referred to in Paragraph 11.2.4 above. The Procurement Department will lead the tendering process in conjunction with the budget holder.

11.2.8 Items estimated to be below the quotation and/or tender limits that subsequently exceed these limits shall be reported to the Director of Finance and Audit Committee along with circumstances where formal procedures have in effect been waived without approval to do so.

11.3 **Procedure for Procurement of Temporary (Agency) Staffing**

11.3.1 For all temporary staffing across all categories of specialty and discipline i.e. medical, nursing, administrative and clerical, etc. an approved supplier, validated via an approved NHS Improvement Framework, must be used to ensure legal compliance and for background checks, validation of qualifications, etc.

11.3.2 A list of approved suppliers is maintained by the Procurement Department. Any proposal to use other than an approved supplier must be approved in accordance with procedures agreed by the Director of Finance.

11.3.3 All agency staffing requirements must be signed-off by an authorised signatory in advance, in accordance with procedures agreed by the Director of Finance.

11.3.4 Agency staffing requirements must be provided via the Trust’s relevant appointed managed service providers, where they exist, in accordance with procedures agreed by the Director of Finance. Any provision of agency staffing out with the managed service providers will only be allowed in exceptional circumstances and will be documented in the aforementioned procedures.

11.3.5 With the exception of provision via a managed service provider, all other temporary staffing requirements must follow the appropriate procurement requirements described elsewhere in Section 11 and require a purchase order to be raised in advance of the services being delivered.
11.3.6 All permanent recruitment of staffing should be in accordance with the requirements outlined in Section 9.

11.4 **Procedure for Competitive Tendering**

11.4.1 Trust standard tendering documentation must be used at all times unless agreed by the Head of Procurement.

11.4.2 The tender specification must be robust and impartial.

11.4.3 Trust tendering procedures must at all times adhere to the transparency agenda set by the European Union and the UK Government. All tenders will be undertaken through the Trust’s electronic tendering system. This shall enable suppliers to be alerted that there is a contract opportunity available, in line with the government’s transparency agenda.

11.4.4 Tenders will be returned to an ‘electronic safe’ locked until the due date for the receipt of bids from invited suppliers. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the tenders shall be opened by the Procurement Department.

11.4.5 The Head of Procurement, as guardian for the e-tendering system, is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of the names of all firms or individuals invited to tender, those from which tenders have been received and the date these tenders were opened.

11.4.6 There is generally no discretion to receive tenders after the due date. In exceptional circumstances the Head of Procurement may approve the inclusion of a late tender. This will only be approved if there is a technical reason why the tender could not be submitted and this reason must be ratified by the e-tendering system supplier.

11.4.7 **Acceptance of Tender:**

(a) Any clarification questions from the Trust to a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract must be undertaken via the Procurement Department and not directly by the budget holder. All questions must be sent via the e-tendering portal for transparency purposes.

(b) The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.

(c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in
accordance with these Instructions except with the authorisation of the Chief Executive. This will be in accordance with the requirements of Paragraph 4.2 above and financial limits contained in Appendix 4.

(d) The Procurement Department will advise on the award of a contract to a supplier and provide a written de-brief to the unsuccessful bidders. Under no circumstances should an individual outside of the Procurement Department de-brief a supplier.

(e) A duly completed formal contract document (terms and conditions) shall be issued by the Procurement Department for authorisation by the Head of Procurement, or Director of Finance if the contract is related to a private finance initiative/lease agreement or its value is over £100,000.

(f) Following completion of the signed contract, an order should be raised for the goods, services or works.

11.4.8 The Head of Procurement will report to the Board on an exceptional circumstance basis as required by the Chief Executive.

11.4.9 Procurement will ensure that appropriate contract management arrangements are put in place for all accepted tenders in relation to contracts in excess of £500,000 per annum to ensure:

(a) Best value is maintained.

(b) Variations are controlled.

(c) Service continuity is maintained.

(d) Risk is managed.

11.5 Frameworks

11.5.1 The Head of Procurement will ensure the Trust’s register of suppliers suitable for the supply of goods or services is kept via the Trust’s contracts database. The Head of Procurement will also access such other registers available for use by the NHS.

11.5.2 The Head of Procurement will determine which register (framework agreements) may be used.

11.5.3 The Head of Procurement shall ensure all tenders provide open competition and comply with relevant Department of Health guidance.
11.5.4 This does not preclude the assessment at either, or both, pre-qualification questionnaire or evaluation of tender stage, of contractor suitability in for example:

(a) Experience and qualifications.

(b) Understanding of the Trust's needs.

(c) Feasibility and credibility of proposed approach.

(d) Viability to deliver the goods or services.

(e) Health and safety record.

(f) Environmental considerations.

(g) Financial standing - Director of Finance responsibility.

(h) Clinical governance - Medical Director responsibility.

11.6 **Waiving of Quotation and Tender Requirements**

11.6.1 Quotation and tender limits are detailed in Appendix 6. Consideration of the need for a waiver of quotation/tendering requirements may occur where:

(a) In very exceptional circumstances formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record.

(b) Specialist expertise or goods and services are required and are available from only one source.

(c) The task is essential to complete the project, and arises as an unforeseen consequence of a recently completed assignment and engaging a different supplier for the new task would be inappropriate.

(d) 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.

(e) Permitted by Department of Health guidance; details of which shall be documented in waiving formal tendering.
11.6.2 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

11.6.3 Where it is decided that competitive tendering is not applicable and therefore, the requirements of Standing Financial Instructions should be waived, the fact of the waiver and the reasons should be documented using the waiver form obtained from the Head of Procurement. Details of both authorised and unauthorised waivers will be reported to the Audit Committee.

11.6.4 All requests to progress with waivers must receive prior approval. All such non-competitive action will require the completion of a waiver form. Waiver forms should be initially sent to the Head of Procurement to review and authorise, if appropriate. Waiver forms require authorisation as set out in accordance with the financial limits detailed in Appendix 6.

11.6.5 It should be noted that European Procurement Law applies at all times and in particular to proposed procurements in excess of the financial thresholds (Official Journal of the European Union limits) appertaining at the time. This cannot be waived and the Procurement Department will advise budget holders as to how compliance can be achieved.

11.6.6 The Audit Committee may, at its discretion, invite regular users of the waiver and non-competitive action procedures, to explain the need and to advise how this action may be avoided.

11.6.7 The Head of Procurement will provide ongoing reports to the Audit Committee detailing the use made of waivers.

11.7 **Auctions**

11.7.1 Should the Trust choose to access auctions (of any kind) as a process for procurement, this must be done through the Procurement Department and the Director of Finance must be assured the process complies with best practice guidelines.
12. EXTERNAL BORROWING AND INVESTMENTS

12.1 Finance & Performance Committee

12.1.1 The terms of reference for Finance & Performance Committee include overseeing all aspects of cash management as well as external borrowing (including temporary overdraft facilities) and investments.

12.1.2 The Finance & Performance Committee must operate within its terms of reference established by the Board.

12.1.3 The terms of reference will be reviewed annually.

12.2 Public Dividend Capital

12.2.1 The Trust must always seek to maximise the amount of public dividend capital available to it, as appropriate, prior to considering any form of external borrowing to fund its capital investment.

12.2.2 The Director of Finance must report to the Board as and when public dividend capital is to be drawn down or repaid.

12.2.3 Repayments of public dividend capital must be approved prospectively by the Board.

12.3 External Borrowing

12.3.1 The Director of Finance will advise the Board, as part of the annual business planning process, concerning the Trust's ability to pay interest on, and repay the capital element of both public dividend capital and any other borrowing within any limits or restrictions set by NHS Improvement.

12.3.2 The Director of Finance is responsible for reporting periodically to the Board, via Finance & Performance Committee concerning any temporary loans and overdrafts, applications for which will only be made by the Director of Finance.

12.3.3 All long-term borrowing must be consistent with the Trust's current business plan and must not exceed any limits or restrictions set by NHS Improvement.

12.3.4 All external borrowing, either short or long-term must be approved prospectively by the Board.

12.4 Investments

12.4.1 Temporary cash surpluses must be held in such public or private sector investments in accordance with the Treasury Management Policy approved by the Board.
12.4.2 The Director of Finance is responsible for advising the Board on the investment of surplus cash and will report quarterly to Finance & Performance Committee and annually to the Board concerning the performance of investments held.

12.4.3 The Director of Finance will prepare detailed procedural instructions for the investment of surplus cash and on the records to be maintained.
13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

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

(c) Shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support, where appropriate, and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every capital expenditure proposal the Chief Executive shall ensure that a business case is prepared, in line with the guidance produced by the Director of Finance, setting out:

(a) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs.

(b) The involvement of appropriate Trust personnel and external agencies.

(c) Appropriate project management and control arrangements.

(d) The payback period for the investment.

(e) That the relevant Director has certified professionally to the costs and revenue consequences detailed in the business case, based upon relevant advice provided by the Director of Finance.

13.1.3 For capital schemes where the contracts stipulate stage payments; the Chief Executive will issue procedures for their management.

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

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

(a) Specific authority to commit expenditure.
(b) Authority to proceed to tender.

(c) Approval to accept a successful tender, subject to the requirements of Standing Orders

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with “ESTATECODE” guidance and the Trust's Standing Orders.

13.1.6 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.2 Post Project Evaluation

13.2.1 Post project evaluation will be undertaken, as a minimum, on all capital investments where the business case is approved by the Board. The post project evaluation will be reviewed by the Board.

13.2.2 The project evaluation shall as a minimum consider:

(a) The extent to which the original objectives have been met.

(b) The cost and the extent to which value for money can be demonstrated.

(c) The outcome compared with, the do nothing or do minimum option.

(d) Risk.

(e) User satisfaction.

(f) Procurement route.

(g) Implementation compared with plan; time and resources.

(h) Lessons learnt.

13.3 Private Finance Initiative and Leasing

13.3.1 The Trust should normally test for private financing or leasing when considering capital procurement. When the Trust proposes to use private financing or leasing (regardless of whether the lease is an operating or finance lease), the following procedures shall apply:

(a) The proposal must obtain approval commensurate with that which is required were the assets, goods or services to be obtained by outright purchase.
(b) The budget holder for the associated private financing/lease cost must authorise that the costs are acceptable within their managed budget.

(c) The Director of Finance shall demonstrate that the financing represents value for money and genuinely provides the desired transfer of risk.

(d) Any finance or lease document must be signed by the Director of Finance (see Paragraph 11.3.8 (c) above).

(e) The proposal must comply with any guidance issued by NHS Improvement.

13.4 Capital Delegated Limits

13.4.1 All initial allocations for capital schemes within the constraints of the Board approved programme will be set by the Director of Finance.

13.4.2 Following the subsequent tendering/quotation action and the approval of the business case the Director of Finance must give approval before any expenditure is committed.

13.4.3 The delegated transactional financial limits detailed in Appendix 2 relate to the subsequent authorisation of all expenditure including staff-related costs, requisitions, orders and invoices. All procurement is subject to the procedures set out in Section 11.

13.5 Asset Registers

13.5.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted at least once a year.

13.5.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within this register shall be consistent with that specified in the Capital Accounting Manual issued by the Department of Health.

13.5.3 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 payroll records for own materials and labour including appropriate overheads.

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

13.5.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices, where appropriate, and in accordance with procedures approved by the Director of Finance. See the Policy and Guidance for the Procurement and Payment of Goods and Services (Procurement Policy).

13.5.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in the ledger against balances on the fixed asset register.

13.5.6 The value of each asset shall be depreciated in accordance with methods and rates determined by the Director of Finance consistent with the requirements of relevant International Financial Reporting Standards, as interpreted by the Department of Health within its Group Accounting Manual.

13.5.7 The Director of Finance shall calculate capital charges as specified in the Capital Accounting Manual.

13.6 Security of Assets

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

13.6.2 Asset control procedures, including donated assets, must be approved by the Director of Finance. These procedures shall make provision for:

(a) Recording managerial responsibility for each asset.

(b) Identification of additions and disposals.

(c) Identification of all repairs and maintenance expenses.

(d) Physical security of assets in accordance with the Trust’s Security Policy.

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

13.6.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of all authorised signatories in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with the Trust’s Security Policy.

13.6.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by employees in accordance with the procedure for reporting losses (see Section 15 and Appendix 7).

13.6.6 Where practical, assets should be marked as Trust property.

13.6.7 The Chief Executive shall be responsible for establishing and maintaining separate records for equipment on loan from suppliers and items provided through operating lease arrangements.
14. STORES AND RECEIPT OF GOODS

14.1 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 in accordance with the Trust’s accounting policies as determined by the Director of Finance taking account of the requirements of International Financial Reporting Standards.

14.2 Subject to the responsibility of the Director of Finance for the systems of control, overall control of stores shall be the responsibility of an officer delegated by the Chief Executive. The day-to-day responsibility may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oils the responsibility of a designated Estates Officer.

14.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the officer delegated by the Chief Executive and agreed with the Director of Finance. Wherever practicable, stocks should be marked as health service property.

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

14.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

14.7 The designated officer shall be responsible for a system, approved by the Director of Finance, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also Section 15). Procedures for the disposal of obsolete stock shall follow those set out for disposal of all surplus and obsolete goods in the Policy and Guidance for the Procurement and Payment of Goods and Services (Procurement Policy).
15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

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

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

(b) Disposed of in accordance with a Board approved policy.

(c) Recorded by the Condemning Officer, who must be an authorised signatory at budget holder level or above, in a form approved by the Director of Finance that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 Losses and special payments are divided into eight categories, as defined below. These categories are:

Losses (excluding family practitioner services):

1. Losses of cash.
2. Fruitless payments, including abandoned capital schemes.
3. Bad debts and abandoned claims.
4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use.

Special payments (excluding family practitioner services):

5. Compensation payments made under legal obligation.
6. Extra contractual payments to contractors.
7. Ex gratia payments.
8. Extra statutory and extra regulatory payments.

15.2.2 The Director of Finance is responsible for ensuring that suitable procedural instructions are produced for the reporting, recording and accounting of all losses and special payments in accordance with the guidance issued by the Department of Health. The Director of Finance must also prepare an Anti-Fraud, Bribery and Corruption Plan that sets out the action to be taken in the event of a suspected fraud being detected.

15.2.3 Any employee discovering or suspecting a loss of any kind must notify their line manager immediately, who will ensure the incident is reported in line with the requirements of the Policy for the Reporting, Investigation, Management and Analysis of Incidents (Including the Management of Serious Incidents). Where a criminal offence is suspected, involving theft or arson, the police will be informed in accordance with the arrangements set down in the Trust’s Security Policy. For all suspected losses, actions should be taken without undue delay having regard to the potential seriousness of the loss in each individual case.

15.2.4 The Director of Finance must ensure that all individual losses and special payments above £50 are reported to the Audit Committee and that smaller losses are reported in aggregate. A report of losses apparently caused by theft, arson, neglect of duty or gross carelessness must be made to the Audit Committee as soon as practicable, and must also be similarly reported to the external auditor.

15.2.5 The Board shall approve the writing-off of losses and the making of special payments in accordance with the approved financial limits detailed in Appendix 7.

15.2.6 The Director of Finance shall be authorised to take necessary steps to safeguard the Trust’s interests in bankruptcies and company liquidations.

15.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made or any other action taken to recover some of the loss.

15.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. Details will be entered as they are known. Where an actual value cannot be immediately determined an estimated value should be inserted. The precise format of the register will be determined by the Director of Finance.

15.2.9 Audit Committee will review updates to the Losses and Special Payments Register at each of its scheduled meetings.
16. INFORMATION TECHNOLOGY

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

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage.

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

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as he or she may consider necessary, are being carried out.

(e) Ensure, as appropriate, compliance with the requirements of the relevant Data Protection Acts.

(f) Ensure that appropriate data back-up and recovery arrangements are in place.

16.2 The Director of Finance shall satisfy him or herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

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

16.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.
16.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy him or herself that:

(a) Systems acquisition, development and maintenance are in line with corporate policies.

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

(c) Finance and other appropriate staff have access to such data.

(d) Such computer audit reviews, as are considered necessary, are being carried out.
17. **PATIENTS' PROPERTY**

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

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) Notices and information booklets.

(b) Hospital admission documentation and property records.

(c) The oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

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

17.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Where a deceased patient is intestate and there is no lawful next of kin, details of any monies or valuables held should be notified to the Treasury solicitor.

17.7 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of that patient's monies held by the Trust.
17.8 Staff should be informed, on appointment, by the appropriate manager of their responsibilities and duties for the administration of the property of patients.

17.9 Where patients' property is received for specific purposes and held for safekeeping the property shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.
18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with guidance contained in the latest edition of the Records Management: NHS Code of Practice issued by the Department of Health.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with the above shall only be destroyed at the express instigation of the Chief Executive and records shall be maintained of documents so destroyed.
19. **RISK MANAGEMENT & INSURANCE**

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board.

19.2 The risk management strategy shall, as a minimum, contain the following elements:

(a) The continuous identification and prioritisation of key risks.

(b) A description of actions taken to manage each key risk.

(c) The identification of how risk is measured.

19.3 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, external audit, clinical audit, health and safety review.

(f) Arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make an annual governance statement within the Annual Report and Accounts as referred to in the Department of Health’s Group Accounting Manual.

19.4 The Director of Finance shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme covering both the Trust and the Charity.
20. FUNDS HELD ON TRUST

20.1 General

20.1.1 All relevant sections of this document equally apply to funds held on trust, which are managed by the Corporate Trustee and registered with the Charity Commission under the charity name of the Rotherham Health Foundation and Related Charities.

20.1.2 There are, however, certain exceptions and specific requirements that only apply to funds held on trust, which are explained further in this section.

20.1.3 In all aspects of managing funds held on trust, the Corporate Trustee must be mindful of relevant legislation and best practice guidance issued by the Charity Commission.

20.1.4 Further operational details are provided within the Charitable Funds Policy.

20.2 External Audit

20.2.1 The external auditor is appointed by the Corporate Trustee and paid for from funds held on trust.

20.2.2 The Corporate Trustee must ensure a cost efficient service by periodically seeking competitive tenders for this service. Cost efficiency must not be used as a reason to compromise the quality of the external audit service.

20.2.3 Competitive tenders should be sought at least every 3 years, with an option to extend this to 5 years at the discretion of the Audit Committee. The reasons for agreeing to any extension must be clearly documented in the minutes of the meeting when it was discussed and agreed.

20.2.4 Should there appear to be a problem with the external audit service being provided then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Corporate Trustee.

20.3 Budgets, Authorisation of Expenditure and Transactional Financial Limits

20.3.1 No budgets are set for funds held on trust.

20.3.2 All expenditure must be authorised and transacted in accordance with the delegated financial limits detailed in Appendix 8.
20.4 **Annual Accounts and Reports**

20.4.1 The Director of Finance, on behalf of the Corporate Trustee, will:

(a) Prepare annual accounts in accordance with International Financial Reporting Standards, as adjusted from time to time with accounting policies and guidance issued by the Charity Commission, the Charity’s own accounting policies and generally accepted accounting practice.

(b) Produce an annual report for funds held on trust, which will comply with the provisions of the latest Statement of Recommended Practice on Accounting and Reporting by Charities issued by the Charity Commission.

(c) Prepare and submit financial returns to the Charity Commission for each financial year in accordance with the prescribed timetable.

20.4.2 The formal published annual accounts and report must be received and approved by the Corporate Trustee and cannot be delegated.

20.5 **Bank Accounts**

20.5.1 All funds shall be held in the name of the Charity.

20.5.2 Only the Director of Finance has the authority to open any bank account in the Charity’s name. He/she has the discretion to open the number and type of bank accounts as necessary to expedite normal day to day business, including the investment of surplus cash.

2.5.3 No arrangements shall be made with the Charity’s bankers for accounts to be overdrawn. This should not happen and any instances should be reported to the Charitable Funds Committee.

20.6 **Income**

20.6.1 All gifts, donations and proceeds of fund raising activities which are intended for the Charity’s use shall be handed immediately to the Director of Finance to be banked directly.

20.6.2 All gifts and donations shall be received and held in the name of the Charity and administered in accordance with the Charitable Funds Policy, subject to the specific objects for any restricted or designated funds.

20.6.3 Where it becomes necessary for the Charity to obtain a grant of representation in order to obtain a legacy due to the Charity under the terms of a will, the Director of Finance shall be the Trust’s nominee for this purpose. Where appropriate, the Director of Finance shall seek legal advice.
upon the liabilities and other implications for the Charity of obtaining any such grant of representation.

20.6.4 All employees of the Trust who receive enquiries regarding legacies, shall keep the Director of Finance informed and shall keep an appropriate record. After the death of a benefactor, all correspondence concerning a legacy shall be dealt with by the Director of Finance who will be solely responsible for legally acknowledging receipt of such monies on behalf of the Charity.

20.6.5 The Director of Finance shall advise the Corporate Trustee on the financial implications of any proposal for fund raising activities that the Charity may initiate, sponsor or approve.

20.7 Terms of Service and Payment of Staff

20.7.1 Any staff working directly on behalf of the Charity will not be directly employed by the Charity. They will be employed by the Trust in accordance with the requirements of Section 9 above and their pay costs recharged to the Charity.

20.7.2 Any associated non-pay costs associated with their employment with the Trust will be similarly recharged to the Charity.

20.7.3 Any non-recurrent restructuring costs e.g. redundancy costs, etc. incurred by the Trust associated with staff working directly on behalf of the Charity will be similarly recharged.

20.7.4 The Director of Finance will ensure that sufficient funds are available within the Charity to be able to absorb any such costs so recharged.

20.8 Expenditure

20.8.1 All expenditure from funds held on trust, with the exception of legitimate expenses for management and administration, must be in accordance with the specific objects for individual funds, as appropriate.

20.8.2 Expenditure must not result in further commitments and or liabilities for either the Charity or the Trust unless these have been fully identified and adequately funded.

20.9 Investments

20.9.1 In order to discharge its duties as Corporate Trustee the Charity must:

(a) Know and understand its investment powers.

(b) Discharge its duties properly when it takes decisions on investments.
(c) Have proper arrangements in place for holding investments on behalf of the Charity.

(d) Follow legal requirements if it is going to use someone to manage investments on its behalf.

(e) Know what it can and cannot do if it is going to apply an ethical approach to investments.

(f) Seek professional external advice where appropriate.

20.9.2 These duties should be undertaken in accordance with a clearly defined investment strategy for the Charity, which is kept under regular review.

20.9.3 The Corporate Trustee may choose to adopt one of several approaches to investment management - advisory, discretionary or collective – and seek appropriate advice in arriving at that decision.

20.9.4 Funds held on trust shall be invested in accordance with the relevant section of the Charitable Funds Policy, which reflects the requirements of the paragraphs above.

20.9.5 All investment decisions must be formally reported to both the Charitable Funds Committee and the Corporate Trustee. For the latter, presentation of the minutes from the previous meeting of the Charitable Funds Committee will be sufficient.

20.10 Capital Expenditure

20.10.1 Any capital investment incurred by the Charity will be directly for the benefit of the Trust rather than the Charity itself and hence, will be accounted for as assets on the balance sheet of the Trust and not the Charity.

20.11 Reserves

20.11.1 The Corporate Trustee is responsible for determining a policy on reserves in accordance with Statements of Recommended Practice issued by the Charity Commission.

20.11.2 This requires the Corporate Trustee to include in the Charity’s annual report information about its reserves policy and the level of reserves held. In particular, the Corporate Trustee should:

(a) Describe its reserves policy.

(b) Explain why it holds or does not hold reserves.

(c) Quantify and explain the purpose of any material designated funds
and, where set aside for future expenditure, the likely timing of that expenditure.

(d) Give the level of reserves at the last day of the financial year to which the report relates.
APPENDIX 1

BUDGET DELEGATION AND FINANCIAL LIMITS FOR AUTHORISED SIGNATORIES: REVENUE FUNDS

Standing Financial Instruction 4.4.1 allows the Chief Executive to delegate management of a budget to permit the performance of a defined range of activities. This appendix details the budgets so delegated on the understanding that the requirements of Standing Financial Instructions 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4.5.2, 10.2.1, 10.2.4 and 10.2.7 will be strictly adhered to.

The budgets delegated include generic subjective (income, pay and non-pay) headings referenced to the objective (cost centre) headings identified for each Service Unit and Division. The generic headings are consistent with those contained in the Trust’s annual accounts as defined in the Department of Health’s Group Accounting Manual, whilst the objective headings reflect the Trust’s internal management and budgetary reporting structure.

The extent of delegation to budget holders will be reviewed annually by the Chief Executive and approved by the Board.

Within these budgets the following transactional financial limits apply:

<table>
<thead>
<tr>
<th>Authorised Signary</th>
<th>Limit (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Holder (Maximum of two per cost centre)</td>
<td>£10,000</td>
</tr>
<tr>
<td>Manager 2nd in line to an Executive or Divisional General Manager</td>
<td>£20,000</td>
</tr>
<tr>
<td>Manager 1st in line to an Executive or Divisional General Manager</td>
<td>£50,000</td>
</tr>
<tr>
<td>Executive/Divisional General Manager &amp; Deputy Director of Finance</td>
<td>£100,000</td>
</tr>
<tr>
<td>Director of Finance/Chief Executive²</td>
<td>No limit</td>
</tr>
</tbody>
</table>

1. Figures exclude VAT
2. Transactions above £1,000,000 must have been approved by the Board.

A detailed organisational structure populated with named authorised signatories is maintained and available on the Trust’s intranet.

Some cost centres may have additional requisition points attached to them, which are not shown here. If there is any confusion about cost centres and/or requisition points please contact the Financial Management section of the Finance Department.

Cost centres may be added to the above list during the financial year to which these Standing Financial Instructions and Scheme of Delegation apply. This can only be done with the prior approval of the Director of Finance.

Responsibility for such new cost centres will be delegated to the appropriate budget holder referred to above and will be subject to the same transactional financial limits referred to above and subsequently included on the organisational structure.
available on the Trust's intranet.

The budget allocated to each cost centre will be consistent with the annual business plan approved by the Board, updated for any in year changes approved by the Director of Finance, Business Investment Committee, Trust Management Committee or the Board. The total adjusted budget available will be shown in monthly budget statements issued by the Director of Finance and the monthly finance report to the Board.

Initial base budgets produced as part of the annual business plan must be signed-off individually by each budget holder.
APPENDIX 2

BUDGET DELEGATION AND FINANCIAL LIMITS FOR AUTHORISED SIGNATORIES: CAPITAL FUNDS

Standing Financial Instruction 13.1.5 authorises the Chief Executive to issue a scheme of delegation for capital investment management. This appendix details the budgets so delegated on the understanding that the requirements of Standing Financial Instructions 4.4.2, 4.4.3, 4.4.5, 4.4.6, 4.5.2, 10.2.1, 10.2.4 and 10.2.7 will be strictly adhered to.

The budgets delegated include generic subjective (pay and non-pay) headings referenced to the objective (cost centre) headings identified for each Scheme Manager. The generic headings are consistent with those contained in the Trust’s annual accounts as defined in the Department of Health’s Group Accounting Manual, whilst the objective headings reflect the Trust’s internal management and budgetary reporting structure.

The extent of delegation to budget holders will be reviewed annually by the Chief Executive and approved by the Board.

Within these budgets the following transactional financial limits apply:

<table>
<thead>
<tr>
<th>Authorised Signatory</th>
<th>Limit (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Holder</td>
<td>£100,000</td>
</tr>
<tr>
<td>Project Director/Executive Director</td>
<td>£1,000,000</td>
</tr>
<tr>
<td>Director of Finance/Chief Executive</td>
<td>No limit</td>
</tr>
</tbody>
</table>

1. Figures exclude VAT.
2. Transactions above £1,000,000 must have been approved by the Board.

A detailed organisational structure populated with named authorised signatories is maintained and available on the Trust’s intranet.

Cost centres may be added to the above list during the financial year to which these Standing Financial Instructions and Scheme of Delegation apply. This can only be done with the prior approval of the Director of Finance.

Responsibility for such new cost centres will be delegated to the appropriate budget holder referred to above and will be subject to the same transactional financial limits referred to above and subsequently included on the organisational structure available on the Trust’s intranet.

The budget allocated to each cost centre will be consistent with the annual business plan approved by the Board, updated for any in year changes approved by the Director of Finance, Business Investment Committee, Trust Management Committee or the Board. The total adjusted budget available will be shown in monthly budget...
statements issued by the Director of Finance and the monthly finance report to the Board.

Due to the nature of certain capital schemes that necessarily involve expenditure on building work, engineering work and/or professional fees, the Director of Estates & Facilities is authorised to commit expenditure on behalf of the budget holder.

Additionally, where services are subject to potential VAT recovery, the Director of Finance, via the Head of Financial Services will be necessarily involved in committing professional fees to identify the extent of such VAT.

Any queries regarding the budget available for any particular capital scheme should be addressed to the Deputy Director of Finance or the appropriate Finance Manager within Financial Management.
APPENDIX 3

VIREMENT RULES AND FINANCIAL LIMITS

This appendix sets down the powers of virement available, both recurrently and non-recurrently, in accordance with Paragraphs 4.2.1 and 4.4.3.

Recurrent Revenue Virement

Budget holders are authorised to vire recurrent savings and under-spends from one budget heading to offset or reduce an existing recurrent overspend on another budget heading. Thus, the impact upon the total budget will be neutral, which will be confirmed by the Director of Finance as part of the monthly budgetary control process.

Recurrent savings and under-spends cannot be utilised to develop new recurrent initiatives without the express agreement of the Director of Finance, Business Investment Committee or the Board.

Recurrent savings or under-spends of a significant nature, as determined by the Director of Finance in discussion with the appropriate Finance Manager, must be declared to the Director of Finance for discussion about their potential use.

Non-Reccurrent Revenue Virement

Non-recurrent savings or under-spends of a significant nature, as determined by the Director of Finance in discussion with the appropriate Finance Manager, must be declared to the Director of Finance for discussion about their potential use.

Non-Recurrent Capital Virement

Capital scheme bids must have robust estimates prepared before funding can be allocated. This must give a clear indication of the split between the cost of works (i.e. building and engineering costs, inclusive of any professional fees) and the cost of equipment. Any savings or under-spends on either of these two elements within a capital scheme cannot be used for virement between each other unless:

(a) This is necessary to keep the overall scheme cost within the total budget allocated,

and is

(b) Formally approved in accordance with the limits detailed below.

Otherwise their impact must be declared as part of year-end out-turn forecasts reported to the Board.

Where a capital scheme is constituted entirely by cost of works or entirely by...
equipment costs, the budget must be used to fund only those items included within the original estimate. Any savings or under-spends generated from the actual costing of the original specifications cannot be used to enhance the nature of the scheme without prior approval of Business Investment Committee or the Board in accordance with authorisation limits contained in Appendix 4.

Capital virement is subject to the following limits:

(a) Virement of up to 5% of the total scheme costs, up to a maximum of £50,000 is allowed at the discretion of the budget holder without any prior approval.

(b) Virement of between 5% and 10% of the total scheme costs, up to a maximum of £100,000 must be approved by the Director of Finance.

(c) Virement in excess of 10% or £100,000 of the total scheme costs, whichever is the lower must be approved by Business Investment Committee or the Board in accordance with authorisation limits contained in Appendix 4.

For example:

(a) Scheme Cost £200,000

- Maximum virement approved by the budget holder is 5% i.e. £10,000.
- Maximum virement approved by the Director of Finance is a further 5% i.e. £10,000 giving a total of £20,000.
- Any virement above £20,000 must be approved by Business Investment Committee in accordance with authorisation limits contained in Appendix 4.

(b) Scheme Cost £1,000,000

- Maximum virement approved by the budget holder is 5% i.e. £50,000.
- Maximum virement approved by the Director of Finance is a further 5% i.e. £50,000 giving a total of £100,000.
- Any virement above £100,000 must be approved by Business Investment Committee or the Board in accordance with authorisation limits contained in Appendix 4.

(c) Scheme Cost £2,000,000

- Maximum virement approved by the budget holder is 2.5% i.e. £50,000.
- Maximum virement approved by the Director of Finance is a further 2.5% i.e. £50,000 giving a total of £100,000.
- Any virement above £100,000 must be approved by Business Investment Committee or the Board in accordance with authorisation limits contained in Appendix 4.
Any savings or under-spends on one capital scheme cannot be used for virement to fund additional expenditure on another capital scheme without approval of Business Investment Committee or the Board in accordance with authorisation limits contained in Appendix 4.
APPENDIX 4

AUTHORISATION LIMITS FOR IN YEAR CHANGES TO BUDGETS

In accordance with paragraph 4.2.1 with the exception of budget transfers and virement (see Appendix 3) there will be no changes to budgets in year unless duly authorised. Only expenditure which has already been budgeted for can be committed by budget holders and in accordance with their delegated spending limits.

The only corporate bodies with the authority to commit additional (net) expenditure on behalf of the Trust and their authorisation limits are detailed below:

<table>
<thead>
<tr>
<th>Authority</th>
<th>Limit (£)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Finance</td>
<td>&lt;£25,000</td>
</tr>
<tr>
<td>Business Investment Committee</td>
<td>£25,000 &amp; &lt;£100,000</td>
</tr>
<tr>
<td>Trust Management Committee, via the Executive Directors</td>
<td>£100,000 &amp; &lt;£250,000</td>
</tr>
<tr>
<td>Board</td>
<td>£250,000 and above</td>
</tr>
</tbody>
</table>

¹. Figures exclude VAT.

No other committee has authority to commit additional expenditure on behalf of the Trust, although Finance & Performance Committee will scrutinise all business cases above £250,000 before being considered by the Board.

It would normally be expected that any business case would be scrutinised by all levels of authority relative to the financial limit involved

These limits equally apply to the virement rules contained in Appendix 3, as appropriate, income generation schemes and discontinuation of, or disinvestment in a service or operation, as referred to in paragraphs 7.2.4 and 7.2.5.
FINANCIAL LIMITS FOR PETTY CASH

In accordance with Paragraph 10.5.1 the delegated transactional financial limits for petty cash are detailed below:

<table>
<thead>
<tr>
<th>Description</th>
<th>Limit (£)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return of patients’ cash</td>
<td>Up to the amount of cash deposited for safe-keeping</td>
</tr>
<tr>
<td>Payment of patients’ fares or funeral expenses for which the Trust is liable</td>
<td>Up to the amount of fares paid or funeral expense</td>
</tr>
<tr>
<td>All other petty cash payments</td>
<td>£100</td>
</tr>
</tbody>
</table>

¹. Figures exclude VAT.

Petty cash shall not under any circumstances be used for the encashment of private cheques.
# APPENDIX 6

## PROCUREMENT PROCESS QUOTATION AND TENDER FINANCIAL LIMITS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Limit (£)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain best value.</td>
<td>&lt;£25,000</td>
</tr>
<tr>
<td>If no contract exists, obtain a minimum of 3 written quotations.</td>
<td>£25,000 &amp; &lt;£50,000</td>
</tr>
<tr>
<td>Formal tendering via the Procurement Department. Advice will be given on</td>
<td>£50,000 &amp; &lt;OJEU Threshold Limit²</td>
</tr>
<tr>
<td>Formal tendering complying with OJEU requirements to be undertaken by the</td>
<td>&gt;OJEU Threshold Limit</td>
</tr>
<tr>
<td>Procurement Department. If insufficient tenders are received, a further</td>
<td></td>
</tr>
<tr>
<td>procurement exercise may be necessary.</td>
<td></td>
</tr>
<tr>
<td>Procure via the use of the Trust’s measured term contract or OJEU tender.</td>
<td>Works &lt;£200,000</td>
</tr>
<tr>
<td>Formal tendering via the Procurement Department. Advice will be given on</td>
<td>Works &gt;£200,000</td>
</tr>
<tr>
<td>the process to be followed.</td>
<td></td>
</tr>
</tbody>
</table>

1. Figures exclude VAT.


Waiving of quotation and tender requirements in accordance with Paragraph 11.5 require authorisation in accordance with the financial limits detailed below:

<table>
<thead>
<tr>
<th>Authority</th>
<th>Limit (£)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Procurement</td>
<td>&lt; £50,000</td>
</tr>
<tr>
<td>Director of Finance or Chief Executive</td>
<td>£50,000 &amp; &lt;£100,000</td>
</tr>
<tr>
<td>Director of Finance and Chief Executive</td>
<td>£100,000 &amp; &lt;£250,000</td>
</tr>
<tr>
<td>acting jointly</td>
<td></td>
</tr>
<tr>
<td>Chairman/Board</td>
<td>Above £250,000</td>
</tr>
</tbody>
</table>

1. Figures exclude VAT.
APPENDIX 7

FINANCIAL LIMITS FOR LOSSES AND SPECIAL PAYMENTS

<table>
<thead>
<tr>
<th>Authority</th>
<th>Limit (£)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget holder</td>
<td>&lt; £250</td>
</tr>
<tr>
<td>Director of Finance and Deputy Director of Finance acting</td>
<td>£250 &amp; &lt;£1,000</td>
</tr>
<tr>
<td>jointly</td>
<td></td>
</tr>
<tr>
<td>Audit Committee</td>
<td>£1,000 &amp; &lt;£10,000</td>
</tr>
<tr>
<td>Board</td>
<td>Above £10,000</td>
</tr>
</tbody>
</table>

1. Figures exclude VAT.

These delegated spending limits only apply to the specific circumstances outlined below.

Delegated limits excluding losses and special payments in category 5 and also payments relating to clinical negligence and personal injury claims within category 7.

Budget holders have authority to write-off losses and approve special payments that occur within their area of responsibility, up to a value of £250 per item. These must be approved by an appropriate authorised signatory as designated within the Trust’s scheme of delegation and be forwarded to the Director of Finance for action.

All items between £250 and £1,000 will be considered jointly by the Director of Finance and his/her Deputy.

All items with a value in excess of £1,000 must have completed a checklist, as appropriate, in a format prescribed by and prepared by the Director of Finance. To avoid delays in making payments to third parties, approval of losses can be agreed jointly by two executive directors, one of which must be the Director of Finance. All such approvals will be reported through to, and formally ratified by, Audit Committee or the Board at its next available meeting.

Delegated limits and procedures for Category 5 payments and payments in respect of clinical negligence and personal injury claims within Category 7.

Where preliminary analysis concludes that the claim is thought to be valid, approval will be sought to settle. For all claims, including all clinical negligence cases, the Company Secretary will notify the NHS Resolution in accordance with the Trust’s Claims Management Policy. The Trust will only be liable for any amount up to its agreed level of excess.
AUTHORISATION OF EXPENDITURE AND TRANSATIONAL FINANCIAL LIMITS: TRUST FUNDS

In accordance with Paragraph 20.3.2 the following financial limits apply for the authorisation of expenditure from funds held on trust.

<table>
<thead>
<tr>
<th>Authority</th>
<th>Limit (£)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable Funds Committee</td>
<td>&lt; £25,000</td>
</tr>
<tr>
<td>Corporate Trustee</td>
<td>No limit</td>
</tr>
</tbody>
</table>

1. Figures exclude VAT.

Due to timing issues, if it is not practical to defer a decision until the next meeting of the Charitable Funds Committee, approval can be given by one of the authorised signatories and then reported retrospectively to the Charitable Funds Committee.

<table>
<thead>
<tr>
<th>Authority¹</th>
<th>Limit (£)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Secretary</td>
<td>&lt; £5,000</td>
</tr>
<tr>
<td>Director of Nursing/Medical Director/Director of Finance</td>
<td>£5,000 &amp; &lt;£10,000</td>
</tr>
<tr>
<td>2 x Executive Directors acting jointly</td>
<td>£10,000 &amp; &lt;£25,000</td>
</tr>
</tbody>
</table>

1. Excluding the Director of Finance.
2. Figures exclude VAT.

No requests that require Corporate Trustee approval can be approved in between meetings.

Once expenditure has been authorised, official orders can then be raised or invoices approved by any of the following authorised signatories:

Company Secretary
Executive Director (Excluding the Director of Finance)
Deputy Director of Finance
Head of Financial Services
Assistant Head of Financial Services

Other expenditure will be necessarily incurred within funds held on trust, whether this is actual cash transactions or non-cash accounting entries.

Cash transactions may include:

(a) Staff and associated non-pay recharges, which will have been previously agreed by the Charitable Funds Committee.
(b) Audit fees, both internal and external, prospectively agreed as necessary by the Corporate Trustee.
(c) Investment brokers fees, as advised by the Charity’s appointed stockbrokers.
(d) Management costs/overheads, recharged from the Finance Department.
(e) Bank charges.
(f) Realised gains and losses on disposal of investments, as advised by the Charity’s appointed stockbrokers.

Non-Cash transactions may include:
(a) Depreciation on any fixed assets held.
(b) Unrealised gains and losses on disposal of investments, as advised by the Charity’s appointed stockbrokers.

All such transactions must be authorised and/or actioned by one of the following authorised signatories.

Deputy Director of Finance
Head of Financial Services
Assistant Head of Financial Services
**APPENDIX 9**

**EQUALITY IMPACT ASSESSMENT**

**Document Name:** Standing Financial Instructions  
**Date/Period of Document:** November 2018

**Lead Officer:** Simon Sheppard  
**Directorate:** Finance  
**Reviewing Officers:** Mark Bloy

---

### 1. Function

<table>
<thead>
<tr>
<th>Policy</th>
<th>Procedure</th>
<th>Strategy</th>
<th>Joint Document, with who?</th>
</tr>
</thead>
</table>

Describe the main aim, objectives and intended outcomes of the above:

---

### 2. Assessment of possible adverse impact against any minority group

You must assess each of the 9 areas separately and consider how your document in section 1 may affect people’s human rights.

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sex (Male and Female?)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Disability (Learning Difficulties/Physical or Sensory Disability)?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race or Ethnicity?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion and Belief?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation (gay, lesbian or heterosexual)?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment (The process of transitioning from one gender to another)?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership?</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

You need to ask yourself:

- Will the document create any problems or barriers to any community of group? Yes/No
- Will any group be excluded because of this document? Yes/No
- Will the document have a negative impact on community relations? Yes/No

If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment.

### 3. Positive impact:

Could the document have a significant positive impact on equality by reducing inequalities that already exist?

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote equal opportunities</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Get rid of discrimination</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Get rid of harassment</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Promote good community relations</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Promote positive attitudes towards disabled people</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Encourage participation by disabled people</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Consider more favourable treatment of disabled people</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Promote and protect human rights</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Summary

On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative impact on equality?

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>LOW</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>LOW</td>
</tr>
<tr>
<td>LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>NIL</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

**Please rate, by circling, the level of impact**

<table>
<thead>
<tr>
<th>Date assessment completed: 13th November 2018</th>
<th>Is a full equality impact assessment required?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑ Yes</td>
</tr>
</tbody>
</table>

(documentation on the intranet)
<table>
<thead>
<tr>
<th><strong>Agenda item</strong></th>
<th>487/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report</strong></td>
<td>Standards of Business Conduct</td>
</tr>
<tr>
<td><strong>Executive Lead</strong></td>
<td>Presenter: Anna Milanec, Director of Corporate Affairs / Company Secretary</td>
</tr>
<tr>
<td><strong>Link with the BAF</strong></td>
<td>The Standards of Business Conduct, alongside the Standing Financial Instructions, Standing Orders, Matters Reserved to the Board and Scheme of Delegation, form key controls for BAF item B6: <em>Insufficiently robust Trust-wide (internal) governance arrangements impede the delivery of a number of plans / objectives.</em></td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Decision ✓ To note □ Approval ✓ For information □</td>
</tr>
</tbody>
</table>

**Executive Summary (including reason for the report, background, key issues and risks)**

This revision of the Standards of Business Conduct (‘the Standards’) incorporates NHS England’s model Conflicts of Interest policy published in April 2017 (implemented from 1 June 2017) and thereby significantly strengthens the Trust’s approach to the declaration of interests for staff members other than Directors. This revision also includes the legal advice sought following the previous revision to the Standards in 2015. The revised Standards include some significant changes:

- Annual declarations required from all ‘decision making staff’ (8D and above)
- Requirement to manage interests and document approach taken
- Declarations are now required for 11 categories, 8 of which the Trust has not previously required declarations for (Outside employment; Shareholding and other ownership interests; Patents; Loyalty interests; Donations; Sponsored research; Sponsored posts; and Clinical private practice)
- Staff are no longer able to take annual leave to work on the Trust’s bank where this does not leave them with at least 28 days of annual leave during which they do not work

The Standards were supported by the Audit Committee at its May 2017 meeting following which a consultation with the Joint Partnership Forum and Local Negotiating Committee (LNC) was undertaken.

The Standards were approved at the Trust Management Committee meeting on 3 April 2018 and, at its August 2018 meeting, the Audit Committee recommended the Standards to the Board of Directors (pending resolution of matters arising at the Local Negotiating Committee).

**Recommendations**

It is recommended that:
The Board of Directors approves the revised Standards of Business Conduct.

**Appendices**

1. Standards of Business Conduct version 9
STANDARDS OF BUSINESS CONDUCT
(including NHS England Conflicts of Interest Guidance)

Author: Lisa Reid, Head of Governance

Revised and Approved by Audit Committee: August 2018

Revised and Approved by Board of Directors

Review date:

Version: 9
FOREWORD

The high quality of the directors and employees of The Rotherham NHS Foundation Trust (“the Trust”) is the Trust’s greatest strength. The resourcefulness, professionalism, and dedication of each of them make the Trust competitive in the short term and well positioned for ongoing success in the long term.

The Trust’s directors and employees are responsible for developing, approving, and implementing plans and actions designed to achieve corporate objectives. The methods we employ to attain results are as important as the results themselves. The Trust’s directors and employees are expected to observe the highest standards of integrity in the conduct of the Trust’s business.

The Board of Directors of the Trust has adopted and overseen the administration of the Trust’s *Standards of Business Conduct*. The policies referred to within the *Standards of Business Conduct* are the core policies of the Trust.

Only the Board of Directors of The Rotherham NHS Foundation Trust has the authority to make exceptions or grant waivers with respect to the core policies. Regardless of how much difficulty we encounter or pressure we face in performing our jobs, no situation can justify the wilful violation of these policies. Our reputation as a corporate citizen depends on our understanding of, and compliance with, these policies.

In February 2017 NHS England published guidance on the management of conflicts of interest superseding 1993 Department of Health circular ‘Standards of Business Conduct for NHS staff’ (HSG(93)5). This was followed in April 2017 by the publication of NHS England’s model policy for the management of conflicts of interest which all NHS and Foundation Trusts must adopt. As a result, the Trust’s Standards of Business Conduct have been revised to incorporate NHS England’s model policy in order to ensure that the Trust’s procedures for the management of conflicts of interest are compliant with the new NHS England conflicts of interest guidance which came into force on 1 June 2017.
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Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

<table>
<thead>
<tr>
<th>As a member of staff you should…</th>
<th>As an organisation we will…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers’ money is spent</td>
<td>• Identify a team or individual with responsibility for:</td>
</tr>
<tr>
<td>• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.</td>
<td>o Keeping this policy under review to ensure they are in line with the guidance.</td>
</tr>
<tr>
<td>• NOT misuse your position to further your own interests or those close to you</td>
<td>o Providing advice, training and support for staff on how interests should be managed.</td>
</tr>
<tr>
<td>• NOT be influenced, or give the impression that you have been influenced by outside interests</td>
<td>o Maintaining register(s) of interests.</td>
</tr>
<tr>
<td>• NOT allow outside interests you have to inappropriately affect the decisions you make when using taxpayers’ money</td>
<td>o Auditing this policy and its associated processes and procedures at least once every three years.</td>
</tr>
<tr>
<td>• NOT avoid managing conflicts of interest.</td>
<td>• NOT interpret this policy in a way which stifles collaboration and innovation with our partners</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The Rotherham NHS Foundation Trust (the ‘organisation’), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

The Standards of Business Conduct outline the principles by which the Trust, its management and staff make decisions and can be held accountable.

Public service values must be at the heart of the National Health Service (NHS). High standards of corporate and personal conduct based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Since the NHS is publicly funded, the Trust must be accountable for the services it provides and for the effective and economical use of taxpayers’ money.

The Trust believes it is the responsibility of all 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.

The Trust’s Core Values are:

- **Ambitious** seeks to set high standards and expectations, for the services we deliver but also for ourselves. For example, we can be ambitious in terms of quality of care for our patients and clinical strategies. Also, we can be ambitious in terms of changes to our ways of working and patient pathways to develop sustainable services for the population we serve.

- **Caring** reflects overwhelming feedback about what our colleagues and patients would like to see from us, embracing the importance of caring for patients and families. Also, it is important that we care for each other as colleagues, and that we care in other ways, such as about our community, our resources, our environment and our future.

- **Together** represents the importance of working together, whether as clinical, non-clinical and multidisciplinary teams, with patients, carers and families to provide high quality patient-centred care. It is also about working with our partners across Rotherham, South Yorkshire and Bassetlaw and further afield, to improve the health and wellbeing of the population we serve.
We all have a desire for our Trust to succeed and prosper, but it is very clear that we will not compromise our values to achieve that success. There are no grey areas when it comes to integrity. At the Trust, integrity encompasses all of the above.

Sometimes, however, it is not always clear how these values apply to our day-to-day activities. One of the reasons these Standards were created was to illustrate the application of our values through specific standards of conduct.

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations
- Supports good judgement about how to approach and manage interests

This policy should be considered alongside the other organisational policies referenced within it and those detailed in section 6.

As a public benefit corporation, in many instances our values will require us to set standards beyond what is legally required or even commonly practiced in other areas. Our values must never be compromised, even in business situations where competitive advantage may weigh in the balance. All of us should consider how our individual actions might affect the integrity and credibility of the Trust as a whole bearing in mind that perception, although not necessarily the truth can be construed as being reality. We must avoid situations that could lead to improper or illegal actions.

If you have any questions about the Standards of Business Conduct, please ask your line manager, but if they cannot provide you the information or assistance you need, you may wish to talk directly to the Company Secretary or the Head of Governance.


NHS England have published some Frequently Asked Questions to assist staff in understanding the new conflicts of interest guidance. These are available here: [www.england.nhs.uk/ourwork/coi](www.england.nhs.uk/ourwork/coi)

In addition managers must comply with the Code of Conduct for NHS Managers, October 2002 (see Appendix D). Additional policies have been developed that build upon the core policies referenced herewith.

At The Rotherham NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as ‘staff’ and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

The standards apply to all Trust staff irrespective of age, race, colour, religion, disability, nationality, ethnic origin, gender, sexual orientation or marital status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. All staff will be treated in a fair and equitable manner and reasonable adjustments will be made where appropriate e.g. interpreter or signing provision, access arrangements, induction loop, etc. The Rotherham NHS Foundation Trust Board of Directors will ensure that the Standards of Business Conduct are monitored and evaluated on a regular basis by the Joint Partnership Forum (JPF). The Standards of Business Conduct may be reviewed at the request of Management or Staff Side by giving four weeks’ written notice with reasons for the review.

Failure to comply with the Trust’s Standards of Business Conduct may result in disciplinary actions up to and including termination of employment and a referral to the Local Counter Fraud Specialist. See section 3.22 Dealing with Breaches for further information.

Failure to read and/or acknowledge the Standards of Business Conduct does not exempt a staff member from his/her responsibility to comply with the Standards of Business Conduct, NHS England’s guidance on the management of conflicts of interest, applicable laws, regulations, and Trust policies that are related to his/her job.

The Rotherham NHS Foundation Trust’s Standards of Business Conduct are a general guide to the Trust and NHS England’s required standards of business practice and regulatory compliance. All staff members are expected to familiarise themselves and comply with their professional code of conduct and the seven Nolan Principles for Public Life (see Appendix B) or https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

The Standards of Business Conduct are endorsed by and have the full support of the Trust's Board of Directors. The Board of Directors and Management are responsible for overseeing compliance with, and enforcing, the Standards of Business Conduct.

Waivers of provisions of the Standards of Business Conduct that are granted to any director or executive officer of the Trust may only be made by the Board of Directors or by Board committee designated by the Board of Directors. Any such waiver that is granted to a director or executive officer will be publicly disclosed as required by applicable laws, rules, and regulations.

1.1 Our Responsibilities

All Trust staff are accountable and responsible for understanding and complying with the Standards of Business Conduct, NHS England’s guidance on the management of conflicts of interest, applicable laws, regulations, and Trust policies that are related to their jobs. In fulfilling these responsibilities each member of staff must:
• Read, understand, and comply with the Standards of Business Conduct and all Trust policies that are related to his/her job.

• Participate in training and educational programs or events required for his/her job.

• Obtain guidance for resolving a business practice or compliance concern if he/she is uncertain about how to proceed in a situation.

• Report possible violations of the Standards of Business Conduct, policies, applicable laws, and regulatory requirements.

• Cooperate fully in any investigation.

• Make a commitment to conduct the Trust’s business with integrity and in compliance with applicable laws and regulatory requirements.

We must expect the best from ourselves because who we are as an organisation and as individuals is as important as our ability to deliver the best care and services. How we manage our hospital and community services internally — and how we think about and work with patients, partners, governments, suppliers and communities — impacts upon our productivity and success. It's not enough to just do the right things; we also have to do them in the right way.

These Standards of Business Conduct provide information, education, and resources to help you make good, informed business decisions and to act on them with integrity. In addition, managers should use this resource to foster, manage, and reward a culture of accountability and integrity within their departments. Working together, we can continuously enhance our culture in ways that benefit patients and partners, and that strengthen our interactions with one another.

All staff members are responsible for understanding and complying with the Standards of Business Conduct, NHS England’s conflicts of interest guidance, applicable government regulations, and the Trust’s policies. As members of Trust staff, you also have a responsibility to raise compliance and ethics concerns through our established channels (see section of Dealing with Breaches for further information about your responsibility to report any breaches of these Standards).

1.2 **Why the Trust has Standards of Business Conduct**

As responsible public sector healthcare providers, it is not enough to intend to do things right, we must also do them in the right way. That means making business decisions and taking appropriate actions that are ethical and in compliance with applicable legal requirements. As we make these decisions, our values must shine through in all our interactions. The Standards of Business Conduct are an extension of the Trust’s values and reflect our continued commitment to ethical business practices and regulatory compliance. In addition, adherence to these Standards will ensure your compliance with NHS England’s guidance on the management of conflicts of interest introduced in February 2017.
1.3 How to use the Standards of Business Conduct

The Standards of Business Conduct summarise the regulatory requirements and business practices that guide our decision making and business activities. The Standards contain basic information about our policies as well as information about a particular practice or compliance concern. It is essential that you thoroughly review this publication and make a commitment to uphold its requirements.

The Standards of Business Conduct are not intended to cover every issue or situation you may face as a Trust employee. Nor do they replace other more detailed policies. You should use the Standards as a reference guide in addition to Trust policies. It is your responsibility to be fully aware of these Standards and to follow them.

If you need details on a specific policy, you may contact the Company Secretary or Head of Governance. If you need guidance regarding a business practice or compliance issue or wish to report a possible violation / breach, talk to your immediate supervisor, manager, another member of management, the Company Secretary, Head of Governance, HR team or Local Counter Fraud Specialist. (See section 3.22 Dealing with Breaches for further information).

The Trust will handle all inquiries discreetly and make every effort to maintain, within the limits allowed by the law, the confidentiality of anyone requesting guidance or reporting a possible violation / breach.
2. GUIDING PRINCIPLES

2.1 The Rotherham NHS Foundation Trust is committed to being a high performing Trust. To that end, we must continuously achieve superior safety, and business results while simultaneously adhering to high ethical standards.

The Trust aspires to be at the leading edge of competition within the field of healthcare provision. That requires the Trust’s resources – financial, operational, technological, and human – to be employed wisely and evaluated regularly.

While we maintain flexibility to adapt to changing conditions, the nature of our business requires a focused, long-term approach. We will consistently strive to improve efficiency and productivity through learning, sharing and implementing best practices.

We aim to achieve our goals by executing our business plans and by adhering to these guiding principles, our values and the core policies.

The following principles guide our relationships with our service users, staff members, external partners and communities:

2.2 Patients – Success depends on our ability to consistently satisfy ever changing patient preferences. We commit to be innovative and responsive in order to provide first class patient care and high quality, safe services. This entails all health professionals keeping up to date with changes in clinical best practice / guidance such as that produced by the National Institute for Health and Care Excellence (NICE), Royal Colleges and other advisory agencies. Health professionals are expected to take such guidance fully into account when exercising their clinical judgment.

2.3 Employees – The quality of our workforce provides a valuable competitive edge. To build on this advantage, we will strive to recruit and retain the highest calibre people available and to maximise their opportunities for success through training and development. We are committed to maintaining a safe work environment enriched by diversity and characterised by open communication, trust, and fair treatment.

2.4 External Partners – We aim to work with our partners in an open and responsive manner. We will maintain high ethical standards, respect and recognise our partners’ expertise and the valid contribution that each can make to the provision of high quality services and an improved patient experience and outcome.

2.5 Communities & Social Responsibility – We commit to being a good corporate citizen, maintaining high ethical standards, obeying all applicable laws, rules and regulations, and respecting local cultures and running safe and environmentally responsible services.
3. CONFLICTS OF INTEREST

3.1 Definition:

A ‘conflict of interest’ is:

“A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

3.2 Interests

Interests fall into the following categories:

- Financial interests:
  Where an individual may get direct financial benefit\(^2\) from the consequences of a decision they are involved in making.

- Non-financial professional interests:
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- Non-financial personal interests:
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- Indirect interests:
  Where an individual has a close association\(^3\) with another individual who has a financial interest, a non-financial professional interest or a non-financial

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\(^1\) ‘Managing Conflicts of Interest in the NHS: Model policy content for organisations, NHS England, April 2017

\(^2\) This may be a financial gain, or avoidance of a loss.

\(^3\) A common sense approach should be applied to the term ‘close association’. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.
personal interest and could stand to benefit from a decision they are involved in making.

The *NHS Code of Conduct and Accountability* (third revision, April 2013) very clearly establishes that Boards of Directors must act in a manner which protects the interest of the NHS in the conduct of their business.

The values of Accountability, Probity and Openness must underpin the work of each and every NHS Board. All Board members must act impartially and must not be influenced (or be perceived to have been influenced by) business or social interests.

Therefore all members of the Board of Directors (including Non-Executive Directors) and Governors must declare interests which are 'relevant and material' and these must be recorded on the Register of Director’s interests which is available to the public and in the minutes of the Board meetings. All existing Board Directors should declare relevant and material interests. Any Board Directors or members of the Council of Governors appointed / elected subsequently should do so on appointment or election. If a conflict of interest is established the Board member should withdraw themselves from the discussion and play no part in the decision to be made.

The Health and Social Care Act 2012 states:

> ‘If a director of a public benefit corporation has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the director must declare the nature and extent of that interest to the other directors.’

See the Trust’s ‘Standing Orders’ Section 6 for further information.

It is the responsibility of all staff members to avoid conflicts of interest and Directors have a statutory duty to avoid such conflicts of interest enshrined within the Health and Social Care Act 2012. It is important to remember that a member of staff does not need to exploit his or her position to obtain an actual benefit (financial or otherwise) for a conflict of interest to occur.

### 3.3 Decision Making Staff

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 example those staff of the Trust who have responsibility for committing resources either directly: by ordering or influencing the ordering of goods and services or by their involvement in the recruitment of new employees; or indirectly: by prescribing or influencing the choice of product or service to be used. For the purposes of this document these people are referred to as ‘decision making staff.’

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Decision making staff in this organisation are:

- Executive and 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

3.4 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

This declaration must include:

- The person’s name and their role with the organisation
- A description of the interest declared (reflecting the type of interest they are declaring e.g. financial interest, non-financial interest etc)
- Relevant dates relating to the interest
- Space for comments (e.g. action taken to mitigate conflict)

A declaration of interest(s) form is available at Appendix E.

Declarations should be made to the Head of Governance. Advice as to the materiality of the conflict of interest can be obtained from the Company Secretary or the Head of Governance.

After expiry, an interest will remain on the register for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

It is the responsibility of the member of staff to ensure that he/she is not placed in a position which risks, or appears to risk, conflict between his/her private interests and his/her duties and responsibilities on behalf of the Trust.
See the Trust’s ‘Standing Orders’ Section 8 for further information.

It is not possible to list all situations or relationships which may give rise to a conflict of interest, or the appearance of one, so each situation must be evaluated on its individual facts. NHS England have published some Frequently Asked Questions designed to assist in understanding what a conflict of interest is. These are available here: www.england.nhs.uk/ourwork/coi

Examples of situations where conflicts of interest may arise, and the principles which should be applied, are given below.

**Personal and Business Integrity**

Staff members must disclose any material financial interest in any competitor, supplier, customer or other business with which the Trust has significant business dealings. As described earlier for the purposes of this policy ‘staff’ include:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

These disclosures should be made using the form at Appendix E.

Staff may not hold any material financial interest in a supplier, customer or other external business if they have any involvement in the Trust’s dealings with that business or supervise anyone with such involvement.

Save as may be expressly permitted in writing, no member of staff may hold a material financial interest in any business the activities of which are:

- In direct competition with the Trust; or
- Otherwise against the interests of the Trust.

The activities of staff members’ close relatives can sometimes create conflicts of interest. Staff should disclose any situation where a close relative works or performs services for, or has a material financial interest in, any competitor, supplier, customer or other business with which the Trust has significant business dealings.

These disclosures should be made using the form at Appendix E.

No member of staff should have any business involvement with a close relative or with any business for which a close relative works or in which a close relative holds a material financial interest.

No staff member should ever be in a situation where they have the ability to employ, supervise, affect terms and conditions of employment, or influence the management of any close relative. A ‘close relative’ is someone with whom you have a close family or personal relationship such that it could give rise to a conflict of interest (or the perception of a conflict of interest) in the
situations described. It includes any spouse, partner, parent, stepparent, child, step-child, sibling, step-sibling, nephew, niece, aunt, uncle, grandparent, grandchild (and any such relationships arising by marriage).  

If you and a close relative both work within Trust you should ensure that you both act in accordance with the Trust’s *Policy for Close Personal Relationships at Work.*

### 3.5 Proactive Review of Interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

### 3.6 Records and Publication

**Maintenance:** The organisation will maintain the following registers:

- Register of Directors’ Interests
- Register of Governors’ Interests
- Register of Gifts, Benefits, Hospitality and Sponsorship for Course / Conference Attendance
- Register of Staff Interests

All declared interests that are material will be promptly transferred to the appropriate register by the Head of Governance or the Corporate Governance Manager.

**Publication:** We will:

- Publish the interests declared by decision making staff at bands 8D (or equivalent) and above in the Register of Directors’ Interests or the Register of Staff Interests. In addition, those interests declared by staff at lower bands who have given their consent for publication will also be published.
- Refresh this information annually
- Make this information available on the ‘key corporate documents’ page of the organisation’s website

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Head of Governance to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

### 3.7 Wider Transparency Initiatives

The Rotherham NHS Foundation Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

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6 With thanks to the British Marine Standards of Business Conduct, June 2011, source: [http://www.britmarine.co.uk/corporate-governance.html](http://www.britmarine.co.uk/corporate-governance.html), last accessed 26/6/15.
Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These ‘transfers of value’ include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: [http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx](http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx)

In addition, the ‘transfers of value’ detailed above should also be declared to the organisation using the forms at Appendix C or E as appropriate.

### 3.8 Management of Interests – General

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and The Rotherham NHS Foundation Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

### 3.9 Management of Interests – Common Situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

#### 3.9.1 Gifts

It is the policy of the Trust to base commercial decisions on commercial criteria. This policy serves the Trust’s business interests and fosters constructive relationships with organisations and individuals doing business, or seeking to do business with the Trust.
Staff should not accept gifts that may affect, or be seen to affect, their professional judgement or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts must be returned and hospitality refused.

It is recognised that gifts are commonplace and often deserved, and in some cases can be accepted. However moral judgement should be exercised, especially when dealing with vulnerable people.

**Gifts from suppliers or contractors:**

- 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 £25 should be treated with caution and only be accepted on behalf of The Rotherham NHS Foundation Trust not in a personal capacity. These should be declared by staff using the declaration form at Appendix C and the advice of the Company Secretary or Head of Governance should be sought before such gifts are accepted on behalf of the organisation.
- Modest gifts accepted under a value of £25 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 £25 where the cumulative value exceeds £50.

Staff must declare, seek approval to accept and register gifts of any kind, from any source (using the form at Appendix C) if they are worth £25 or more, even where they have been refused / declined.

Similarly a declaration (using the form at Appendix C) must be made if several small gifts, benefits, hospitality or sponsorship of any kind are offered totalling over £50 from the same or a closely related source in a 12-month period. A declaration is required when:

- items have been refused or returned; or
- approval is required to accept the item(s) being offered.

**Information to be declared on the form at Appendix C:**

- Staff name and their role with the organisation.
• A description of the nature and value of the gift, including its source.
• Date of receipt.
• Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.9.2 Hospitality
• Staff should not ask for, or accept, hospitality that may affect, or be seen to affect, their professional judgement.
• Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
• Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

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.
• 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:
  o offers of business class or first class travel and accommodation (including domestic travel)
  o offers of foreign travel and accommodation.

Information to be declared on the form at Appendix C:
• Staff name and their role with the organisation.
• The nature and value of the hospitality including the circumstances.
• Date of receipt.
• Any other relevant information (e.g. action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.10 Outside Employment

• Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
• Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
• Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Information be declared on the form at Appendix E:
• Staff name and their role with the organisation.
• The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
• Relevant dates.
• Other relevant information (e.g. action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.11 Outside Interests

All Trust staff (excluding medical staff) are expected to devote the whole of their professional time and ability to deliver the requirements of their post and any other roles and activities, as approved by their line manager, to further the Trust’s business.

All Trust employees (including medical staff unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed) must notify their line manager if they intend to take up external employment or carry out paid work particularly work which may conflict with their work for the Trust. The line manager (with the support of HR Department) will determine whether the interests of the Trust are likely to be harmed in accordance with sections 3.20 and 4.3 of these Standards.

Where any such employment or paid activity (e.g. consultancy, speaking at conferences) is intended to take place during the employee’s normal contracted hours, line manager approval is required.

If the work carried out is part of the employee’s normal duties, or could reasonably be regarded as falling within normal duties of the post and is
carried out during the normal working hours of that employee, then any fee must be made payable to the Trust.

If the employee wishes to undertake during what would be their normal working hours any paid activity which is personal in nature rather than forming part of the employee’s normal duties, they must seek approval to an appropriate period of leave from their normal duties, paid (i.e. annual leave but not study leave) or unpaid, to enable them to undertake the activity. In those circumstances the fee may be retained by the employee.

Any employee who wishes to undertake a ‘one off’ paid activity entirely in their own time using their own materials and subject matter, that attracts a fee will be able to retain the fee paid, however it would be their responsibility to inform the tax office as appropriate.

Where an employee holds another appointment outside the Trust, including self-employment and is off sick from their Trust post, or on Carers’ or Bereavement leave, they should not normally undertake any paid work during the period of sickness and any intention to do so should be agreed with their manager in advance.

Where an employee is found to be working elsewhere, including self-employment, whilst in receipt of contractual sick pay and a GP Fit Note (which stated that the employee could work elsewhere) cannot be provided to confirm their eligibility to work, this may be treated as gross misconduct under the Trust’s Disciplinary Procedure and the Trust’s Local Counter Fraud Specialist will also be notified, which could result in criminal prosecution.

Employees must not take up any paid or unpaid employment during periods of Study Leave during their contracted hours. Such conduct may be treated as gross misconduct under the Trust’s Disciplinary Procedure and will be referred to the Trust’s Local Counter Fraud Specialist.

Employees must not take up any paid or unpaid employment during periods of annual leave where such work would prevent the employee from taking their full annual leave entitlement under the Working Time Regulations (28 days). Employees must not take up any paid employment with the Trust (i.e. any bank shifts or consultancy work) during periods of paid annual leave. In the event that an employee receives payment for a bank shift when they are in a period of paid annual leave from their employment with the Trust, payment for the bank shift must be reimbursed to the Trust.

The Trust may deduct from the salary, or any other sums owed to the employee, any money owed to the Trust under this policy.

All staff should not undertake work outside of their contracted hours where such work would be in breach of the Working Time Regulations, although they are entitled to opt out of this if they so wish. This needs to be formally agreed with their manager in writing.

Information be declared on the form at Appendix E:

- Staff name and their role with the organisation.
- The nature of the outside interest (e.g. who it is with, a description of duties, time commitment).
3.12 Shareholdings and other ownership issues

- 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.

- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

Information to be declared on the form at Appendix E:

- Staff name and their role with the organisation.

- Nature of the shareholdings/other ownership interest.

- Relevant dates.

- Other relevant information (e.g. action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.13 Patents

- 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.

- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

Information to be declared on the form at Appendix E:

- Staff name and their role with the organisation.

- A description of the patent.

- Relevant dates.

- Other relevant information (e.g. action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy)
3.14 Loyalty interests

- Loyalty interests should be declared by staff involved in decision making where they:
  - Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
  - Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers’ money for example Strategic Transformation Partnership (STP), Working Together Programme (WTP) or Operational Delivery Network (ODN) groups.
  - Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
  - Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Information to be declared on the form at Appendix E:

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.15 Donations

- 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.
- Staff who receive a charitable funds donation on behalf of the Trust Charity (The Rotherham Hospital and Community Charity) or affiliated appeals are expected to ensure they act in accordance with the appropriate policy and procedures in place for the receipt of charitable funds. Should staff have
any concerns regarding this process they should liaise with their line
manager or the Charity Engagement and Development Manager.

- 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.

Information be declared on the form at Appendix E:

- The organisation will maintain records in line with the above principles and
  rules and relevant obligations under charity law.

3.16 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved
  if a reasonable person would conclude that the event will result in clear
  benefit to the organisation and the NHS.

- During dealings with sponsors there must be no breach of patient or
  individual confidentiality or data protection rules and legislation.

- No information should be supplied to the sponsor from whom they could
  gain a commercial advantage, and information which is not in the public
  domain should not normally be supplied.

- At the organisation’s discretion, sponsors or their representatives may
  attend or take part in the event but they should not have a dominant
  influence over the content or the main purpose of the event.

- The involvement of a sponsor in an event should always be clearly
  identified.

- Staff within the organisation involved in securing sponsorship of events
  should make it clear that sponsorship does not equate to endorsement of a
  company or its products and this should be made visibly clear on any
  promotional or other materials relating to the event.

- Staff arranging sponsored events must declare this to the organisation.

Information to be declared on the form at Appendix E:

- The organisation will maintain records regarding sponsored events in line
  with the above principles and rules.

3.17 Sponsorship for courses, conferences, meetings and publications

- Staff may accept commercial sponsorship for courses, conference,
  meetings and publications if they are reasonably justifiable and in
  accordance with the principles set out in this policy. In cases of doubt,
  advice should be sought from your line manager or the Company
  Secretary or Head of Governance. Permission (with details of the proposed
  sponsorship) must be obtained from the Company Secretary or Head of
Governance in writing (using the form at Appendix C for course, conferences and meetings or Appendix E for publications) in advance of accepting the sponsorship from the company.

- Acceptance of commercial sponsorship should not in any way compromise purchasing decisions.
- Where sponsorship is related to study leave, authorisation should be obtained via the approved system at the time and a copy of the study leave form attached to the declaration form (Appendix C) and forwarded to the Head of Governance for inclusion in the register.

**N.B.** for medical staff a copy of the study leave form is forwarded to the Medical Education Manager for inclusion in the register held by PGME which is provided to the Company Secretary Department on an annual basis. If training / study is undertaken in the staff member’s own time this should be indicated on the declaration form.

- If staff are in any doubt as to when a declaration should be made they should err on the side of caution and are strongly advised to make a declaration.
- See the Trust’s *Standing Orders*; NHS England’s Conflicts of Interest Guidance included at Appendix A and the *Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy)* for further information.

Information to be declared on the form at Appendix C:

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

### 3.18 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

Information to be declared on the form at Appendix E:

The organisation will retain written records of sponsorship of research, in line with the above principles and rules.

Staff should declare:
• Their name and their role with the organisation.
• Nature of their involvement in the sponsored research.
• Relevant dates.
• Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.19 Sponsored posts

• External sponsorship of a post requires prior approval from the organisation.
• Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
• Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise. Under no circumstances should staff agree to “linked deals” whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources.
• Sponsored post holders must not promote or favour the sponsor’s products, and information about alternative products and suppliers should be provided.
• Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

Information be declared on the form at Appendix E:

The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
• Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

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 or the viability of the Trust. 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.
3.20 **Clinical private practice**

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises\(^7\) including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.\(^8\)
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: [https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf](https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf)

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

**Information be declared on the form at Appendix E:**

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate a conflict, details of any approvals given to depart from the terms of this policy).

3.21 **Management of Interests**

**Strategic decision making groups**

In common with other NHS bodies The Rotherham NHS Foundation Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.

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\(^7\) Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: [https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf](https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf)

\(^8\) These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: [https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf](https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf)
• Making procurement decisions.
• Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:
• Board of Directors
• Corporate Trustee
• Charitable Funds Committee
• Business Investment Committee
• Medical Devices Management Group
• Rotherham Medicines Optimisation Group

These groups should adopt the following principles:
• Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
• Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
• Any new interests identified should be added to the organisation’s register(s).
• The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:
• Requiring the member to not attend the meeting.
• Excluding the member from receiving meeting papers relating to their interest.
• Excluding the member from all or part of the relevant discussion and decision.
• Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
• Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

3.22 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no
discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

In the interest of the Trust, its officers and clinicians, it is important to ensure that contact with commercial representatives is conducted in a satisfactory way.

The Procurement department has adopted the former NHS Supplies/PASA code of conduct to protect staff, its own interests and those of the NHS as a whole. The Code applies to every level of the organisation. Advice may be sought from the Head of Procurement.

See the Trust's Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy)
3.23 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

3.23.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Company Secretary, the Head of Governance or the Local Counter Fraud Specialist:

Anna Milanec  
Company Secretary  
General Management  
Corridor  
Level D  
Rotherham General Hospital  
Moorgate Road  
S60 2UD  
01709 427021  
anna.milanec@rothgen.nhs.uk

Lisa Reid  
Head of Governance  
General Management  
Corridor  
Level D  
Rotherham General Hospital  
Moorgate Road  
S60 2UD  
01709 4227747  
lisa.reid@rothgen.nhs.uk

Amanda Smith  
Local Counter Fraud Specialist  
Oak House,  
Moorhead Way  
Bramley  
Rotherham  
S66 1YY  
01709 428701  
amanda.smith61@nhs.net

Any suspicions of fraud should only be reported to the Local Counter Fraud Specialist.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised see the section 4.10 Procedures and Open Door Communication.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.
3.23.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation, the Counter Fraud, Bribery and Corruption Policy and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

3.23.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at least six monthly.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published within the Standards of Business
Conduct Annual Report published on the ‘key corporate documents’ page of the Trust’s website as appropriate, or made available for inspection by the public upon request.
4. **CORE POLICIES UNDERPINNING THE TRUST'S STANDARDS OF BUSINESS CONDUCT** (not exhaustive)

4.1 **Alcohol and Substance Misuse**

The Trust's Staff Charter makes specific reference to safeguarding the health and safety and well-being at work of all staff, and recognises that at times jobs may have stresses, for which the Trust will provide help through the Workplace Health and Wellbeing (Occupational Health) Department.

Employees are expressly forbidden to bring onto the premises, or to consume, alcohol while at work. There are, however, a limited number of certain occasions when the Trust’s Board of Directors will make an exception to the rule concerning consumption of alcohol on Trust premises. Such occasions will be clearly notified to employees in advance e.g. fundraising events.

Employees are expressly forbidden to use unlawful drugs (which have not been prescribed on medical grounds) neither must they be involved in the buying or selling or be in possession of such drugs on Trust premises or while at work.

See the Trust's *Employee Alcohol and Substance Misuse Policy*

4.2 **Anti-Fraud**

One of the basic principles of public sector organisations is the proper use of public funds. It is, therefore, important that all those who work in the public sector and at the Trust are aware of the arrangements in place for the protection of NHS funds against fraud, bribery, corruption and other illegal acts involving dishonesty.

Fraud, bribery and corruption can exist even in the best organisations, including the NHS. Added to this, the current economic conditions will prompt some people who would not normally consider breaking the law to take uncharacteristic actions they may later regret.

Fraud can be loosely defined as any deception that might result in a gain. Examples might include claiming time or expenses not really due; falsifying qualifications or experience to secure a job or dishonestly obtaining property. Corruption can be defined as a lack of integrity or honesty, including the use of a position of trust for dishonest gain.

The above offences may be in association with the destruction, falsification or concealment of official records which, when linked to seeking a dishonest advantage, is also a criminal offence.

Offences may also be linked to corruption, i.e. the offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person in respect to the activities.

To help ensure the Trust is properly protected against fraud and corruption, and to enable all staff, visitors and other stakeholders to understand how seriously fraud, bribery and corruption are treated here, the Trust has
developed a Counter Fraud, Bribery and Corruption Policy in conjunction with staff-side representatives and the Trust’s Local Counter Fraud Specialist. This policy, which can be found on the Intranet, details the Trust’s zero-tolerance approach to fraud, bribery and corruption and includes guidance for staff or others who suspect fraud, bribery or corruption may be taking place. The policy is a key aspect of the Trust’s Standards of Business Conduct, which underpin all of the work that we do and protect patients, staff and the reputation of the Trust.

If you have any concerns or would like to discuss any of the issues raised, you can contact the Trust’s Local Counter Fraud Specialist by telephone on 01709 428701 or by email at: amanda.smith61@nhs.net. Alternatively, call the NHS Fraud and Corruption Reporting Line on 0800 028 40 60 in confidence or submit and on-line report at https://www.reportnhsfraud.nhs.uk

See the Trust’s Counter Fraud, Bribery & Corruption Policy (version 2, July 2018)

4.3 Bribery Act 2010 (see also 3.10 Gifts, Sponsorship and Entertainment)

The Bribery Act 2010, which came into force in July 2011, makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe whether in the UK or abroad. It is also a criminal offence under this Act for any director, manager or officer of the Trust to allow or ‘turn a blind eye’ to acts of bribery within the organisation. The penalty for bribery can be up to 10 years’ imprisonment, with an unlimited fine.

Bribery is defined by the Act as:

‘...giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.

Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

For example, a member of staff recruiting to a job might be offered tickets to an event by one of the candidates or someone linked to them. In the context of the Bribery Act 2010, the offence of bribery refers to accepting, as well as offering, a bribe.

A new corporate offence was also introduced by the Bribery Act:

- Failure of a commercial organisation to prevent bribery

This means that the Trust can be held responsible if it fails to enact adequate procedures to prevent bribery.

9 Source: http://www.thebriberyact2010.co.uk/what-is-a-bribe.asp last accessed on 30/1/17.
Any member of senior management or any Board member who consents to, or connives in, any active or passive bribery offence will, together with the Trust, be liable for the corporate offence under the Act.

Any individual associated with the Trust who commits acts or omissions forming part of a bribery offence may be liable under the Act. This also applies where an individual is part of a conspiracy to commit the offence with others – including, for example, their employer.

Anyone can report concerns about bribery in the NHS. The Trust’s Local Counter Fraud Specialist wants to hear about any suspicions or concerns about bribery. All allegations will be thoroughly and professionally investigated.

Staff should report any suspicions or allegations of bribery immediately to one of the following:

- The Trust’s Local Counter Fraud Specialist (LCFS) to deal with in line with the usual procedures for investigating NHS fraud and corruption
  
  Amanda Smith
  
  LCFS
  
  Oak House
  
  Moorhead Way
  
  Bramley
  
  Rotherham
  
  S66 1YY
  
  ☎ 01709 428701
  
  📩 amanda.smith61@nhs.net

- The Trust’s whistleblowing officer. Please see latest version of the Trust’s Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing) for contact details

- The NHS Fraud and Corruption Reporting Line (0800 028 40 60) or the online fraud reporting form at www.reportnhsfraud.nhs.uk

All of the above will treat your referral with the utmost discretion and investigate the matter in a professional and impartial manner.

4.4 Environment – Corporate Social Responsibility

The Rotherham NHS Foundation Trust stands to benefit from behaving as a good corporate citizen, offering the benefits of tackling health inequalities, public health gains, financial savings, faster patient recovery rates and improved staff morale.
4.5 Ethics

The policy of the Trust is to comply with all governmental laws, rules and regulations applicable to its business.

The Trust cares how results are obtained, not just that they are obtained. Directors and employees must deal fairly with each other and with the Trust’s service users (patients, other professionals), suppliers and competitors.

The Trust expects compliance with standards of integrity throughout the organisation and will not tolerate employees who achieve results at the cost of violation of laws or who operate unscrupulously.

It is the Trust’s policy to make full, fair, accurate, timely and understandable disclosure in reports and documents required by Government or Regulatory bodies and in other public communications. All employees are responsible for reporting material information known to them to higher management so that the information will be available to senior executives responsible for making disclosure decisions. The Care Act 2014 introduced a new criminal offence of providing false or misleading information. From April 2015 if false or misleading information is published or supplied by the organisation in order to comply with a statutory or other legal obligation both the organisation and the individual(s) can be prosecuted. The intent of the organisation to supply accurate information is not a defence against such a prosecution.

All employees are expected to familiarise themselves and comply with their professional code of conduct and the seven Nolan Principles for Public Life (see Appendix B) or [https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2](https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2).

4.6 Equality and Diversity

All public bodies have a statutory duty under equalities legislation to set out arrangements to assess and consult on how their policies and functions impact on race, gender, disability, age, sexuality and human rights, in effect to undertake equality impact assessments on all policies/procedures and practices. The Rotherham NHS Foundation Trust is committed to providing services that meet the equality and diversity needs of staff and service users within the framework of current legislation.

Current equality and diversity legislation includes disability, gender, age, race, sexual orientation, religion and human rights. It is the responsibility of managers and staff to ensure that they act on this policy in a manner that meets the needs of people from these groups. It is always best to check with individual staff/service users what their needs are, but needs may include providing information in an accessible format, considering mobility and communication issues and being aware of sensitive and/or cultural issues.

4.7 Fit and Proper Person

On 27 November 2014 the Care Quality Commission’s (CQC) new regulation ‘Fit and Proper Persons: Directors’ came into force. As of this date the Trust must comply with this regulation by ensuring that all newly appointed
Executive and Non-Executive Directors appointed to the Board of Directors (including interim directors and associate director positions irrespective of their voting rights) meet the Fit and Proper Person criteria and do not meet any of the ‘unfit’ criteria. The regulation states that:

“This means that board directors should be of good character, have the required skills, experience and knowledge and that their health enables them to fulfil the management function. None of the criteria of unfitness should apply, which include bankruptcy, sequestration and insolvency, appearing on barred lists and being prohibited from holding directorships under other laws. Directors should not have been involved or complicit in any serious misconduct, mismanagement or failure of care in carrying on a regulated activity.’"

The Trust’s pre-recruitment checks for all directors to whom this new regulation applies ensure that the Trust is able to provide the required assurance to the CQC that all its directors meet the fitness test and do not meet any of the ‘unfit’ criteria.

Whilst members of the Council of Governors are not required a part of the CQC’s regulation 5 to be ‘fit and proper’ the Trust’s Provider Licence issued by the Foundation Trust regulator, Monitor, does require Governors to be ‘fit and proper’ as does NHS Improvement’s (previously known as Monitor) NHS Foundation Trust Code of Governance11, which states in B.2.2:

‘B.2.2. Directors on the board of directors and governors on the council of governors should meet the “fit and proper” persons test described in the provider licence. For the purpose of the licence and application criteria, “fit and proper” persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.’

4.8 Harassment in the Workplace

The Trust supports the right of all people to be treated with dignity and respect at work. The Trust is committed to promoting a working environment free from all forms of harassment and bullying and will ensure that steps are taken to achieve this.

The Trust specifically prohibits any form of harassment by, or toward, employees, contractors, suppliers or customers.


4.9 **Health of Employees**

It is the Trust’s policy for health services to be provided / arranged for the treatment of employee occupational illnesses.

See the Trust’s *Managing Attendance Policy*

4.10 **Procedures and Open Door Communication**

The Trust recognises the importance of encouraging a climate of openness and dialogue in which all employees can freely express their views and contribute to the development of the Trust and its services.

The Public Interest Disclosure Act, which came into effect in January 1999, gives legal protection to employees against being dismissed or penalised by their employer as a result of publicly disclosing certain serious concerns. It is a fundamental term of every contract of employment that an employee will faithfully serve her or his employer and not disclose confidential information about the employer's affairs. However, where an individual discovers information which they believe shows malpractice or wrongdoing within their organisation then ultimately that information may be disclosed without fear of reprisal and may be made independently of line management.

The Trust consulted with staff side representatives to revise the existing policy in relation to “blowing the whistle” in July 2015. The policy aims to provide a framework to counter the risk of victimisation when an employee, or group of employees, have raised serious concerns in a responsible way. The Trust will assure protection to anyone who discloses their concerns provided that: the disclosure is made in accordance with the law; that it is in good faith and that it is not made for personal gain.

In addition the Trust supports the Nursing Times' ‘Speak out Safely’ campaign and has acted in relation to Sir Robert Francis’ Freedom to Speak Up review report published in February 2015 by appointing eight members of Trust staff as ‘Freedom to Speak up Guardians’¹² in addition to the Trust’s Senior Independent Director to whom staff may also speak should they wish to raise concerns. In addition the Trust has a dedicated confidential hotline 01709 427009 (ext: 7009) for staff to use to highlight their concerns.

See the Trust’s *Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing)* and *A Colleague’s Guide to Raising Concerns (Whistleblowing).*

4.11 **Health and Safety**

The Trust recognises the importance of implementing and maintaining effective risk management arrangements in order to underpin the organisation’s reputation and performance.

The Trust is committed to ensuring the safety of patients, staff and the public through an integrated approach to managing risk, regardless of whether the risk is clinical, organisational, health and safety or financial.

Staff are expected to comply with Trust and relevant departmental policies, protocols and Standard Operating Procedures.

The delivery of health care will always involve a degree of risk; effective risk management systems and a positive culture of learning from experience in an environment that supports improvements in patient care and safety will reduce that risk.


4.12 **Information Technology Security and Acceptable Use**

Many roles within the Trust require some contact with Information Technology (IT) equipment or services and there are various policies that specifically relate to the use of general IT equipment, services and Connecting for Health.

IT Services can be defined as desktop devices and peripherals, storage devices, network services and Connecting for Health applications.

These policies aim to give staff and stakeholders of IT Services clear guidance on acceptable practices when working with IT Services, and include how to report actual and potential breaches of security.

The policies provide clarification for staff on the use of computing facilities provided by the Trust; define the responsibilities of staff and managers; advise staff of the various policies and procedures which apply to their use of computing services and facilities and advise staff of the Trust’s monitoring of the use of e-mail and internet usage.

See the Trust’s *Policy for Information Technology Acceptable Use*.

4.13 **Confidentiality**

You shall not, during the continuance of your employment, or at any time after its termination for any reason, use or disclose to any person or persons whatsoever (except the proper Officers of the Foundation Trust or under the authority of the Board) any confidential information or trade secrets or secret information and you shall use your best endeavours to prevent any such use or disclosure.

This clause shall not apply to:
Information disclosed pursuant to any order of any Court of competent jurisdiction;

Or any information which, except through any breach of this or any other agreement by you:

- Is in the public domain;
- Is required by an appropriate regulatory authority;
- Or information disclosed for the purpose of making a protected disclosure within the meaning of Part IVA of the Employment Rights Act 1996.

Failure to abide by this rule will lead to disciplinary action, and may also lead to prosecution. The most common legislation that all Trust employees are required to comply with is the Data Protection Act (1998).

### 4.14 Delegated Authority

As it is recognised that a number of staff find their way onto external decision making bodies, planning groups and clinical networks. It is important that such attendances are not assumed to comprise delegated authority to represent and commit the Trust to a course of action without formal delegation of authority by the Chief Executive to an individual to commit the Trust.

Any person to whom authority is delegated is still required to brief an Executive Director about the financial or service implications of such decisions.

All Trust employees engaged in externally controlled committees without formal delegation of authority risk decisions being overruled with obvious personal and professional, as well as corporate, consequences for them and their responsible manager.

All Trust employees engaged in clinical networks are responsible for ensuring that any Network-agreed policies are submitted to the Trust’s Clinical Effectiveness and Research Group and the Trust’s Document Ratification Group to ensure any Trust-wide implications of these policies are appropriately addressed.

### 4.15 Intellectual Property

Intellectual property (IP) is an umbrella term that is used to describe a range of legal rights that attach to certain types of information and ideas and to their particular forms of expression. Different IP rights can be used to ensure that the Foundation Trust, is able to protect what they create; maximise their competitive position and avoid infringing the IP rights of other people and businesses.

One of the common methods of protecting intellectual property is via Copyright which seeks to protect the form of expression of ideas (not the ideas themselves as such). The primary purpose of copyright law is to reward authors for the creation of original works, that is works where the author has expended independent effort to create the work and which is not copied from...
other sources. (In the UK protection stems from the Copyright Designs and Patents Act 1988.*) In the UK there are no formalities for the creation of copyright - in particular there is no requirement for registration:

- The rights arise automatically if certain requirements are met.
- All copies of the work published, display the Copyright Convention symbol © together with the name of the owner of the copyright i.e. The Rotherham NHS Foundation Trust), and the year of publication. The notice therefore read for works created this year: ' © The Rotherham NHS Foundation Trust 20**. Using such a notice draws third party's attention to the fact that the Trust is aware of its rights.

*Provisions in relation to patents are set out in section 3.13 of these Standards

5. **REVIEW**

This policy will be reviewed in three years’ time unless an earlier review is required. This will be led by the Head of Governance.

6. **ASSOCIATED DOCUMENTATION**

- Freedom of Information Act 2000
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- Employee Alcohol and Substance Misuse Policy
- Counter Fraud, Bribery & Corruption Policy (version 1, April 2016)
- Standing Orders
- Standing Financial Instructions
- Policy for Close Personal Relationships at Work.
- Policy and Guidance for the Procurement of Goods, Services and Works (Procurement Policy)
- Policy for Managing Bullying and Harassment
- Managing Attendance Policy
- Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing)
- A Colleague’s Guide to Raising Concerns (Whistleblowing)
- Risk Management policies
- Guidance For Supplier Representatives Attending Trust Sites
• Policy for Information Technology Acceptable Use
7. SHORT GUIDE FOR STAFF

DO:

- Make sure you understand the guidelines on standards of conduct, and consult your manager if you are unsure.
- Make sure you are not in a position where your private interests and NHS duties may conflict.
- Declare to your employer any relevant interests: if in doubt, ask yourself:
  - Am I, or might I be, in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
  - Do I have access to information which could influence purchasing decisions?
  - Could my outside interest be in any way detrimental to the NHS or patients' interests?
  - Do I have any other reason to think I may be risking a conflict of interest?
- If still unsure, declare it!
- Observe the Trust's Standing Orders rules on tendering if you are involved in any way with the purchase of goods and services.
- Seek your line manager's permission before taking on any outside work, if there is any question of it adversely affecting your NHS duties (special guidance applies to doctors)
- Obtain your manager's permission before accepting any commercial sponsorship.

DO NOT:

- Accept any inducements, personal gifts (other than items of nominal value of a personal nature) or inappropriate hospitality.
- Abuse your past or present official position to obtain preferential rates for private deals.
- Unfairly advantage one competitor over another or show favouritism in awarding contracts.
- Misuse or make available confidential information.
Appendix A: NHS England Guidance on the Management of Conflicts of Interests

February 2017
Managing Conflicts of Interest in the NHS

Guidance for staff and organisations
## Managing Conflicts of Interest in the NHS

This guidance provides guidance for the management of conflicts of interest in the NHS. It is applicable to Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts and NHS England. Other bodies involved in the provision of NHS services are invited to consider implementing this guidance.

**Cross Reference**
Managing Conflicts of Interest: Revised Statutory Guidance for CCGs

**Superseded Docs**
Revised Statutory Guidance for CCGs

**Contact Details for further information**
england.psu@nhs.net

**Document Status**
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

### Additional Circulation List
Care Trust CEs, GPs

### Target Audience
CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, Foundation Trust CEs, Medical Directors, Directors of Nursing, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, Directors of Finance, NHS Trust CEs

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This guidance comes into force 1 June 2017

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<table>
<thead>
<tr>
<th>Action Required</th>
<th>Review and update existing relevant organisational policies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing / Deadlines (if applicable)</td>
<td>This guidance comes into force 1 June 2017</td>
</tr>
</tbody>
</table>

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This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.
Scope of this guidance

This guidance is intended to protect patients, taxpayers and staff covering health services in which there is a direct state interest. It comes into force on 1 June 2017.

It is applicable to the following NHS bodies:

- Clinical Commissioning Groups (‘CCGs’)
- NHS Trusts (all or most of whose hospitals establishments and facilities are situated in England) and NHS Foundation Trusts - which include secondary care trusts, mental health trusts, community trusts, and ambulance trusts
- NHS England

For the purposes of this guidance these bodies are referred to as ‘organisations’.

The principles of this guidance will be included in a revised version of the statutory guidance for CCGs issued by NHS England pursuant to its powers under s.14O and s.14Z8 of the National Health Service Act 2006. Until this guidance comes into force existing guidance issued under these powers continues to apply, and is accessible at: https://www.england.nhs.uk/commissioning/pc-co-comms/coi/

NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS Standard Contract pursuant to General Condition 27.

Its applicability to NHS England will be delivered through amendments to our Standards of Business Conduct.

This guidance does not apply to bodies not listed above (i.e. independent and private sector organisations, general practices*, social enterprises, community pharmacies, community dental practices, optical providers, local authorities – who are subject to different legislative and governance requirements). However, the boards/governing bodies of these organisations are invited to consider implementing the guidance as a means to effectively manage conflicts of interest and provide safeguards for their staff. The requirements of GC27.2 of the generic NHS Standard Contract (2017/18 and 2018/19 edition) should be interpreted in that light.

* However, GP practice staff should note that the requirements in the statutory guidance for CCGs on the management of conflicts of interest (referred to above) continue to apply to GP partners (or where the practice is a company, each director) and individuals in a practice directly involved with the business or decision making of their CCG.
1 Purpose
2 Action
3 Definitions
4 Declarations
5 Management
6 Transparency
7 Breaches
8 Resource annexes
1. Purpose

1.1. Every year the taxpayer entrusts NHS organisations with over £110 billion to care for millions of people. This money must be spent well, free from undue influence.

1.2. To deliver high quality and innovative care organisations need to work collaboratively with each other, local authorities, industry and other public, private and voluntary bodies. Partnership working brings many benefits, but also creates the risk of conflicts of interest.

1.3. Organisations and the people who work with, for, and on behalf of them (referred to as ‘staff’ in this guidance) want to manage these risks in the right way. Staff and organisations may already be taking steps to do this. However, how this should be done has not always been made clear and there is variation in current practice – implementation of this guidance will make things easier and enable greater consistency across the NHS.

1.4. By implementing this guidance staff and organisations will understand what to do to take the best action and protect themselves from allegations that they have acted inappropriately.

This guidance:

• Introduces consistent principles and rules for managing conflicts of interest.
• Provides simple advice to staff and organisations about what to do in common situations.
• Supports good judgement about how interests should be approached and managed.
2. Action: What should staff and organisations do?

<table>
<thead>
<tr>
<th>Action for staff</th>
<th>Action for organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DO</strong></td>
<td><strong>DO</strong></td>
</tr>
<tr>
<td>• Familiarise yourself with this guidance and your organisational policies and follow them.</td>
<td>• Ensure that you have clear and well communicated processes in place to help staff understand what they need to do.</td>
</tr>
<tr>
<td>• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent.</td>
<td>• Identify a team or individual with responsibility for:</td>
</tr>
<tr>
<td>• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.</td>
<td>- Reviewing current policies and bringing them in line with this guidance.</td>
</tr>
<tr>
<td><strong>DON’T</strong></td>
<td><strong>DON’T</strong></td>
</tr>
<tr>
<td>• Misuse your position to further your own interests or those close to you.</td>
<td>• Avoid managing conflicts of interest.</td>
</tr>
<tr>
<td>• Be influenced, or give the impression that you have been influenced by, outside interests.</td>
<td>• Interpret and deploy this guidance in a way which stifles the collaboration and innovation that the NHS needs.</td>
</tr>
<tr>
<td>• Allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.</td>
<td></td>
</tr>
</tbody>
</table>

Organisations should ensure their policies as a minimum meet the standards in this guidance. They can also introduce local requirements that are more stringent, on the basis of their own circumstances, should they think this is necessary. Organisations may wish to adopt or adapt the Model Policy at Annex A to assist with implementation.
3. Definitions: Conflict of interest

3.1. For the purposes of this guidance a ‘conflict of interest’ is defined as:

“A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

3.2. A conflict of interest may be:

<table>
<thead>
<tr>
<th>Actual</th>
<th>Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a material conflict between one or more interests</td>
<td>There is the possibility of a material conflict between one or more interests in the future</td>
</tr>
</tbody>
</table>

3.3. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.
3. Definitions: Interests

3.4. ‘Interests’ can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers’ money because the interest has relevance to that decision.

3.5. Interests fall into the following categories:

<table>
<thead>
<tr>
<th>Financial interests</th>
<th>Non-financial professional interests</th>
<th>Non-financial personal interests</th>
<th>Indirect interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making</td>
<td>Where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career</td>
<td>Where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career</td>
<td>Where an individual has a close association** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making</td>
</tr>
</tbody>
</table>

* A benefit may arise from the making of gain or avoiding a loss
** These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners. A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

Further guidance on how to interpret these categories is at Annex B.
4. Declarations: Processes to follow

4.1. Organisations should support staff to understand that having interests is not in itself negative, but not declaring and managing them is.

4.2. All staff must be aware of how and to whom declarations should be made, declaring material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to their organisation. Therefore, declarations should be made:

- On appointment with an organisation
- When a person moves to a new role or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise

4.3. 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’.

4.4. Because of their influence in the spending of taxpayers’ money, organisations should ensure that, at least annually, decision making staff are prompted to update their declarations of interest, or make a nil return.

4.5. Organisations should define decision making staff according to their own context, but this should be justifiable and capture those groups of staff that have a material influence on how taxpayers’ money is spent.

4.6. The following non-exhaustive list describes who these individuals are likely to be:

- Executive and non executive directors* 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.

4.7. There may be occasions where staff declare an interest but, upon closer consideration, it is clear that this is not material and so does not give rise to the risk of a conflict of interest. The team or individual responsible for managing organisational policy should decide whether it is necessary to transfer such declarations to an organisation’s register(s) of interests.

* equivalent roles in different organisations carry different titles – this should be considered on a case by case basis

5. Management: Principles and situations

5.1. Organisations should manage interests sensibly and proportionately. If an interest presents an actual or potential conflict of interest then management action is required.

5.2. Some common sense management principles should be adopted by organisations which, for the purposes of this guidance, are referred to as ‘general management actions’:

- Requiring staff to comply with this guidance
- Requiring staff to proactively declare interests at the point they become involved in decision making
- Considering a range of actions, which may include:
  - deciding that no action is warranted
  - restricting an individual’s involvement in discussions and excluding them from decision making
  - removing an individual from the whole decision making process
  - removing an individual’s responsibility for an entire area of work
  - removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role
- Keeping an audit trail of the actions taken

5.3. Each case will be different. The general management actions, along with relevant industry/professional guidance, should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.

5.4. However, there are a number of common situations which can give rise to risk of conflicts of interest, being:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership interests
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

The following pages discuss the risks and issues posed in these situations, and the principles and rules that staff and organisations should adopt to manage them.
### Gifts

**What are the issues?**

Staff in the NHS offer support during significant events in people’s lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way.

A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.

### Principles and rules

**Overarching principle applying in all circumstances:**
- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

**Gifts from suppliers or contractors:**
- Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value.
- Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total, and need not be declared.

*The £6 value has been selected with reference to existing industry guidance issued by the ABPI: [http://www.pmcpa.org.uk/thecode/Pages/default.aspx](http://www.pmcpa.org.uk/thecode/Pages/default.aspx)*
## Gifts (continued)

<table>
<thead>
<tr>
<th>Principles and rules</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gifts from others sources (e.g. patients, families, service users):</strong></td>
<td></td>
</tr>
<tr>
<td>• Gifts of cash and vouchers to individuals should always be declined.</td>
<td></td>
</tr>
<tr>
<td>• Staff should not ask for any gifts.</td>
<td></td>
</tr>
<tr>
<td>• Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e. to an organisation's charitable funds), not in a personal capacity. These should be declared by staff.</td>
<td></td>
</tr>
<tr>
<td>• Modest gifts accepted under a value of £50 do not need to be declared.</td>
<td></td>
</tr>
<tr>
<td>• 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).</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
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</table>

<table>
<thead>
<tr>
<th>What should be declared</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staff name and their role with the organisation.</td>
<td></td>
</tr>
<tr>
<td>• A description of the nature and value of the gift, including its source.</td>
<td></td>
</tr>
<tr>
<td>• Date of receipt.</td>
<td></td>
</tr>
<tr>
<td>• Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).</td>
<td></td>
</tr>
</tbody>
</table>
**What are the issues?**

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of ‘traditional’ working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.

**Principles and rules**

Overarching principles applying in all circumstances:

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors – these can be accepted if modest and reasonable but individuals should always obtain senior approval and declare these.

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.
- Over a value of £75* - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an 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 an estimate that a reasonable person would make as to its value).

*The £75 value has been selected with reference to existing industry guidance issued by the ABPI [http://www.pmcpa.org.uk/thecode/Pages/default.aspx](http://www.pmcpa.org.uk/thecode/Pages/default.aspx)
## Hospitality (continued)

<table>
<thead>
<tr>
<th>Principles and rules</th>
<th>What should be declared</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Travel and accommodation:</strong></td>
<td>• Staff name and their role with the organisation.</td>
</tr>
<tr>
<td>• 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.</td>
<td>• A description of the nature and value of the hospitality including the circumstances.</td>
</tr>
<tr>
<td>• 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 an organisation’s register(s) of interest as to why it was permissible to accept travel and accommodation of this type.</td>
<td>• Date of receipt.</td>
</tr>
<tr>
<td>• A non exhaustive list of examples includes:</td>
<td>• Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).</td>
</tr>
<tr>
<td>o offers of business class or first class travel and accommodation (including domestic travel).</td>
<td></td>
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</tbody>
</table>
# Outside employment

The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation. (Clinical private practice is considered in a separate section).

## What are the issues?

- The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

## Principles and rules

- Staff should declare any existing outside employment on appointment, and any new outside employment when it arises.
- Where a risk of conflict of interest is identified, the general management actions outlined in this guidance should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment.
- Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even this does not give rise to risk of a conflict. Nothing in this guidance prevents such enquiries being made.

## What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).
Shareholding and other ownership interests

What are the issues?

Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with an organisation. For instance, if they are involved in their organisation’s procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.

Principles and rules

- 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 their organisation.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the shareholding/other ownership interest.
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).
# Patents

## What are the issues?

The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed.

However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.

## Principles and rules

- 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 their organisation.
- Staff should seek prior permission from their 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.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

## What should be declared

- Staff name and their role with the organisation.
- A description of the patent or other intellectual property right and its ownership.
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).
# Loyalty interests

**What are the issues?**

As part of their jobs staff need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means - it can be as simple as having informal access to people in senior positions. However, loyalty interests can influence decision making.

Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

**Principles and rules**

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers’ money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Where holding loyalty interests gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

**What should be declared**

- Staff name and their role with the organisation.
- A description of the nature of the loyalty interest.
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).
## Donations

### What are the issues?

A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

### Principles and rules

- Acceptance of donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier 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 an organisation, or is being pursued on behalf of that organisation’s registered charity (if it has one) or other charitable body and is not for their own personal gain.

- Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.

- 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 a professional fee they receive 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.

### What should be declared

- Organisations should maintain records in line with their wider obligations under charity law, in line with the above principles and rules.
# Sponsored events

**What are the issues?**

Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result there should be proper safeguards in place to prevent conflicts occurring.

**Principles and rules**

- Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the organisation and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At an organisation’s discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- Organisations should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff should declare involvement with arranging sponsored events to their organisation.

**What should be declared**

- Organisations should maintain records regarding sponsored events in line with the above principles and rules.
## Sponsored research

<table>
<thead>
<tr>
<th>What are the issues?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principles and rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Funding sources for research purposes must be transparent.</td>
</tr>
<tr>
<td>• Any proposed research must go through the relevant health research authority or other approvals process.</td>
</tr>
<tr>
<td>• There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.</td>
</tr>
<tr>
<td>• The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.</td>
</tr>
<tr>
<td>• Staff should declare involvement with sponsored research to their organisation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What should be declared</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organisations should retain written records of sponsorship of research, in line with the above principles and rules.</td>
</tr>
<tr>
<td>• Staff should declare:</td>
</tr>
<tr>
<td>• their name and their role with the organisation</td>
</tr>
<tr>
<td>• a description of the nature of the nature of their involvement in the sponsored research</td>
</tr>
<tr>
<td>• relevant dates</td>
</tr>
<tr>
<td>• any other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance)</td>
</tr>
</tbody>
</table>
# Sponsored posts

**What are the issues?**

Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

**Principles and rules**

- Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor’s specific products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

**What should be declared?**

- Organisations should retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this guidance.
Clinical private practice

What are the issues?

Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.

Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on Outside Employment.

Principles and rules

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:

- where they practise (name of private facility)
- what they practise (specialty, major procedures).
- when they practise (identified sessions/time commitment)

*Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: [https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf](https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)
## Clinical private practice (continued)

<table>
<thead>
<tr>
<th>Principles and rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):</td>
</tr>
<tr>
<td>• Seek prior approval of their organisation before taking up private practice.</td>
</tr>
<tr>
<td>• Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.**</td>
</tr>
<tr>
<td>• Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: <a href="https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf">https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What should be declared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf.**</td>
</tr>
<tr>
<td>** These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: [<a href="https://www.bma.org.uk/-/media/files/pdfs/practical">https://www.bma.org.uk/-/media/files/pdfs/practical</a> advice at work/contracts/consultanttermsandconditions.pdf](<a href="https://www.bma.org.uk/-/media/files/pdfs/practical">https://www.bma.org.uk/-/media/files/pdfs/practical</a> advice at work/contracts/consultanttermsandconditions.pdf)</td>
</tr>
</tbody>
</table>

Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.
5. Management: Strategic decision making groups

5.5. Many organisations use boards (or committees and sub-committees of boards), advisory groups, and procurement panels to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts
- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

These are referred to in this guidance as ‘strategic decision making groups’.

5.6. It is important that the interests of those who are involved in these groups are well known to those involved. Organisations must therefore identify relevant strategic decision making groups and ensure they operate in a manner consistent with the following principles, which reflect wider standards of good governance:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the organisation’s register
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement

5.7. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting
- Ensuring that the member does not receive meeting papers relating to the nature of their interest
- Requiring the member to not attend all or part of the discussion and decision on the related matter
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process altogether

5.8. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. An example is the need for clinical involvement, when clinicians may hold and represent a diversity of interests. Good judgement is required to ensure proportionate management of risk. The composition of groups should be kept under review to ensure effective participation.
5. Management: Procurement decisions

5.9. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients.

5.10. Organisations should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. NHS Improvement and NHS England have published detailed and specific guidance on procurement processes which staff and organisations should consult.

5.11. For the avoidance of doubt, nothing in this section or this guidance waives or modifies any existing legal requirements relating to conflicts of interest and procurement decisions.
6. Transparency: Maintenance and publication of register(s)

<table>
<thead>
<tr>
<th>Maintenance of Register(s)</th>
<th>Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1. Organisations must ensure that a nominated team or individual collates and maintains up to date organisational register(s) of interests. An interest should remain on the register(s) for a minimum of 6 months after the interest has expired. Organisations should retain a private record of historic interests for a minimum of 6 years after the date on which it expired.</td>
<td>6.4. All staff should declare interests and, as a minimum, organisations should publish the interests of decision making staff at least annually in a prominent place on their website. Organisations without websites should maintain registers locally, available for inspection on request.</td>
</tr>
<tr>
<td>6.2. Template declaration of interests and register of interests forms for organisations to use are provided at Annex C and D. They should always contain:</td>
<td>6.5. The format of published registers should be accessible and contain meaningful information. Adopting the templates and advice on content in this guidance will assist organisations in this task.</td>
</tr>
<tr>
<td>• The returnee’s name and their role with the organisation</td>
<td>6.6. Organisations should put in place processes for staff to make representations that information on their interests should not be published. This will allow for, in exceptional circumstances, an individual’s name and/or other information to be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.</td>
</tr>
<tr>
<td>• A description of the interest declared (reflecting the content of section 5 of this guidance for common situations)</td>
<td>6.7. As well as taking these steps, organisations should seek to ensure that staff who are subject to wider transparency initiatives such as the ABPI Disclosure UK scheme are aware of and comply with them:</td>
</tr>
<tr>
<td>• Relevant dates relating to the interest</td>
<td><a href="http://www.abpi.org.uk/our-work/disclosure/Pages/disclosure.aspx">http://www.abpi.org.uk/our-work/disclosure/Pages/disclosure.aspx</a></td>
</tr>
<tr>
<td>• Space for comments (e.g. action taken to mitigate conflict)</td>
<td></td>
</tr>
</tbody>
</table>

6.3. Using the common format in the templates will help minimise burdens on staff who might need to submit returns to multiple organisations.

Declaration of interests template

Register of interests template
7. Breaches: How should these be dealt with?

7.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or organisations. For the purposes of this guidance these situations are referred to as 'breaches'.

7.2. Organisations should identify a team or individual to be notified of breaches, and be clear as to how staff or other parties can raise concerns about these. Staff should be encouraged to speak up about actual or suspected breaches, in compliance with their organisation’s whistleblowing policy.

7.3. Organisations should also identify a team or individual empowered to investigate breaches, involving organisational leads for human resources, fraud, audit etc. as appropriate. Each breach needs to be investigated and judged on its own merits and this should start with those involved having the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigations organisations should:

- Decide if there has been or is potential for an actual breach and the severity
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum
- Consider who else inside and outside the organisation should be made aware of the breach
  - Take appropriate action, such as clarifying existing policy, taking action against the staff member(s) responsible for the breach, or escalating to external parties such as auditors, NHS Protect, the Police, statutory health bodies and/or regulatory bodies

7.5. When dealing with instances of breach organisations may want to take legal or other appropriate advice prior to imposing sanctions which could have serious consequences for those involved. A range of responses should be considered in terms of proportionate sanctions for breaches, including:

- Employment law action
- Reporting incidents to external bodies
- Contractual or legal consequences

Further information on the consequences of breaches and the range of potential sanctions is at Annex E.

7.6. Organisations should consider whether reports on breaches, the impact of these, and action taken (i.e. if strong management action or sanctions are taken) should be considered by their governing body, audit committee, executive team or similar on a regular basis.

7.7. To aid transparency organisations should consider whether anonymised information on breaches and action taken in response should be prepared and published on websites on a regular basis.
8. Resource Annexes

ANNEX A – Model Conflict of Interest Policy
[due for publication in March 2017]

ANNEX B – Types of interests

ANNEX C – Template interests declaration form

ANNEX D – Template interests register

ANNEX E – Potential sanctions for breach of conflicts of interest policies
## Annex B – Types of interests

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial interests</td>
<td>Where an individual may get direct financial benefits* from the consequences of a decision their organisation makes. This could include:</td>
</tr>
<tr>
<td></td>
<td>• A director (including a non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding</td>
</tr>
<tr>
<td></td>
<td>• A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding</td>
</tr>
<tr>
<td></td>
<td>• Someone in outside employment</td>
</tr>
<tr>
<td></td>
<td>• Someone in receipt of secondary income.</td>
</tr>
<tr>
<td></td>
<td>• Someone in receipt of a grant.</td>
</tr>
<tr>
<td></td>
<td>• Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence).</td>
</tr>
<tr>
<td></td>
<td>• Someone in receipt of sponsored research.</td>
</tr>
<tr>
<td>Non-financial professional interests</td>
<td>Where an individual may obtain a non-financial professional benefit* from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is:</td>
</tr>
<tr>
<td></td>
<td>• An advocate for a particular group of patients.</td>
</tr>
<tr>
<td></td>
<td>• A clinician with a special interest.</td>
</tr>
<tr>
<td></td>
<td>• An active member of a particular specialist body.</td>
</tr>
<tr>
<td></td>
<td>• An advisor for the Care Quality Commission or National Institute of Health and Care Excellence.</td>
</tr>
<tr>
<td></td>
<td>• A research role.</td>
</tr>
</tbody>
</table>

* A benefit may arise from the making of gain or avoiding a loss
Annex B – Types of interests (continued)

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>Description</th>
</tr>
</thead>
</table>
| Non-financial personal interests | This is where an individual may benefit* personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:  
  • A member of a voluntary sector board or has a position of authority within a voluntary sector organisation.  
  • A member of a lobbying or pressure group with an interest in health and care.                                                                 |
| Indirect interests            | This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making. This would include**:  
  • Close family members and relatives.  
  • Close friends and associates.  
  • Business partners.                                                                                                                   |

* A benefit may arise from the making of gain or avoiding a loss  
** A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.
Disciplinary sanctions

Staff who fail to disclose any relevant interests or who otherwise breach an organisation’s rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. This may include:

- Employment law action which might include:
  - Informal action – such as reprimand or signposting to training and/or guidance.
  - Formal action – such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion or dismissal.
- Referring incidents to regulators.
- Contractual action against organisations or staff.

Professional regulatory sanctions

Statutorily regulated healthcare professionals who work for, or are engaged by, organisations are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. Organisations should consider reporting statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. These healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate be struck off by their professional regulator as a result.

Information and contact details for the healthcare professional regulators are accessible from the Professional Standard Authority website:
### Civil sanctions

If conflicts of interest are not effectively managed, organisations could face civil challenges to decisions they make – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

### Criminal sanctions

Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for the organisation concerned and linked organisations, and the individuals who are engaged by them.

The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation
- Fraud by failing to disclose information and
- Fraud by abuse of position.

In these cases an offender’s conduct must be dishonest and their intention must be to make a gain, or a cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine and can be committed by a body corporate.

The Bribery Act 2010 makes it easier to tackle this offence in public and private sectors. Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

The offences of bribing another person or being bribed carries a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.
Appendix B: The Seven Principles of Public Life

As recommended by the Committee on Standards in Public Life Committee (Nolan Committee), 1995

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.

These principles apply to all aspects of public life

Source: https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2 last accessed 30/1/17
APPENDIX C

STANDARDS OF BUSINESS CONDUCT DECLARATION FORM FOR GIFTS, BENEFITS, HOSPITALITY OR SPONSORSHIP

The Standards of Business Conduct require staff to declare gifts, benefits, hospitality or sponsorship, which are relevant and material to the Trust. All staff are required to comply with all Trust policies and procedures for procurement. Please complete the declaration below if your situation satisfies any of the following criteria:

1. Hospitality over the value of £25

Offers made by suppliers, third parties, other NHS organisations to pay travelling, hotel or other such expenses should be formally recorded.

Prior authorisation must be obtained before acceptance of hospitality over the value of £25. Hospitality cannot be accepted without prior authorisation.

2. Gifts over an apparent value of £25

Gift offered with an apparent value of over £25 should not be accepted without prior authorisation.

In addition gifts should be declared if several small gifts, worth a total of over £50 are received from the same or closely related source in a 12 month period.

All gifts or hospitality over £25 must be declared, whether accepted or not. Your line manager will be able to advise you if it is appropriate to accept the gift.

3. Sponsorship for Attendance at Courses and Conferences including fees and travel (over the value of £25)

Commercial sponsorship includes NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.

| Name of person completing form: | Date form completed: |
| Job Title: | Date(s) of event: |
| Ward/Department: | |
| Telephone extension and email address: | |

| Is this hospitality / a gift / commercial sponsorship | Hospitality Yes / No | Gift Yes / No | Commercial Sponsorship Yes / No |
| Nature of hospitality / gift / commercial sponsorship for which approval is sought: | |
| Location venue, town/city, country | |
| Sponsor name(s) of companies | |
| Financial Value of Sponsorship indicate whether actual or estimated value | Total value £ | Travel £ | Accommodation £ | Other £ |

Declaration form Aug 2018
**Extent of sponsorship**
travel,
delegate fees, hospitality etc

| Is receipt of the benefit to be undertaken in: | Work time / study leave / personal time / annual leave (delete as appropriate and append additional information and a copy of study leave form as appropriate) |
| Who has approved receipt of the benefit? |  |
| Has the offer of Gift / Hospitality / Benefit / Sponsorship been declined? | Yes / No If Yes, specify nature of offer: |
| Declaration | I have read and understood The Rotherham NHS Foundation Trust’s Standards of Business Conduct as they relate to conflicts of interest, personal activities and hospitality and declare that the information I have provided on this form is correct and complete. I understand that failure to abide by the Standards of Business Conduct will render me liable for disciplinary action and civil recovery procedures, including termination of employment, and potentially liable to criminal prosecution for any fraudulent actions. |

| Signature of person completing form |  |

Submit completed form to: Head of Governance, General Management Corridor, D Level, lisa.reid@rothgen.nhs.uk
Tel: 01709 427747

**For Office Use Only**

| Request Approved |  |
| Request Not Approved |  |
| Reasons: |  |

| Date form received: |  |

| Signature: | Date: |
| Copy to Central Register | Copy to Requestor |

**N.B.** The details of each declaration will be published in the Standards of Business Conduct Annual Report and this information is available to the public via the Trust’s website.

With thanks to Rotherham, Doncaster and South Humber NHS Foundation Trust.

Declaration form Aug 2018
NOTES FOR THE COMPLETION OF THE
STANDARDS OF BUSINESS CONDUCT DECLARATION FORM FOR
GIFTS, BENEFITS, HOSPITALITY OR SPONSORSHIP

1. This proforma **must** be completed for all offers of funding by an external (non NHS) source for all or part of the costs of:

- A member of staff
- Staff training
- Equipment
- Costs associated with meetings
- Buildings or premises
- Hotel and transport costs (including trips abroad)
- Provision of free services (speakers)
- Pharmaceuticals
- Meeting rooms
- Meals
- Hospitality
- Gifts*

* Staff must declare and register gifts, benefits, hospitality or sponsorship of any kind if they are worth £25 or more, whether refused or accepted. Similarly a declaration must be made if several small gifts, benefits, hospitality or sponsorship of any kind are offered totalling over £50 from the same or a closely related source in a 12-month period. A declaration is required when items have been refused or returned; or approval is required to accept the item(s) being offered

2. Provide as much detail as possible regarding the event/gift/benefit for declaration, e.g. dates of travel, method and class of travel, accommodation, food and drinks included etc.

3. Provide details of costs and indicate whether actual or estimate.

4. Provide the name of the company and/or individual offering the sponsorship/gift/hospitality.

5. Indicate the date and the name of the person referred to for approval.

Approval arrangements for sponsored study leave are:

- Medical Staff to be approved by Clinical Directors
- Clinical Directors to be approved by Medical Director
- Non-medical staff to be approved by Line Manager

Approval for all other offers of gifts, hospitality and sponsorship will be via the Trust's Head of Governance or Company Secretary.

6. Staff should indicate whether sponsorship of study leave has been accepted or refused.

7. Refusal of sponsored events/offer of gifts or benefits should be declared.

8. The proforma should be completed as soon as is practicably possible as **no retrospective approval** for gifts, hospitality or sponsorship will be provided.

9. If you are unsure what to declare, please discuss with your immediate manager in the first instance. Further advice can be obtained from the Head of Governance, Company Secretary, Director of Finance and the Director of Human Resources

10. The details of each declaration will be published in the Standards of Business Conduct Annual Report and this information is available to the public.

Declaration form Aug 2018
Code of Conduct for NHS Managers

October 2002
Code of Conduct for NHS Managers
29495/Code of Conduct for NHS Managers can also be made available on request in braille, on audio cassette tape, on disk, in large print, and in other languages on request.
Introduction

1. As part of the response to the Kennedy Report, the attached *Code of Conduct for NHS Managers* has been produced by a Working Group chaired by Ken Jarrold CBE.

2. The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:
   - to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.
   - to reassure the public that these important decisions are being made against a background of professional standards and accountability.

3. The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.
4. The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity. A document on implementation is attached.

NIGEL CRISP
NHS Chief Executive
As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

This means in particular that:

1. I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
be guided by the interests of the patients while ensuring a safe working environment;

● act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and

● seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

2 I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

● the public are properly informed and are able to influence services;

● patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;

● relatives and carers are, with the informed consent of patients, involved in the care of patients;

● partners in other agencies are invited to make their contribution to improving health and health services; and

● NHS staff are:
  – valued as colleagues;
  – properly informed about the management of the NHS;
  – given appropriate opportunities to take part in decision-making.
  – given all reasonable protection from harassment and bullying;
  – provided with a safe working environment;
  – helped to maintain and improve their knowledge and skills and achieve their potential; and
  – helped to achieve a reasonable balance between their working and personal lives.

3 I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.
I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4 I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.
If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

5 I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

6 I will take responsibility for my own learning and development.
I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.

Department of Health

October 2002
IMPLEMENTING THE CODE

1. The Code should be seen in a wider context that NHS managers must follow the ‘Nolan Principles on Conduct in Public Life’, the ‘Corporate Governance Codes of Conduct and Accountability’, the ‘Standards of Business Conduct’, the ‘Code of Practice on Openness in the NHS’ and standards of good employment practice.

2. In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

   In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who

   (i) manage their staff or services; or

   (ii) manage units which are primarily providing services to their patients also observe the Code.

3. It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek
to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;
- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

**Breaching the Code**

4 Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

5 Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

**Application of Code**

6 This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the ‘Agenda for Change’ negotiations is likely to be
used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

7 For all posts at Chief Executive/Director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:

- include the Code in new employment contracts;
- incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity.

**Action**

8 Employers are asked to:

(i) incorporate the Code into the employment contracts of Chief Executives and Directors at the earliest practicable opportunity and include the Code in the employment contracts of new appointments to that group;

(ii) identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply. (The new framework for pay and contractual arrangements will help more tightly define this group in due course.)

(iii) investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five;

(iv) provide a supportive environment to managers (see paragraph three above).

**October 2002**
NATIONAL HEALTH SERVICE ACT 1977
NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

The Code of Conduct for NHS Managers Directions 2002

The Secretary of State for Health, in exercise of the powers conferred by section 17(a), paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977, and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990(b), hereby gives the following Directions:

Application, commencement, interpretation

1.- (1) These Directions apply to all NHS bodies in England and shall come into force on 9 October 2002.

(2) These Directions shall be referred to as The Code of Conduct for NHS Managers Directions 2002.

(3) In these Directions “NHS bodies” means:

(i) Strategic Health Authorities
(ii) Special Health Authorities
(iii) NHS Trusts
(iv) Primary Care Trusts

Implementation of Code of Conduct for NHS Managers

2. NHS bodies shall take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers appended to these Directions.

Effect of Direction 2

3. The fact of compliance or non-compliance with Direction 2 shall in itself have no effect on the validity or enforceability of a contract entered into by an NHS body to which these Directions apply.

Signed by authority of the Secretary of State for Health
M G Sturges

4 October 2002

Department of Health

(a) 1977 c. 49. Section 17 was substituted by section 12(1) of the Health Act 1999 (c.8) and was amended by Schedule 5, Part 1, paragraph 5(1) and (3), to the Health and Social Care Act 2001 (c.15) and by Schedule 1, paragraph 7 to the NHS Reform and Health Care Professions Act 2002 (c.17).

(b) Paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977 (1977 c.49), and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990 were amended by section 6 of the Health and Social Care Act 2001 (c.15).
Working Group Members

Ken Jarrold CBE
Chief Executive
County Durham and Tees Strategic Health Authority

Dr Gill Morgan
Chief Executive
NHS Confederation

Stuart Marples
Chief Executive
Institute of Healthcare Management

Professor Jenny Simpson OBE
Chief Executive
British Association of Medical Managers

John Flook
Chairman
Healthcare Financial Management Association

Penny Humphris
Director
NHS Leadership Centre
Appendix E:

Standards of Business Conduct Declaration Form for Declarations of Interest

NAME:  

JOB ROLE:  

<table>
<thead>
<tr>
<th>Category</th>
<th>Type and Description of Interest (see guidance notes below)</th>
<th>Relevant Dates</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaker Fees</td>
<td></td>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>Outside Employment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Outside Interests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shareholdings and other ownership issues</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patents</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loyalty Interests</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Donations</td>
<td></td>
<td></td>
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<tr>
<td>Sponsored Events</td>
<td></td>
<td></td>
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<tr>
<td>Sponsorship for publications</td>
<td></td>
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<tr>
<td>Sponsored Research</td>
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<td></td>
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<tr>
<td>Sponsored Posts</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Clinical Private Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Commercial sponsorship includes NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings / events, provision of free services (speakers), buildings or premises.
### Declaration of interests of family members

**Details of business interests of immediate family (to include spouse/partner, siblings/step-siblings, children, parents/step-parents, nephew/niece, aunt/uncle, grandparent/grandchild and any such arrangements arising by marriage)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Organisation</th>
<th>Type and Description of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

**Declaration:**

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to The Rotherham NHS Foundation Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result. I **do/do not (delete as applicable)** give my consent for this information to be published on registers that The Rotherham NHS Foundation Trust holds and which will be made available to the public via the Trust’s website.  

**N.B.** for colleagues at band 8D (or equivalent) and above the default position is that your declarations will be published in accordance with the NHS England Conflicts of Interest guidance.

**Signed:** ___________________________ **Date:** ___________________________

The information submitted will be held by The Rotherham NHS Foundation Trust for personnel or other reasons specified on this form and to comply with the organisation’s policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that The Rotherham NHS Foundation Trust holds. These registers will be made available to the public via the Trust’s website.

<table>
<thead>
<tr>
<th>For Office Use Only</th>
<th>Date form received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request Approved</td>
<td>Request Not Approved</td>
</tr>
<tr>
<td>Reasons:</td>
<td></td>
</tr>
</tbody>
</table>

**Signature:** ___________________________ **Date:** ___________________________

**Copy to Central Register** ___________________________ **Copy to Requestor** ___________________________
GUIDANCE NOTES FOR COMPLETION OF SPECIMEN INTERESTS DECLARATION FORM

Name and Role:
Insert your name and your position/role in relation to the organisation you are making the return to

Description of Interest:
Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any sponsorship, speaker fee, donation etc). That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.

Types of interest:
• Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making

• Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career

• Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career

• Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making

A benefit may arise from both a gain or avoidance of a loss.

Relevant Dates:
Detail here when the interest arose and, if relevant, when it ceased

Comments:
This field should detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action.
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>488/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Review of Risk Management Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Angela Wood, Chief Nurse</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>All Board Assurance Framework Risks</td>
</tr>
</tbody>
</table>

**Purpose**

- **Decision**
- **To note** ✓
- **Approval**
- **For information**

*(Tick only one box)*

**Executive Summary**

This report is provided to enable the Board Members to recognise the positive features of the Trust’s current arrangements for risk management, there are also some deficits which should be addressed.

**Recommendations**

It is recommended that:

The process for the Trust Risk Management arrangements are noted.

**Appendices**

1. Operational Plan Risks
2. Risk Analysis Group Terms of Reference
1. Introduction

1.1 This report provides an update on the current risk management processes in the Trust.

2. Risk Management Strategy and Appetite

2.1 The Trust has a Risk Management Strategy (2015-20) in place which sets out the approach and risk appetite. It was last reviewed in 2017.

2.2 The Risk Appetite sets out the level of risks the organisation is willing to accept for:

- quality and safety of services.
- innovation
- staff safety
- non-delivery of quality improvement priorities
- financial
- organisational reputation and branding

2.3 The Trust has Risk Management Guidelines in place which was developed and approved in July 2017 and is a guide for staff in the Trust’s expectation of their role in risk management.

3. Board Assurance Framework

3.1 The HM Treasury Guidance on Assurance Frameworks (2012) defines an assurance framework as:

‘An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect.’

3.2 The Board Assurance Framework or BAF is the mechanism through which the Board of Directors manages the principal risks to the achievement of its strategic objectives. It enables the Board to effectively focus on the management of these principal risks.

3.3 It provides the structure for the evidence to support the Trust’s Annual Governance Statement (contained with the Annual Report & Accounts) because it allows the Board to demonstrate how it has been effectively informed about all of its key risks whether they are related to quality, finance, performance or sustainability etc.

3.4 It takes the principles of risk management (identification, evaluation, establishment of risk appetite, identification of controls and monitoring of effectiveness) and applies them to the organisation’s strategic risks.

4. Operational Risks

4.1 The operational plan included a list of internal and external risks in the delivery of the operational plan for 2018/19, along with appropriate mitigation actions. These are detailed in the table in Appendix 1, and cross referenced to the relevant risk assessment.

4.2 In addition to this, each operational objective and enabler has its own risk on the risk register (irrespective of scoring) which is reviewed in line with the risk score. Divisions are currently undertaking a review of whether there are any risks associated with the
achievement of key performance indicators (quality, operations, workforce, finance, estates and IT etc).

5. **All Risks**

5.1 All staff have a responsibility to identify risks in their areas. These are then added onto Datix (the risk management database). This is widely used across the NHS and therefore even when colleagues move into the Trust they are often already familiar with the risk management software system. There are (as at 7 December 2018) 1273 risks logged on the Trust's risk register.

5.2 Whilst it is undoubtedly helpful to have a specific risk management database in place, there are some aspects of the risk management software functionality which are restrictive, this includes the ability to easily identify similar risks occurring across multiple areas.

5.3 The risks are approved and reviewed in line with the table below

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Primary Descriptor</th>
<th>Management Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>Minor Risk</td>
<td>Usually managed at local ward/team level. May be retained if any further control limits management capacity to control higher scoring risks.</td>
</tr>
<tr>
<td>8-10</td>
<td>Moderate Risk</td>
<td>These must be reported to the local CSU Governance meeting. There should be a review by the Divisional leadership team. Again, they may be retained if any further control limits management capacity to control higher scoring risks.</td>
</tr>
<tr>
<td>12</td>
<td>Significant Risk</td>
<td>These must be reported to the General Manager or Divisional Director to the monthly performance meeting led by the Chief Operating Officer, along to the Divisional Governance Meeting. Executive Directors will manage risks at this level within their own portfolio.</td>
</tr>
<tr>
<td>15+</td>
<td>Significant Serious Risk</td>
<td>These must be reviewed by the Risk Analysis Group at each meeting. They will also be reviewed by the Board and its assurance committees quarterly.</td>
</tr>
</tbody>
</table>

5.4 Risk Management Training is essential for all band 8a’s (or equivalent) and above, however it is open to all staff. Risk awareness within the Trust has significantly improved with 78% (as at November 2018) of relevant staff having undertaken the Risk Management Training.

6. **Risks Scoring 15 or above**

6.1 All risks scoring 15 or above are presented to the Risk Analysis Group for approval for addition to the 15 or above register. The risks are reviewed on a monthly basis by the risk owner. These risks require Divisional/Corporate Director oversight and management. They then should be reviewed at each Risk Analysis Group meeting until either the risk score reduces (below 15) or they are closed. They are then approved for removal by the Risk Analysis Group.
7. **Divisional Reporting**

7.1 The ownership of the risks sits within the division or corporate service in which it relates, the divisional governance structure should ensure discussion, mitigation and escalation to the appropriate level for all risks regardless of score.

8. **Risk Analysis Group (RAG)**

8.1 The primary purpose of the Trust’s Risk Analysis Group is to provide assurance to the Board on the function of systems of risk management via the Trust Management Committee (TMC). The aim of the Trust’s Risk Analysis Group is to operationalise the overall strategic approach to risk management across the organisation, ensuring that the approach adopted is effective and proactive. This is undertaken by reviewing, approving and removing risks of 15 and above from the risk register.

8.2 The Risk Analysis Group meets monthly, and has membership from Corporate and Divisional Services (see Appendix 2 for the Terms of Reference). The Group ensures that effective risk management processes encompass the following:

- **Improvement to risk response.** Good risk management should provide the rigour to identify appropriate responses to risks (avoid, mitigate, share or accept).
- **Reduction of operational surprises.** The group should be able to identify potential issues that might adversely affect the organisation and be better able to respond in the event of a crisis.
- **The identification and management of multiple and cross organisational risks.** Effective risk management should determine the scope of cross organisational risks and facilitate response to inter-related risks across the organisation.
- **Improve deployment of resources.** The group should ensure that the Trust has robust information on risk to allow the Board and Trust Management Committee to effectively assess the needs for capital and appropriate allocation of resources.

8.3 The intention of the group is also to assist the Chief Executive in ensuring a strong risk culture whereby colleagues (staff) at all levels are able to discuss and debate openly the risks that should be taken to meet the organisation’s objectives and ensure traction in terms of mitigation.

8.4 During each meeting, the RAG members review the risks being presented at 15 or above for addition to the register and approves, where appropriate. The risks where the score has been reduced to lower than 15 or where the risk has been closed are also presented for approval. The members ensure consistency of risks assessed. In addition to this, the Key Performance Indictors are reviewed along with discussing any potential risks that should be added. The group also escalates to Trust Management Committee.

9. **Trust Management Committee**

9.1 The Trust Management Committee receives a monthly report on all risks scoring 15 or above, including those that have been escalated by the Risk Analysis Group for addition or removal or to remain.

9.2 It is the role of the Committee to utilise the risk register to understand and ensure effective management of the risks to delivering high quality patient care and achieving the operational plan. Thereby ensuring resilience and sustainability of services. Highlighting any additional risks that should be considered for inclusion onto the risk
register. Evaluating and identifying any additional resources required, where appropriate, to support the mitigation of risks.

10. **Board and Assurance Committees**

10.1 The Trust Board and its Assurance Committees receive reports on risks scoring 15 or above on a quarterly basis. It is the members of those meetings role to scrutinise and challenge the risks and mitigation, and identify any risks for addition to the register.

11. **Review of Risk Management**

11.1 The review of risk management is to continue, focusing on:

- The Risk Management Strategy and Appetite
- The Risk Analysis Group
- Reporting Arrangements

11.2 The learnings from the NHS Providers Risk Management seminar, attended by the Company Secretary on 11 December, will also feed into that review.

11.3 The current review will be presented in a report to the March 2019 Board meeting

12.0 **Conclusion**

12.1 Whilst there are many positive features of the Trust’s current arrangements for risk management, there are also some deficits which should be addressed.

12.2 A number of opportunities for improvement have been identified and a proposal for a programme of work will be submitted in March to implement changes to the current arrangements.

13.0 **Recommendation**

13.1 That the process for the Trust Risk Management Arrangements are noted.
Appendix 1 – Operational Risks

The operational plan included a list of internal and external risks in the delivery of the operational plan for 2018/19, along with appropriate mitigation actions. These are detailed in the table below and cross referenced to the relevant risk assessment;

<table>
<thead>
<tr>
<th>Area</th>
<th>Risk Description and Mitigation</th>
<th>Potential Impact</th>
<th>Relevant Risk</th>
<th>Risk Score</th>
</tr>
</thead>
</table>
| Income             | **Risk**: Activity levels are below contracted levels and / or the Trust fails to capture all activity and income levels  
**Mitigation**: Regular discussions underway with CCG to undertake monthly reconciliation. Contract compliance meeting in place internally to track progress against plan. Provision of information being prioritised to provide divisional teams with progress against contracted levels | Potential impact of under delivery of activity and income plan | Failure to deliver operational objective 2 – Deliver the financial plan and contract (Risk Reference 5517) | Extreme Risk (20) |
|                    | **Risk**: Unable to recruit to key areas resulting in continued reliance on agency and / or on ability to deliver the plan | Pay controls not delivered in full Key milestones not achieved | Failure to deliver enabler 1 – Recruit to the top 30 key posts (Risk Reference 5521) | Significant (15) |
| Workforce & Controls | **Mitigation**: Identification of the Top 30 key posts with a focus on filling these roles. Also, weekly operational workforce planning in place and establishments agreed at a divisional level |                                                                                      | Lack of Substantive Gastro Consultant leading to reduced Locum led service affecting patient experience (Risk Reference 4514) | Extreme Risk (20) |
|                    |                                                                                                 |                                                                                      | Vacancies and not being able to obtain Medical Staffing which leads to increase use of agency and affecting patient safety (Risk Reference 5536) | Extreme Risk (20) |
|                    |                                                                                                 |                                                                                      | Insufficient Nursing Staffing Levels for Acute Stroke (Risk Reference 3698) | Extreme Risk (20) |
|                    |                                                                                                 |                                                                                      | Risk of Service Interruption at REWS due to low staffing levels following the tender process announcement (Risk Reference 4740) | Extreme Risk (16) |
|                    |                                                                                                 |                                                                                      | The Divisions ability to ensure that there are adequate numbers of suitable qualified, competent and experienced nurses (Risk Reference 4959) | Extreme Risk (20) |
|                    |                                                                                                 |                                                                                      | Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety. (Risk Reference 5442) | Extreme Risk (16) |
| CIP Delivery       | **Risk**: The Trust has traditionally delivered against the CIP target, but has become more challenging in recent years, particularly with cash-releasing savings and this may continue into 2018/19. Leadership of the CIP programme also remains a concern.  
**Mitigation**: The Trust has commenced planning for CIP delivery earlier than in previous years. The Programme Management Office is being reconfigured. Workforce solutions are being implemented to ensure appropriate capacity and capability is in place. | Inability to deliver the CIP target in FY18/19 of £8.3m Additional costs incurred to secure external support | Failure to deliver the annual cost improvement target (Board Assurance Framework – B9) | Significant (15) |
<p>| CQC Inspection     | <strong>Risk</strong>: Reduced focus on delivery of the operational plan in the event of an adverse CQC inspection | Costs of additional resource to plan &amp; | Non-compliance with CQC Regulation 18 Action in relation to pharmacy staffing, leading to reputational damage | Extreme Risk (16) |</p>
<table>
<thead>
<tr>
<th>Risk Area</th>
<th>Risk Description</th>
<th>Mitigation</th>
<th>Potential Impact</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse operationa l pressures</strong></td>
<td>Activity levels and demand are significantly above plan and/or the Trust experiences variability in demand leading to operational pressures in delivering performance</td>
<td>Increased costs for staff extra capacity and operational standards not met. Rotational planning undertaken in previous years and to be built into planning cycle. Bed reconfiguration plan underway to right-size the bed allocation. Operational escalation plans to continue to be strengthened to respond to increased pressures and surges.</td>
<td>Failure to achieve the 4 hour access standard. Failed to meet the 4 hour access target. Operational challenge in the delivery of the 4 hour access target.</td>
<td>Extreme Risk (20)</td>
</tr>
<tr>
<td><strong>Failure of Capital Equipment</strong></td>
<td>Breaches of cyber security occur across main network and digital facilities. Regular update of data security 'patches' across PC and server estate. Removal of out-of-date operating systems. Internal audit reviews of cyber security. Engagement with NHS Digital assessments. Monthly Cyber Security focus group.</td>
<td>Loss of systems and operational activity. Ability to deliver services.</td>
<td>Unable to provide services due to a cybersecurity incident.</td>
<td>Significant (15)</td>
</tr>
<tr>
<td><strong>Cyber Security</strong></td>
<td>Clinical service(s) experience sustainability challenges due to changing workforce levels and uncertainty around future provision. Consistent application of clinical specialty reviews. Active involvement in Hospital Services Review. Recruitment to key posts.</td>
<td>Changes to clinical pathways required to make services sustainable in the ICS, may initially lead to a decrease in the quality of care locally. Uncertainty over future services configuration.</td>
<td></td>
<td>High Risk (9)</td>
</tr>
<tr>
<td><strong>Sustainability of Services</strong></td>
<td>Changes in service models and provision of services, may lead to workforce unrest and industrial action. Regular staff communication and engagement. Structured discussions with union representatives. Consistent application of QIA process.</td>
<td>Increased agency / locum spend. Reduced activity and income.</td>
<td></td>
<td>High Risk (9)</td>
</tr>
<tr>
<td><strong>Industrial Action</strong></td>
<td>Small changes in service models and provision of services, may lead to workforce unrest and industrial action. Regular staff communication and engagement. Structured discussions with union representatives. Consistent application of QIA process.</td>
<td>Ability to deliver services. Increased bank and agency costs.</td>
<td></td>
<td>This is not currently deemed to be a risk.</td>
</tr>
</tbody>
</table>
## Appendix 2 – Risk Analysis Group Terms of Reference

| Primary Purpose | The primary purpose of the Trust’s Risk Analysis Group is to provide assurance to the Board on the function of systems of risk management via the Trust Management Committee (TMC). |
| Purpose | The purpose of the Trust’s Risk Analysis Group is to operationalise the overall strategic approach to risk management across the organisation, ensuring that the approach adopted is effective and proactive. The Risk Analysis Group needs to ensure that effective risk management processes encompass the following: |
| - Improvement to risk response. Good risk management should provide the rigor to identify appropriate responses to risks (avoid, mitigate, share or accept). |
| - Reduction of operational surprises. The Committee should be able to identify potential issues that might adversely affect the organisation and be better able to respond in the event of a crisis. |
| - The identification and management of multiple and cross organisational risks. Effective risk management should determine the scope of cross organisational risks and facilitate response to inter-related risks across the organisation. |
| - Improve deployment of resources. The Committee should ensure that the Trust has robust information on risk to allow the Board and Trust Management Committee to effectively assess the needs for capital and appropriate allocation of resources. |
| To assist the Chief Executive in ensuring a strong risk culture whereby colleagues (staff) at all levels are able to discuss and debate openly the risks that should be taken to meet the organisation’s objectives. |
| Operational Duties | - To assist the Trust Management Committee (TMC) to develop and monitor the Trust’s Risk Management Strategy. |
| - To develop, and monitor the Trust’s Risk Management Guidance in conjunction with expert Committees. |
| - To assist the Trust Management Committee and Trust Board in defining acceptable levels of risk (risk tolerance and risk appetite) within the organisation. |
| - To oversee the delivery of an annual risk management training programme. |
| - To ensure that adequate organisational systems are in place for implementing, monitoring and reviewing assurances on controls. |
| - To make recommendations to the Trust Management Committee on priority risk areas and the appropriate allocation of resources. |
| - To oversee the maintenance and development of the Trust risk registers. |
| - To approve risks with a score of 15 or more, and report to TMC on those risks approved. |
| - To review the Risk Management Strategy on an annual basis. |
| - To renew generic trends of risks. |
Membership
- Executive Chief Nurse (Chair)
- Quality Governance, Compliance and Risk Manager (Deputy Chair)
- Director of Workforce or a representative
- Director of Finance or a representative
- Director of Corporate Affairs
- Medical Director or a representative
- Head of Health and Safety and Compliance (Estates)
- Named Divisional Representatives (Either Governance Lead or Head of Nursing or representative)

Standing Invitees
Leads for Risk Types
- Clinical Patient Safety and Quality – Deputy Chief Nurse
- Staff, Public and Contractors – Head of Health and Safety and Compliance (Estates)
- Patient Experience – Assistant Chief Nurse (Vulnerabilities)
- Environmental – Head of Health and Safety and Compliance (Estates)
- Staffing and Competency – Human Resources Representative
- Complaints and Claims – Deputy Chief Nurse
- Business/Service Interruption – Emergency Planning and Business Resilience Manager
- Inspection/Statutory Duties – Quality Governance, Compliance and Risk Manager/Head of Governance
- Adverse Publicity/Reputation – Communications Team
- Fire/General Safety – Head of Health and Safety and Compliance (Estates)
- Information Governance – Director of Corporate Affairs
- Information Technology/Health Informatics – Director of Health Informatics
- Projects – Associate Director of Transformation
- Infection Control – Lead Nurse/Assistant Director of Infection Prevention and Control
- Medical Devices – Nurse Consultant
- Learning from an SUI – Deputy Chief Nurse
- Clinical effectiveness – Research, Innovation and Clinical Effectiveness Manager
- Cost Improvement Plans – Deputy Director of Finance
- Work Experience – Human Resources Representative
- Chief Operating Officer

Declarations of Interest
If any member has an interest, pecuniary or otherwise, he or she must declare that interest as soon as possible and not participate in the discussion. The declaration will be recorded in the minutes. The Chair may take a view that the member should withdraw from the meeting until the Group’s consideration is complete. There would be no right of appeal against that decision.

Quorum
The Chair or the Deputy Chair, and 3 other persons. At least two Executive Directors must be present for the meeting to be quorate.

Frequency of Meetings
Every month
## Business Papers/Agsenda
- Agendas will be signed off by the Chair
- Members will receive the agenda and papers (electronically), at least three working days before the meeting (all members will need an nhs.net email address)
- No papers will be circulated after the papers have been electronically issued and any member wishing to use PowerPoint to present a discussion paper must advise the Chair in advance of the meeting.
- The approved minutes will be signed by the Chair of the approving meeting.

<table>
<thead>
<tr>
<th>Secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Governance, Compliance and Risk Manager</td>
</tr>
</tbody>
</table>

## Business Conduct
The Terms of Reference will be subject to review annually:
- All members are expected to have read papers before the meeting and contribute to the discussion and decisions of the group;
- All members have an equal voice. The Chair will facilitate active participation of all members.
- All members are expected to act with integrity and honesty;
- All members are expected to respect the sensitivity and confidentiality of some of the matters put to the committee
- Members are expected to arrive on time and participate in the full meeting.
- Unless members are on call, mobile telephones should be switched off during meetings and other distractions (e.g. emails) should be avoided.
- It is highly important that members attend the Risk Management Committee on a regular basis. No more than two meetings should be missed in any one year unless due to extenuating circumstances. Where possible a delegated deputy should attend the meeting in the absence of a Risk Management Committee member.

Trust values should be mapped against the business conduct statements.

## Performance/Effectiveness
The effectiveness of the Risk Analysis Group is monitored through the:
- Trust Management Committee minutes.
- Audit Committee minutes.
- Corporate Risk Register and BAF.

## Review
The Terms of Reference will be reviewed annually or sooner if necessary in conjunction with the Company Secretary.

### DOCUMENT CONTROL

Author: Anne Rolfe  
Date: Dec 2018  
Version: 2  
Status: Final
### Integrated Performance Dashboard (December 2018)

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>Performance</th>
<th>Trend</th>
<th>Benchmark</th>
<th>Data-Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 A&amp;E % Left without being seen</td>
<td>Sep-18</td>
<td>5.00%</td>
<td>5.79%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 IP Friends &amp; Family Test (% Positive)</td>
<td>Nov-18</td>
<td>95.0%</td>
<td>98.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3 % LAC assessments reported &lt;20 days</td>
<td>Nov-18</td>
<td>95%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4 New Complaints per WTE</td>
<td>Nov-18</td>
<td>7.6</td>
<td>7.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1 Ambulance Turnaround % &gt; 60 mins</td>
<td>Oct-18</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E2 Cancelled Operations</td>
<td>Nov-18</td>
<td>0.8%</td>
<td>0.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E3 Delayed Transfer of care</td>
<td>Nov-18</td>
<td>3.5%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E4 Dementia Assessment</td>
<td>Oct-18</td>
<td>90.0%</td>
<td>79%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E5 Hip Fracture Best Practice Compliance</td>
<td>Oct-18</td>
<td>65.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E6 Mortality (HSMR Rolling 12 Month)</td>
<td>Sep-18</td>
<td>100</td>
<td>105.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E7 Stroke: admitted to ward within 4 hours</td>
<td>Nov-18</td>
<td>60.0%</td>
<td>17.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R1 Urgent Care (4 Hour)</td>
<td>Nov-18</td>
<td>95.0%</td>
<td>88.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R2 Cancer Standards 62 Day</td>
<td>Sep-18</td>
<td>85.0%</td>
<td>86.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3 Cancer Standards 62 Day Screening</td>
<td>Sep-18</td>
<td>90.0%</td>
<td>88.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R4 Diagnostics DM01</td>
<td>Oct-18</td>
<td>1.0%</td>
<td>0.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R5 18 weeks (RTT Incomplete)</td>
<td>Oct-18</td>
<td>92.0%</td>
<td>94.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R6 e-Referral Slot Issues Rate</td>
<td>Oct-18</td>
<td>4.0%</td>
<td>37.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1 Access to Antenatal Services within 90 days</td>
<td>Nov-18</td>
<td>90.0%</td>
<td>93.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2 C Diff incidence rate per 100,000 bed days</td>
<td>Nov-18</td>
<td>12.9</td>
<td>9.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3 Emergency Caesarean Section Rate</td>
<td>Nov-18</td>
<td>16.5%</td>
<td>17.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4 Harm Free Care</td>
<td>Nov-18</td>
<td>95.0%</td>
<td>94.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5 MRSA bacteraemia rate per 100,000 bed days</td>
<td>Nov-18</td>
<td>0.65</td>
<td>0.63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S6 Potential under reporting of incidents</td>
<td>Nov-18</td>
<td>43.3%</td>
<td>35.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S7 Readmissions (Non Elective 28 day)</td>
<td>Oct-18</td>
<td>13.3%</td>
<td>9.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8 VTE Assessment Completion %</td>
<td>Oct-18</td>
<td>95.0%</td>
<td>95.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W1 Incident Reporting Culture - % Incidents Severe</td>
<td>Nov-18</td>
<td>0.35%</td>
<td>0.14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W2 Variance from Plan</td>
<td>Nov-18</td>
<td>0.0%</td>
<td>0.40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W3 Proportion of Temporary Staff</td>
<td>Nov-18</td>
<td>4.99%</td>
<td>7.78%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W4 Sickness Rates (12 Month Rolling)</td>
<td>Nov-18</td>
<td>3.95%</td>
<td>4.16%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W5 Staff Turnover</td>
<td>Nov-18</td>
<td>0.88%</td>
<td>0.40%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Top Achievements

- **Hip Fracture Best Practice Compliance**
  - Performance for October has demonstrated continued excellence on the trauma pathway with 100% of patients receiving treatment that meets the national best practice standards. This raises the 12 month rolling performance to 87.8% (3rd best nationally).

### Most Improved

- **Ambulance Turnaround Times**
  - For the month of November there were no ambulance transfer delays greater than 60 minutes and 34 delays greater than 30 minutes, which is a significant improvement on previous months where the average has been 120.

### Key Concerns

- **Proportion of Temporary Staff**
  - The percentage of staff working at TRFT via bank or agency has risen from 5.86% in April to 7.78%. This is the 19th highest temporary staff rate in the country. This increase also coincides with and increased staff sickness rate.

### Most Deteriorated

- **Diagnostics DM01**
  - A backlog in sleep studies has resulted in 34 breaches of the 6 week waiting time standard. This is predominantly due to an increase in out of area referrals which is above capacity levels. TRFT is working with RCCG and NHSE to address the wider system challenges.

### Most Achieved

- **Diagnostics DM01**
  - Performance for October has demonstrated continued excellence on the trauma pathway with 100% of patients receiving treatment that meets the national best practice standards. This raises the 12 month rolling performance to 87.8% (3rd best nationally).

### Friends and Family Test - Patients % Positive

- **Performance for November is a significant improvement on recent months with 98.6% of patients completing the survey recommending TRFT as a place to receive care. This level of feedback is in the national top 10.**

### In Month Activity (MB)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Diff. %</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Diff. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>459</td>
<td>441</td>
<td>-18</td>
<td>-4%</td>
<td>3,601</td>
<td>3,743</td>
<td>-126</td>
<td>4%</td>
</tr>
<tr>
<td>2,288</td>
<td>2,408</td>
<td>121</td>
<td>5%</td>
<td>17,892</td>
<td>18,148</td>
<td>256</td>
<td>1%</td>
</tr>
<tr>
<td>2,156</td>
<td>2,376</td>
<td>221</td>
<td>10%</td>
<td>17,452</td>
<td>17,613</td>
<td>161</td>
<td>1%</td>
</tr>
<tr>
<td>4,957</td>
<td>4,377</td>
<td>-580</td>
<td>-12%</td>
<td>38,725</td>
<td>35,374</td>
<td>3,351</td>
<td>-9%</td>
</tr>
<tr>
<td>8,881</td>
<td>9,522</td>
<td>641</td>
<td>7%</td>
<td>69,466</td>
<td>73,269</td>
<td>3,823</td>
<td>6%</td>
</tr>
<tr>
<td>4,575</td>
<td>5,047</td>
<td>473</td>
<td>10%</td>
<td>35,737</td>
<td>38,202</td>
<td>2,465</td>
<td>7%</td>
</tr>
<tr>
<td>327</td>
<td>292</td>
<td>-35</td>
<td>-11%</td>
<td>2,653</td>
<td>2,515</td>
<td>-138</td>
<td>-5%</td>
</tr>
<tr>
<td>418</td>
<td>262</td>
<td>-156</td>
<td>-37%</td>
<td>3,346</td>
<td>2,862</td>
<td>-484</td>
<td>-14%</td>
</tr>
<tr>
<td>948</td>
<td>1,206</td>
<td>258</td>
<td>27%</td>
<td>7,699</td>
<td>12,216</td>
<td>4,517</td>
<td>59%</td>
</tr>
<tr>
<td>METRIC</td>
<td>Target</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------</td>
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<td>-----</td>
<td>-----</td>
<td>-----</td>
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<td>-----</td>
</tr>
<tr>
<td>% of Stroke patients who spend at least 90% of their time on a stroke unit</td>
<td>&gt;= 80%</td>
<td>84%</td>
<td>92%</td>
<td>89%</td>
<td>85%</td>
<td>92%</td>
<td>75.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23/36</td>
<td>23/35</td>
<td>33/37</td>
<td>33/39</td>
<td>33/36</td>
<td>28/37</td>
</tr>
<tr>
<td>% of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional</td>
<td>&gt;= 60%</td>
<td>60%</td>
<td>70%</td>
<td>66%</td>
<td>75%</td>
<td>62%</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9/15</td>
<td>7/10</td>
<td>2/3</td>
<td>6/8</td>
<td>8/15</td>
<td>9/14</td>
</tr>
<tr>
<td>% of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital</td>
<td>&gt;= 90%</td>
<td>33%</td>
<td>80%</td>
<td>81%</td>
<td>54%</td>
<td>63%</td>
<td>42.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/36</td>
<td>15/25</td>
<td>22/36</td>
<td>21/39</td>
<td>24/38</td>
<td>16/37</td>
</tr>
<tr>
<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>&gt;= 60%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3/3</td>
<td>5/5</td>
<td>8/8</td>
<td>3/3</td>
<td>6/6</td>
<td>4/4</td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>&gt;= 50%</td>
<td>44%</td>
<td>45%</td>
<td>58%</td>
<td>59%</td>
<td>60%</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15/34</td>
<td>10/22</td>
<td>22/38</td>
<td>23/39</td>
<td>22/37</td>
<td>14/37</td>
</tr>
<tr>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
<td>&gt;= 100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33/34</td>
<td>22/22</td>
<td>38/38</td>
<td>38/39</td>
<td>37/37</td>
<td>37/37</td>
</tr>
<tr>
<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
<td>&gt;= 40%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9/9</td>
<td>26/26</td>
<td>19/19</td>
<td>15/15</td>
<td>13/13</td>
<td>11/11</td>
</tr>
<tr>
<td>Proportion of patients and carers with joint care plans on discharge from hospital</td>
<td>&gt;= 85%</td>
<td>100%</td>
<td>100%</td>
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<td>8/8</td>
<td>7/7</td>
<td>3/3</td>
<td>6/6</td>
<td>5/5</td>
<td>8/8</td>
</tr>
<tr>
<td>Proportion of stroke patients that are reviewed six months after leaving hospital</td>
<td>&gt;= 95%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
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<td>21/23</td>
<td>28/28</td>
<td>28/28</td>
<td>25/25</td>
<td>20/20</td>
<td>14/14</td>
</tr>
<tr>
<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>&gt;= 40%</td>
<td>19%</td>
<td>52%</td>
<td>64%</td>
<td>52%</td>
<td>30%</td>
<td>34.4%</td>
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<tr>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>&gt;= 11%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5%</td>
<td>10.0%</td>
<td>5.3%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

% of patients who receive thrombolysis following an acute stroke

Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke

Proportion of patients and carers with joint care plans on discharge from hospital

Proportion of stroke patients that are reviewed six months after leaving hospital

Proportion of patients supported by a stroke skilled ESD team

% of patients who receive thrombolysis following an acute stroke
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>489/18(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Quality Report</td>
</tr>
</tbody>
</table>
| Executive Lead | Angela Wood, Chief Nurse  
|              | Callum Gardner, Interim Medical Director |
| Link with the BAF | BAF: B1, B4, B7  
|              | Corporate Risk Register: 3908, 4733, 4174, 4080 |
| Purpose     | Decision ☐  
|             | To note ☑  
|             | Approval ☐  
|             | For information ☐ |
| Executive Summary | This report is provided to enable the Board Members to summarise a set of quality indicators and to provide assurance to the Board of Directors.  
| (including reason for the report, background, key issues and risks) | The majority of quality indicators for this month are static or improving with improvements noted in harm free care scores, looked after children initial health assessments, and Friends and Family scores.  
|              | Two areas of deterioration are reported. Complaints responsiveness has decreased although due to small numbers, this relates to two delayed responses. There has also been a slight deterioration against the national baseline is for mortality.  
|              | The Trust continue to meet the conditions placed on the Trust registration by the Care Quality Commission in relation to Paediatric UECC. |
| Recommendations | It is recommended that the Board of Directors note the contents of the report.  
|              | It is recommended that the mortality position doesn’t fall further away from the national standard and therefore there needs to be continued focus on identifying diagnosis codes where quality improvements can be made, such as with sepsis. |
| Appendices  | 1. Harm Free Care  
|             | 2. Hospital Acquired Infections  
|             | 3. Dementia, Delirium and Patient-centred Care  
|             | 4. Nurse Staffing Report |
1.0 **Patient Safety**

1.1 **Harm Free Care** – The overall Trust score for November 2018 is 95.09% a slight increase from 94.40% in October 2018. This continues to be above the national average score which is currently at 94.12%. The breakdown of the scores shows that the Acute areas had a harm free score of 96.68% with 93.85% for the Community. This is the third month in a row to see an increase in the overall harm free care score. This was due to a reduction in new VTEs and UTIs. See Appendix 1.

1.2 **Hospital Acquired Infection** - The Trust continues to monitor and report all hospital acquired infections as shown in Appendix 2 with no notable areas of concern. The first influenza case for this season has been reported in November.

1.3 **Looked After Children (LAC)** - The number of Initial Health Assessments (IHA) completed within 20 working days (statutory) has increased between October (50%) and November (80%). 20 IHAs were completed in November, of which 16 were within 20 working days.

1.4 **Mortality** – The Trust has been in a position of static performance for the last few months, but this month has shown a slight deterioration against the national baseline. It is important over the coming months that this position doesn’t fall further away from the national standard and therefore there needs to be continued focus on identifying diagnosis codes where quality improvements can be made, such as with sepsis. The current position Oct 17 to Sep 18 is that HSMR sits at 105, which is slightly worse than previous months. However, SHMI is published as 103, which is a marked improvement on the last rebasing figure.

2.0 **Patient Experience**

2.1 **Complaints** – The Trust received 91 concerns (100 in October) and 28 formal complaints (18 in October) in the month of November. 19 complaints were closed, of which 6 were local resolutions meetings. Two of the thirteen written responses were not completed within the agreed timescale resulting in a decrease in performance to 85% from 97% in October.

2.2 **Friends and Family Test (FFT)** - The Trust FFT positive score for November is 98.2% for inpatients (97.3% in October), and 99% for day case (97.9% in October). The combined national average for these two areas remains at 96%. Maternity services achieved 100% in November (98.4% in October / 97% national average), 97.8% for outpatients (96.7% in October / national average 94%). The Urgent and Emergency Care Centre achieved 93.9% against a target of 85% in November (93.1% in October / national average 87%). The Community positive score for November is 97.6% against a target of 95% (92.8% in October / national average 96%).

2.3 **Dementia, Delirium and Patient-centred Care** – Progress is monitored monthly via the Dementia, Delirium and Patient-centred Care Group, led by the Associate Medical Director for Person-Centred Care and Innovation. See Appendix 3 for details of key achievements in November.

2.4 **Patient Equality and Inclusion** – The Trust supports and promotes appropriate care for patients with protected characteristics on a daily basis. It has been identified that provision of this support, monitoring and reporting needs to be strengthened. To deliver this, a Trust Patient and Public Involvement Strategy is being produced by the Chief Nurse. A business case is also being completed to recruit a Patient Engagement and Inclusion officer.
3.0 Clinical Effectiveness

3.1 Nurse Staffing - There has been a small decrease in Registered Nurse fill rates on days and a marginal increase on nights when compared to those for October. There has been a small reduction in Healthcare Support Worker shift fill rates on days and increase on nights in November. The overall vacancy rate has slightly reduced during November 2018; the largest number of vacancies continues to be in the Division of Medicine. Please see appendix 4 for details.

3.2 CQUIN - Most of the CQUIN programme is now on track, however further focused work is required on the specific schemes identified. The Chief Nurse is discussing this with the relevant Executive Director and supporting a recovery plan.

3.2.1 The income for 2018/19 for CQUIN is £3,852,487 and Local Incentive Schemes is £1.2m.
3.2.2 Quarter two data submission has occurred.
3.2.3 Progress is currently being made with all but two of the CQUIN schemes (Sepsis and Alcohol & Tobacco). These two schemes have been discussed with the Interim Medical Director to enable him to provide further leadership support to these areas and recovery plans are being developed.

3.3 Research & Development (R&D) – Research Activity Report - The number of recruits into clinical research studies on the National Institute for Health Research (NIHR) Clinical Research Network portfolio at The Rotherham NHS Foundation Trust is 920, including 434 for Yorkshire Health Study, against a target of 550 for the financial year 2018/19 [data cut 04 December 2018, taken from NIHR]

There are 87 studies that are currently active (recruiting or in follow up), with 9 new studies in set up including 2 commercially sponsored studies. Current funding for R&D includes the Clinical Research Network 17/18 allocation of £218,780, £20 000 Research Capability Funding and commercial and non-commercial research income of £46 499 in the financial year 18/19 to date.

4.0 Quality Governance in Paediatric UECC

4.1 In October 2018, the Care Quality Commission (CQC) served a condition on the Trust registration relating to mitigating the risks within paediatric UECC with a focus on medical and nursing staffing levels. In response, the Trust continue to submit all necessary information to the CQC every week including updated action plans and requested data.

4.2 The Trust have been able to report that the required standards have been maintained. An identified doctor is available to support Paediatric UECC 24/7 and this doctor remains in the paediatric area. A minimum of two paediatric nurses are rostered into the area 24/7. On the rare occasions when this cannot happen, the patients are decanted into the adult area, following risk assessment by the senior manager and director on call. A successful recruitment programme is underway with the lead nurse post already filled.

4.3 Progress is being made with all other actions including increased training, improved monitoring of patients and completion of record keeping audits.

5.0 Conclusion
5.1 The majority of areas are reporting similar performance to last month with some minor variation.

5.2 The Interim Medical Director will continue to monitor the mortality position to ensure this doesn’t fall further away from the national standard and support measures to improve this.
Harm Free Care

Pressure Ulcers (All) Grade 2-4

VTE Assessment & Prophylaxis

UTI old & New

Falls Resulting in Harm

282
Harm Free Care

- Falls WH - TRFT
- Falls WH - National

- HFC - TRFT
- HFC - National
Hospital Acquired Infections

- The 2018/19 trajectory is for zero cases of Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia. The Trust continues to report 1 hospital acquired case from April.

- Blood culture contamination: reduction in blood culture contamination is being monitored via the Infection Prevention and Control Committee. The national benchmark for blood culture contamination is a maximum of 3%; TRFT are reporting 3.1% for October (4.13% in September). A review of line colonisation versus line contamination is being completed to ensure the Trust is only reporting contaminated samples. The numbers reported are relatively small so only a couple of cases can impact on the overall monthly figure.

- Clostridium difficile infection: The 2018/19 hospital trajectory is 25 cases. There have been 6 hospital acquired cases under the 2018/19 Public Health England (PHE) reporting algorithm which is what will be reported nationally.

- Gram negative bacteraemia: National mandatory surveillance of gram negative bacteraemia is for the specific organisms of E.coli, Klebsiella species and Pseudomonas aeruginosa. No trajectory for providers was set but CCG’s were challenged to reduce E.coli cases by 2020 within each CCG by 50%.

Q1-11 hospital acquired cases (50 community acquired cases)
Q2-11 hospital acquired cases (56 community acquired cases)
Q3- 2 cases to date. (31 community acquired cases to date)

A review of each case is carried out jointly by TRFT IPC team and the CCG Lead IPCN.

- Tuberculosis (TB) – All patients and staff that were potentially exposed to TB from the three unconnected patients diagnosed after admission have been contacted by post with appropriate follow up by the TB nurse specialist in line with NICE guidance. Confirmation is awaited from the PAM occupational health providers that all staff reviews are complete and that no further action is currently required. Following a shortage of TB vaccination, there is an unknown number of staff who have not received occupational vaccination. The PAM group have been informed that vaccine is now available so they can review records and determine who requires the vaccine, the IPC team and TB nurse specialist are awaiting confirmation of when vaccination will commence. This has been escalated through Clinical Governance Committee.

- Influenza (Flu) - The annual flu season covers Q3 and Q4. The current levels reported within the region are low, as expected at the beginning of the season. All positive cases identified from in-patients will be reported to PHE as TRFT is a voluntary sentinel reporting site. Point of care testing for flu in the UECC department has commenced for this year to support rapid identification, effective isolation where indicated and to improve patient flow. Staff vaccination plans are fully in place using the recommended quadrivalent vaccine and vaccination has commenced with 68% of front line staff vaccinated by the end of November.

- Norovirus and Rotavirus- The winter months are more likely to see cases of gastroenteritis with the main viral causes of Norovirus or Rotavirus. These are highly infectious with rapid spread once introduced into a populated area such as a hospital ward. Prompt isolation and cohorting of symptomatic or incubating people is required along with scrupulous hand hygiene and environmental cleaning in order to reduce onwards spread.
Dementia, Delirium and Patient-centred Care

1. We held the meeting of the dementia, delirium and person-centred care on the 22nd of November, this was well attended with good participation from a multidisciplinary group. Ideas which came from this meeting included a plan to determine whether This is Me forms can be scanned to Meditech to allow community viewing and work towards developing a document to support people living with dementia in the event of acute hospital admission. We have adapted the internal hospital transfer policy to specifically include people living with dementia; the excerpt is as follows – it will be forwarded to the relevant groups for ratification:

   Transfer and escort of patients policy
   Suggested amendments:
   Section 4.8 Patient groups
   To add in an additional section:
   4.8.3 Ward and bed transfers for people living with dementia or those experiencing can be significantly harmful, contribute to worse outcomes, such as increased confusion and falls and increase length of stay.
   We should minimise the number of ward moves or transfers experienced by this group of patients.
   It is the responsibility of the nurse handing over the patient, ensure the receiving ward is fully aware of a patient's diagnosis and any measures already taken to ensure Person-Centred Care, and, in particular, to ensure that the family/significant others have been informed of the move.
   All possible measures should be taken to avoid the transfer of patients with dementia/delirium between the hours of 21:00 and 07:00. Multiple moves and moves inside of these times should be reported through the Date system.
   Patients requiring 1:1 care or those with a high falls risk must not be transferred to cubicles or to Oakwood Community Unit unless there is sufficient staffing to provide adequate supervision (determined by the receiving ward, based upon patient dependencies).

2. The National Charity Camerados has awarded the Trust funding equivalent to £8,000 to host a tepee in the hospital entrance. This follows a successful pilot at Blackpool Hospital. For more information, please see the film here or follow this link to their website.

3. Sister Hinton attended the Person-Centred Care training day at Doncaster Royal Infirmary with the intention of developing an equivalent course in Rotherham addressing person-centred care, dementia, delirium, falls and end of life care.

4. Dr Kersh led a South Yorkshire trainee session in collaboration with the RCP focusing on the recently published NICE guidance on Tuesday the 13th of November in Sheffield. This was well attended with positive feedback.

5. Dr Kersh chaired a Yorkshire and Humber-wide event for the Clinical Network for Dementia in Wakefield on the 29th of November; this was attended by clinical, commissioning, user groups, voluntary sector and managerial staff working in dementia across the region. Themes for the meeting were anxiety and depression in older people, diversity and equality relating to older people and those living with dementia. You can find a link to some of the work here.

6. Dr Kersh and Sr Hinton held a meeting with palliative and community care colleagues to progress work developing an Advance Care Plan for patients in their last year of life living in Rotherham. Dr Kersh is taking this work forwards and has met with James Rawlinson to consider the creation of a template on Sepia.

7. Dr Kersh is running a Quality Improvement training day for F2 doctors on the 4th of December. Much of this will focus on improving patient safety and the creation of a person-centred organisation through QI methodologies.
8. Meetings are proceeding to determine ways to change the function and operation of the Ferns Ward currently overseen by RDaSH – this would include broadening the referral criteria and addressing issues relating to length of stay.

9. Dr Kersh and Sr Hinton have held meetings with the dementia audit clerk, improvement and data-warehousing staff and is reviewing the process for completing the dementia and delirium screening.

Data is below:

Thanks to Ruth Gallagher, Senior Performance Analyst for help with data presentation

Dr Rod Kersh 3/12/18
Nurse Staffing Report

1. Registered Nurse/Midwife (RN/M) shift fill rates (daytime) were 94.4% in November 2018 compared to 95.2% in October 2018 and 95.9% on nights compared with 95.6%. Healthcare Support Worker (HCSW) fill rates were 102.3% on days compared with 102.7% in October and for nights were 110.6% compared with 108.7%.

2. Five in-patient areas had Registered Nurse fill rates (days) below 90%. These were A1, A7, B4, Fitzwilliam and Keppel. Of these, one had a day time shift fill rate less than 80% and this was Keppel at 78.7% compared with 74.5% in October.

3. No areas had a fill rate below 80% on nights.

4. There were 12 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared to 9 in October. There has been an increase in the percentage of Registered Nurses/Midwives flexible staffing (internal bank) in the Division of Surgery and a reduction in the Divisions of Medicine and Family Health resulting in an overall reduction. RN/M agency usage has increased across all Divisions during November. In the Division of Medicine this is in part due to the use of agency RSCNs in the Urgent and Emergency Care Centre, it is anticipated that this will improve in the New Year as recruitment to these posts is currently underway. The percentage of shifts not staffed to plan has reduced to 16.41% in November as compared with 17.84% in October.

5. There were no internal staffing never events relating to one Registered Nurse on duty during November 2018.

6. In the Community, sickness absence has marginally increased with 4.4% currently absent from work compared with 4.1% last month. The majority of which are long term sickness, maternity related sickness and colleagues having planned surgery/treatment. There was 2.4% of District Nursing day shifts below plan, the number of nurses that this equates to is 0.45% of nurses against plan, which represents a worse position compared with October and can be accounted for annual leave taken during the half term at the beginning of the month.

7. Care Hours per Patient Day (CHpPD) is a metric introduced following Lord Carter’s review of efficiency in the NHS[1] to record a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. During November the overall actual CHpPD remained unchanged at 7.17.

8. The overall Registered Nurse and HCSW vacancy remains in a negative position at -160.93 wte compared with -169.88 wte last month. The position when recruitment plans are included is -53.43 wte as at 30 November 2018 compared with -64.34 wte at 31 October 2018.

The overall band 5 vacancy remains in a negative position of -69.61 wte compared with -80.18 wte at 31 October 2018. There are 35.54 wte band 5s in the recruitment process.

Band 2 vacancy is in a negative position at -40.32 wte. There are 32.13 wte band 2s in the recruitment process.

The large number of vacancies continues to pose a challenge across the divisions to ensure safe, effective and sustainable staffing. The substantive workforce is supported by bank and agency staff to ensure safe and effective staffing. There is a correlation between safe staffing

and patient outcomes and this is monitored on a daily basis by the Matrons and all incidents reported by the trusts Datix system.

9. A recruitment open day took place on 18 August 2018 particularly aimed at nurses due to qualify in March 2019. 18 conditional offers were made on the day and further interviews took place on 19 September 2018 with a further 8 conditional offers made. Colleagues are maintaining regular contact with those offered posts in an attempt maintain their interest in TRFT as their preferred place to work and to covert the conditional offers to actual starters. To date 2 have withdrawn, 24 are still due to start at TRFT in March 2019.
<table>
<thead>
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<th>Agenda item</th>
<th>489/18(b)</th>
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<tbody>
<tr>
<td>Report</td>
<td>Operational Performance Report</td>
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<tr>
<td>Executive Lead</td>
<td>George Briggs, Chief Operating Officer</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1 B2 B4 and B5: Q3 Risk scores for the above have remained static.</td>
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<td>Purpose</td>
<td>Decision</td>
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<tr>
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<td>Sustainability and Transformation Standards:</td>
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<tr>
<td></td>
<td>- Emergency 4-hour Access target – November 2018 position: 88.8% and the submitted trajectory was 90%</td>
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<tr>
<td></td>
<td>- The Rotherham Cancer 62 Day position for Quarter 3 2018 is 84% un-validated against the 85% compliance target</td>
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<td>- Diagnostics (DMO1) – the un-validated position for DMO1 for October 2018 is 1.3% which reflects 43 breaches</td>
</tr>
<tr>
<td></td>
<td>- 18 week RTT incomplete pathway – un-validated position for October 2018 is sustained at 94.4%</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that:</td>
</tr>
<tr>
<td></td>
<td>The Trust Board notes the report</td>
</tr>
<tr>
<td>Appendices</td>
<td>289</td>
</tr>
</tbody>
</table>
1.0 Introduction

This paper covers key operational indicators, an overview of performance in November 2018, and summarises headline progress and actions being taken to address areas of concern and deliver improvements.

2.0 Four-Hour Emergency Access Target

2.1. November 2018 performance against the 4-hour access target was 88.85% and this shows a slight improvement in the last month. The agreed local trajectory is 91%, therefore, we are below our locally agreed trajectory. However, I have included a focused target based on the team’s recovery plans.

![Graph showing 4 hr transit standard from April to March]

2.2 Overview of UECC activity and performance

Fill rate for posts has shown a positive change in November with GP cover hitting 90% plus on every week.

<table>
<thead>
<tr>
<th>Date</th>
<th>ANP</th>
<th>UECC</th>
<th>GP</th>
<th>OOH GP</th>
<th>ED Consultant</th>
<th>Middle Grade</th>
<th>STR Lower</th>
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<tbody>
<tr>
<td>04.11.18</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>91%</td>
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<td>11.11.18</td>
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<td>100%</td>
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<td>100%</td>
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<td>100%</td>
<td>96%</td>
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<tr>
<td>25.11.18</td>
<td></td>
<td>86%</td>
<td>95%</td>
<td>98%</td>
<td>100%</td>
<td>96%</td>
<td>98%</td>
</tr>
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</table>
Performance has shown to be reliant upon patient flow across wards over the past month as well as in correct staffing levels.

Over the last 8 weeks a number of wards have been closed due to confirmed Norovirus with up to minimal beds closed in the last month.

The activity has remained on plan and within expected parameters.

During the week of 25 November the Trust hit 95% for 6 consecutive days.

More detailed examination of the breaches below show that admitted patients are waiting longer and breaching more than non-admitted even within the major's stream.

| Majors - non admitted breaches rolling 6 weeks | 64 | 20 | 74 | 79 | 64 | 31 |
| In hours admitted breaches rolling 6 weeks | 210 | 54 | 184 | 173 | 117 | 102 |
| OOHs/weekends admitted breaches rolling 6 weeks | 65 | 24 | 26 | 58 | 11 | 8 |

The weekend performance has improved over the last period coinciding with patient breach trackers who are now on duty at weekends.
## Time to Triage

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<tr>
<td>Paeds</td>
<td>15 mins</td>
<td>11.89</td>
<td>11.62</td>
<td>12.89</td>
<td>14.91</td>
<td>15.05</td>
<td>9.20</td>
</tr>
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</table>

### Engage with the NHS Improvement Academy

As part of the continuous improvement programme the Academy has met with the management and clinical teams in the UECC to agree scope and dates for the diagnostics review. This is planned for January and February 2019.

### Winter

The Winter Team is in place acting as delivery and support for key actions and deliverables reinforcing actions and driving changes in processes. The focus has been on the site management and the site room changes are underway with the team now utilising a predictor tool on attends and activity. The development of the breach chaser role in UECC has also commenced.

The Director of Operations is leading the 4-hour Improvement Plan.
As above the 4-hour national position shows TRFT at number 56 nationally and above the median of our peer’s performance.
3.0 Cancer

3.1 The Rotherham 62-day cancer position for Quarter 3 is 81% against the national 85% compliance target. 2 week waits for all patients are above target.

<table>
<thead>
<tr>
<th>Q3 2018/19 SUMMARY</th>
<th>Expected achievement (%) - includes treated and confirmed cancers with a planned treatment date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (click on a target to see a breakdown by Tumour Group)</td>
<td>OCT 2018 Validation ongoing</td>
</tr>
<tr>
<td>2ww</td>
<td>Before reallocations</td>
</tr>
<tr>
<td>62 Day from GP</td>
<td>80.8</td>
</tr>
<tr>
<td>62 Day Consultant Upgrade</td>
<td>81.4</td>
</tr>
<tr>
<td>62 Day from Screening</td>
<td>80</td>
</tr>
<tr>
<td>Faster Diagnosis Standard</td>
<td>71.1</td>
</tr>
</tbody>
</table>

3.2 The current forecast position against the 62-day cancer pathway is that Quarter 3 will be at 84% compliance. The position is complex and reliant upon a number of factors. We have identified 35 breaches this quarter which are awaiting clinical validation and, of these, 27 are due to reducing the backlog at Sheffield which we will share.

Summary – Quarter 2 was achieved with Quarter 3 now being the area of continued focus. Prediction 84% based on 35 breaches.

4.0 18 Week RTT Incomplete

4.1 The un-validated position for November 2018 is 94.4% against the 92% 18 week RTT incomplete target. This represents a continued strong operational performance against this performance metric.

4.2 This puts TRFT in the upper quartile performance in the country. Over 60% of Trusts are failing the standard nationally.

4.3 Gynaecology

Gynaecology was the main area of concern within our 18-week programme. 207 patients were showing at 18 weeks plus with a performance of 84.4%. The service has implemented the following actions to ensure recovery.

- The additional full day list has continued on alternate weeks within our theatres which has supported the reduction in long waits.
The waiting list for Gynaecology patients is now showing 122 patients at 91.71%

4.4 Cancelled Operations

October 15 cancelled operations down from 26 in September. November shows 19 un-validated cancellations.

5.0 6 Week Wait Diagnostic Tests

5.1 The un-validated position for DMO1 for November 2018 is 89.8%, which shows 36 people waited 6 weeks or longer for sleep diagnostic tests and a further 7 echo cardiology. These patients have breached due to staff issues. This is slightly under the national target. The Respiratory Team has a number of plans in place to improve the issue. Validation is not complete which means the position may improve. The denominator this month is lower than previous months with a reduction local population referrals and we have seen a marked increase in out of area referrals.

6.0 Improvement Planning

6.1 Planned internal bed reconfiguration update:

The Acute plans centre on creating a Surgical Assessment Unit (SAU) on Ward B1 next to AMU and Ambulatory Care, which will allow the closure of Ward B5. The Surgical Team will move the present SAU and admission beds on Ward B5 to Ward B1. This is planned for the beginning of February 2019.

The next phase of the reconfiguration to create the NIV respiratory Assessment area is under development, this phase will create flexibility and control for the medical divisions staff.

7.0 Conclusion

Performance against the 4-hour access standard in November 2018 has been challenged considerably and we remain under trajectory. We have seen some failures in performance over the last 2 months, with key operational points of failure around capacity across the medical beds. The numbers of medically fit patients have reduced and is below our internal thresholds. Performance against the DMO1 diagnostic target in month is below the national standard and has seen an expected rise in sleep breaches and this is a key area of focus for the team.

Performance against the Cancer 62-day target remains challenged as a result of both activity demand and access across a number of pathways delays. Whilst action continues to achieve Quarter 3, this continues to increase in risk of non-delivery.

Trust performance against the 18-week RTT incomplete target for the month continues to perform well with Gynaecology on track to hit 92% in December 2018.

G Briggs
Chief Operating Officer
12 December 2018
### Board of Directors’ Meeting
18 December 2018

<table>
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<tr>
<th>Agenda item</th>
<th>489 /18(c)</th>
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</thead>
<tbody>
<tr>
<td>Report</td>
<td>Workforce Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Paul Ferrie – Acting Director of Workforce</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B4, B5</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ☑ Approval ☐ For information ☐</td>
</tr>
</tbody>
</table>

#### Executive Summary (including reason for the report, background, key issues and risks)

- The staff in post figure for November 2018 is 3765.52 whole time equivalent (WTE), an increase of 2.63 WTE compared to October 2018.
- This month’s sickness absence is 4.53% for November 2018, this is 0.58% above the 3.95% target. Mental health illness is the primary absence reason (27%) being reported.
- The Trust delivered the PDR operational objective; and is currently achieving an overall compliance rate of 93.11% in November; against the target of 90%.
- The Trust improved its overall Mandatory and Statutory Training (MaST), performance is currently 89% against the 85% target.
- The National Staff Survey closed on the 7th December 2018 having been extended by 1 week due to national technical issues when launched.
- The seasonal flu campaign is in progress. The Trust has achieved 71% of its frontline workers vaccinated so far against a CQUIN target of 75%.
- A Trust employee was the Silver Medal winner at the World Skills UK Health and Social Care Competition 2018.

#### Recommendations

It is recommended that the Board of Directors note the content of the report.

#### Appendices

1. Workforce Report
1.0 **Recruitment and Retention**

1.1 Turnover in November 2018 is 0.40% (99.60% retention), 0.22% improvement against November 2017; the retention rate continues to compare favourably with national benchmarks.

1.2 There are currently 18.35 Whole Time Equivalent (WTE) Newly Qualified Nurses currently awaiting their registration (this includes 2.40 Newly Qualified Midwives).

1.3 There were 24 (19.90 WTE) leavers in November 2018, 9 (7.36 WTE) were Nursing & Midwifery colleagues with 3 (2.48 WTE) retiring permanently.

1.4 In addition to the 37 (30.47 WTE) colleagues joining the Trust in November 2018 there was a further 6 (4.93 WTE) bank only employees who have commenced with a substantive contract.

2.0 **Sickness Absence**

2.1 The Trust’s sickness absence for November 2018 increased to 4.53% (4.44% Nov 2017), which is above the 3.95% target.

2.2 Short term absence increased to 1.80% from previous month (1.43%); however, the long term sickness absence rate decreased to 2.74% from (2.90%).

2.3 The highest reported sickness reason for both long term and short term was anxiety, stress and depression (27.29%). The Trust is working with the new OH provider to identify support programmes and targeted interventions which will focus on mental health wellbeing. The Trust has trained 31 mental health champions during the year and this cohort of colleagues will support this work.

3.0 **Mandatory and Statutory Training (MaST)**

3.1 The Trust core MaST compliance has increased to 89% and remains 4% above the Trust target of 85%.

3.2 The table below highlights the Trust’s overall mandatory and statutory core training compliance by division at the end of November 2018.

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>93%</td>
</tr>
<tr>
<td>Corporate Operations L3</td>
<td>91%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>85%</td>
</tr>
<tr>
<td>Family Health</td>
<td>92%</td>
</tr>
<tr>
<td>Medicine</td>
<td>87%</td>
</tr>
<tr>
<td>Surgery</td>
<td>87%</td>
</tr>
</tbody>
</table>

4.0 **PDR**

4.1 The PDR compliance is currently at 93% for the Trust. The table below shows overall PDR compliance by division at the end of November 2018. The focus for 2019 is to improve the quality of the appraisal process in relation to the conversations being held, clarity of objectives, meaningful development and talent
opportunities, etc., which will support the Trust deliver its operational objectives in 2019/20.

<table>
<thead>
<tr>
<th>Division</th>
<th>Assignment Count</th>
<th>Reviews Completed</th>
<th>Reviews Completed %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>888</td>
<td>817</td>
<td>92.00</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>446</td>
<td>421</td>
<td>94.39</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>240</td>
<td>222</td>
<td>92.50</td>
</tr>
<tr>
<td>Family Health</td>
<td>602</td>
<td>542</td>
<td>90.03</td>
</tr>
<tr>
<td>Medicine</td>
<td>1,044</td>
<td>979</td>
<td>93.77</td>
</tr>
<tr>
<td>Surgery</td>
<td>725</td>
<td>692</td>
<td>95.45</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3,945</strong></td>
<td><strong>3,673</strong></td>
<td><strong>93.11</strong></td>
</tr>
</tbody>
</table>

5.0 **Leadership, Culture and Engagement**

5.1 Cohort 10 of the LEAD programme went ahead successfully on the 26-30 November. Cohort 11 planned for February 2019 is fully booked, and Cohort 12 in March has a small number of places available. Feedback continues to be very positive; evaluation is on-going to measure impact at individual and team level.

5.2 The next LEAD forum will take place in January 2019, with a theme of *Future Focus- learning disability in the workplace*. Guest speaker is Paul Sylvester – Headmaster of Newman Community Special School.

5.3 The Trust’s Management Skills Programme is currently underway.

5.4 The Senior Clinical Leadership Development Programme has attracted applications from 29 Consultant’s and SAS grades, the remaining 11 places have now been offered to colleagues in senior clinical positions. We aim to have all 40 places secured by Christmas.

5.5 A Coaching Forum will be held on 13 December, this is open to the coaching community in the Trust with the aim of supporting best coaching practice.

5.6 The recruitment process is currently underway for Trainee Nursing Associates (TNA) from the Medicine and Surgery divisions. This cohort is due to start in January 2019 with the University of Sheffield. There are interviews taking place on the 10 and 20 of December with enrolments at the University on the 18 December and 04 January.

5.7 The current TNA’s undertook a Teamwork training session as part of unit completion, led by Learning and Development and supported by the University of Sheffield.

5.8 Abiola Lugboso, Therapy Support Worker was the Silver Medal winner at the World Skills UK Health and Social Care Competition 2018.

5.9 TRFT have agreed to provide input and ideas to the design of the new NHS Talent Management Toolkit, the aim is for to be able to embed inclusive and sustainable talent approaches for staff at all levels. This work will be closely connected to the
Organisational Talent Management Diagnostic/Improvement Tool which is being developed by Leadership Academy colleagues.

6.0 Communication & Engagement

6.1 The Communications Team are increasing the levels of both internal and external communications in relation to winter preparedness. Working closely with NHS Rotherham CCG this involves a series of public facing messages, online and offline, highlighting the most appropriate place to go for care, and when it is (and isn’t) appropriate to attend the Urgent and Emergency Care Centre.

6.2 Work is also being done to highlight the increased security presence at the Trust over key dates around the festive season, with support from South Yorkshire Police. An external media release, social media activity and posters are due to be used.

6.3 The seasonal flu campaign is in progress. The Trust has achieved 71% of its frontline workers vaccinated so far against a CQUIN target of 75%.

6.4 The National Staff Survey closed on the 07 December 2018 having been extended by 1 week due to national technical issues when launched.

6.5 The Trust has created its own Choir to support good health and wellbeing and generate an environment where colleagues can come together and support each other. In addition, throughout December a series of wellbeing events are taking place to help keep colleagues well and to provide tips and hints on preventing burn out and managing the additional pressure Christmas can bring.

6.6 Following last year’s successful winter wish tree. The Engagement and wellbeing team are encouraging patients, colleagues and members of the public to hang a star on our winter wish tree, sharing their thoughts, positive comments and sentiments.

Paul Ferrie  
Acting Director of Workforce  
December 2018
### Board of Directors’ Meeting
**18 December 2018**

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>489/18(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Finance Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Simon Sheppard, Director of Finance</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B9 and B10: This report provides assurance regarding the delivery of the financial plan including the Cost Improvement Programme</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ✓ Approval ☐ For information ☐</td>
</tr>
<tr>
<td>(Tick only one box)</td>
<td></td>
</tr>
</tbody>
</table>

**Executive Summary (including reason for the report, background, key issues and risks)**

The detailed integrated finance report provides the details around the M8 (end of November) financial performance and the year-end forecast.

The key indicators are:

- At the end of November the Income and Expenditure position is ahead of plan by £0.24m
- The deficit to 30 November is £13.88 against a plan of £14.12m, a favourable variance from plan of £0.24m year to date.
- The Trust is forecasting delivery of the year end £20.3m deficit plan
- Cost Improvement Programme is ahead of the year to date trajectory by £0.8m, with £6.0m of schemes delivered by 30 November
- The Capital programme is underspent
- Cash balance at the end of the month is £1.395m

Senior members of the finance and operational teams have met the Divisions following the M8 results and agree a number of specific actions to ensure delivery of the financial plan.

Whilst the M8 position encouraging and the Trust is forecasting to deliver the year end position there are a number of risks and actions senior members are taking to ensure deliver of this target.

**Recommendations**

It is recommended that the Board of Directors **note** the financial position, year-end forecast, risk and mitigating actions.

**Appendices**

1. Income & Expenditure Account
2. Activity
3. Cost Improvement Programme
1. Key Financial Headlines

1.1. The key financial metrics for the Trust are shown in the table below. These are:

- Performance against the monthly income and expenditure plan
- Performance against the internal agency spend and against the NHSI ceiling
- Cost Improvement Programme
- Capital
- Cash

![Table showing key financial metrics]

Note – Capital costs, in month, include £1.7m linked to the assessment floor scheme

1.2. As at the end of November 2018 (month 8) the Trust is reporting favourable variances against all of the key metrics with the exception of agency spend. The following sections provide further information against these financial metrics, with the Income & Expenditure Account shown in Appendix 1.

2. Income & Expenditure (in month)

2.1. As the Board of Directors is aware, the Trust submitted its final operational and financial plan on the 30 April 2018. The financial plan for 2018/19 is to deliver a £20.3m deficit or better.

2.2. The key points to highlight to the Board at the end of November are;

Clinical Income & Activity

2.3. Clinical income is £2,319K favourable to Plan at the end of November. Adjusting for the additional pay award funding and GP schemes (see Pay and Non Pay section), the Trust is showing a small under-performance to date (£33k), predominately due to critical care activity.

2.4. The activity performance year to date is shown in the appendix 2. The key points to draw from the table are;
For the main points of delivery, elective, non-elective and ED attendances, the Trust is on Plan at the end of November. This reflects the robust planning process and profiling by the clinical management teams.

- Under performance on critical care, both paediatrics and adults, with a particular under performance on paediatrics in November.
- Over-performance on outpatients and assessments – these areas continue to be the focus for ongoing discussions and actions with the internal teams and Rotherham CCG, linked to referral trends.

**Pay and Non Pay**

2.5. Pay costs are showing an overspend of £2,652k year to date. However, the following factors must be noted:

- The Agenda for Change (AfC) pay award was agreed in July, with back pay in August. The Trust is receiving additional income above the planned level to fund this (£1,771k year to date). This was in addition to the new pay rates paid in July.
- The Trust is now the lead employer for the GP Vocational Training Scheme. This is fully funded for the pay costs incurred, £565k for August - November.
- Additional income to support the cancer programme, approximately £200k.

2.6. The total impact of the 3 factors above year to date is £2,536k. In line with the agreed financial reporting budgets are fixed for the financial year to align with the 2018/19 submitted financial and operational plan, and so the £2,536k is showing as an over-performance on income. Adjusting for these factors would show the pay position being slightly adverse to plan by £116k.

2.7. There needs to be continued focus on the use of temporary workforce across the remaining months of the year to ensure the year-end financial plan is delivered. (see section 3.5)

2.8. Non pay costs are showing an adverse position, £1,766k against budget predominately due to excluded drugs and devices and premises, which are offset by income.

2.9. To support delivery of the financial plan, there are now monthly Financial Operational Meetings with each Division, led by the Director of Finance and supported by the Chief Operating Officer and senior members of the finance team.

These meetings with Divisional teams have focused on;

- Year-end forecast including risks and opportunities. These risks and opportunities, including actions to mitigate the risk or secure the opportunity have been discussed at the Finance & Performance Committee.
- Accuracy of forecasts for both the monthly reports and year end position
- Clear actions required to improve performance and/or mitigate any risks.
- Escalation of any issues to the Executive Management Committee

2.10. Whilst the financial performance to date is encouraging there is continued focus on delivering the monthly profiles throughout the remaining months of 2018/19. It is critical to the delivery of the overall financial plan that the Trust continues to deliver against the monthly profiles.
3. **Agency Expenditure**

3.1. As was the case in 2016/17 and 2017/18 providers have received an agency target from NHSI for the new financial year. The target for 2018/19 is an annual spend of £8.8m which is a reduction of £1.4m from the £10.2m target in 2017/18.

3.2. Whilst the Trust will strive to meet the target, this ambition needs to be set in the context of 2017/18 costs being in excess of £11m. These costs were predominately driven by medical vacancies and the requirement to use agency staff. In light of the spend in 2017/18 the Trust has therefore set an internal budget for agency expenditure profiled across the financial year to reflect forecast costs.

3.3. During 2018/19 performance against both the NHSI ceiling and internal budget will be monitored.

3.4. At the end of November 2018 the Trust incurred costs of £8,413k inclusive of supporting the additional capacity. This year to date spend is above the internal budget, £749k, and £2.6m adverse to the NHSI ceiling.

3.5. Further actions implemented to support delivery against these targets include;

- Agreement and monitoring of the key vacant posts – individual recruitment strategies
- Working with external partners to secure permanent recruitment including from overseas
- Expansion of the direct engagement model
- Overseas recruitment to key posts
- Enhanced controls and escalation management in certain areas including sickness absence, rota management and time to recruit.
- In the medium term it is important the Trust continues to look at alternative workforce models and roles such as Trainee Nurse Associates and Physicians Assistants and Associates.

Progress against these actions and the impact on the agency spend will be reported through the operational committees and assurance committees.

4. **Cost Improvement Programme**

4.1. The Trust has a cost improvement (CIPs) target for 2018/19 of £9.7m, 3.6% of costs.

4.2. The month end and year to date position is shown in Appendix 3 and includes both cash releasing and efficiency schemes, the headlines being;

- Performance in November of £880k, £118k adverse to plan.
- Year to date performance £788k above the plan of £5,203k

4.3. In addition to the in-month performance, continued focus and action is being taken to secure the £9.7m in year target and the full year effect of £13.1m

4.4. Total schemes identified for 2018/19 are now in excess of the annual target, with a full year effect value of £10.8m.
5. **Capital**

- Total capital expenditure plans have been produced in accordance with the maximum internally generated funds available to the Trust and in conjunction with appropriate colleagues throughout the Trust.
- The Trust has a planned capital expenditure programme for 2018/19 of £5,800K.
- In addition the Trust has been successful in securing additional external capital funds in 2018/19 to support:
  - Assessment Unit, £2.1m
  - Electronic Prescribing and Medicines Administration, £0.75m
  - WiFi Upgrades, £0.2m
- Expenditure year to date (to 30 November 2018) is £3,804k. However, excluding the costs incurred for the assessment centre, £1,909k, the net expenditure is £1,895k. This net expenditure is against a year to date plan of £3,519k (£2,631k excluding Endoscopy).
- Whilst the year to date capital programme is £736k underspent, the revised monthly forecasts are being delivered, and the year-end forecast of meeting the plan will be met.
- The Trust as part of the South Yorkshire & Bassetlaw Integrated Care System has received confirmation that no further funding will be received on the business cases submitted as part of the national capital programme.

6. **Cash**

- The trust ended November 2018 with a bank balance of £1.395m compared to a planned level of £1.350m which is an £0.045m favourable variance.
- All non NHS and NHS suppliers are paid within the payment terms approved by the Board of Directors (45 days).

7. **Finance & Performance Committee**

7.1. The Finance & Performance Committee met on Monday 17 December 2018 to discuss the year to date financial and operational performance. The meeting focussed on:

- Financial performance year to date and forecast, including risks and mitigating actions.
- Operational performance against the constitutional standards, particularly the 4 hour standard, Cancer 62 day target, and the total waiting list numbers.
- Performance against CQUIN (Commissioning for Quality and Innovation).
- 5 Year Plan.
- Progress for the 2019/20 Operational and Financial Plan.
- Planning for the EU Exit.
## Appendix 1 – Income & Expenditure Account to 30 November 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>In Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Clinical</td>
<td>18,432</td>
<td>18,670</td>
</tr>
<tr>
<td>Excluded Drugs Income</td>
<td>863</td>
<td>929</td>
</tr>
<tr>
<td>Income From Activities</td>
<td>19,295</td>
<td>19,599</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>1,587</td>
<td>2,419</td>
</tr>
<tr>
<td>Total Income</td>
<td>20,882</td>
<td>22,018</td>
</tr>
<tr>
<td>Pay</td>
<td>(14,784)</td>
<td>(15,482)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>(6,431)</td>
<td>(6,762)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(21,215)</td>
<td>(22,244)</td>
</tr>
<tr>
<td>Operating (Surplus)/Deficit</td>
<td>(332)</td>
<td>(226)</td>
</tr>
<tr>
<td>Financing Costs</td>
<td>(881)</td>
<td>(951)</td>
</tr>
<tr>
<td>Financing Costs</td>
<td>(881)</td>
<td>(951)</td>
</tr>
<tr>
<td>Total Cost of Services</td>
<td>(1,214)</td>
<td>(1,177)</td>
</tr>
<tr>
<td>Underlying (Surplus)/Deficit</td>
<td>(1,214)</td>
<td>(1,177)</td>
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</table>
Appendix 2 – Activity Performance to 30 November 2018

<table>
<thead>
<tr>
<th></th>
<th>In Month Activity (M8)</th>
<th>YTD Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>459</td>
<td>441</td>
</tr>
<tr>
<td>Elective Day case</td>
<td>2,288</td>
<td>2,408</td>
</tr>
<tr>
<td>Non Elective</td>
<td>2,156</td>
<td>2,376</td>
</tr>
<tr>
<td>ED Attendance</td>
<td>8,243</td>
<td>8,316</td>
</tr>
<tr>
<td>Outpatient New (CL)</td>
<td>4,957</td>
<td>4,377</td>
</tr>
<tr>
<td>Outpatient FU (CL)</td>
<td>8,881</td>
<td>9,522</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>4,575</td>
<td>5,047</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>327</td>
<td>292</td>
</tr>
<tr>
<td>Paediatric Critical Care</td>
<td>418</td>
<td>262</td>
</tr>
<tr>
<td>Assessments</td>
<td>948</td>
<td>1,206</td>
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</tbody>
</table>
## Appendix 3 – Cost Improvement Programme

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Division</td>
<td>In-Year Plan (£,000)</td>
<td>In-Year Actual (£,000)</td>
<td>In Month Variance (£,000)</td>
<td>YTD In-Year Plan (£,000)</td>
<td>YTD Actual (£,000)</td>
<td>YTD Variance Actual/Plan (£,000)</td>
<td>% YTD Performance to Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>243</td>
<td>279</td>
<td>36</td>
<td>1,274</td>
<td>1,136</td>
<td>-138</td>
<td>89 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>228</td>
<td>253</td>
<td>25</td>
<td>1,155</td>
<td>1,449</td>
<td>294</td>
<td>125 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Health</td>
<td>122</td>
<td>71</td>
<td>-51</td>
<td>852</td>
<td>746</td>
<td>-107</td>
<td>97 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>168</td>
<td>102</td>
<td>-66</td>
<td>392</td>
<td>649</td>
<td>257</td>
<td>166 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>114</td>
<td>52</td>
<td>-62</td>
<td>547</td>
<td>1,027</td>
<td>480</td>
<td>188 %</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Central</td>
<td>123</td>
<td>123</td>
<td>0</td>
<td>983</td>
<td>984</td>
<td>1</td>
<td>100 %</td>
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<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>998</td>
<td>880</td>
<td>-118</td>
<td>5,203</td>
<td>5,991</td>
<td>788</td>
<td>115 %</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

**In Month Performance to Plan**

88 %

**YTD Performance to Plan**

115 %
### Board of Directors Meeting
18 December 2018

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>490/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Data Quality Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Chris Holt, Deputy Chief Executive / Director of Strategy &amp; Transformation</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B8: This paper reports on data quality assurance and potential resilience in delivery</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note √ Approval ☐ For information ☐</td>
</tr>
</tbody>
</table>

### Executive Summary (including reason for the report, background, key issues and risks)

To present to the Board Meeting details of activity and key headlines related to progress with data quality assurance:

- All additional new indicators in the IPR (16 in total) have been assessed and revised as part of the regular Data Quality Assurance review cycle
- The DQ Team continue to work with services to identify and improve on operational data quality
- A briefing was given to all Executive Directors on 4<sup>th</sup> December 2018 outlining roles and responsibilities as IPR indicator owners.
- The Health Informatics Service Manager is now undertaking individual meetings to sign off the latest indicators

### Recommendations

To note

### Appendices

N/A
1.0 Introduction

1.1. This paper provides an update on the data quality (DQ) assurance processes undertaken to provide assurance that the indicators reported to the TRFT Board of Directors and externally to NHS regulators follow national guidance and are reported and monitored accordingly.

2.0 Data Quality

2.1. From the last update to the board where we covered the data quality assurance process for the Integrated Performance Report (IPR) the refresh of IPR indicators has been completed. A summary of their evaluation is available on The Hub.

2.2. An overview of DQA Process was presented to the Executive Directors on 4th December 2018. This briefing reinforced that the DQ process identifies weaknesses in the monitoring and recording of the information to provide assurance that the indicators reported on the Integrated Performance Report are accurate and follow robust processes.

2.3. A summary of the headlines includes:

- A full data quality review of all Trust Board performance indicators (including constitutional KPIs) has been carried out, including the new IPR 2018/19 indicators
- Data Quality Assurance statements have been written for each indicator
- The process supports the Information Governance Standard 500
- The process has been acknowledged by the Trust’s auditors as an example of best practice

2.4. Following the assessment, the resulting Data Quality Kite Mark is created, and this is based upon the following criteria:

<table>
<thead>
<tr>
<th>TRFT Data Quality Assurance Standard</th>
<th>Sub-categories</th>
<th>To Be Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consistency - Is there sufficient data to make this easy to understand?</td>
<td>Is the data available at the highest possible level?</td>
<td>Not Yet Assessed</td>
</tr>
<tr>
<td>2. Completeness - Is data available in a format that can be understood?</td>
<td>Is the data available at the required time?</td>
<td>Not Yet Assessed</td>
</tr>
<tr>
<td>3. Accuracy - Is the data recorded into the system at the correct time?</td>
<td>Is the data accurate at the required time?</td>
<td>Not Yet Assessed</td>
</tr>
<tr>
<td>4. Relevance - Are there any relevant elements been completed?</td>
<td>Does the output get invalidated or corrected by a named individual?</td>
<td>Not Yet Assessed</td>
</tr>
<tr>
<td>5. System/Data Source - Is there a data analysis tool process that supports the capture of data?</td>
<td>Is the data captured in a fully documented system with validation rules and validation processes?</td>
<td>Manual, paper-based processes are used</td>
</tr>
<tr>
<td>6. Auditable Process - Is this a process that can be audited and has it been audited recently?</td>
<td>Audited by external body in the last 12 months</td>
<td>Not audited in last 12 months</td>
</tr>
</tbody>
</table>
2.5. Each indicator has an Executive Director lead and an operational lead, and the kite marks and action plan will be signed off during Q4 2018/19.

2.6. The approach is also extended to the Divisional Integrated Performance Reports and these will also be signed off during Q4 2018/19.

3.0 **Clinical Coding – Annual Information Governance and Data Quality Audit**

3.1 The annual Clinical Coding – Information Governance and Data Quality Audit was completed by external auditors on 20 Nov 2018. We have again excelled and improved our position for most of the indicators:

- Primary Diagnosis is now at 95.5% last year after challenge and adjustments we scored 95.5%
- Secondary Diagnosis is now at 97.1% last year after challenge and adjustments we scored 96%
- Primary Procedure is now at 100% last year 95.3%
- Secondary Procedures is now at 97.1% last year after challenge and adjustments we scored 98% - this is a slight drop but we are looking at some of the four digit areas being challenged

3.2 Overall, TRFT maintained a level 3 (top score available) keeping us in the top range of trusts in England to achieve this standard.

4.0 **Conclusion**

3.1. The Trust has committed to fully implementing the quality assurance process for the Integrated Performance Report (IPR). This provides the Trust with a robust process for quality assuring all indicators report on the IPR.

3.2. An on-going process of review by data owners, operational leads and internal / audit has happened and action plans have been identified to articulate and address any data quality concerns, and these are being resolved by the relevant teams with executive director oversight and support to ensure completion.

Chris Holt
Deputy Chief Executive / Director of Strategy & Transformation
December 2018
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>491/18</th>
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</thead>
<tbody>
<tr>
<td>Report</td>
<td>Strategy and Transformation Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Chris Holt, Deputy Chief Executive / Director of Strategy &amp; Transformation</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B11 &amp; B8: This report provides an update on a number of the Place Plan initiatives with partner organisations. Where appropriate it also reports on the digital agenda and potential resilience in delivery</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note √ Approval ☐ For information ☐</td>
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**Executive Summary (including reason for the report, background, key issues and risks)**

- The purpose for this report is to provide the Board with an update across the transformation, digital and estates & facilities agenda
- Progress is being made with a number of Place schemes, and in particular the configuration of intermediate care services and the integrated point of contact.
- We now have viewable social care services data viewable within SEPIA, following many months of discussion and technical alignment
- Work continues on the reconfiguration of the Assessment Floor and following the removal of the asbestos on B1, work has recommenced in this area

**Recommendations**

To note

**Appendices**

N/A
1.0 Introduction

1.1. This report provides an update on the transformation, digital and estates & facilities agenda including the key priorities within the operational plan.

2.0 Annual Planning Cycle

2.1. Work continues around the development of the 2019/20 1-year operational plan, with good engagement with divisional and corporate teams. A presentation and update on progress was provided to the Trust Management Committee, and this identified the work that had been undertaken around the activity and financial assumptions as well as the operational objectives and priorities for 2019/2020.

2.2. An update on the draft operational plan is included on the agenda for December’s Trust Board and further outlines the progress made to date, the planning timeframes (both national and local), the initial operational objectives and enablers for 2019/20 as well as the change related programme to progress the 5-year strategy and 5-year plan.

2.3. We remain on track for presenting the 2019/20 plan to the Trust Board for approval in February 2019.

3.0 Transformation Update

3.1. Within the Acute Care programme, the focus remains on the reconfiguration of the assessment facilities and ensuring this work progresses to plan to also support the operational winter planning. In this regard, the phlebotomy team have moved into the refurbished facilities on B10 and the discharge lounge has also moved onto B10, freeing up bays on B4 to support early winter planning.

3.2. Within the Community Care programme, key developments and progress since the last update include a multi-disciplinary visit to Wakefield to understand the Connecting Care Hubs that have been developed, and the role of integrated, multi-disciplinary working. Work also continues on the proposed reconfiguration of Intermediate Care Services with all partners working towards developing a proposed model for early 2019.

3.3. As outlined in section 2 above, work has progressed on the work programme for 2019/20 and the scoping of the various schemes. This will see a continuation of many of the work programmes underway, in line with our overall 5-year strategy.

4.0 Digital Update

4.1. Adult social services data is now live within our bed view of SEPIA. This allows clinicians and nurses to see whether patients have active social care services and, if applicable, which social services locality teams are allocated. Work is now progressing in making this information available within the GP viewer and the automation of regular updates.
4.2. Electronic nursing observations roll-out continues as planned with Ward A2 having received their training and preparing for go live w/c 10th December. This will be followed with AMU, currently planned for the 21st of January. In addition, patient flow screens are now fitted and active within Keppel, Wharncliffe, ITU/HGU, B11, SAU and Sitwell wards.

4.3. We continue to support our local GPs migration to SystmOne, notably at St. Anne’s, Market Surgery and Thorpe Hesley. We have also successfully completed a pilot of sending electronic tasks to SystmOne GPs, notifying them of new community correspondence available to view directly within their system, which will significantly reducing the admin overhead of printing and dispatching letters to GPs. Due to the success of this pilot and the positive feedback from the services, this is now being rolled out to all our community services.

4.4. Our community tissue viability nurse teams are now live with smartphones that capture wound-care progress with electronic integration into their patient records; this enables any electronic patient record user to visually see progress and negate the need for medical photography to visit patient’s homes.

4.5. Finally, following a significant amount of work, our NHSMail2 migration project comes to a close. All mailboxes have been migrated, including those that were awaiting mop-up, and through a separate piece of work access to our intranet https://thehub.rothgen.nhs.uk/ is securely available over the internet, meaning our staff can access document, policies etc.

5.0 Estates & Facilities Update

5.1. Work on the SAU and AMU assessment units continues at pace. Enabling works on Ward B10 (Phlebotomy and Discharge Lounge) is complete, with teams now transferred across on the 1st and 11th December respectively. Overall, the target date for completion is now the 19th January 2019 due to the delays incurred by unforeseen asbestos removal works.

5.2. The Carbon Energy Fund proposal is now at preferred bidder stage with contractual design and legal meetings taking place. The next milestone is to have a full business case, contract and scheme design completed and signed off by the end of February/early March 2019 to allow the scheme to then progress into the construction phase in April 2019.

5.3. Work is nearing completion at Woodside. The remaining Integrated Rapid Response (IRR) teams are moving this week to the first floor; this will then allow the IT Service desk to relocate to the ground floor of the West Wing around the 20th December. The RICC teams (Rotherham Intermediate Care Centre) are being transferred to both RCHC and Woodside on the 14th December along with any equipment moves.

5.4. A new licence has now been agreed for the Opal Centre (Dental) in Doncaster and the rent review for Woodlands (RDaSH) has now been agreed.
5.5. Estates are continuing to work with the new REWS (Rotherham Equipment and Wheelchair Services) provider to enable a smooth transition regarding them taking over occupation of the existing building when the contract transfers on the 1st February 2019.

5.6. Major electrical works are being planned for the New Year within substation E; new switchgear is being installed and the transferring of various electrical services will be undertaken on a phased basis, all of which will improve the Trusts infrastructure resilience.

Chris Holt
Deputy Chief Executive / Director of Strategy & Transformation
November 2018
## Agenda item 492/18

### Report

**Governance Report**

### Executive Lead

Anna Milanec, Director of Corporate Affairs (non-voting) / Company Secretary

### Link with the BAF

B7 and B8

### Purpose

<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
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<td>✓</td>
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### Executive Summary

- NHSI announce the names of their new regional directors;
- Revised transactions guidance has now been published following the NHSI consultation regarding wholly owned subsidiaries;
- A review of NHS executive leadership has been undertaken by Sir Ron Kerr for the Department of Health and Social Care, making a number of recommendations to promote a better culture for the NHS;
- More guidance has been published on Brexit, particularly relating to the potential for a 'no deal' position.

### Recommendations

The Board is asked **to note** the content of the report

### Appendices

- European Health Economy Statement re Brexit (12 December)
1.0 Introduction

1.1 This report provides an update since the last Board Meeting on 27 November 2018.

2.0 NHS Improvement

2.1 During December 2018 NHS Improvement and NHS England announced the names of the new joint directors of the regional teams:
   - South West – Elizabeth O’Mahony (current NHSI Chief Financial Officer).
   - South East – Anne Eden (current joint NHSE and NHSI Regional Director for the South East).
   - Midlands – Dale Bywater (current NHSI Regional Director for the Midlands and East).
   - East of England – Ann Radmore (current Kingston Hospital Foundation Trust Chief Executive).
   - North West – Bill McCarthy (current Deputy Vice Chancellor at Bradford University and Chair of Bradford Teaching Hospital Foundation Trust as well as a former NHS England and Department of Health Executive Director).
   - London – Sir David Sloman (current Royal Free London Foundation Trust Chief Executive)

2.2 On 26 November 2018 NHSI published an addendum to its transactions guidance detailing its future approach to wholly owned subsidiaries which came into immediate effect. This followed the conclusion of its consultation which ran from September to November 2018.

2.3 The addendum applies to all Foundation Trusts and NHS Trusts ‘considering transactions involving the creation of subsidiaries or material changes to existing subsidiaries…’ and means that all such transactions are reportable to NHSI.

3.0 ‘Empowering NHS Leaders to Lead’ Report

3.1 Sir Rom Kerr was commissioned to undertake a review of executive leadership within the NHS by the Department of Health & Social Care. His report was published in late November 2018 and concluded that NHS leaders were operating within a ‘...negative working culture in which both bullying and discrimination are prevalent and accepted.'

3.2 The report makes a series of recommendations designed to move towards a more ‘modern working culture’ where staff felt more supported respected and valued.

4.0 ‘The role of volunteers in the NHS; views from the front line’, report

4.1 This report was commissioned by Royal Voluntary Service and Helpforce in July 2018.

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1 'Addendum to the transactions guidance – for trusts forming or changing a subsidiary November 2018', source: https://improvement.nhs.uk/documents/3509/Addendum_to_transactions_guidance.pdf last accessed 13/12/18

4.2 Its intention is to ascertain the perceptions of frontline NHS staff working in acute care about the operational pressures they face, how they understand the roles and value of volunteers and what gaps there are that volunteers could help fill.

4.3 Key findings from the report confirm that frontline staff recognised the broad range of activities carried out by volunteers in NHS hospitals and they agreed that volunteering in hospitals adds value for patients, staff and volunteers. One of the main challenges for staff, was found to be the lack of clarity regarding role boundaries between them and the volunteers, although they felt that volunteers would have more impact through better training and greater joined-up working.

5.0 Brexit Update

5.1 With formal ratification of the Withdrawal Agreement by the UK Parliament on hold, the European Health Community has reiterated the importance of putting the safety of patients and public health at the forefront of the Brexit debate.

5.2 In their latest statement (12 December) (appendix 1), they stressed that whatever the outcome of the UK parliament vote on the Withdrawal Agreement, it is vital that immediate and intense focus is given to healthcare issues including the regulation and supply of medicines and medical technologies in the post-Brexit relationship.

5.3 The statement called for a series of immediate actions to be taken in order to protect patients and public health in the event of a no-deal scenario, including:

- A mutual recognition agreement for all CE marked medical technologies granted by a UK based notified body (for the EU27) or granted by an EU27 based notified body (for the UK).
- Temporarily exemption from any new customs and borders checks for medicines and medical technologies, including clinical trial materials.
- The introduction of measures to enable the continued UK participation in key data sharing platforms that protect public health and medicines and medical technologies' safety in Europe.

5.4 On December 7, Matt Hancock, Secretary of State for Health and Social Care wrote again to health and care organisations with updated guidance outlining the actions that the NHS should take if the UK leaves the EU without an agreement on 29 March 2019. (At the time of writing, the letter is due to be considered at the Trust’s Finance and Performance Committee on 17 December 2018).

5.5 The actions outlined in this guidance covered six key areas of activity that are likely to be impacted by a no-deal Brexit. The letter stated that the health and care system should continue to prepare for a no-deal scenario as part of existing local business continuity plans.

Anna Milanec
Director of Corporate Affairs / Company Secretary
December 2018
Putting patients at the forefront of Brexit decisions

As formal ratification of the Withdrawal Agreement and the Political Declaration is delayed in the UK, the European healthcare sector highlights the importance of putting the safety of patients and public health at the forefront of the debate.

A disorderly exit from the EU by the UK has very real and tangible consequences for patients in both the EU and the UK. From the healthcare sector’s perspective, the transition period afforded by the withdrawal agreement and political declaration is critical as it provides some time for healthcare partners to continue to adapt to new regulatory requirements, manufacturing and supply issues including customs arrangements to ensure an uninterrupted supply of medical technologies to patients.

The scale of the task should not be underestimated;

- around 45 million packs of medicines leave the UK destined for patients in Europe every month with 37 million packs heading the opposite way. In total that is around 1 billion packs of medicine crossing the border between the UK and the EU each year;
- In large scale trauma incidents, such as recent terrorist attacks in both the Europe Union and UK, Hospital and even local Distribution Centre stock piling of specialist Emergency Trauma Packs can suddenly run low owed to unforeseen demand. These products are not routinely stock piled to a large enough scale for an unexpected major event owed to efficiency and shelf-life reasons. However, owed to the scale of free movement of goods between the UK and EU, emergency trauma packs can be flown in – at a moment’s notice – from any other distribution centre in Europe.

Given the uncertainty around the process of voting on the withdrawal deal and the terms of the UK’s future relationship with the EU, the healthcare sector has invested heavily in ensuring that stakeholders are prepared for every eventuality.

As part of those contingencies, a series of immediate actions must be taken in order to protect patients and public health in the event of a no-deal scenario, including:

- The introduction of measures that will continue to recognise UK based testing at least until it can be transferred to the EU.
- A mutual recognition agreement for all CE marked medical technologies granted by a UK based notified body (for EU) or granted by an EU continent based notified body (for UK).
- The introduction of measures to enable the continued UK participation in key data sharing platforms that protect public health and medicines and medical technologies safety in Europe.
- Discussions between relevant authorities and the sector to co-ordinate contingency plans such as putting fast track lanes or priority routes for medicines and medical technologies into ports and airports.
- Medicines and medical technologies, including clinical trial materials, should be temporarily exempted from any new customs and borders checks.
- Enable paperwork and regulatory checks to be completed away from the physical border.
• The European Air Safety Authority (EASA) should recognise certificates issued in the UK to ensure that planes can continue to fly.
• Exploring the possibility of, for a defined period, also exempting active pharmaceutical ingredients (API) and raw materials for medicines from border checks to ensure manufacturing of medicines continues with limited disruption.

To prevent patients being impacted, the members of the Brexit HealthCare Alliance underline the importance of the UK’s orderly exit from the EU. Whatever the outcome of the UK parliament vote it is vital that immediate and intense focus is given to healthcare issues including the regulation and supply of medicines and medical technologies in the post-Brexit relationship.

The Alliance members believe that an explicit commitment to securing long-term, extensive cooperation in the field of health is in the best interests of patients and public health. In addition to the above, this includes agreements in vital areas we have been calling for since the start of the negotiations; the establishment of a common framework for collaboration in health research and knowledge exchange between the EU27 and the UK, clinical trial legislation, European Reference Networks, and cross border healthcare and reciprocal healthcare arrangements including movement of professionals, and a collective efforts from both sides to ensure a high level of public health.

ENDS
### Agenda item
| 493/18 |

### Report
How We Learn from Deaths, Report

### Executive Lead
Dr Callum Gardner, Interim Medical Director

### Link with the BAF
- BAF: B1
- Corporate Risk Register: No risks on risk register

### Purpose
- Decision
- To note: ✓
- Approval
- For information

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### Executive Summary
This is the fifth report on learning from deaths following the initial introductory report in September 2017. This report will be used to reiterate to the Board the mortality process and the current position.

The Trust continues to review mortality cases in each division; however, performance has dropped in the Division of Integrated Medicine and work is underway to improve the current position both now and moving forward. Nevertheless, our HSMR and SHMI rates continues to improve and the Trust has very few recorded avoidable deaths.

Particular focused efforts will be made over the coming months to clear the outstanding backlog within medicine, to agree a 2-stage review process, and to ensure that engagement in both the review process and the Trust’s Mortality Review Group significantly improves moving forward. I would propose that I continue to update both the Board and QAC as to the incremental improvements in both the proportion of deaths undergoing a mortality review, as well as regarding attendance at the Trust’s Mortality Review Group.

### Recommendations
It is recommended that the Board of Directors note the contents of the report.

### Appendices
1.0 **Background:**

1.1 The Trust has developed the mortality governance structure in a way that issues can be highlighted and acted upon, and so both the Medical Director and the Board have visibility of all aspects of mortality within the Trust.

1.2 The mortality policy highlights the review process, the escalations required of divisions following the review, and the actions to be taken if problems have been identified. This policy also includes the process of learning from those deaths and the dissemination of the actions taken across the organisation.

2.0 **Trust Process**

2.1 The Trust currently aims to review all mortality cases by using the case record review; however, this has a significant resource implication and only a proportion of the cases can be reviewed in depth. Although certain divisions have reviewed all cases due to reduced numbers of mortality in these divisions, such as maternity and surgery, as most deaths occur in the division of integrated medicine, it is a significant challenge for them to review all their deaths. However, all identified serious incidents and inquests are reviewed, along with those involving patients with learning disabilities and when diagnosis codes trigger a review in depth review.

2.2 The Learning from death review in learning disabilities patients has been introduced within the Trust. The learning disabilities review is a more in depth review than simply the hospital admission and medical management. It involves all services from birth to death, including families and carer’s opinions, with the intention of providing valuable learning for the wider health economy.

2.3 All paediatric deaths are reviewed within the division and the wider paediatric community for areas of improvement and learning and does not follow the same process currently as the adult population within the Trust. There is to be a national review of the paediatric process at a later date, which the Trust will endeavour to follow as appropriate guidance is published.

2.4 The number of deaths undergoing mortality reviews within the division of integrated medicine has been poor for several months now. As such, particular focus is underway in order to clear the current backlog and to agree refinement of our current policy, with a view to us adopting a 2-stage review process in which only certain deaths go on to require an in-depth review.

2.5 I chaired this month’s Mortality Review Group, which was again poorly attended, including no representation from the medical division. As such, I have pulled a meeting together with all divisional directors and divisional governance leads, with a view to agreeing the refinement to our mortality review procedures moving forward and to remind all DCSs and governance leads of their responsibilities in ensuring that such reviews take place. I would propose that I keep both the Board and QAC regularly sited on the incremental improvements made in both the attendance at the Mortality Review Group as well as in the proportion of deaths undergoing a formal review.

3.0 **Learnings from Reviews**

3.1 Previous reports highlighted where the reviews had taken place in the event of NCEPOD and PRISM scoring falling below the standard the Trust would expect. The themes from those cases were: poor communication; failure to recognise a deteriorating patient; lack
of advance care planning; and delayed/missed diagnosis. These themes have since been taken on as quality improvement work streams throughout the Trust, including the roll out of electronic observations.

3.2 Themes from other cases have highlighted communication issues between junior doctors and senior clinicians, and interdivisional lack of communication. There is therefore work ongoing regarding handover processes to improve this for the future.

3.3 Some of the cases have previously highlighted unexpected admissions into critical care and this is subject to continuous scrutiny by the critical care team and outreach. These cases are also reported to the weekly Harm Free meetings in the Trust, chaired by the Interim Medical Director.

3.4 Sepsis, including the timeliness of antibiotics and antibiotics omissions, continues to be a theme and an area of intense focus. There have also been recent CHKS alerts regarding septicaemia and such cases will continue to be reviewed to determine where improvements can be made. A task and finish group for sepsis has been working on a number of initiatives, including the introduction of sepsis boxes across the Trust, although I am looking to merge this group with the Deteriorating Patient Group. The Meditech sepsis tool has also gone live in UECC, which will alert clinicians on deterioration and actions required, with the aim to roll it out wider if the pilot is successful. The hope is that this prompt will reduce the number of incidents occurring across the Trust. Antibiotics have also now been classified as “critical medicine”, which should trigger actions out of hours if not available.

3.5 On analysis of the CUSUM charts, the early warning alerts still has small numbers involved; however, by reviewing these small numbers, it may highlight the possibility of significant changes that can be made to avoid larger cohorts of patients being categorised as such in future.

3.6 Following a review of 7 patients with diagnosis codes “other upper respiratory disease”, one patient has not died according to Meditech, and therefore further investigation is needed. Of the other patients, most were frail with metastatic cancerous disease or life-limiting illnesses. The review also focused on what this diagnosis code actually pertains to, and this diagnosis code will continue to be observed for any further incidences. However, the Trust is not unduly concerned at this stage.

3.7 A review of 4 patients with a diagnosis code of “other abdominal pain” will be reported at a later stage.

4.0 Current mortality performance

4.1 The Trust is currently sitting with an HSMR of 105. It had steadily fallen since July 2017 and been 104 for the preceding 3 consecutive months. However, as mortality figures fluctuate throughout the year, particularly during the winter months, it is important not to only focus on the number but the trend. It is therefore important to continue to focus on diagnosis codes such as sepsis over the next few months and to aim for quality improvement in these codes.

4.2 The national peer rate is 98. Following a rebasing of the figure, the Trust no longer sits in the upper quartile for mortality which is encouraging, and work will continue to protect that position.

4.3 The crude rate of mortality in proportion to discharges this month has seen an increase, with 75 deaths against last month’s 65. This gives a crude rate of 1.51% and a three
month running total of 1.48%. However, the Trust has consistently seen a crude rate trend of less than 1.5% for a significant amount of time. Weekend crude rate is 2.87%, which has equally been consistently been below 3% for a significant time now.

5.0 In summary

5.1 The concept of reviewing deaths and reporting to NHS improvement with a national framework for case record reviews is embedded within most divisions in the Trust, but performance has dropped in the medical division. The improvement within the mortality data has shown that by concentrating on themes and trends and continual review of the mortality data that the national mortality picture can be improved.

5.2 Particular efforts will be made over the coming months to clear the outstanding backlog within medicine, to agree a 2-stage review process, and to ensure that engagement in both the review process and the Trust's Mortality Review Group significantly improves moving forward.

Dr Callum Gardner
Interim Medical Director
December 2018