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Frimley Health NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting in Public

Friday 6th October 2017, 11:40-14:30

Lecture Theatre, PGMC, Wexham Park Hospital, SL2 4HL

A G E N D A

Time	Agenda Item		Paper	Action	Lead
11:40	**1.**	**Welcome and Apologies for Absence**		-	Chairman
	2.	**Declarations of Interest**	Oral	-	Chairman
	3.	**Minutes of the Previous Public Board Meeting held on 1st September 2017**	Attached	For Approval	Chairman
	4.	**Action Log from Previous Meeting**	Attached	To Action	Chairman
QUALITY					
11:45	**5.**	**Ward to Board – Wexham Surgical Wards** Ian Laidlaw, Chief of Service General Surgery Kirstie Hodgson, Surgical Matron Lisa Snow, Head of Nursing.	Presentation	For Information	Director of Nursing & Quality
12:05	**6.**	**Chief Executive's Report including Quarterly Board Objective s and Quality & Performance Report**	Attached	To Note	Chief Executive & Executive Directors
12:35	**7.**	**Quality Improvement Plan**	Attached	To Note	Medical Director
FINANCE & PERFORMANCE					
12:40	**8.**	**Finance Report - Month 5**	Attached	To Note	Director of Finance & IM&T
12:50	**9.**	**CIP Update**	Attached	To Note	Directors of Operations
GOVERNANCE AND COMPLIANCE					
12:55	**10.**	**Safeguarding Annual Reports** **10.1 Safeguarding Adults Annual Report** **10.2 Safeguarding Children Annual Report**	Attached/ Presentation	For Assurance	Director of Nursing
13:30	**11.**	**Corporate Risk Assurance Framework**	Attached	To Note	Chief Executive
13:35	**12.**	**Senior Information Risk Owner (SIRO) Quarterly Report**	Attached	To Note	Director of Finance & IM&T

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13.40	**13.**	**Revision to Standing Financial Instructions**	Attached	For Approval	Director of Operational Finance
13:45	**14.**	**Infection Control Report**	Attached	For Assurance	Medical Director
14:00	**15.**	**Board Sub-Committee Summaries**			
	15.1	**Charitable Funds Committee, 1st September 2017**	Attached	To note	Chair of CFC
	15.2	**Audit Committee, 14th September 2017**	To follow	To note	Chair of Audit
	15.3	**Commercial Development & Investment Committee, 15th September 2017**	To follow	To note	Chair of CDIC
	15.4	**Quality Assurance Committee, 15th September 2017**	To follow	To note	Chair of QAC
	15.5	**Performance & Remuneration Committee, 15th September 2017**	Attached	To note	Chair of PRC
	15.6	**Nominations Committee, 15th September 2017**	Attached	To note	Chairman
	15.7	**Nominations Committee, 26th September 2017**	Attached	To note	Chairman
OTHER BUSINESS					
14:10	**16.**	**Any Other Business**	Oral	-	All
14:15	**17.**	**Meeting Review**	Oral	-	All
14:20	**18.**	**Questions from Members of the Public**		-	
	19.	**Date of Next Meeting;** Friday 3rd November 2017 Board Room, Frimley Park Hospital		-	

NB: An 'Acronym Buster' has been included at the end of the Public Board papers pack.

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Frimley Health NHS
NHS Foundation Trust

3

BOARD OF DIRECTORS MEETING IN PUBLIC

Friday 1st September 2017, 11:40 to 14:45

Large Meeting Room, Forest Lodge, Heatherwood Hospital

MINUTES OF MEETING

Present:	Pradip Patel	(PP)	Chairman
	Janet King	(JK)	Director of HR & Corporate Services
	Nigel Foster	(NF)	Director of Finance & IM&T
	Alison Szewczyk	(AS)	Deputy Director of Nursing & Quality FPH
	Sally Brittain	(SB)	Deputy Director of Nursing & Quality WPH
	Helen Coe	(HC)	Director of Operations FPH
	Lisa Glynn	(LG)	Director of Operations WPH
	Mark Escolme	(ME)	Non-Executive Director
	Dawn Kenson	(DK)	Non-Executive Director
	Mike O'Donovan	(MOD)	Non-Executive Director
	Rob Pike	(RP)	Non-Executive Director
	Thoreya Swage	(TS)	Non-Executive Director
	John Weaver	(JW)	Non-Executive Director
	William Jewsbury	(WJ)	Deputy Medical Director (Frimley) for Tim Ho
In Attendance:	Emma Luhr	Item 5	Head of Midwifery
	Karen Plews	Item 5	Clinical Matron
	Alison Kirkpatrick	Item 5	Chief of Service
	Duncan Burton	(DB)	Prospective Director of Nursing & Quality observing
	Susanne Nelson-Wehrmeyer	(SNW)	Company Secretary
	Kevin Jacob	(KJ)	Assistant Company Secretary (minutes)

1.	Welcome, Introduction and Apologies for Absence	
a.	PP welcomed everyone to the meeting and asked Nigel Foster, the new Director of Finance & IM&T, and Duncan Burton, the new Director of Nursing & Quality, to introduce themselves as this was their first board meeting. Duncan Burton was attending the meeting as an observer before his official start date with the Trust on 18th September 2017.	
b.	PP advised that Sally Brittain would soon depart to take up the post of Director of Nursing at Kingston. LG thanked both AS and SB for covering the interim period since Nicola Ranger's departure. SB was seen as supportive and had a calm and respectful approach and was able to balance local and national strategies. LG considered her friendly approach set the tone for nursing and midwifery staff at Wexham. She was a part of the core team at Wexham comprising of LG and Emmanuel. She would be much missed and would go with the organisation's best wishes.	
c,	SB responded by thanking the board - it had been a fantastic place to work and a great opportunity to work with such a group of good people.	
d.	Apologies for absence were received from Andrew Morris, Tim Ho and Ray Long.	

2.	**Declarations of Interest**	
a.	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting**	
a.	The minutes of the previous Board meeting held in public on Friday 7th July 2017 were approved as a correct record subject to the following; • MOD page 17, para 17.f- amendment to reflect effect of new regulations relating to any contact with the public by charities.	**KJ**
4.	**Action Log from the Previous Meeting**	
a.	With respect to the actions in progress not on the agenda; 5th May-4d. IT strategy. The Directors' strategy session scheduled for 22nd September had been cancelled as more time was required for NF to assess with the Chief Information Officer, (CIO) the situation going forward.	
5.	**Ward to Board – Maternity Frimley Park**	
a.	**FHFT Maternity and Gynaecology** Chief of Service: Alison Kirkpatrick Trust Head of Midwifery: Emma Luhr Clinical Matron: Karen Plews, Maternity Matron, Frimley Park	
b.	A comprehensive presentation was delivered by the Maternity and Gynaecology senior staff, a new formed team, which identified the following; • There had been a lot of collaboration and hard work on governance processes. • There had been a huge investment of capital at Wexham Park to rebuild the facilities. Running services whilst building work was taking place all around them was very difficult and was a daily challenge. • There were a lot of national initiatives such as saving babies lives, births and others including the local maternity system sub group of the Strategic Transformation Plan alongside the patient safety agenda and MDT discussions for specific issues of the day which included safeguarding, estates and staffing issues. • The neonatal unit at Frimley Park had achieved a stage 3 UNICEF Baby Friendly Initiative accreditation and Wexham had achieved stage 1 and were on progress to achieve stages 2-3 over the next few years. • Challenges included having a new senior leadership team and the need to refocus on hand hygiene and audits. • Day assessment and triage was new. All pregnant women now come into the department like they would do for A&E which required the development of new facilities and treatment modes which represented a significant challenge for the business. • IT remained an issue with two separate maternity systems in place along with the inability to use data on one site for national metrics. • There was a national shortage of sonographers along with other staff such as midwives, nurses and registrars and this was also hampered by a third of them on currently being on maternity leave. • Caesarean Section rates were higher than they would like them but this was not a priority at present due to having to manage the service within a building site.	

c.	AK indicated there were two areas where they were seeking the board's support;- • In the area of IT as the current system blocks integration and was inefficient in the use of resources. The example provided was of moving patients from one hospital to another, which required a complete re-booking. • The need for the board to support and publicise the opening of the new unit to help increase demand and income.	
d.	Questions from the board were raised and discussed; • MOD wondered about the trend in women now attending in an A&E way and whether this should be reversed with more assistance being available in the community. AK agreed this would be preferable however they were finding that some GPs would not see pregnant women now even for blood pressure checks. • DK asked whether the approach would be different through the STP group. AK responded that part of the change would involve hubs in the community and some sharing of responsibilities. If there were no changes then the pressure at the front door would be intolerable. • RP had undertaken a walkabout at Frimley in May which had been very positive and wanted clarification about recruitment and retention, whether this was at Frimley, or Wexham or both sites. AK indicated she knew there was a 16% vacancy for midwifery and high numbers had been recruited for October. The challenge across the board was due to high rates of maternity leave and seniors relocating or retiring. AK advised they had filled consultant vacancies, but junior doctors were recruited annually on a 4 month basis and turnover was very high so making long terms plans was difficult. • JK added that on the midwifery side there was a big imbalance between numbers of qualified midwives and health care assistants, so there may be more scope for work diversification. AK indicated there may be other opportunities to redistribute administrative tasks away from midwifes. She was considering this and working this through, although this would take some time. • TS asked about the hand hygiene results and sought an explanation about planned improvements. AK explained there were many transient staff, agency and locum staff and others such as volunteers coming into the wards. There had recently been a real drive on this issue, particularly when Infection Control was launched but there was often regression when the ward got busy. TS asked whether patients challenged this on the wards. AK was aware of the national initiative and there were posters, but the patients also needed to be reminded. Ward nurses were now asked 'how would you feel if someone comes to you with unwashed hands?' to try and personalise the message. • JK asked EL whether the old role of supervisor of midwives had been abolished. EL confirmed it had been on 31 March and that NHSE was creating a different non-statutory process. There were now two slightly different systems on both sites with senior community midwives, being empowered to deal with those not waiting for hospital supervision. For others there would be a slightly different position on each site. The statutory role had been abolished on the back of Morecambe Bay.	
e.	PP thanked the team for presenting a comprehensive report, indicating that the board recognised the difficulty in working in a building site at Wexham, but that the £10 million investment would be worth it. The board thanked the whole team and would support the launch of the service when the works were complete. The Board **noted** the report.	

6.	**Chief Executive's Report** • **Quality & Performance Report**	
a.	LG presented the Chief Executive's report and the Quality and Performance report, highlighting the following key points; • Performance against key targets for July continued to be consistent with delivery on 18 weeks, 6 week diagnostics and 62 day cancer treatment standards. June was the first month for all tumour sites with the exception of one, to achieve the standard. • On the 4 hr. standard the Trust delivered 91.5% for July but since the junior doctor changeover in early August performance had been at around 90% which was a concern and put at risk the STF funding element for ED performance for Q2. This remained a daily challenge although the aspiration was to achieve 95%. • The Trust needed to better last year's performance of 91.4% for the quarter ending 30th September. • The high number of Emergency Department breaches, particularly at Wexham, remained a concern due to gaps in the medical grade rotas which resulted in long delays particularly at nights and weekends. Medical staffing levels should improve following 12 job offers to doctors at middle grade level which should stabilise the position. There was a need to change the clinical model at the front door at Wexham. The new deputy Chief of Service at Wexham was trying new approaches to reduce admissions.	
b.	On the finances; • July was a disappointing month with a continued underlying deficit run rate. The position at month 4 was a YTD deficit of £4.7 million against plan. There were several factors that have caused this. 1. Activity was below plan and in previous years the Trust would benefit from more income due to over performance for emergency and planned activity. While this demonstrated that some of the investment in out of hospital services was starting to impact positively for the System, the Trust was not experiencing any help to offset its fixed expenditure. 2. Non CCG income i.e. private patient income, car parking and catering were £1.5 million below plan. 3. Agency and Bank pay costs were higher than plan by £1.4m. The spend on medical locums was much higher than anticipated particularly in ED and the Medical specialties. From October the Medical Director would be only officer in the Trust authorised to approve all medical locum requests that exceed one month in duration.	
c.	**Heatherwood** The planning application for a new £90 million hospital in the green belt on the Heatherwood site was approved by the Royal Borough's Members Panel on 22nd August. The Trust would work with the planning officers during September to develop the Section 106 agreement which will set out the detailed conditions associated with the approval in principle. As the new hospital would sit in the green belt the Secretary of State for Communities and Local Government would also need to give approval. Assuming this is granted, the aim was to start the work in March 2018.	
d.	**Berkshire and Surrey Pathology Services, (BSPS)** The ambitious plans to incorporate the pathology services at The Royal Berkshire Hospital and Wexham Park Hospital were currently being implemented and when	

	completed in full later this year would create one of the biggest pathology networks in England. While every District General Hospital, (DGH), in BSPS would have a rapid response laboratory, the specialist services within pathology had been rationalised into a fewer number of sites and where possible BSPS had used leading edge robotics to enhance efficiency and quality. The addition of two further DGHs would reduce the operating costs by over £5 million by the year end.	
e.	A discussion followed; • MOD indicated that previously Wexham was on par with Frimley but had now fallen back on ED performance and he wanted to better understand the reasons for this? LG responded that when comparing sites, there had been greater changes at Frimley with the medical model and speed of service. Performance had previously been sustained at Wexham at above 90%, but now struggled at 89% with the challenges at nights, weekends and out of hours, as most days, performance was still at 95% during day time hours. At night ambulance arrivals were up by 20-25% and acuity tended to be higher. Out of hours also had greater impact on rotas as there were a limited number of staff available. This meant a higher reliance on agency and locum doctors for out of hours. There were a lot of improvement plans with a particular focus on two issues –the clinical model and a different out of hours support model. • ME on Heatherwood- gave credit to JK and the capital projects team in securing planning permission. There had been a lot of engagement from local communities. There was still uncertainty as the Secretary of State needed to make a decision on the green belt, and the conditions were still to be negotiated. He wondered about the impact on the timeline even if the board was able to approve the business case in October. JK indicated there could be a number of conditions on all of the schemes, which could impact on phasing and enabling works. Windsor and Maidenhead had requested the Trust lead on conditions and these had been offered up. What could emerge as an issue was the amount we had in the overall budget for planning contingency, which may not be enough if onerous conditions were imposed. The biggest risk was around mitigation for the woodland- there had been no decision as to whether the woodland was considered to be an ancient woodland and this remained contentious. • JK added that it would be important to try and start enabling works before the bird nesting season in February. • ME indicated it was important to clarify to the planners that there was no more money and no more time. The current plan was already coming out at £95 million and this needed to be reduced to £90 million, otherwise the project would be unaffordable. • JK reminded the board that although CDIC had been helpful in terms of direction and guidance, work would not start until everything was agreed and the Secretary of State had signed it off so there was still some distance to go. She would confer with SNW if the issue became intractable. • JW was also conscious that the press reported the case as if everything had already been settled. Staff at HWP would be very happy with the result due to the history of the site but there would be wider benefits for the Frimley site too. HC confirmed that staff at Frimley were positive about the development as Frimley Park was landlocked, so moving some elective work off site provides us with possibilities for future development. The Board **noted** the report.	

7.	**Quality Improvement Plan (QIP)**	
a.	WJ introduced the QIP report for July 2017 as set out in the Agenda. The following points were highlighted; • This had been updated following the HEB meeting with the heads of nursing and deputy Chiefs of Service with the CQC work in mind. • Some progress had been made on some items including dealing with the challenges around recruitment, retention and medical agency. • There had been good progress on the deteriorating patient and on recovery following cardiac arrest which at 30.5%, which was well above the national average of 20%. • Emergency admissions were still problematic but the conversion rate was reducing at Frimley and they were still ongoing work of patient flow through the hospital. • 7 day services were performing well against national and local comparators.	
b.	RP noted that there remained challenges with EDMS both logistical and cultural and queried whether this was moving forward. WJ replied that the organisation was still in acceptance phase and whilst EDMS had been physically rolled out there still remained a lot of work on the process in dealing with background records. There still remained significant challenges with searching the legacy record and IT issues. Instead of an integrated system, there were lots of individual systems like ERS. This was not easy for staff and there remained frustration with moving forward.	
c.	RP suggested there was a need to smarten the process before automating it. LG responded that some of the changes depended on technology such as with electronic forms. WJ indicated that e-forms were the next big change which when implemented would result in large savings but he anticipated this would be a long and difficult process.	
d.	JW asked that as there was now a new Quality Strategy would the QIP be revised. WJ confirmed this was reviewed regularly with AS and SB. The difficulties were in sustaining messaging and a lot of effort had gone into this but without resulting in the step change required.	
e.	DK also wanted to acknowledge the progress with updating the plan. The Board **noted** the report.	
8.	**Quality Improvement Strategy 2017-2020**	
a.	The Quality Improvement Strategy was introduced by WJ as set out in the Agenda. It had been discussed at two board seminars previously and the board was asked to approve the strategy.	
b.	MOD considered that the targets on patient experience could be more challenging. SB had discussed this with DB but it was difficult to drive improvement due to the methodology. The current target of 20% in the top box was a real stretch, as last year the trust had none in this box. She suggested the trust should look for month on month improvements in other areas and noted that those trusts performing generally well were specialist providers and not acute providers.	
c.	RP asked about the recent plaudits on our friends and family results from Jeremy Hunt. SB responded that whilst we were doing very well on friend and family test, there were many different metrics to measure patient satisfaction, which made it	

	difficult to triangulate results. The trust had undertaken a range of activities and the questions that we were focused on saw continued improvement. Having said this results had fallen in July.	
d.	PP considered this was a clear and focused strategy and the more difficult work now was in implementing the strategy. QAC would monitor this on a quarterly basis with a bi-annual report to the board. PP asked the thanks of the board to be passed on to the whole team that were involved in developing this strategy. They should be very proud of the final result. The Board **approved** the Quality Improvement Strategy for 2017-2020.	
9.	**Finance Report - months 3 & 4**	
a.	NF reported on the Month 4 finance report and highlighted the following key points; • The trust continued to be on plan, mainly because of the stock adjustment but the underlying position had not improved. • Page 109 of the agenda summarised the current position and what would happen if a straight-line forecast was taken. This would result in a £10 million deficit. The final column indicated where anticipated improvements would result from and this represented about 50% of the income forecast. • For the core clinical income from the Clinical Commissioning Groups, (CCGs) the trust assumption was for no over performance, but the CCG side was anticipating some over performance. • There remained some challenges around income, particularly for speciality commissioning. There was still some un-coded activity which had been priced in at average cost. Additional staff had been brought in to sort out the un-coded work which had partly resulted from the introduction of EDMS. • The plan was to avoid any further one off items but really focus on improving the CIP position- especially around medical agency.	
b.	Going forward, NF indicated there was unlikely to be any improvement in position for August. He considered October would be the key month to see any trajectory change. Other points made; • M4 showed a break-even pre STF but the plan was to achieve a £1.4m surplus. The Trust was therefore £1.4 million adverse to plan in month and £4.7 million adverse YTD. • Income had not recovered from the Q1 dip but this may be due to an unprecedented level of un-coded episodes at the month end (worth about £16 million). Once these were processed through there may be a better position on the income. • Pay and non-pay continued to be an issue. In particular medical, ad-hoc and agency costs were significantly over plan by £1.4 m YTD. Bank costs continued to be high. The upside to this was that agency costs were steady at £2 million per month and this was within the NHSI cap. • Two exceptional items were booked last month, the stock of £4.7 million which was transferred to the balance sheet and income for donated assets of £700,000 meant the Trust was able to report a positive variance YTD for NHSI reporting purposes and so accrued the M4 STF of £1.2 million. • Agency spend was holding at around £2 million per month but total pay was overspent due to much higher bank and medical agency costs. • CIP for the month was at 92% delivery (83% YTD). The yearend forecast had been set to original NHSI plan because at this stage the Trust was committed to a producing a recovery plan to reverse the position. The Board **noted** the report.	

10.	**Cost Improvement Programme (CIP) Update 2017/18 – months 3 & 4**	
a.	HC reported on the CIP Programme Performance and noted that M3 at 74.5 % was very disappointing but they had got to 92.3% by M4 noting; • At the close of M4, the Trust delivered £8.206 million against the plan of £9.875 million, which was an adverse variance of -£1.669 million and a delivery of 83.1%. This was an improvement on previous months, partly due to new schemes and higher delivery on some existing schemes. The gap was now £4-5 million and it was necessary to get to 93% for CIPs. The forecasted out turn was 88%, so they were still 5% off plan. • There were some concerns, for example whilst pathology was bringing in new partners, it was felt that they would not recover the shortfall from M1-4 but they were still likely to deliver for the rest of the year. • CIPs were not realised quickly on locum consultants and on the different theatre schemes due to 50 vacancies and the delay with the pain service- resulting in premium staffing rates being paid. • Execs had met recently to consider mitigation. They had also considered bank staff payments and met with all directors revisiting the directorate improvement plan to try and get to 93% delivery. They had also sought substitute schemes.	
b.	Highlights had included the significant reduction in agency costs and wards were now within budget for the first time. Nursing agency was 30% down at Frimley and 20% down at Wexham and medical agency was 30% down at Frimley and 27% down at Wexham.	
c.	PP indicated that finance was on the agenda on the October board away days and this would be a good opportunity to review the year end forecast, at the end of H1.	
d.	RP queried whether at page 115 of the agenda, which set out monthly agency trend vs. monitor plan spending, the bank costs could be placed at the top of pyramid, as it would be useful to see where bank spend is in addition to agency spend. The Board **noted** the report.	
11.	**Capital Investment Programme Update**	
a.	PP noted this was an update report and asked JK to pass on the boards thanks to Stephen Holmes for a very well written report. The Trust continued to invest in infrastructure and was one of few trusts able to do this.	
b.	JK added the report was also to provide the board assurance on fire mitigation, in particular as a lot of work had been done with fire doors and compartments for fire control. An internal inspection had been conducted with no significant risks arising; however the fire brigade had been busy and whilst they had assessed us as low risk, it was still necessary to have their formal endorsement towards the end of the year and also to assess the new Emergency Department scheme at Wexham. This had been going well and whilst it was running a week behind programme, it was felt that this would be made up. The cladding for the unit was compliant with current standards, but if this had to change, it would add £150,000 to the project. If this happened the issue would be taken to CDIC for discussion. The Board **noted** the report	

12.	**Nurse Staffing Update**	
a.	PP opened the item for discussion as the report was self-explanatory and should be taken as read. Questions and discussion followed; • TS on the NMC registration indicated her surprise about lapses in individual notifications. SB indicated there had been two in the last six months but JK confirmed the reasons for this were inexplicable. • DK wondered whether workforce planning was being undertaken for the Accountable Care System. SB indicated this had started and there had been a sector wide meeting with the other directors of nursing to map out what we thought the future would look like. They had also discussed sharing training and development and how to build practitioner and community relations. • JW asked how the MOD nurses were treated in the dashboard. SB replied they were included but because of their other MOD commitments, two or three of them equated to one FTE nurse. • PP advised that he was aware through his briefing from Tom White that a huge amount of work had gone into recruitment and retention. He particularly liked the red flag system, which allowed anyone to raise it, if they felt staffing was not appropriate to ensure patient safety. • PP made the further point that the issue of nursing vacancies were not going away at time soon and there was a real need for a complete re-think on the skill mix at ward level. The next 5 years would be very challenging with Brexit and the challenge needed to be reframed. The Board **noted** the report.	
13.	**Trust Recruitment Report**	
a.	JK noted; • There were very serious recruitment and retention issues in groups other than nurses- especially in the area of allied health professionals. The work needed to be re-balanced to shift the focus away from just nursing. Medical staffing turnover was also the highest within the local network. • This required a big team effort and the organisation was in the same position as other trusts.	
b.	MOD indicated this issue had been discussed at the Quality Assurance Committee. TH had previously indicated that the Trust had a reputation for being more demanding than others. JK replied that the deep dive in retention showed that this was not in the top 5 reasons cited by people leaving the organisation. It may be that this may be included in the scores citing work life balance as one of the reason for leaving the trust. The Board **noted** the report.	
14.	**Corporate Risk Assurance Framework**	
a.	PP indicated the report was self-explanatory and it was felt that no further discussion was required on this occasion. Audit committee to consider this in depth and bring back any items that the board need to be aware of. DK was going to do more work on this in the Audit Committee on the board's behalf. The Board **noted** the report.	**DK**

15.	Responsible Officer's Annual Report	
a.	WJ advised that the Board was required to receive this report for the purposes of assurance on how the Responsible Officer was carrying out his legislative duties in relation to medical appraisal, medical revalidation, pre-employment checks and managing concerns about doctors.	
b.	Following the meeting the Chairman was being asked to sign the Designated Body Statement of Compliance (Appendix F).	
c,	The report was taken as read and discussion included; • DK queried some commentary in the QA which had found that some appraisals were deficient in evidencing the reflections of staff. She wondered whether the action points sufficiently covered what was required. WJ confirmed that some were better than others and they needed to work with appraisers in providing quality and consistency in asking the right questions. The idea of reflection was a relatively new concept, as was writing a summary from a 360 degree point of view, which were two separate exercises. • DK queried whether this was a compliance exercise. PP indicated he was required to confirm that TH was fulfilling his statutory obligations. • TS asked in relation to clinical governance and the SI events, whether the learning had been useful and could be developed further. WJ responded that it was an excellent place to capture this and that excellent learning had resulted from the Serious Incidents Requiring Investigations where a multi-layered approach was apparent. • ME queried how the trust tracked locum and agency workers. WJ responded that locums employed on a short term basis were the responsibility of the locum agency which had a designated appraiser. If the trust employed a locum for longer than 3 months, the trust conducted the appraisal, however dealing with locum and bank doctors was an area of constant debate at RM meetings as it was recognised as a weak point in the system. • JK considered that revalidation was much bigger than appraisal. She expressed concerns about the results in appendix D as 50% of them were not sharing their CPD reflections and were not showing quality improvement. 30 out of 34 did not include data on clinical activity so how were appraisals with such serious omissions accepted? WJ indicated that when undertaking revalidation all appraisals came to Emmanuel or himself before they could go forward and were challenged. This resulted in a high level of deferrals of revalidation if appraisals were considered incomplete. Also revalidation was a statutory re-licensing of medical staff controlled by the GMC. The bar to revalidate was low and the bar for appraisals was high as the latter was set by NHSE. • WJ responded that these were fresh audit results and that they would be examined in the MARG and discussed with the Chiefs of Service and medical appraisers.	
d.	PP indicated that last year the Trust's compliance rate was below the whole sector and below our peers as well. He had discussed this with TH and set him the challenge to be better than his peers. At 98.5% compliance for this year, this was higher than peers and sector, which was good news. The next challenge would be to address JK's point in terms of following through with the audit findings to raise this game. The Board **approved** the Chairman signing the Designated Body Statement of Compliance for submission to NHS England.	**TH**

16.	**Board Sub-Committee Summaries & Recommendations**	
a.	**16.1 Commercial Development & Investment Committee -13th July** ME summarised the main items considered; • The new CT scanner was now up and running and had been delivered under plan at £1.2 million as opposed to the budget of £1.4 million. All projects were reviewed after a year to ensure the project delivered as expected. • On capital projects there was a 3 year plan, reviewed in terms of annual projects. Each project then comes to CDIIC for a stress test. Four projects were presented and included the WP hot water system, drainage, and the refurbishment of radiology. In all there were £5 million worth of approvals. • The Block 40 admin site had been approved as part of the private board meeting and subject to obtaining final planning approvals for the main site. There were additional capital projects including the Heatherwood redevelopment.	
b.	**16.2 Performance & Remuneration Committee-13th July** DK reported that the PRC met to complete the appraisal process including the Chair and CEO and the executive directors objectives. The OD development strategy had also been considered and noted that the trust had scored in the best 20% trusts on the staff survey. Talent management and succession planning had been reviewed for Tier 2 staff.	
c.	**16.3 Nominations Committee-16th August** PP reported that the committee convened to begin the process of the chief executive recruitment. Given the size of the challenge a small team would be involved with the planning process which included advertising, long and short listing. PP would ensure that the board and Council of Governors were briefed as appropriate. The Board **noted** the summaries.	
17.	**Any Other Business**	
a.	There was no other business.	
18.	**Meeting Review**	
a.	JW indicated the board got through a lot of material.	
b.	MOD considered there was greater clarity from the ward to board. He expressed concern that obstetrics were undertaking work that should be done by the GPs.	
c.	JK referenced the need to revisit the nurse staffing and trust recruitment reports as there was too much duplication between them.	
d.	TS on the ward to board presentation indicated the board had not seen anyone from the Emergency Department for some time and whether it would be good to have them come along to a future board meeting. HC responded that a request could be logged with ED but it would be better if this was avoided during the winter months.	
e.	RP indicated it had been a good meeting but with the volume of reports and information it remained a struggle to identify what information was designed for the board as opposed to being simply copied for the board from another meeting. He	

	appreciated this would require more work but the board pack was not purpose designed. PP agreed that this needed to be resolved as it was not possible to do justice to the volume of papers presented. Filters were needed and he agreed to take this on as a personal challenge. He used the patient safety annual report as an example of a report that had not been written for the board and so he had rejected its inclusion in the board pack.	**PP**
f	BB mentioned that clinical governance sat twice a month and wondered whether it needed to meet so frequently.	
19.	**Questions from Members of the Public**	
a.	Sarah Peacey thanked JK and the team with respect to all the work they had done to get the members to overrule the planning officers on the Heatherwood project.	
b.	John Lindsay also thanked JK but was concerned about whether the conditions would delay the process.	
c.	Ralph Smith, a surgical trainee at Frimley asked about the growing drive at a number of trusts promoting physician associates and whether the trust was pursuing this. JK indicated that there were a few pilots scheme and there had been nervousness at the beginning as there had been a limited number of training providers. She acknowledged it had taken off in popularity and it was on our radar	
20.	**Date of the Next Meeting**	
	Friday 6th October 2017 Lecture Theatre, PGMC, Wexham Park Hospital	

These minutes of the meeting were duly approved by the Board:

Name:	Pradip Patel
Signature:	
Date:	

Frimley Health NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING – PUBLIC

6th October 2017

ACTION LOG

AGREED ACTION	LEAD	END DATE
ACTIONS COMPLETE		
1st September 2017 - 3.a Minutes from the previous meeting The minutes of the previous Board meeting held in public on Friday 7th July 2017 were approved as a correct record subject to the following; MOD page 17, para 17.f- amendment to reflect effect of new regulations relating to any contact with the public by charities.	Kevin Jacob	Complete
1st September 2017 - 14.a Corporate Risk Assurance Framework Audit committee considered this report in depth and brought back any items that the board need to be aware of. DK was going to do more work on the Risk Assurance Register in the Audit Committee on the board's behalf.	Dawn Kenson	Complete
7th July 2017 – 10.b Cost Improvement Programme 2017/18 MOD referred to theatre utilisation performance which remained static and asked how the Trust's performance compared to other Trusts. LG indicated that more information on benchmarking will be provided in the next report. The Trust had recently taken part in a national theatre utilisation survey run by Deloitte.	Lisa Glynn	1st September 2017
7th July 2017 – 5.k Ward to Board Deputy Heads of Nursing to consider capturing any retention ideas from the wards that might be applied across the whole organisation.	Sally Brittain, Alison Szewczyk	Fed into work by JK on retention
ACTIONS IN PROGRESS		
5th May 2017 – 4.d Action Log from Previous Meeting IT Strategy to come back to the Board – confirm a date. **Update**: Date to rearranged.	Nigel Foster	
5th May 2017 – 9.d Cost Improvement Programme Learning review on the 2016/17 CIP to be undertaken by the Finance Assurance Committee	Helen Coe/Lisa Glynn Rob Pike	TBC
3 March 2017 – 11.c Board Sub-Committee Terms of Reference Board Sub-Committee Terms of Reference to be amended and brought back to the Board.	Susanne Nelson-Wehrmeyer	3rd November 2017
1st September 2017 - 15.d Responsible Officer's Annual Report The Board approved the Chairman signing the Designated Body Statement of Compliance for submission to NHS England.	Tim Ho	
1st September 2017 - 18.e Meeting Review PP to undertake a review of board packs.	Pradip Patel	1st December 2017
ACTIONS OVERDUE		

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5

Report Title	Ward to Board Report Wexham Park Hospital Surgical Wards
Meeting	Board of Directors – Public
Meeting Date	Friday, October 6th, 2017
Agenda No.	5
Report Type	Presentation
Prepared By	A Walker (Infection Prevention and Control Nurse Consulant) V Gentry (Infection Prevention and Control Lead Nurse FPH) J Wyeth (Infection Prevention and Control Lead Nurse HWP) P Flattery (Pharmacy Dept) and C Simpson (Facilties Dept)
Presented By	Chief of Service: Ian Laidlaw Head of Nursing: Lisa Snow Clinical Matrons: Kirstie Hodgson,
Background	The Health and Social Care Act 2008 (Code of Practice on the Prevention and Control of infections and related guidance July 2015) states that NHS provider organisations must demonstrate that infection prevention and cleanliness are an integral part of quality assurance. Please find the report to the Board by Chief of Service and Clinical Matrons for WPH Surgical wards NB this report is presented in conjunction with the performance data provided by the Quality Team
Issues / Actions	Areas of the Infection Control Section are RAG rated for information
Recommendation	Board members are asked to discuss and note this report
Appendices	NA

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Wards →	**WX10**	**WX11**	**Christiansen**
MRSA bacteraemia for year	0	26/8/17 (no lapse in care)	0
Date of most recent *Clostridium difficile* Infection case	1/8/17 and 19/8/17	24/8/17	0 for year to date

Most recent Hand Hygiene Audit Score (audits done by IC Team)	100%	100%	100%
Spot check audit of alcohol hand sanitizer availability (July 2017)	100%	100%	100%
Infection Control link rep attendance at quarterly forum	Matron attended July meeting		
Clinical Consultant Lead attendance at monthly HICC (Last 6 meetings)	0		
Consultants and Trust doctors who have completed Annual Infection Control Training	86%		

Cleanliness monitoring data obtained from Facilities Dept.

Wards →	WX10	WX11	Christiansen
National Standards for Cleanliness score (July)	98%	97%	99%

Antibiotic Audits obtained from Pharmacy Dept:

Wards →	WX10	WX11	Christiansen
Was Stop/review date documented on the prescription? (June 17)	Not included		
Was the correct Indication specified on chart?	85%		
Is the prescribing compliant with antibiotic guidelines?	98%		

Ward Performance Report

Ward 10

Frimley Health NHS
NHS Foundation Trust

Ward 10

WARD QUALITY REQUIREMENTS	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
Dementia Assessment	87%	100%	100%	100%	100%	100%								90%
Home between 4pm & 7.59pm (number)	108	7	3	13	12	6								N/A
Home between 4pm & 7.59pm (percentage)	69%	64%	38%	81%	75%	67%								N/A
Home 8pm & Later (number)	14	1	2	1	2	1								N/A
Home 8pm & Later (percentage)	9%	9%	25%	6%	13%	11%								N/A
PATIENT EXPERIENCE	**Outurn 16/17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Target 2017/18**
Survey questions: (No. of questionnaires completed)	155	9	12	13	21	13								5
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	97%	100%	100%	92%	91%	92%								95%
Did you have confidence and trust in the doctors treating you?	91%	89%	75%	85%	86%	85%								95%
Were you involved as much as you wanted to be in decisions about your care and treatment?	N/A	100%	75%	85%	91%	77%								90%
Did nurses talk in front of you as if you weren't there?	N/A	100%	100%	85%	91%	100%								95%
Were you bothered by noise at night from other patients?	74%	N/A	100%	62%	67%	77%								80%
Were you ever bothered by noise at night from hospital staff?	87%	100%	100%	85%	91%	77%								90%
Did you find a member of staff to talk to about your worries and fears?	85%	100%	33%	88%	93%	100%								95%
Did you get enough help from staff to eat your meals?	99%	100%	100%	N/A	100%	100%								90%
Within the first couple of days of admission did a member of staff ask you about your home situation?	62%	43%	22%	80%	87%	40%								80%
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	N/A	75%	88%	88%	98%	90%								95%
Beforehand, were you told how you could expect to feel after you had the operation or procedure?	N/A	75%	100%	38%	50%	50%								95%
Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she put you to sleep or control your pain in a way you could understand?	N/A	100%	88%	71%	82%	N/A								95%
Have you and your family or carers been involved in discussing your discharge from hospital?	84%	100%	100%	80%	86%	100%								80%
Did you feel threatened during your stay in hospital by other patients or visitors?	N/A	89%	92%	92%	95%	100%								99%
FFT response rate	42%	75%	32%	24%	58%	38%								40%

	FFT % Would recommend	96%	100%	93%	100%	97%	97%								90%
	FFT no. *extremely unlikely* and *unlikely* responses	4	0	0	0	0	0								0

Ward 10	INFECTION CONTROL	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
	MRSA	0	0	0	0	0	0								0
	C-Diff	1	0	0	0	0	2								N/A
	Was the indication for antibiotics specified on the drug chart? (% Yes)	N/A													N/A
	Was a stop/review date for antibiotics documented on the prescription? (%Yes/Prophylaxis/Long term)	N/A													N/A
	Does this antibiotic treatment meet the care bundle requirements? (% Yes)	N/A													N/A
	Overall Cleaning %	97%	NDA	NDA	99%	98%	95%								95%
	Hand hygiene	93%	NDA	NDA	85%	90%	90%								90%
	Staff hand hygiene (IPCN Audits)	N/A	N/A	82%	82%	N/A	N/A								
	Overall saving lives compliance	N/A	N/A	NDA	89%	100%	94%								
	PATIENT SAFETY PERFORMANCE	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
	Hospital acquired pressure ulcer - Grade 2	4	0	0	0	0									N/A
	Hospital acquired pressure ulcer - Grade 3	0	0	0	0	0									N/A
	Hospital acquired pressure ulcer - Grade 4	0	0	0	0	0									N/A
	Safety Thermometer (% harm free care)	N/A	N/A	N/A	N/A	N/A									N/A
	VTE Risk Assessment	91%	98%	82%	93%	100%	100%								95%
	Complaints (by number)	8	1			1	1								N/A
	Compliments (by number)	0				22	15								N/A
	Total number of falls	30	5	4	0	0	1								N/A
	Total number of falls (with significant injury)	2	0	0	0	0	0								N/A
	Medication errors	23	2	0	0	0	0								N/A
	Medication errors with harm	2	0	0	0	0									N/A
	SIRI's	3	0	0	1	0	0								N/A
	Staffing incidents	1	2	0	0	0	0								N/A
	Number of Cardiac Arrest	2	0	0	0	0	0								N/A
	Emergency Crash Trolley Compliance	91%	90%	94%	93%	77%	94%								100%
	Suction (quarterly)	N/A	96%												N/A

Ward 10

WORKFORCE	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
Standard 1 - minimum x2 trained per shift	100%	100%	100%	100%	100%	100%								
Standard 2 - Total compliance against planned staffing	100%	95%	99%	96%	95%	93%								
Standard 3 - Trained compliance against planned staffing	100%	98%	98%	93%	95%	93%								
Trained Vacancies WTE	N/A	8.43	8.1	8.1	9.1	7.4								
Untrained Vacancies WTE	N/A	3.75	3.75	3.75	3.34	2.93								
Statutory Mandatory Rates - Annual	N/A													
Statutory Mandatory Rates - 3 Yearly	N/A													
Appraisal Rates	N/A	ongoing	ongoing	ongoing	80%	82%								
Sickness	N/A	36d	33d	23d	40.5d	25.5d								
Leavers from the organisation	N/A													
Leavers from the ward	N/A	0	0	0	0	0								
COMMENTS														

Ward Performance Report

Ward 11

Frimley Health NHS
NHS Foundation Trust

Ward 11

WARD QUALITY REQUIREMENTS	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
Dementia Assessment	97%	100%	100%	100%	100%	100%								90%
Home between 4pm & 7.59pm (number)	73	6	7	8	8	5								N/A
Home between 4pm & 7.59pm (percentage)	63%	55%	58%	67%	67%	6%								N/A
Home 8pm & Later (number)	11	1	2	2	0	1								N/A
Home 8pm & Later (percentage)	9%	9%	17%	17%	0%	11%								N/A
PATIENT EXPERIENCE	**Outurn 16/17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Target 2017/18**
Survey questions: (No. of questionnaires completed)	146	12	13	10	15	7								5
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	95%	100%	85%	100%	100%	86%								95%
Did you have confidence and trust in the doctors treating you?	86%	92%	100%	90%	80%	100%								95%
Were you involved as much as you wanted to be in decisions about your care and treatment?	N/A	75%	85%	80%	87%	86%								90%
Did nurses talk in front of you as if you weren't there?	N/A	92%	92%	100%	100%	100%								95%
Were you bothered by noise at night from other patients?	86%	100%	92%	70%	73%	71%								80%
Were you ever bothered by noise at night from hospital staff?	90%	100%	100%	90%	93%	71%								90%
Did you find a member of staff to talk to about your worries and fears?	90%	80%	100%	100%	100%	100%								95%
Did you get enough help from staff to eat your meals?	99%	100%	100%	100%	100%	100%								90%
Within the first couple of days of admission did a member of staff ask you about your home situation?	65%	70%	92%	63%	64%	50%								80%
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	N/A	80%	100%	33%	60%	100%								95%
Beforehand, were you told how you could expect to feel after you had the operation or procedure?	N/A	80%	100%	33%	60%	71%								95%
Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she put you to sleep or control your pain in a way you could understand?	N/A	60%	100%	100%	100%	N/A								95%

	Have you and your family or carers been involved in discussing your discharge from hospital?	86%	100%	100%	100%	100%	67%								80%
	Did you feel threatened during your stay in hospital by other patients or visitors?	N/A	100%	100%	100%	100%	100%								99%
	FFT response rate	41%	34%	42%	40%	41%	46%								40%
	FFT % Would recommend	99%	100%	100%	98%	100%	100%								90%
	FFT no. *extremely unlikely* and *unlikely* responses	0	0	0	0	0	0								0

Ward 11

INFECTION CONTROL	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
MRSA	0	0	0	0	0	1								0
C-Diff	N/A	0	0	0	0	1								N/A
Was the indication for antibiotics specified on the drug chart? (% Yes)	N/A													N/A
Was a stop/review date for antibiotics documented on the prescription? (%Yes/Prophylaxis/Long term)	N/A													N/A
Does this antibiotic treatment meet the care bundle requirements? (% Yes)	N/A													N/A
Overall Cleaning %	97%	NDA	NDA	NDA	97%	94%								95%
Hand hygiene	89%	85%	85%	80%	100%	NDA								90%
Staff hand hygiene (IPCN Audits)	N/A	N/A	91%	91%	N/A	N/A								
Overall saving lives compliance	N/A	N/A	100%	100%	100%	100%								
PATIENT SAFETY PERFORMANCE	**Outurn 16/17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Target 2017/18**
Hospital acquired pressure ulcer - Grade 2	5	0	4	1	1									N/A
Hospital acquired pressure ulcer - Grade 3	0	0	0	0	0									N/A
Hospital acquired pressure ulcer - Grade 4	0	0	0	0	0									N/A
Safety Thermometer (% harm free care)	N/A	N/A	N/A	N/A	N/A									N/A
VTE Risk Assessment	94%	89%	90%	94%	86%	81%								95%
Complaints (by number)	4	0			0	1								N/A
Compliments (by number)	0	28	35	29	31	30	27							N/A
Total number of falls	20	2	1	1	0	0								N/A
Total number of falls (with significant injury)	1	0	0	0	0	0								N/A
Medication errors	15	0	3	2	0	1								N/A
Medication errors with harm	0	0	0	0	0									N/A
SIRI's	1	0	0	0	0	0								N/A
Staffing incidents	2	0	0	0	0	0								N/A
Number of Cardiac Arrest	3	0	0	1	0	0								N/A
Emergency Crash trolley compliance	97%	100%	100%	100%	100%	100%								100%
Suction (quarterly)	N/A	100%												N/A

Ward 11	WORKFORCE	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
	Standard 1 - minimum x2 trained per shift	100%	100%	100%	100%	100%	100%								
	Standard 2 - Total compliance against planned staffing	100%	98%	102%	99%	98%	96%								
	Standard 3 - Trained compliance against planned staffing	98%	99%	104%	99%	94%	94%								
	Trained Vacancies WTE	N/A	1.14	1.14	2.14	2.14	2.59	2.59							
	Untrained Vacancies WTE	N/A	1.05	2.17	2.17	3.20	3.20	3.20	1.20						
	Statutory Mandatory Rates - Annual	N/A				72%	73%	76%							
	Statutory Mandatory Rates - 3 Yearly	N/A				87%	87%	90%							
	Appraisal Rates	N/A	78%	80%	50%	84%	90%	97%							
	Sickness	N/A	4	16	42	5 days	7 days								
	Leavers from the organisation	N/A	0.00	1.00	0.00	0	0.00	0.00							
	Leavers from ward	N/A	0	1	0	1	0	0							
	COMMENTS														
	Sickness = Bradford score														

Ward Performance Report

Christiansen Unit

Frimley Health NHS Foundation Trust

Christiansen Unit

WARD QUALITY REQUIREMENTS	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
Dementia Assessment	96%	100%	100%	100%	100%	100%								90%
Home between 4pm & 7.59pm (number)	66	1	7	5	4	5								N/A
Home between 4pm & 7.59pm (percentage)	51%	17%	44%	56%	44%	45%								N/A
Home 8pm & Later (number)	10	0	3	0	0	1								N/A
Home 8pm & Later (percentage)	8%	0%	19%	0%	0%	9%								N/A
PATIENT EXPERIENCE	**Outurn 16/17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Target 2017/18**
Survey questions: (No. of questionnaires completed)	103	11	13	9	18	6								5
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	99%	91%	92%	100%	100%	100%								95%
Did you have confidence and trust in the doctors treating you?	93%	73%	62%	89%	89%	83%								95%
Were you involved as much as you wanted to be in decisions about your care and treatment?	N/A	91%	62%	89%	72%	83%								90%
Did nurses talk in front of you as if you weren't there?	N/A	100%	85%	100%	100%	83%								95%
Were you bothered by noise at night from other patients?	77%	N/A	62%	44%	63%	17%								80%
Were you ever bothered by noise at night from hospital staff?	92%	55%	92%	78%	75%	100%								90%
Did you find a member of staff to talk to about your worries and fears?	94%	80%	86%	100%	75%	100%								95%
Did you get enough help from staff to eat your meals?	98%	100%	100%	100%	100%	N/A								90%
Within the first couple of days of admission did a member of staff ask you about your home situation?	70%	57%	73%	57%	79%	67%								80%
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	N/A	100%	100%	100%	100%	N/A								95%
Beforehand, were you told how you could expect to feel after you had the operation or procedure?	N/A	50%	100%	100%	100%	33%								95%
Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she put you to sleep or control your pain in a way you could understand?	N/A	50%	100%	100%	100%	67%								95%

Have you and your family or carers been involved in discussing your discharge from hospital?	90%	100%	75%	0%	33%	100%								80%
Did you feel threatened during your stay in hospital by other patients or visitors?	N/A	90%	100%	100%	100%	100%								99%
FFT response rate	52%	53%	43%	53%	55%	42%								40%
FFT % Would recommend	98%	99%	97%	94%	98%	97%								90%
FFT no. *extremely unlikely* and *unlikely* responses	2	0	2	2	1	1								0

Christiansen Unit

INFECTION CONTROL	Outurn 16/17	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Target 2016/17
MRSA	0	0	0	0	0	0								0
C-Diff	1	0	0	0	0	0								N/A
Was the indication for antibiotics specified on the drug chart? (% Yes)	N/A													N/A
Was a stop/review date for antibiotics documented on the prescription? (%Yes/Prophylaxis/Long term)	N/A													N/A
Does this antibiotic treatment meet the care bundle requirements? (% Yes)	N/A													N/A
Overall Cleaning %	98%	NDA	NDA	NDA	99%	96%								95%
Hand hygiene	92%	90%	100%	95%	95%	95%	95%							90%
Staff hand hygiene (IPCN Audits)	N/A	NDA	100%	100%	NDA	NDA								
Overall saving lives compliance	N/A	NDA	100%	100%	100%	100%								
PATIENT SAFETY PERFORMANCE	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
Hospital acquired pressure ulcer - Grade 2	0	0	0	0	0	0	0							N/A
Hospital acquired pressure ulcer - Grade 3	0	0	0	0	0	0	0							N/A
Hospital acquired pressure ulcer - Grade 4	0	0	0	0	0	0	0							N/A
VTE Risk Assessment	98%	97%	96%	95%	96%	98%	99%							95%
Complaints (by number)	4	0	2	1	1	0	0							N/A
Compliments (by number)	474	50	44	44	39	36	55							N/A
Total number of falls	12	0	1	0	0	0	1							N/A
Total number of falls (with significant injury)	0	0	0	0	0	0	0							N/A
Medication errors	6	1	0	1	1	2	0							N/A
Medication errors with harm	0	0	0	0	0	0	0							N/A
SIRI's	0	0	0	0	0	0	0							N/A
Staffing incidents	0	0	0	0	0	0	2							N/A
Number of Cardiac Arrest	1	0	0	0	0	0	0							N/A
Emergency Crash trolley compliance	100%	100%	100%	100%	100%	100%	100%							100%
Suction (quarterly)	N/A	100%												N/A

Christiansen Unit

WORKFORCE	Outurn 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Target 2017/18
Standard 1 - minimum x2 trained per shift	100%	100%	100%	100%	100%	100%								
Standard 2 - Total compliance against planned staffing	96%	98%	99%	91%	99%	85%								
Standard 3 - Trained compliance against planned staffing	97%	101%	101%	95%	115%	100%								
Trained Vacancies WTE	N/A	3.14%	3.69%	2.75%	1.98%	1.75%								
Untrained Vacancies WTE	N/A	-0.38%	0.30%	0.77%	1.08%	2.71%								
Statutory Mandatory Rates - Annual	N/A	48%	61%	65%	74%	83%								
Statutory Mandatory Rates - 3 Yearly	N/A	95%	95%	95%	95%	95%								
Appraisal Rates	N/A	86%	86%	86%	86%	86%								
Sickness	N/A	87 days	57 days	90 days	56 days	57 days								
Leavers from the organisation	N/A													
Leavers from the ward	N/A	0	0	0	0	1	1							
COMMENTS														
1 RN started in May 2017, 1 band 4 working out of trained vacancies														

	Year to Date (M5)		
	Budget £	Actual £	Variance £
7337 Ward 11 (Old 3)	640,506	532,320	- 8,186
7340 Ward 10 (Old 2)	577,454	599,813	22,359

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Chief Executive's Report**
Meeting	Board of Directors - Public
Meeting Date	Friday 6th October 2017
Agenda No.	6.
Report Type	To Note
Prepared By	Andrew Morris, Chief Executive Officer
Executive Lead	Andrew Morris, Chief Executive Officer
Performance Overview	**Performance against key standards** The Trust is continuing to deliver on 18 weeks, the 6 week target for diagnostics and the cancer 62 day standard. Most hospitals in England are struggling to maintain these standards. Indeed the NHS as a whole is failing on 18 weeks and the cancer standard. On cancer the performance for all tumour groups is very strong with very low numbers waiting over 62 days. Considerable effort has been applied to ensuring that people get treated in a very timely way. The 4 hour standard continues to be a challenge. Performance for Sept is likely to out turn at 90.5% and 90.8% for the second quarter. This is disappointing despite a huge effort to improve. Medical staffing in ED remains a big problem with insufficient doctors on some weekend and night shifts to handle the volume of work. The trajectory to qualify for the 4hr element of the Sustainability and Transformation Fund was 91.5% for Q2 and unfortunately this has not been achieved however NHSI has signalled that it will allow the inclusion of the performance of the walk centres in Bracknell and Upton in the calculation and once this is applied the performance of the whole system is likely exceed the trajectory and FHFT may well receive the Q2 payment of £750k. The NHS faces its biggest ever challenge to deliver 95% in March 18 and it is anticipated that medical staffing will improve as part of the winter plan but the Frimley system will need to reduce delayed transfers of care to 3.5% of the total inpatients and CCGs will need to ensure that 85% of assessments for continuing health care funded patients are carried out outside of hospital. These are two important success factors. Patients in delay consume vast numbers of beds days. At the present the percentage of delayed transfers is about 5% (which equates to about 54 beds Trust wide) and very few of the CHC assessments are being done out side of hospital.

	In addition to establishing a smoother flow of the inpatient activity through the hospital the EDs will need to ensure that none of the walk in patients breach and the two departments are revising their streaming models to ensure to improve the flow of patients and lift the performance. The Ops Directors have been heavily involved in developing the winter plan for the whole system and provided every action is delivered performance in Q4 should be better than last years outturn of 89%. So far this year the system has worked hard to manage emergency inpatient activity to plan with high degree of success. Clostridium difficile The number of Cdiff cases to the end of Sept is 22 against a target of 31. This is a disappointing trend and the control of infection team are working tirelessly to try lift the hand washing rates and achieve better compliance with the antibiotic policy. Without stronger hand hygiene compliance the is a greater risk of norovirus this winter. NHSI has signalled that targets for E. Coli are likely to be introduced next year as nationally there is a growing concern over the increase in E Coli. So far this year the Trust has had 62 inpatient cases. **Activity** Activity remains broadly just on plan. The various demand management initiatives in the STP are resulting in changes in activity flowing to the Trust. GP referrals are down 2% and emergency admissions are at -1% so far this year. Elective admissions including day cases are also down 2% compared to last year. In previous years the Trust has benefited from £8m to £10m in additional income. This will not be achieved this year which creates an added financial risk but given that the winter will undoubtedly generate more emergency activity than plan there may well be around £2m to £4m additional income to offset some overspending budgets. Performance – April 2017 to August 2017 | | Apr | May | June | July | August | | --- | --- | --- | --- | --- | --- | | 18 weeks | √ | √ | √ | √ | √ | | 62 day | √ | √ | √ | √ | √ | | C.Diff | √ | √ | √ | √ | 18 | | 4 hour target | 92.3% | 90.1% | 91.3% | 91.54% | 91.5% | | 6 week diagnostics | √ | √ | √ | √ | √ |
Finance	The position for August looks better in terms of CIP delivery and income and with the stock adjustment the Trust is likely to earn the sustainability and transformation funding for Q2. However medical agency spend is a continued cause for concern particularly in ED and General Medicine and other overspending areas need to be brought back on target. With the introduction of EDMS the coding of activity is behind plan which creates a degree of uncertainty on income. Extra coders have been employed to reduce the backlog. However the Trust has covered an underlying £5m in year deficit with non recurrent funding and this will need other recurrent initiatives in year to avoid this

	being carried into next year as additional CIP. At present the CIP target for next year looks really challenging at £37m.
Issues/ Points to Note	**Hyper Stroke Service - Frimley** The outcome of the public consultation on the future of stroke in the Royal Surrey System has endorsed the continuation of the current arrangements. Patients suffering from a stroke in the RSCH catchment will be blue lighted to the Hyper Acute Unit at Frimley or St Peters for the initial treatment and care. At Frimley patients will remain for the first 72hrs and when fit to move will be transferred to the RSCH for rehabilitation or be discharged home and supported by the Early Supported Discharge Team for a period of up to 6 weeks. It is expected that Frimley Park will pick up most of the activity. Frimley has retained it's A status for performance against all of the key standards for stroke care which continues the place the service in the best 20% of Trusts. **Seven Day Consultant Delivered Service** All Trusts were asked to undertake an audit against the key national standards. The table below shows the results for FHFT compared to the national average. This is an important quality marker and good progress has been made. **7 Day Consultant Delivered Service Audit** **March 2017 survey** • First consultant review within 14hrs of admission — FHFT 96% — National average 75% • Daily consultant reviews — 97% — 87% • Twice daily review high dependency/critical care — 98% — 90% • Access to diagnostics within 48hrs — 94% — 89%  **Renal Unit - Frimley Park Hospital** The renal Unit at Frimley is due to open in October. This is a joint venture with St Heliers Hospital and avoids the need for most patients to be referred to St Helier for acute renal care. The provision of cardio vascular hyper acute stroke and renal services in a DGH setting is quite unusual. These services are normally found in a tertiary centre.

	Frailty model of care The System has secured £450k to develop a model of care for frail patients. It's hoped to target this cohort of patients with an intensive assessment and increase the proportion of patients who can be turned around quickly and supported at home. **CQC System Reviews** The CQC has at the request of the Secretary of State has started to review the efficiency and effectiveness of health and care systems. Four systems have been selected nationally as pilots and Bracknell was one of them. The report is due to be published in November and all of the leaders who have responsibility for delivering health and care services have been interviewed to assess the effectiveness of services the degree of joint working and the impact that the STP initiatives. **Visit by the leadership team from Canterbury Health System in New Zealand** The leadership team from the Canterbury System in New Zealand is visiting the Frimley System to present the changes that they have made to a population of around 600,000 in New Zealand. This particular system has successfully developed primary and community services at scale with more care is provided at home which has in turn resulted in less activity going into the hospital element of the system. The Canterbury System has a global reputation for transforming the way in which care is delivered care and there are lots of parallels with what the Frimley Accountable Care System is trying to achieve. It is hoped to learn more about how they have gone about making a significant transformational change in the way health care is provided. **System control total** Guidance from NHSE will be issued in October on a shadow control totals for 2017/18 for STPs. The sovereign bodies within the STP will be expected to achieve a target financial out turn for 2017/18. The STP is working on developing an memorandum of understanding for CCGs and Trusts to consider which will set out a proposed framework on how this will operate. It is expected that if the STP is given the final go ahead to proceed to forming an Accountable Care System in February it will work to a live control total for 2018/19. **Board Objectives for Quarter 2** The attached paper illustrates the progress against key objectives for the second quarter of the financial year. The Board is asked to discuss and note the progress so far this year.
Recommendation	The Board is asked to note the Report.

Frimley Health NHS Foundation Trust
Board Objectives 2017/18

	OBJECTIVE	Q1	Q2	Q3	Q4	PROGRESS	BSC Benefit	Exec Lead
1.								
a.	Implement year 1 of the Quality Strategy. Compliance with: deteriorating patient standards sepsis and acute kidney injury bundles maternity collaborative new pathway for mental health patients national standards for mortality and morbidity reviews					NEWS Implemented. Latest audit results indicating improvement in compliance - Deteriorating patients and resus presentation to November Board SEPSIS & AKI - Monitoring education continues Maternity Collaborative in place attended by HOM. Mental Health - active workstream. Successful STP bid in relation to improving service on WPH site. SSoN working with the CCG Chief Nurse requesting LD Nurse Liaison for WPH site.Mental Health Action Plan reviewed at QAC. Berkshire commissioning gap for CAMHS is being addressed M&M - Process and guidance has been implemented and the Trust has written guidelines and a consultant lead. Presentation of preventable deaths to the October Board		NR/TH
b.	Conclude the final year of the "Sign up to Safety" initiative - compliance with new consent policy compliance with handover policy reduce perinatal tears					Most recent consent audit indicated 80% of patients consented on the day of procedure further work is needed to address this practice. EDMS workstream is in place. Good practice noted in documentation of risks and benefits. Additional consent education and training being rolled out. Safe Handover and safety huddles implemented cross Trust. 85% compliance in undertaking these indicated in last Trust wide audit. Hospital at night handover to be reviewed by Medical Director Perineal tears - implemented Sign up to Safety within maternity on both sites.	Patients	NR
2.	**TRANSFORMING OUR INFRASTRUCTURE**							
	Progress and deliver key capital investments:							
a.	Women's Services project complete on time (October 2017) to budget (11m inc £1m backlog)					Phases 1 and 2A complete. Phase 2B on track to complete Oct 17. Project remains within budget.		LG
b.	EDAR project completed on programme (Watertight building Feb 2018 completion Dec 2018) and to budget £49m) subject to DH approval by end of March 2017.					Construction is proceeding and the superstructure has started. Interior design agreed Progressing according to programme and within budget..	Patients/ Operational Efficiency/Staff	JK/LG
c.	Achieve FBC for Heatherwood (interim FBC May 2017) and obtain planning approval May 2017.					Planning approved 22nd Aug 17. Trust is currently working with RBWM planning to agree conditions and details of 106 and 278 agreements. Papers to be presented to CDIC meeting in Oct relating to the fees to move design to next stage to achieve GMP and full FBC. Enabling works costs and programme. I&E paper for operating costs.	Patients/ Operational Efficiency/Staff	AVM/JK
d.	Produce OBC for Diagnostic Inpatient Unit at Frimley June 2017					OBC being prepared for Oct CDIC. P22 selection of preferred partner interviews on 25th Sep 17.	Patients/ Operational Efficiency/Staff	HC

e.	Complete programmed backlog scheduled for 2017/18					Various projects are being undertaken to address backlog maintenance priorities including replacement of generators (tenders returned), refurbishment of corridors (on site), relaying on drains (contract let) and renewal of hot & cold water sevices (out to tender).	Patients/ Operational Efficiency/Staff	JK/LG
3.	**DEVELOPING OUR STAFF AND CULTURE**							
a.	Refresh of the Trust's People and OD Strategy Q2					Strategy refresh meeting within HR and OD took place 20th Jun 17. HR evaluation survey planned this month. Draft strategy to be considered by Top Team in Oct 17.	Staff	JK
b.	Refresh of the Leadership Development Strategy and Framework Q2					Strategy refresh in line with NHS Leadership Framework `Developing People - Improving Care'. Draft strategy now prepared for consideration by Top Team.	Staff/ Finance	JK
C.	Launch of Well-Being Strategy and implementation of action plans to achieve CQUINSs on flu, MSK and health and well-being Q1					Strategy launch took place on all sites in Jul 17 attended by 150 people and an implementation plan for year 1 now in progress. Plans developed for CQUINs. Flu plan now underway formally commencing 19th Sep 17 with a target of vaccinating 70% of patient-facing staff (approx 5000 staff plus bank only staff who work during the flu period).	Staff	JK
d.	Support workforce planning in each directorate and produce Trust wide workforce plan Q3.					Workforce planning skills training organised for delivery to service managers/clinical LADs during autumn. Medical workforce planning sessions in progress with specialties - 2 completed so far, with aim of completing all by the end of Nov. In addition, plans to develop directorate-wide workforce plans are being implemented. Trust wide plan will be developed alongside this work.	Staff	JK
e.	Deliver a Trust wide workforce plan and reduce agency staff expenditure to £23m maximum					We are on course to meet our financial target in 2017/18 to reduce agency spend by £6.2m across all staff groups/ We have made significant progress in reducing agency spend across all staff groups with the exception of medical agency where overall spend has not been reduced.. Medical agency currently makes up 50% of the current agency spend and is costing the Trust over £1m a month (NHSI have informed us that we are in the top 20% of Trusts in the country regarding our spend on agency staff). A new electronic Medical Agency Request Form (MARF) has been developed and an enhanced approval process has been agreed which will be implemented by the end of Sep. No medical agency bookings will be made unless the process has been followed.	Staff	Execs
4.	**BREAKTHROUGH TRADITIONAL CARE BOUNDARIES**							

a.	Continue to work with the STP to progress the accountable care system; devise appropriate governance arrangements for a shadow year 2017/18.Agree and commence to implement the key initiatives					STP will run with a shadow control total • From October in shadow form. • All projects have received pump priming finance/£2.7m. • Bids to roll out GP hubs totalling £28m to be • Hospital activity is on plan which is the result of more care being provided in the community and alternatives to admission being implemented in ED. The first meeting of the Health Alliance board has taken place with chairs of the Health and Wellbeing boards who fully endorse the STP.	Patients/ Finance	Execs
5.	**KEEPING CONTROL OF RESOURCES AND DELIVERING KEY STANDARDS**							
a.	Achieve segment 1 rating from NSI by delivering all targets including: 6 week max wait for diagnostics A&E 4 hours 18 weeks Cancer 62 days					• 6 week diagnostics/18 weeks/62 days achieved Q2 • Failed to deliver 91.48% for Q2. It is likely that performance of walk in centres will be mapped in for the Frimley target to be eligible to achieve the STF funding. • 4hrs will continue to very challenging for Q2.	Patients/ Finance/ Operational Efficiency	LG, HC
5.2	Deliver a surplus control total of £22m. Achieve a continuous improvement programme and synergy savings target of £30m by Q4. Achieve a £22m surplus by Q4.					CIP Programme delivery YTD 86.5% at month 5. Expect to achieve £30m. Trust on track to earn Q2 STF payment	Finance	NF
6.	**DEVELOPING SUSTAINABLE CLINICAL SERVICES**							
a.	Establish a MADU with general medicine at Wexham by Q1.					MADU at Wexham Park Hospital established in June. Complete.	Patients/ Operational Efficiency	LG
b.	Finalise new Surrey stroke service by Q3 and incorporate the outcome of the public consultation led by Guildford and Waverley CCG.					Piloting new arrangements till September with RSCH ASU in place. New arrangements have been agreed with RSCH and Guildford & Waverley CCG, hyper-acute at FPH and stepdown at RSCH for their catchment of patients.	Patients/ Operational Efficiency	HC
c.	Full roll-out of EDMS to cover all clinical services by Q4					Roll-out complete. However, Smart indexing needs to be added to improve speed of access.	Patients	NF

Frimley Health NHS
NHS Foundation Trust

Quality and performance report

August 2017




Contents

This report covers the period from August 2016 to allow comparison with historic performance. However, the key messages and targets relate to August 2017 for the financial year 2017/18

RAG key

- Achieving target
- Between target and threshold (where applicable)
- Worse than target or threshold (where applicable)

Chief executive's overview (1)

Performance overview

Performance against key standards

- The Trust is continuing to deliver on 18 weeks, the 6 week target for diagnostics and the cancer 62 day standard. Most hospitals in England are struggling to maintain these standards. Indeed the NHS as a whole is failing on 18 weeks and the cancer standard. On cancer the performance for all tumour groups is very strong with very low numbers waiting over 62 days. Considerable effort has been applied to ensuring that people get treated in a very timely way.

- The four hour standard continues to be a challenge. Performance for September is likely to out turn at 90.5% and 90.8% for the second quarter. This is disappointing despite a huge effort to improve. Medical staffing in emergency department (ED) remains a big problem with insufficient doctors on some weekend and night shifts to handle the volume of work. The trajectory to qualify for the four hour element of the Sustainability and Transformation Fund (STF) was 91.5% for Q2 and unfortunately this has not been achieved however NHSI has signalled that it will allow the inclusion of the performance of the walk-in centres in Bracknell and Upton in the calculation and once this is applied the performance of the whole system is likely exceed the trajectory and Frimley Health NHS Foundation Trust (FHFT) may well receive the Q2 payment of £750k.

- The NHS faces its biggest ever challenge to deliver 95% in March 2018 and it is anticipated that medical staffing will improve as part of the winter plan but the Frimley system will need to reduce delayed transfers of care to 3.5% of the total inpatients and Clinical Commissioning Groups (CCGs) will need to ensure that 85% of assessments for continuing health care (CHC) funded patients are carried out outside of hospital. These are two important success factors. Patients in delay consume vast numbers of bed days. At the present the percentage of delayed transfers is about 5% (which equates to about 54 beds Trust wide) and very few of the CHC assessments are being done outside of hospital.

- In addition to establishing a smoother flow of the inpatient activity through the hospital the EDs will need to ensure that none of the walk in patients breach and the two departments is revising their streaming models to ensure to improve the flow of patients and lift the performance. The Operation Directors have been heavily involved in developing the winter plan for the whole system and provided every action is delivered performance in Q4 should be better than last year's outturn of 89%. So far this year the system has worked hard to manage emergency inpatient activity to plan with high degree of success.

Clostridium difficile

- The number of Clostridium difficile cases to the end of September is 22 against a target of 31. This is a disappointing trend and the control of infection team are working tirelessly to try lift the hand washing rates and achieve better compliance with the antibiotic policy. Without stronger hand hygiene compliance there is a greater risk of Norovirus this winter. NHSI has signalled that targets for E. Coli are likely to be introduced next year as nationally there is a growing concern over the increase in E Coli. So far this year the Trust has had 62 inpatient cases.

Chief executive's overview (2)

Performance overview (continued)

Activity

- Activity remains broadly just on plan. The various demand management initiatives in the Sustainability and Transformation Plan (STP) are resulting in changes in activity flowing to the Trust. GP referrals are down 2% and emergency admissions are at -1% so far this year. Elective admissions including day cases are also down 2% compared to last year. In previous years the Trust has benefited from £8m to £10m in additional income. This will not be achieved this year which creates an added financial risk but given that the winter will undoubtedly generate more emergency activity than plan there may well be around £2m to £4m additional income to offset some overspending budgets.

Performance – April 2017 to August 2017

	Apr	May	June	July	August
18 weeks	√	√	√	√	√
62 day	√	√	√	√	√
C.Diff	√	√	√	√	18
4 hour target	92.3%	90.1%	91.3%	91.54%	91.5%
6 week diagnostics	√	√	√	√	√

Chief executive's overview (3)

Finance

The position for August looks better in terms of cost improvement plan (CIP) delivery and income and with the stock adjustment the Trust is likely to earn the sustainability and transformation funding for Q2. However medical agency spend is a continued cause for concern particularly in ED and General Medicine and other overspending areas need to be brought back on target.

With the introduction of Electronic Document Management System (EDMS) the coding of activity is behind plan which creates a degree of uncertainty on income. Extra coders have been employed to reduce the backlog. However the Trust has covered an underlying £5m in year deficit with non recurrent funding and this will need other recurrent initiatives in year to avoid this being carried into next year as additional CIP. At present the CIP target for next year looks really challenging at £37m.

Chief executive's overview (4)

Issues / points to note

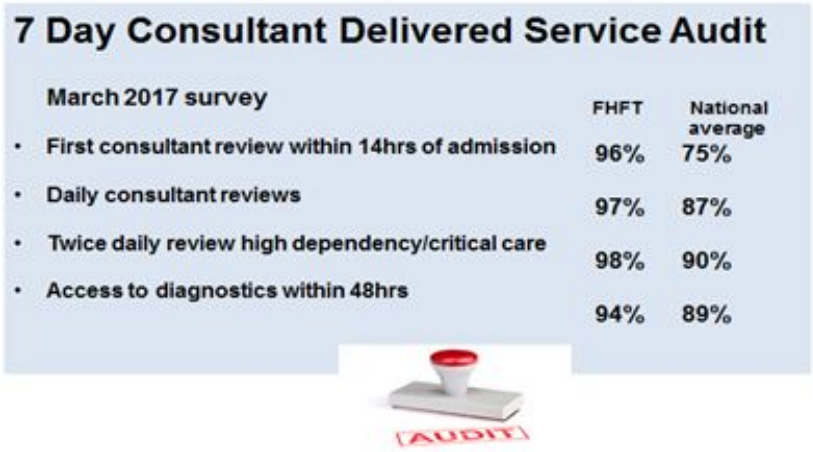
Hyper Stroke Service – Frimley

- The outcome of the public consultation on the future of stroke in the Royal Surrey System has endorsed the continuation of the current arrangements. Patients suffering from a stroke in the Royal Surrey County Hospital (RSCH) catchment will be blue lighted to the Hyper Acute Unit at Frimley or St Peters for the initial treatment and care. At Frimley , patients will remain for the first 72 hours and when fit to move will be transferred to the RSCH for rehabilitation or be discharged home and supported by the Early Supported Discharge Team for a period of up to 6 weeks. It is expected that Frimley Park will pick up most of the activity.

- Frimley has retained it's A status for performance against all of the key standards for stroke care which continues the place the service in the best 20% of Trusts.

Seven Day Consultant Delivered Service

- All Trusts were asked to undertake an audit against the key national standards. The table below shows the results for FHFT compared to the national average. This is an important quality marker and good progress has been made.



Renal Unit - Frimley Park Hospital

- The renal Unit at Frimley is due to open in October. This is a joint venture with St Heliers Hospital and avoids the need for most patients to be referred to St Helier for acute renal care. The provision of cardio vascular hyper acute stroke and renal services in a DGH setting is quite unusual. These services are normally found in a tertiary centre.

Chief executive's overview (5)

Issues / points to note (continued)

Frailty model of care

- The System has secured £450k to develop a model of care for frail patients. It's hoped to target this cohort of patients with an intensive assessment and increase the proportion of patients who can be turned around quickly and supported at home.

Care Quality Commission (CQC) System Reviews

- The CQC has at the request of the Secretary of State has started to review the efficiency and effectiveness of health and care systems. Four systems have been selected nationally as pilots and Bracknell was one of them. The report is due to be published in November and all of the leaders who have responsibility for delivering health and care services have been interviewed to assess the effectiveness of services the degree of joint working and the impact that the STP initiatives.

Visit by the leadership team from Canterbury Health System in New Zealand

- The leadership team from the Canterbury System in New Zealand is visiting the Frimley System to present the changes that they have made to a population of around 600,000 in New Zealand. This particular system has successfully developed primary and community services at scale with more care is provided at home which has in turn resulted in less activity going into the hospital element of the system. The Canterbury System has a global reputation for transforming the way in which care is delivered and there are lots of parallels with what the Frimley Accountable Care System is trying to achieve. It is hoped to learn more about how they have gone about making a significant transformational change in the way health care is provided.

System control total

- Guidance from NHSE will be issued in October on a shadow control totals for 2017/18 for STPs. The sovereign bodies within the STP will be expected to achieve a target financial out turn for 2017/18. The STP is working on developing a memorandum of understanding for CCGs and Trusts to consider which will set out a proposed framework on how this will operate. It is expected that if the STP is given the final go ahead to proceed to forming an Accountable Care System in February it will work to a live control total for 2018/19.

Board Objectives for Quarter 2

- The attached paper illustrates the progress against key objectives for the second quarter of the financial year. The Board is asked to discuss and note the progress so far this year.

Recommendation

The Board is asked to note the Report

CQC overall rating & NHSI single oversight framework

Care Quality Commission (CQC) overall rating		
Frimley Park Hospital	September 2014	Outstanding
Wexham Park Hospital	February 2016	Good
Heatherwood Hospital	May 2014	Good

	15/16	16/17	Aug-16	Sep	Q2	Oct	Nov	Dec	Q3	Jan-17	Feb	Mar	Q4	Apr	May	Jun	Q1	Jul	Aug-17	YTD	Target	Threshold
NHS Improvement (NHSI) – overall segment score																						
Segment score	New	2	*Introduced from October 2016*			1				2	2	2		in arrears							1	2
Operational performance																						
A&E maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge	94.7%	91.6%	88.5%	95.9%		94.9%	91.3%	88.7%		84.7%	91.2%	91.4%		92.3%	90.2%	91.3%		91.5%	90.4%		Trajectory	None
A&E maximum waiting time of 4 hours - trajectory	New	New	94.7%	94.0%		94.5%	95.0%	95.0%		94.2%	95.0%	95.0%		90.0%	90.0%	90.0%		91.47%	91.47%		Q1=90%, Q2=91.47%, Q3=91.65%, Mar 2018 = 95%	None
Maximum time of 18 weeks from point of referral to treatment (RTT) − patients on an incomplete pathway	93.3%	92.6%	91.7%	92.6%		92.7%	93.4%	92.2%		92.5%	92.2%	92.5%		92.2%	93.2%	92.8%		92.9%	92.3%		>=92%	None
Maximum 62-day wait for first treatment from urgent GP referral for all suspected cancers	88.7%	89.9%	93.1%	87.5%		85.4%	90.3%	92.6%		87.9%	89.0%	91.0%		90.2%	92.6%	92.8%		95.7%	in arrears		>=85%	None
Maximum 6-week wait for diagnostic procedures	0.8%	0.4%	0.4%	0.3%		0.3%	0.4%	0.3%		2.3%	0.8%	0.4%		0.7%	0.4%	0.4%		0.4%	0.4%	0.5%	<=1.0%	None

	Year to Date (Month 05)				Forecast Outturn			
	Plan	Actual	Target	Threshold	Plan	Actual	Target	Threshold
NHS Improvement's score for financial performance								
Use of resources score (1 - 4)	1	1	1	2	1	1	1	2

Key messages – by exception (1)

Domain	Key points	Action taken
Safe	**C.difficile rate** ▪ In August there were six cases; one was at FPH and five were at HWP. One HWP case was agreed to have a lapse in care related to a delay in commencing C.difficile treatment ▪ As there were two cases in August on the same HWP ward this indicates a "period of Increased Incidence" **MRSA bacteraemia** ▪ There was one case of MRSA in August at HWP, the root cause is unknown and no lapse of care was identified **SEPSIS CQUIN identification and treatment** ▪ See CQUINs – Key messages **Never events and Serious Incidents Requiring Investigation (SIRIs)** ▪ There has ben one never event reported (wrong site surgery) on the FPH site ▪ There were 14 serious incidents requiring investigation (SIRIs) reported in August (11 at HWP and 3 at FPH), the highest number in one month **Safe staffing** ▪ Reported overall staffing level compliance was above the 90% target, at 92.5% for August 2017 across the trust ▪ The overall Trust performance is lower than for previous months, but the YTD average (Jan-Aug 2017) is 94.2% ▪ Overall staffing levels were reported as 93.9% at FPH, 91% at WX and 88.9% at HH ▪ Registered Nurse (RN) day fill rate for FHFT fell to 88.1% in August 2017 with RN night fill rate at 93.5%. RN day fill rate % was noted to be <90% at all three sites ▪ The August bank fill rate fell overall for the Trust to 67.51% for FPH and 37.92% for HW. This is a noted annual occurrence during summer school holiday period	**C.difficile rate** ▪ Local ownership is required at ward level to ensure a continued improvement in hand hygiene ▪ Departmental managers have been reminded to ensure staff are booked to attend mandatory Annual Infection Control Training ▪ Extra training sessions will be provided (also weekends/out of hours) ▪ A consultant has been identified to discuss the case where a lapse in care has been identified at a Board meeting ▪ Enhanced auditing and cleaning of the HWP ward with a "period of Increased Incidence" in line with DoH guidelines **SEPSIS CQUIN identification and treatment** ▪ See CQUINs – Key messages **Never events and Serious Incidents Requiring Investigation (SIRIs)** ▪ Each incident will be subject to a Root Cause Analysis ▪ Key messages will be included in the safety newsletters ▪ Patient safety team have introduced safety snippets which contain key messages to all clinical teams at the time of the incident for immediate learning and raising awareness **Safe staffing** ▪ Mitigating actions were taken at the time of any shortfall of staffing levels across the trust, with areas escalating any staffing concerns through the Red Flag escalation process or through to a Senior Nurse ▪ There are no direct indications of the lower-than-planned actual nursing hours adversely affecting patient safety, however quality of care was reported to have been compromised in some Datix reports ▪ Agency usage at HWP rose in the month of August to assist with the staffing gaps. The higher percentage of unfilled temporary staff shifts directly affected the overall reported RN compliance. This was due to the reliance in some areas on temporary staffing and the increased demand of shifts requested over the Summer period. We are awaiting new starters (NQN/M) to commence employment in October and November 2017

Key messages – by exception (2)

Domain	Key points	Action taken
Effective	**Emergency readmissions** ▪ Emergency readmissions following an elective or emergency spell continue to flag red, although they have reduced from 7.6% in June to 7.0% in July ▪ The rates are 6.5% at FPH and 7.4% at HWP respectively ▪ HWP has shown a good improvements since last month when the rate was 9.1%	**Emergency readmissions** ▪ Analysis has taken place of the readmissions on the HWP sites to assess the readmissions by wards and specialty. The view is that the data is accurate and reflects the true situation ▪ The trust continues to review the readmissions at specialty level in the specialty dashboards. Readmissions can be for unrelated treatment but are still included in readmission rate calculations
	Complaints received; response rate; number re-opened ▪ 75 complaints were received in July and 11 complaints were re-opened. The increase at WPH is partly due to an intentional focus in PALs of appropriately escalating more serious concerns to formal complaints ▪ Response rates continue to improve, with 30% of cases that exceeded the 25 days KPI completed within 30 days	**Complaints received; response rate; number re-opened** ▪ Continued focus in PALs in relation to appropriate escalation of serious concerns through the formal complaints process ▪ Response rates progress will be maintained to ensure timely responses and avoid a backlog
Caring	**Noise at Night** ▪ 89% of patient were bothered by noise at night from staff and 72% were bothered by noise at night from other patients	**Noise at Night** ▪ There continues to be focused work through the patient experience forum with ward and directorate action plans ▪ Eye masks and ear plugs are now available across the trust
	Maternity friends and family test (for those giving birth at the trust) ▪ For August the response rate was 94.6% (year to date 97.5%)	**Maternity friends and family test (for those giving birth at the trust)** ▪ The refurbishment of the labour ward on HWP site is of significance and continues to impact on patient experience
	Mixed sex accommodation ▪ A bay was mixed in Emergency Department Observation Unit (EDOU) due to severe capacity issues, compounded by a closure of the Emergency Department at RSCH ▪ Head of Nursing for Emergency & Cardiovascular Medicine confirmed with the nurse in charge of EDOU that patients were informed and all agreed to go into a mixed bay ▪ Head of Nursing confirmed with one of the patients that they were asked if they were happy to go into the mixed bay before being moved and she had no issue with it	**Mixed sex accommodation** ▪ Patients were appropriately grouped and the curtains were pulled in a manner to maintain privacy & dignity ▪ An incident form was completed, and the mix was agreed by the Emergency Department Consultant and nurse in charge, and the mix was also reported in the morning bed report ▪ Any proposal to create a mixed sex area must now be escalated via the administrator on call, and requires Director on Call agreement before an area can be mixed

Key messages – by exception (3)

Domain	Key points	Action taken
Responsive	▪ **A&E four-hour target** ▪ HWP has shown an improvement in month achieving over 91% for first time in over 6 months. The focus is now on sustaining progress and making further improvement ▪ FPH improved from 91.7% in July to 93% in August however meeting the target still remains a challenge **Delayed transfers of care (DTOCs)** ▪ Overall the percentage of bed days occupied by delayed patients has risen to 6.1% from 5.1% last month ▪ At FPH there are four on-going issues: Domiciliary capacity Placement/capacity Continuing Healthcare (CHC) Patient/family choice	▪ **A&E four-hour target** ▪ There has been a medical rota review, with changes in place from October to increase senior decision makers on shift ▪ Medical model; an acute physician presence in A&E has been implemented, and the pathway for GP referrals and acute medical patients is under review ▪ At FPH, recruitment and retention of all staff remains the key focus to ensure rota management is as effective as possible ▪ FPH continue to have shifts with additional Emergency Nurse Practitioners (ENPs) and increased overnight cover **Delayed transfers of care (DTOCs)** ▪ HWP – Housing delays and patient choice 'Self funders' delays continue, ongoing work with local councils & care homes ▪ Domiciliary care in south Buckinghamshire continue with capacity blockage – weekly resilience continue ▪ The "7 Pillar hospital-to-home" framework is in progress with the setup of the HWP Integrated Hub (IRIS) ▪ FPH are taking the following actions: ▪ Hants Social Services (SS) aims to maximise the use of short term beds and plans to have a joint approach with the Discharge Team; reablement beds are now offered to the community to create capacity in the acute ▪ Surrey SS – a new contract for existing care providers has been renewed from October with new guidelines/expectations; a meeting with all providers is planned for September; they plan to keep packages of care (POCs) open for two weeks when patients are re-admitted; and electronic sourcing of POCs is now available for both SS and health ▪ Bracknell SS has contracted 20 beds in a new care home; and are piloting the "Discharge to Assess" model to improve the process ▪ Hampshire CHC are looking to recruit more staff ▪ There is an on-going workshop with Surrey CHC and SS to improve the process ▪ Protocol of choice letters are pro-actively being issued and we are working jointly with SS and health to manage expectations

Key messages – by exception (4)

Domain	Key points	Action taken
Well-led (Workforce)	**Vacancy rate for nurses** ▪ Nurse recruitment remains a key risk. Despite all attempts, nurse recruitment has decreased by 30% and this is impacting on our ability to fill key vacancies.	**Vacancy rate for nurses** ▪ We have increased the number of international recruitment agencies we are working with in order to improve supply from overseas. ▪ All wards have been asked to produce a local Recruitment and Retention Action plan and HR are providing support to high risk areas. ▪ Review of the Trust retention rate and how we improve this figure
	Appraisal rate (non-medical staff) ▪ Appraisal rates have increased, although still remain below target. Appraisal status is also included on the MAST training system for staff and managers easily to identify where appraisals are due.	**Appraisal (non-medical staff)** ▪ Monthly appraisal compliance reports are being run by the workforce information team; HR Business Partners and the Learning & Organisational Development team are using this information to target areas of concern
Well-led (Efficiency)	▪ No exceptions to report	

Key messages – by exception (5)

Domain	Key points	Risks
	In summary, for month 05 the trust is on plan at £2.3m deficit (excluding sustainability and transformation fund (STF)) and £4.7m behind YTD. The YTD deficit has turned to a surplus due to the one-off exceptional items booked in month 03 (stock £4.7m and £0.7m donated asset). The forecast has been adjusted down due to the risk expected on the A&E element of the STF of £2.8m. This will not impact on achievement of the control total BUT the underlying position, particularly on pay, remains at significant risk due to the lack of reduction in cost base	
Well-led (Finance)	**Income** ▪ Clinical income is above plan, but there remains a very high level of uncoded episodes this month (£18m). Other income is above plan driven by overseas visitors income but YTD remains behind by circa £1.6m mainly in the private patients' unit (£500k) and corporate income (£0.8m)	▪ Uncoded episodes may not lead to over-performance income when resolved ▪ Other income is significantly below plan YTD
	Expenditure ▪ Operational spend YTD is ££2.6m over plan of £252m (excluding integration funding) due mainly to high pay costs (medical agency and ad-hoc sessions). Pay costs were overspent in-month, but agency spend held around £2m. Integration and transaction spend is £2.3m YTD which has been matched to income on a spend-recover basis	▪ Underlying costs significantly higher than plan ▪ Urgent recovery action planning required
	Net surplus/deficit ▪ The trust is £4.7m adverse YTD against its set budget ▪ One-off exceptional items mean the trust is showing a positive variance on the bottom line ▪ Sustainability and transformation funding (STF) achieved £1.2m for month 05 because of the one-off benefits booked in month 03, but has been adjusted for Q3-4 for the A&E element	▪ CIP recovery, due mainly to start in month 06, must deliver for the trust to achieve its plans

Safe - Key measures (1)

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Infection control																		
Clostridium difficile *	41	33	3	3	5	4	2	4	2	2	3	1	5	4	6	19	None	None
Clostridium difficile due to lapses in care	13	4	0	1	1	1	0	0	0	0	0	0	0	0	2	2	<=31	None
Clostridium Difficile - infection rate per 100,000 bed days			8.18	8.45	13.63	14.09	5.45	10.91	6.04	5.45	8.45	2.73	14.09	10.91	16.36		<=7.60	>10.40
MRSA Bacteraemia	2	2	0	0	0	0	0	0	0	1	0	0	1	0	1	2	0	None
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rate	New	New																
Medication errors resulting in harm																		
Low	56	22	1	2	2	2	1	1	4	1	2	0	2	2	in arrears	6	None	
Moderate *	4	8	0	0	1	0	0	1	0	1	1	1	0	0	in arrears	2	<=42	None
Severe *	0	0	0	0	0	0	0	0	0	0	0	0	0	0	in arrears	0	0	None
Pressure ulcer incidence																		
Hospital acquired - grade 2 *	143	169	12	10	13	18	18	21	16	21	20	18	21	17	in arrears	76	<=216	None
Hospital acquired - grade 3 *	6	5	0	1	0	0	0	2	1	1	0	2	0	1	in arrears	3	<=12	None
Hospital acquired - grade 4 *	0	0	0	0	0	0	0	0	0	0	0	0	0	0	in arrears	0	0	None
Community acquired - lapses in care											1	0	0	0	in arrears	1	TBC	TBC
Incident reporting																		
Never events	6	4	0	0	0	0	0	1	0	0	1	0	1	1	1	4	0	None
Serious incidents requiring investigation (SIRI) (total trust incl Fleet) * **	73	70	5	4	5	5	8	11	3	7	3	11	12	6	14	46	<=90	>96
Fleet community services SIRIs											1	0	0	1	0	2	TBC	TBC
Potential under-reporting of patient safety incidents (definition TBC)			27.2		30.7						Bi-annual published data						>=44.9	<34.5
NHS England/NHS Improvement Patient Safety Alerts outstanding		0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	None
Incidents triggering a duty of candour response	New	96	6	5	8	6	12	12	6	9	10	13	8	10	in arrears	41	TBC	TBC
Failure to notify of a suspected or actual reportable patient safety incident	New	0	0	0	0	0	0	0	0	0	0	0	0	0	in arrears	0	0	None
Falls resulting in significant injury																		
Number of falls *	28	20	2	2	2	0	1	4	1	2	1	3	3	2	1	10	<=37	None
Number of falls per 1000 bed days	0.06	0.04	0.05	0.05	0.05	0.00	0.03	0.10	0.03	0.05	0.03	0.08	0.08	0.05	0.03	0.05	TBC	
Safe staffing - hours filled as planned																		
Registered nurse day		92%	92%	93%	93%	95%	93%	92%	90%	89%	88%	91%	90%	90%	88%	89%	>=90%	None
Unregistered care staff day		96%	92%	95%	96%	96%	94%	98%	95%	95%	95%	98%	98%	98%	95%	97%	>=90%	None
Registered nurse night		96%	94%	97%	97%	98%	97%	98%	96%	94%	94%	96%	96%	96%	94%	95%	>=90%	None
Unregistered care staff night		100%	97%	98%	98%	99%	98%	100%	97%	96%	96%	99%	99%	99%	98%	99%	>=90%	None

** monthly targets are as follows: TBC*

*** retrospective data for Fleet community services to be added to create a new trust total for SIRIs. Fleet community services were transferred under FHFT from January 2017*

Safe - Key measures (2)

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
VTE (venous thromboembolism) risk assessment																		
Admitted adult patients who have been risk assessed for VTE	98%	97%	97%	97%	98%	98%	97%	98%	98%	98%	98%	98%	97%	98%	in arrears	97%	>=95%	None
Delivering a 7-day service																		
Emergency admissions reviewed by a consultant within 14 hours of admission	New		Bi-annual audit data	89%								in arrears					TBC	
Access to diagnostics *	New			78%								in arrears					TBC	
Access to consultant-directed interventions *	New			82%								in arrears					TBC	
Twice daily consultant reviews for high acuity areas *	New			90%								in arrears					TBC	
Sepsis CQUIN - Timely identification of Sepsis in emergency department (ED) and acute inpatient settings																		
The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	New	78%	75%	78%	78%	82%	79%	81%	81%	80%	69%	65%	67%		Available quarterly		>=90%	None
Sepsis CQUIN – Timely treatment of Sepsis in emergency department (ED) and acute inpatient settings																		
The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	New	75%	78%	68%	73%	73%	78%	78%	78%	83%	52%	63%	67%		Available quarterly		>=90%	None
Sepsis CQUIN – Antibiotic Review																		
% of antibiotic prescriptions for patients diagnosed with sepsis that were documented and reviewed by a clinician within 72 hours												82%					Q1 >=25% Q2 >=50% Q3 >=75% Q4 >=90%	
Reduction in antibiotic consumption per 1,000 admissions												4828 baseline					TBC	
Reduction in total consumption of carbapenem per 1,000 admissions																	TBC	
Reduction in total consumption of piperacillin-tazobactam per 1,000 admissions																	TBC	

** Audit data to be treated with caution due to loose national definitions and the use of questions that were open to interpretation*

Safe – Other CQUINS 2017/18 (1)

	15/16	16/17	Apr-17	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan-18	Feb	Mar-18	Q4	YTD	Target	Threshold
Improving Staff Health and Wellbeing																					
Staff Survey Question : Does your organisation take positive action on Health and Wellbeing		33%	Improvement plans to be in place								Improvement plans to be in place									>35%	None
Staff Survey Question : In the last 12months have you experienced musculoskeletal problems (negative response measured)		76%	Improvement plans to be in place							Staff survey for 2017 to go live	Improvement plans to be in place					Staff survey due to be reported	Review for 2018 requirement			>78%	None
Staff Survey Question : During the last 12 months have you felt unwell as a result of work related stress (negative response measured)		69%	Improvement plans to be in place								Improvement plans to be in place									>71%	None
Healthy Food – changes to food and drink provision																					
Percentage of drink lines stocked that are sugar-free		New				Due				Due				Due				Due		>=70%	None
Percentage of confectionary and sweets stocked that do not exceed 250 calories		New				Due				Due				Due				Due		>=60%	None
Percentage of pre-packed sandwiches and other savoury pre-packed meals that contain less than 400 calories		New				Due				Due				Due				Due		>=60%	None
Improving the uptake of 'flu vaccinations for Frontline Clinical Staff																					
Cumulative uptake of 'flu vaccination by frontline staff		38.5%	Launch of 'flu campaign				Launch of 'flu campaign				Due	Due	Due		Due	Due	Due			>70%	None
NHS e-Referral System (e-RS)																					
% of referrals to first outpatient services able to be received through e-RS		New				Due				Due				Due				Due		Q2 >=80% Q3 >=90% Q4 =100%	None
Appointment slot issue (ASI) reduction		New				25%	28%													<=4% by Q4	None

Safe - Other CQUINS 2017/18 (2)

	15/16	16/17	Apr-17	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan-18	Feb	Mar-18	Q4	YTD	Target	Threshold
Advice and Guidance																					
Advice and Guidance Services to be in place for services agreed with CCG and be operational to cover at least 35% of total GP referrals		New	Agree specialities, trajectories, timetable and implementation plan												Advice and guidance services to be operational from Jan-18					>=35% by Jan-18	None
Provide asynchronous responses within 2 working days		New	Agree local quality standard for provision of responses																	>=80%	None
Supporting Safe Proactive Discharge																					
Increase the number of patients discharged to usual place of residence (applicable to patients aged 65yrs and above)		New	Map and streamline existing discharge pathways across acute, community and NHS care home settings – roll out protocols in partnership across local whole systems. Deliver and agree with commissioners a plan, baseline and trajectories to reflect impact of local initiatives agreed																	Q3, Q4 2.5% point increase	None
Implement Emergency Care Data Set (ECDS)		New	Demonstrate credible planning to evidence that the ECDS can be collected and returned from 01/10/2017								Return data weekly and ensure 95% of patients have valid chief complaint and diagnosis									Q3 >=95%	None
Improving services for people with mental health needs																					
Reduce by 20% the number of attendances to emergency department (ED) for those within a selected cohort of frequent attenders		New	Identify and agree cohort. Review and develop care plan for each person with the patient and other relevant care organisations																	20% reduction in ED attendances within selected cohort	None
Improve Mental Health need coding data		New					Conduct internal audit of ED mental Health Coding. Agree data quality improvement plan				Review progress against data quality improvement plan and confirm systems are in place to ensure ED HES data submissions are correct									None	None

Safe – CQUINS – key messages

Area	Key points	Action taken
Sepsis and antimicrobial resistance (AMR)	**Sepsis** ▪ Use of sepsis screening tool remains a challenge ▪ New sepsis guidance released 13th September which requires local interpretation and Trust wide agreement on the way forward. **AMR** ▪ Review of antibiotics within 72 hours ▪ CQUIN target met for Q1 and on track for meeting Q2 target	▪ Training has been increased for all staff ▪ The availability of bundles has been standardised across wards ▪ Sepsis bundle packs and awareness information is attached to all observation machines ▪ Performance has been discussed at the Nursing & Midwifery Board, the Quality Committee and the weekly performance meeting ▪ AMR Q1 data shared with Consultants
Health and Wellbeing	▪ Staff survey – the improvement plan is in place ▪ Healthy food – On track to achieve Q4 targets ▪ 'Flu vaccination – Campaign launched. Peer vaccinators in place, regular Flu clinics running led by occupational health.	▪ Numerous Health and Wellbeing initiatives are in place to support staff in terms of physical and mental health; all are advertised on the intranet ▪ 'Flu vaccination – communications circulated and vaccine in place.
NHS e-Referrals	▪ Q1 CQUIN requirement met ▪ October 1st 'go live' for Haematology, Urology, Obstetrics & Gynaecology, Plastics and Respiratory ▪ The appointment slot issue (ASI) level remains high ▪ IT issues regarding Smartcards and printers have been resolved	▪ Extra resource employed to ensure Consultants have smartcards ▪ Each speciality tasked with reducing ASI ▪ Internal and External e-Referrals meetings embedded and implementation plans are in place
Advice and Guidance	▪ The specialities and timetable have been agreed ▪ CCG is to set up a local quality standard for agreement with the trust ▪ A 2-day turnaround for asynchronous responses via e-Referrals will be challenging	▪ The project will be managed via the e-Referrals project group
Supporting Proactive and Safe Discharge	▪ Site specific workstreams set up under the umbrella of the Urgent Care Board to deliver the 7 pillars ▪ Emergency Care Data Set (ECDS) – phased implementation in accordance with the CQUIN. HWPH site delayed target date, now agreed as December ▪ The system supplier has been engaged with to understand the delivery timeline ▪ Individual departmental meetings with stakeholders are planned	▪ Emergency Care Data Set (ECDS) implementation plan has been written ▪ Commissioners informed of delay (due to supplier issues) ▪ Starting to plan soft launches of ECDS for Element 2 (chief complaint and diagnosis) ▪ Performing a gap analysis for elements 3-6 of this CQUIN
Improving Mental Health	▪ Q1 met. However the intensity of work and resources required to deliver CQUIN requirements is enormous	▪ Governance arrangements implemented ▪ Meetings in place with Mental Health Trusts and other Multi-Disciplinary Team (MDT) providers of care ▪ Cohort agreed and attendance trackers in place

Effective - Mortality and morbidity – key measures & messages

In-hospital mortality and summary hospital-level mortality indicator (SHMI)

In-hospital mortality (one month's data)

	16/17	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	YTD
In-hospital deaths	2640	204	189	195	234	239	285	244	193	209	217	206	185	201	1018
Discharges	212501	17003	18338	17997	18943	17006	17822	16300	18629	16140	18408	17588	17570	16968	86674
% deaths	1.2	1.2	1.0	1.1	1.2	1.4	1.6	1.5	1.0	1.3	1.2	1.2	1.1	1.2	1.2

SHMI (rolling 12 months)

	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
Overall	**93.3**	**93.4**	**92.9**	**92.6**	**91.3**	**91.0**	**90.9**	**91.2**	**91.4**	**91.0**	**88.9**	**87.9**	**87.4**
Non-elective	93.3	93.3	92.7	92.6	91.1	90.7	90.5	90.8	91.0	90.5	88.5	87.3	86.9
Elective	92.6	100.3	99.2	94.8	100.0	103.4	108.8	109.3	110.7	112.9	110.5	118.4	117.9

KEY:	Higher than expected	Within expected range : 90 - 110 (overall and non-elective) 70 - 130 (elective)	Lower than expected

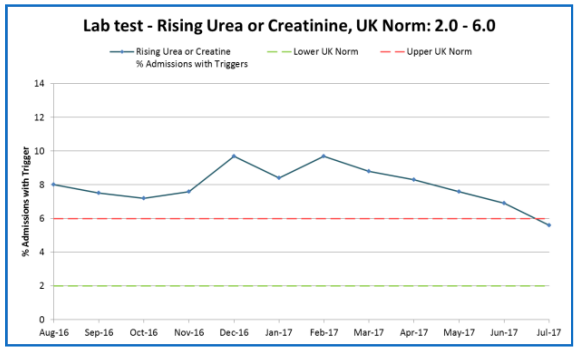
	15/16	16/17	Jul-16	Aug	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul-17	YTD	Target	Threshold
Potentially avoidable deaths																		
Total deaths reviewed		New													In arrears		None	
Case-notes screened		New													In arrears		None	
Deeper review		New					This will be published from October 2017								In arrears		None	
Total number of deaths considered to have been potentially avoidable where RCP score <=3 (definitely, strong evidence or probably avoidable)		New													In arrears		TBC	

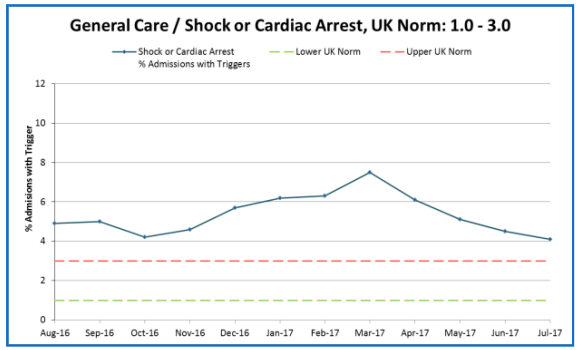
Key messages

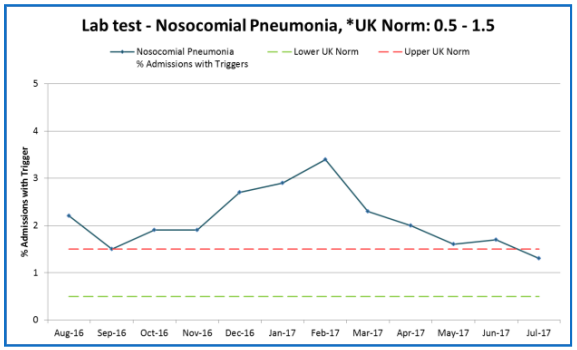
Area	Key points	Action taken
Mortality	▪ Trust wide emergency SHMI is as or below expected levels ▪ Elective SHMI is higher, this effect is from HWP. ▪ Deaths of elective patients are all investigated under the Serious Incidents Requiring Investigation (SIRI) or mortality review process and learning is disseminated	▪ Continued monitoring
Potentially avoidable deaths	This data will be published from October 2017	

Effective – CRAB morbidity – key measures & messages

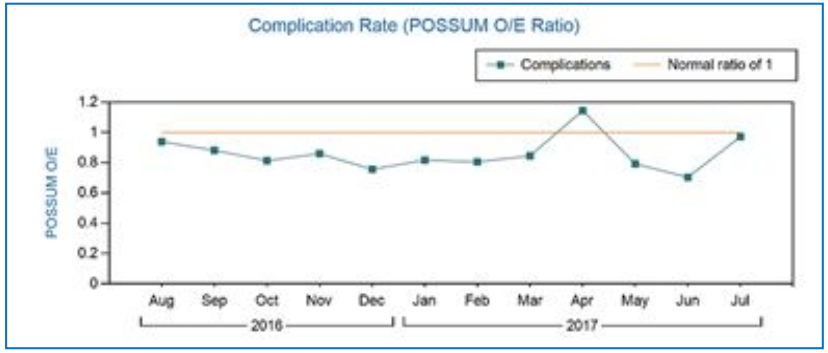
Medical practice trigger trends *

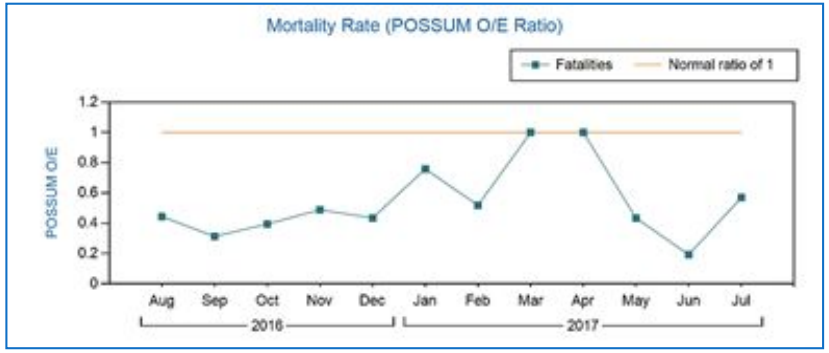






Surgical complications *





Key messages

Area	Key points	Action taken
	▪ All medical triggers in the trust continue to improve.	▪ The Mortality Surveillance Group (MSG) are discussing plans to prevent an increase in the winter months.
CRAB data	▪ Surgical morbidity and mortality remain at or below expected levels	▪ Continued monitoring and triangulation with the retrospective case record review (RCRR)

**The final data point may be subject to change due to late reported data*

Effective - Clinical performance measures

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Stroke *																		
% of patients admitted directly to the stroke unit in 4 hours	66%	72%	68%	70%	78%	82%	68%	55%	83%	80%	84%	76%	78%	83%	79%	80%	>=80%	<72%
% of patients scanned within 1 hour of arrival	58%	64%	66%	47%	59%	71%	63%	69%	71%	71%	69%	76%	66%	52%	50%	63%	>=50%	<45%
% of patients receiving a swallow screen within 4 hours of arrival	75%	81%	73%	70%	81%	89%	63%	84%	87%	86%	80%	80%	82%	77%	89%	81%	>=90%	<80%
Cardiology																		
% of eligible patients receive treatment; call to balloon within 150 minutes	93%	92%	90%	94%	93%	96%	86%	90%	90%	92%	96%	95%	100%	94%	in arrears	96%	>=85%	<80%
Trauma and orthopaedics																		
% fractured neck of femur patients meeting best practice criteria	87%	83%	74%	73%	65%	83%	74%	77%	82%	80%	61%	74%	80%	71%	in arrears	71%	>=65%	<55%
% fractured neck of femur patients going to theatre within 36 hours	87%		79%	75%	81%	89%	85%	90%	90%	91%	74%	86%	89%	77%	in arrears	81%	>=90%	<80%
Critical care																		
Critical care non-clinical transfers out of the trust	New	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	None
Theatres																		
Compliance with the WHO surgical safety checklist	New	99%	100%	99%	98%	99%	99%	98%	98%	98%	98%	98%	99%	99%	99%	99%	>=95%	<90%
Obstetrics																		
Caesarean section rate (planned & unscheduled)	26%	26.9 %	23%	27%	25%	27%	32%	28%	27%	29%	27%	29%	30%	27%	26%	28%	<=25%	>27%
Emergency C-section rate	New	14%	11%	14%	12%	15%	17%	14%	13%	16%	13%	15%	15%	14%	13%	14%	<=14.0%	>15.0%
Still births over 24 weeks	New	41	3	5	2	2	4	4	4	6	4	1	3	2	3	13	None	None
Emergency readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.0%	6.9%	7.1%	6.7%	6.5%	6.7%	7.1%	6.5%	7.2%	6.5%	7.1%	7.2%	7.6%	7.0%	in arrears	7.2%	<=6.8%	None

* *Stroke data is for FPH only as the unit at Wexham Park was decommissioned during 2016/17*

Caring - Key measures (1)

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Local Surveys *																		
1. Overall did you feel you were treated with respect and dignity while you were in this ward?	96%	96%	96%	96%	97%	97%	96%	97%	96%	97%	97%	97%	98%	96%	97%	97%	>=95%	<90%
2. Do you have confidence and trust in the doctors treating you?	92%	93%	92%	93%	91%	93%	91%	92%	93%	93%	93%	93%	95%	92%	94%	94%	>=95%	<90%
3. Were you bothered by noise at night from hospital staff? (percentage of patients saying no)	87%	87%	87%	87%	87%	87%	88%	90%	86%	87%	85%	88%	87%	89%	88%	87%	>=90%	<80%
4. Were you ever bothered by noise at night from other patients? (percentage of patients saying no)	69%	66%	68%	67%	67%	65%	59%	65%	63%	69%	77%	70%	73%	72%	67%	70%	>=80%	<70%
5. If you needed it, did you get enough help from staff with eating and drinking?	88%	90%	88%	91%	89%	93%	92%	90%	88%	92%	92%	90%	95%	90%	95%	93%	>=90%	<80%
6. Have you and your family or carers been involved enough in discussing your discharge from hospital?	70%	82%	83%	84%	84%	84%	85%	77%	83%	86%	84%	85%	88%	84%	84%	85%	>=80%	<70%
7. Were you involved as much as you wanted to be in decisions about your care and treatment? ****	New	92%	90%	93%	91%	91%	92%	91%	92%	92%	86%	87%	90%	84%	88%	87%	>=90%	<80%
8. Within the first couple of days of admission did a member of staff ask you about your home situation?	New	83%	81%	84%	80%	82%	86%	83%	86%	86%	84%	87%	86%	88%	88%	87%	>=80%	<70%
9. Did nurses talk in front of you as if you weren't there? (percentage of patients saying no)	New	New									89%	92%	94%	92%	95%	93%	>=95%	<85%
10. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	New	New									86%	94%	93%	98%	95%	94%	>=95%	<90%
Complaints																		
Number of complaints received ** ***	765	920	87	95	81	82	64	75	71	49	63	70	80	75	94	382	<=77	>88
Number of complaints per 100 patient contacts	0.00	0.07	0.08	0.08	0.08	0.07	0.07	0.08	0.07	0.04	0.06	0.06	0.07	0.07	0.09	0.07	<=0.07	>0.09
% of complaints answered within 25 working days	60%	37%	40%	29%	27%	29%	46%	33%	29%	8%	47%	64%	55%	48%	in arrears	54%	>85%	<70%
Number of complaints re-opened	71	97	9	14	2	8	10	5	11	9	2	12	11	11	13	49	<=8	>9

** Note all targets and thresholds have been reviewed and made more challenging for 2017/18, but have been applied retrospectively to 2016/17 as well*
*** provisional data for the reporting month*
**** Annual targets are as follows: Number of complaints (923)*
***** Note – this question last year was "Did the doctors clearly explain the treatment plan?"*

Caring - Key measures (2)

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Patient Friends and Family Scores - What % would recommend this trust to friends and family if they needed similar care or treatment?																		
Emergency department - % positive		91.1%	89.3%	90.1%	90.3%	91.0%	89.2%	91.5%	92.4%	93.1%	94.2%	94.5%	94.0%	91.3%	92.3%	93.3%	>=94.4%	<89.1%
Outpatients - % positive		95.9%	95.9%	95.3%	94.8%	96.3%	96.5%	95.5%	95.6%	96.4%	95.6%	96.2%	97.1%	96.5%	96.1%	96.3%	>=96.8%	<94.6%
Inpatients - % positive		97.4%	97.8%	97.0%	97.3%	97.5%	97.2%	97.1%	97.4%	97.6%	98.0%	97.7%	97.5%	97.3%	97.9%	97.7%	>=97.7%	<96.4%
Maternity - % positive (of those giving birth here)		96.7%	96.2%	96.6%	98.3%	97.5%	95.3%	95.1%	95.3%	95.6%	97.5%	95.4%	98.4%	97.5%	94.3%	96.9%	>=99.0%	<97.9%
Community - % positive											98.8%	98.6%	100%	100%	90.9%	97.9%	>=98.3%	<97.0%
CQC inpatient survey																		
Overall satisfaction out of 10 (Q72)			8.30													8.30	>=8.40	<7.99
Mixed sex accommodation breaches																		
Mixed sex accommodation breaches		6	0	0	0	0	0	6	0	0	0	0	0	0	6	6	0	None
Dementia care - % of all admitted patients (75+) who :																		
Have been screened for Dementia (within 72 hours)	95%		94%	95%	94%	97%	96%	97%	99%	99%	99%	99%	100%	99%	In arrears	100%	>=90%	None
Scored positively on the dementia screening tool that then received a dementia diagnostic assessment (within 72 hours)	97%		96%	95%	95%	89%	97%	96%	96%	100%	100%	100%	100%	100%	In arrears	100%	>=90%	None
Received a dementia diagnostic assessment with a "positive" or "inconclusive" outcome that were then referred for further diagnostic advice/follow up (within 72 hours)	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	In arrears	100%	>=90%	None

Responsive - Key measures

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Diagnostics																		
Diagnostics waiting 6 weeks and over	87	49	35	35	35	42	27	224	87	49	76	40	40	44	48	248	None	
% waiting 6 weeks and over for a diagnostic procedure	0.8%	0.4%	0.4%	0.3%	0.3%	0.4%	0.3%	2.3%	0.8%	0.4%	0.7%	0.4%	0.4%	0.4%	0.4%	0.5%	<=1.0%	None
Referral to treatment (RTT)																		
% waiting within 18 weeks	93.3%	92.6%	91.7%	92.6%	92.7%	93.4%	92.2%	92.5%	92.2%	92.5%	92.2%	93.2%	92.8%	92.9%	92.3%		>=92.0%	None
Incomplete waiting list – Total	35470	36093	35999	35553	35611	34879	34787	34430	35470	36093	36097	36694	36772	36587	37031			
Incomplete waiting list – Admitted	8145	7727	9231	9083	9410	9182	8485	8294	8145	7727	7976	7904	8099	8407	8364			
Incomplete waiting list – Non-admitted	27325	28366	26768	26470	26201	25697	26302	26136	27325	28366	28121	28790	28673	28180	28667			
Waiting 18 weeks and over (backlog)	2775	2715	3003	2636	2585	2288	2697	2582	2775	2715	2812	2489	2729	2692	2833			
Waiting 35 weeks and over	160	149	93	103	157	132	164	153	160	149	136	136	156	141	124	693		
Waiting 52 weeks and over	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	None
Cancelled operations																		
Last minute cancelled operations for non-clinical reasons (% of elective admissions)	0.9%	0.9%	1.0%	0.6%	0.9%	0.9%	1.3%	1.1%	0.9%	0.7%	0.8%	0.8%	0.9%	1.1%	in arrears	0.9%	<=0.8%	>1.2%
% of cancelled patients admitted within 28 days	93.3%	91.5%	92.9%	87.0%	93.9%	92.3%	94.9%	92.5%	96.8%	79.2%	100%	95.0%	88.9%	89.5%	in arrears	92.7%	100%	<90%
Delayed transfers of care																		
% of bed days lost due to delays	3.5%	4.4%	3.7%	5.0%	4.5%	4.5%	4.5%	3.9%	4.6%	5.8%	4.5%	3.6%	4.3%	5.1%	6.1%	4.7%	<=3.5%	>4.0%
Number of patients delayed at the end of each month	305	395	63	59	61	63	53	72	60	65	55	53	66	64	74	312		
Emergency department																		
% admitted or discharged within 4 hours	94.7%	91.6%	88.5%	95.9%	94.9%	91.3%	88.7%	84.7%	91.2%	91.4%	92.3%	90.2%	91.3%	91.5%			>=95.0%	None
% of all ambulance handovers taking longer than 60 mins?	0.8%	1.2%	1.5%	1.3%	0.7%	1.1%	1.3%	2.1%	0.5%	0.3%	0.1%	0.5%	0.2%	0.5%	In arrears	0.3%	<=1.0%	>2.0%
Number of patients spending >12 hours from decision to admit to admission	12	4	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	None

Responsive – Cancer – Key measures

	Aug-16	Sep	Q2	Oct	Nov	Dec	Q3	Jan-17	Feb	Mar	Q4	Apr	May	Jun	Q1	Jul	Aug-17	Target
Cancer																		
2 week waits – urgent GP referrals	94.7%	95.3%	94.9%	95.2%	96.2%	96.3%	95.9%	95.6%	97.9%	96.8%	96.8%	95.6%	96.4%	96.4%	96.2%	96.8%	in arrears	>=93%
2 week waits - Breast symptomatic referrals	95.3%	99.4%	97.5%	95.7%	95.8%	96.8%	96.8%	97.2%	97.1%	97.0%	97.1%	95.8%	96.2%	95.7%	95.9%	97.5%	in arrears	>=93%
31 day wait for first treatment	98.0%	100%	99.3%	99.5%	100%	99.5%	99.7%	98.5%	100%	100%	99.5%	98.9%	99.2%	97.8%	98.6%	99.6%	in arrears	>=96%
31 day wait for second or subsequent treatment – Surgery	100%	93.3%	96.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96.9%	98.8%	100%	in arrears	>=94%
31 day wait for second or subsequent treatment – Anti-cancer drugs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	in arrears	>=98%
62 day wait for first treatment	93.1%	87.5%	89.7%	85.4%	90.3%	92.6%	89.7%	87.9%	89.0%	91.0%	89.3%	90.2%	92.6%	92.8%	91.9%	95.7%	in arrears	>=85%
62 day wait for screening patients	100%	100%	100%	100%	100%	100%	100%	95.9%	100%	100%	98.2%	100%	97.0%	97.1%	97.8%	94.2%	in arrears	>=90%

Responsive – Cancer 62-day waits standard by tumour group

	Aug-16	Sep	Q2	Oct	Nov	Dec	Q3	Jan-17	Feb	Mar	Q4	Apr	May	Jun	Q1	Jul	Aug-17	Target
Brain/CNS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	in arrears	>=85%
Breast	97.3%	100%	98.7% (76/77)	100%	100%	100%	100.0% (77.5/77.5)	100%	100%	100%	100% (65/65)	94.1%	100%	89.4%	94.7% (62.5/66)	100.0%		
Childrens	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
Gynaecological	100%	62.5%	77.8% (7/9)	80%	83.3%	50.0%	78.3% (9/11.5)	75.0%	100%	88.9%	91.3% (10.5/11.5)	77.8%	88.9%	100%	86.4% (9.5/11)	75.0%		
Haematological	100%	57.1%	77.1% (13.5/17.5)	70%	85.7%	100%	83.6% (23/27.5)	75.0%	76.5%	100%	81.8% (13.5/16.5)	90.9%	100%	100%	96.6% (28.5/29.5)	100.0%		
Head & Neck	76.9%	100%	83.3% (12.5/15)	0%	100%	66.7%	76.9% (5/6.5)	100%	100%	81.8%	88.2% (7.5/8.5)	100%	75.0%	100%	93.3% (7/7.5)	100.0%		
Lower GI	94.4%	93.5%	95.9% (35.5/37)	100%	100%	79.2%	93.0% (33/35.5)	100%	100%	89.2%	95.1% (39/41)	90.9%	84.6%	100%	92.1% (35/38)	93.3%		
Lung	100%	62.5%	90.9% (15/16.5)	64.7%	75.0%	90.0%	74.2% (11.5/15.5)	75.0%	100%	72.7%	82.6% (19/23)	75.0%	86.7%	86.7%	84.2% (16/19)	88.9%		
Sarcomas	100%	NA	100% (0.5/0.5)	100%	0.0%	NA	25.0% (0.5/2)	66.7%	100%	100%	83.3% (2.5/3)	100%	NA	100%	100% (1.5/1.5)	100.0%		
Skin	100%	100%	100% (80/80)	96.8%	100%	91.9%	97.1% (68/70)	96.4%	100%	96.9%	97.6% (82/84)	100%	92.3%	100%	96.9% (63.5/65.5)	100.0%		
Upper GI	92.3%	71.4%	67.4% (15.5/23)	88.2%	50.0%	87.5%	81.8% (13.5/16.5)	66.7%	100%	100%	81.6% (15.5/19)	66.7%	81.8%	90.9%	80.7% (23/28.5)	85.7%		
Urological	83.6%	81.9%	80.3% (75.5/94)	71.4%	82.4%	95.2%	83.3% (80/96)	84.0%	75.9%	82.6%	80.5% (93/115.5)	88.0%	94.7%	87.5%	90.5% (86/95)	96.6%		
Other	NA	100%	100% (3/3)	NA	100%	100%	100.0% (5/5)	0.0%	100%	0.0%	20.0% (0.5/2.5)	100%	NA	0.0%	66.7% (1/1.5)	100.0%		
Total	**93.1%**	**87.5%**	**89.7% (333.5/372)**	**85.4%**	**90.3%**	**92.6%**	**89.7% (325.5/361.5)**	**87.9%**	**89.0%**	**91.0%**	**89.3% (345.5/386.5)**	**90.2%**	**92.6%**	**92.8%**	**91.9% (332/361.5)**	**95.7%**		
Cancer – 62-day referral to treatment standard – over 104 day waiters																		
Number of patients waiting over 104 days	10	8		9	11	10		7	5	3		3	3	2		2	3	
% of patients waiting over 104 days	0.6%	0.5%		0.5%	0.6%	0.7%		0.5%	0.3%	0.2%		0.2%	0.2%	0.1%		0.1%	0.2%	0%

Half numbers are where a patient has been referred here for treatment from another provider or vice versa; the patient is shared between providers
The additional figures provided for the quarters are the number of patients treated within the 62-day standard out of the total number of patients treated for that tumour group

Well-led – Workforce Key measures (1)

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Staff numbers																		
Staff in post FTE	90182	93395	7677	7714	7802	7839	7831	7921	8003	8011	8062	8081	8066	8038	8079	N/A	None	
Vacancy FTE	11539	10096	1012	1009	816	757	797	801	609	649	706	779	867	819	922	N/A	None	
Starters FTE	1189	1564	83	159	175	97	81	225	192	94	118	87	71	115	311	702	None	
Leavers FTE	1135	1197	95	110	127	75	103	95	87	132	102	80	101	111	327	721	None	
Turnover																		
Turnover rate %	14.8%	14.6%	15.1%	14.8%	14.8%	14.5%	14.7%	14.4%	14.6%	15.0%	15.1%	15.7%	15.1%	14.9%	14.8%		<=14.5%	>15.0%
Nursing turnover rate %	16.9%	14.6%	14.9%	14.4%	14.4%	14.4%	14.4%	14.0%	14.3%	14.3%	14.6%	15.1%	15.0%	14.9%	14.8%		<=15.0%	>16.0%
Executive team turnover (definition TBC)	New	0	0	0	0	0	0	0	0	0	1	0	0	1	0	2	None	
Time to recruit																		
Time to recruit from date vacancy created to date of unconditional offer (days)	New	53.9	59.6	55.6	54.4	47.6	50	52.6	64.1	48.7	50.5	53.4	55.5	52.7	48.7		<=40	>50
Vacancy																		
Vacancy rate - total %	11.9%	10.2%	12.2%	11.9%	9.3%	9.2%	9.7%	9.8%	7.4%	8.8%	8.5%	9.3%	10.2%	9.7%	10.8%		<=11.5%	>13.0%
Vacancy rate – doctors % *	New	New			*												<=5.0% by Q3	>5.5%
Vacancy rate – nurses %	New	15.4%	15.9%	15.8%	14.6%	13.9%	13.9%	15.8%	15.3%	14.3%	14.0%	15.7%	17.1%	18.0%	17.7%		<=14.5% by Q3	>15.5%
Agency spend																		
Agency spend as % of pay bill	9.9%	7.7%	7.0%	6.9%	8.1%	7.2%	8.0%	8.4%	7.3%	6.3%	5.6%	5.7%	5.9%	6.0%	5.3%		<=8.0%	>10.0%
Agency spend – total (£000s) **	40705	30473	2293	2265	2679	2397	2626	2830	2483	2137	1886	1917	2036	2012	1789		<=1917	>2013
Agency - doctors (£000s) ***	17375	12656	828	1085	1234	995	1113	1333	1052	557	911	794	1018	958	792		<=898	>988
Agency - nurses (£000s)	13534	8490	622	598	615	617	556	724	582	619	604	465	406	485	492		None	
Agency - other (£000s)	9796	9327	843	582	830	785	957	773	849	961	371	658	612	569	505		None	
Sickness																		
Sickness absence rate %	3.0%	2.9%	2.5%	2.7%	3.1%	2.9%	3.2%	3.3%	3.0%	2.8%	2.9%	3.0%	2.9%	2.8%	2.9%		<=2.9%	>3.2%

** On-going reviews with finance are being undertaken to ensure the establishments reflect the actual position trust-wide; data will be available as soon as possible*
*** The agency spend total is a control target based on an annual total target of £23m or £1.917m per month*
**** Agency spend for doctors – the target is based on an overall reduction in spend of £1.88m for 2017/18*

Well-led – Workforce Key measures (2)

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Appraisal rates																		
Appraisal (non-medical) % *	N/A	N/A	75%			79%		48.4 %	48.8%	55.3 %	54.8%	56.2%	56.9%	58.2%	61.8%	N/A	>=80.0%	<70.0%
Appraisal (medical) %	N/A	N/A	95.4%	96.0%	95.8%	97.7%	97.4%	96.9%	97.2%	98.3%	98.6%	98.1%	97.2%	97.2%	98.1%	N/A	>=95.0%	<85.0%
Training																		
Statutory and mandatory training % **	N/A	N/A					52.9%	55.0%	62.3%	64.2%	66.7%	68.2%	68.9%	73.7%	72.8%	N/A	>=85.0%	<60.0%
Friends & family test for staff																		
% recommending here as a place to work	N/A	N/A	72%			67% ***			71%			73%		in arrears	in arrears		Q1, 2, 4 >=70% Q3 >= 66%	Q1, 2, 4 <62% Q3 <62%
% recommending here as a place for care	N/A	N/A	90%			77% ***			88%			89%		in arrears	in arrears		Q1, 2, 4 >=86% Q3 >=76%	Q1, 2, 4 <79% Q3 <70%
NHS staff survey																		
NHS staff survey - engagement score (definition TBC)	New	3.91	3.91														>=3.87	<3.79

** The data up to December 2016 has been taken from the staff friends and family test, where a question has been added to assess appraisals undertaken in the previous 12 months; data after this is sourced from the electronic staff record (ESR)*

*** Work continues to standardise the electronic staff record (ESR) trust-wide from which this data is taken*

**** Friends and family test (FFT) replaced by National Staff Survey in Q3; the question is worded slightly differently "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation". Note the target and threshold for Q3 is based on the National Staff Survey results; Q1, 2 and 4 are based on FFT results*

Well-led – Efficiency Key measures

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	Target	Threshold
Outpatients																		
Did not attend (DNA) rates	6.5%	6.8%	6.9%	7.0%	6.7%	6.9%	7.8%	7.3%	6.5%	6.3%	6.6%	6.8%	7.3%	7.4%	7.4%	7.1%	<=7.6%	>10.2%
Outpatient new to follow-up ratios	2.16	2.03	2.02	2.02	1.99	2.02	2.05	2.00	1.97	2.04	1.97	2.00	2.01	1.89	1.92	1.96	<=2.41	>3.59
Average length of stay																		
Elective length of stay	2.53	2.53	2.73	2.49	2.60	2.53	2.53	2.47	2.58	2.50	2.69	2.94	2.55	2.67	3.08	2.79	<=2.77	>3.59
Non-elective length of stay	4.10	4.07	4.32	4.00	3.84	3.96	4.01	4.20	4.28	4.19	4.25	4.10	4.14	3.99	3.98	4.09	<=3.91	>5.05
Day case rate																		
% day cases of all electives	81%	81%	82%	82%	82%	82%	81%	83%	82%	81%	81%	82%	82%	82%	82%	82%	>=80%	<70%
Pre-procedure bed days																		
Pre-procedure non-elective bed days	New	New																
Pre-procedure elective bed days	New	New																
Theatre utilisation																		
Intra-session theatre utilisation rate	73%	73%	73%	73%	74%	74%	73%	73%	74%	73%	75%	73%	74%	73%	71%	73%	>=85%	<70%

Well-led - Finance Key measures

	Year to Date (Month 05)					Forecast Outturn				
	Plan £m	Actual £m	Variance £m	Target	Threshold	Plan £m	Actual £m	Variance £m	Target	Threshold
Income	268.4	266.2	(2.2)	See EBITDA		657.6	653.3	(4.3)	See EBITDA	
Expenditure	251.4	248.6	2.8	See EBITDA		603.4	601.7	1.7	See EBITDA	
EBITDA (income less expenditure)	17.0	17.6	0.6	0.0	(0.2)	54.2	51.6	(2.6)***	0.0	(0.25)
Financing costs	12.8	12.8	0.0	0.0	(0.2)	31.4	31.4	0.0	0.0	(0.25)
Net / surplus deficit	4.2	4.8	0.6	0.0	(0.2)	22.8	20.2	(2.6)***	0.0	(0.25)
CIPs	2.6	2.5	(0.0)	0.0	(1.0)	30.5	26.5	(4.0)	0.0	(1.0)
Cash balance	77.3	93.4	16.1	0.0	(2.5) *	67.1	86.9	19.8	0.0	(6.0) *
Capital expenditure	30.6	19.2	(11.5)	0.0	(1.0) **	96.9	80.0	(16.9)	0.0	(0.5)

Figures in brackets indicate an adverse position
** Cash balance - threshold is cumulative at £0.5m per month , given material variances are correlated to STF payments*
*** Capital expenditure – timing differences / slippage in-month can mean the month threshold is lower than for the forecast*
**** Although figures are above target, the RAG rating has been adjusted from red to amber as we are forecast to make our control total (green) but will not receive all the STF income due to A&E (red)*

Well-led – Finance and Use of Resources

NHS
Frimley Health NHS Foundation Trust

Model Hospital

Finance & Use of Resources, Use of Resources

Clinical Services	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Pre-procedure elective bed days	Q4 2016/17	0.20	0.11	0.15			
Pre-procedure non-elective bed days	Q4 2016/17	1.44	1.24	1.66			
Did not attend (DNA) rate	Q4 2016/17	5.84%	6.95%	7.09%			

Clinical Support Services	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Overall cost per test	-	NOT AVAILABLE	-	-			

Clinical Support Services	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Top 10 Medicines - % Delivery of Savings Target Achieved to Current Month	To Jul 2017	103%	80%	100%			

People	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff retention rate	May 2017	83.6%	81.8%	85.3%			
Sickness absence rate	Apr 2017	2.83%	2.88%	3.63%			
Total pay cost per WAU	2015/16	£2,151	£2,079	£2,146		No trendline available	
Medical staff cost per WAU	2015/16	£523	£571	£517		No trendline available	
Nursing staff cost per WAU	2015/16	£693	£656	£710		No trendline available	
AHP staff cost per WAU	2015/16	£91	£116	£122		No trendline available	

Corporate services, procurement, and estates and facilities	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Total non-pay cost per WAU	2015/16	£1,320	£1,234	£1,320		No trendline available	
Finance cost per £100m turnover	2015/16	£639.66k	£674.87k	£685.22k		No trendline available	
HR cost per £100m turnover	2015/16	£843.77k	£780.72k	£761.29k		No trendline available	
Estates & Facilities Cost (£ per m2)	2015/16	£351	£310	£326	Click for national variation		

Corporate services, procurement, and estates and facilities	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Overall Process and Performance Score	Q1 2017/18	71.9	64.6	79.0			

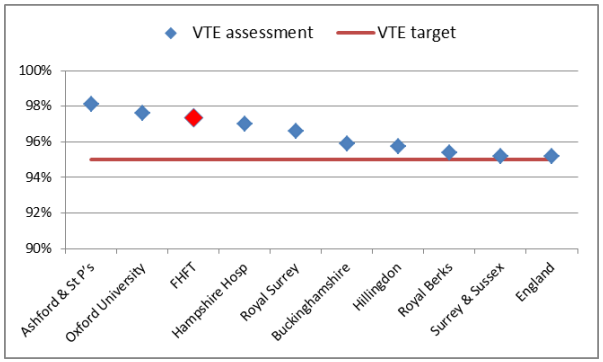
Key:

Our trust

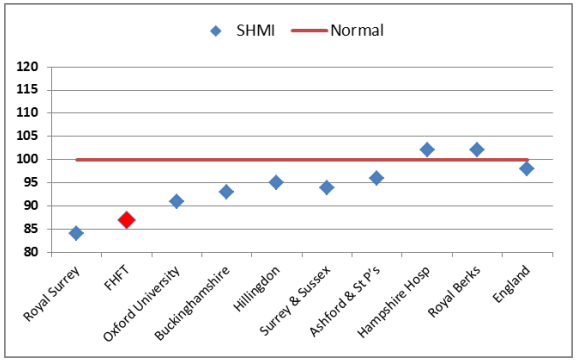
Selected Peers

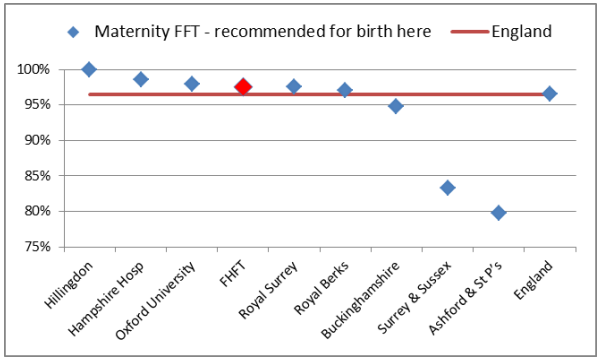
Benchmarking – selected measures (1)

Safe

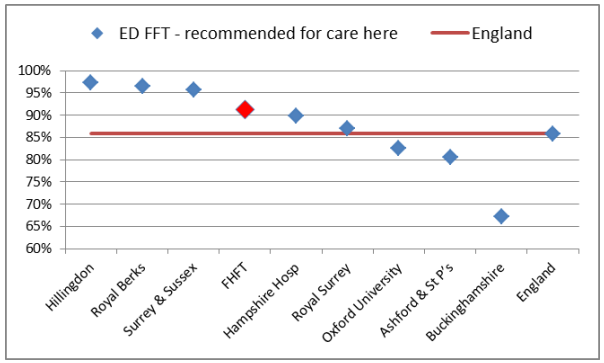


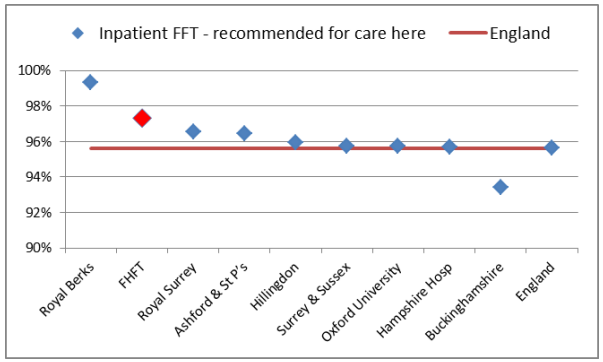
Effective

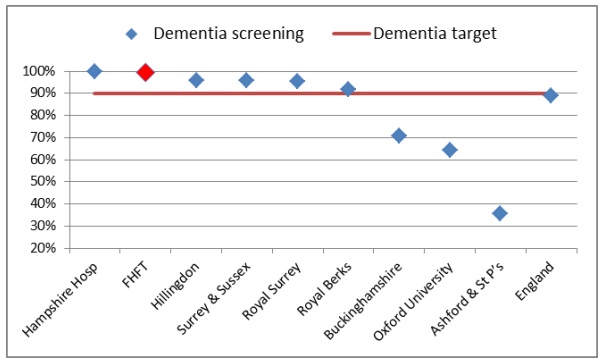




Caring



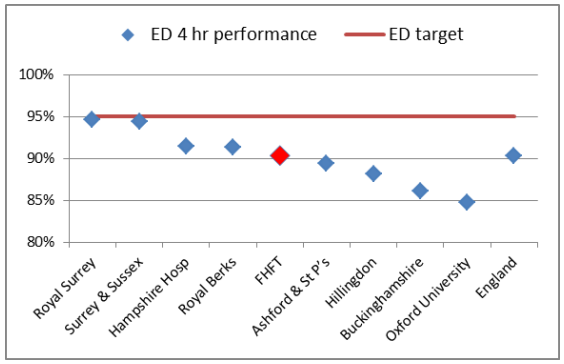


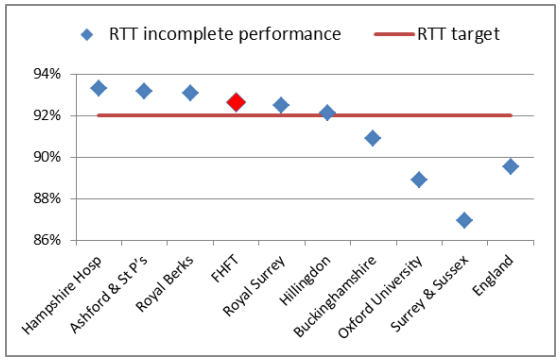


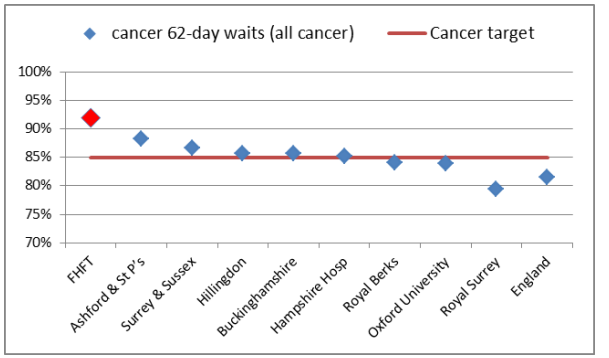
***NOTE** – for each graph, the position furthest to the left is the best performing trust*
***Data periods:** VTE = Q1 2017/18; SHMI = June 2016 – May 2017; ED FFT, Inpatient FFT, Maternity FFT (friends & family test) = Jul 2017; Dementia = Q1 2017/18*

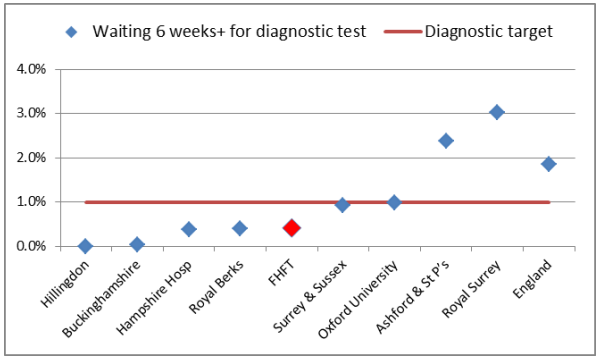
Benchmarking – selected measures (2)

Responsive

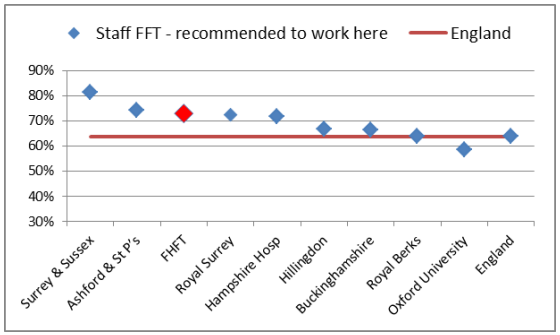


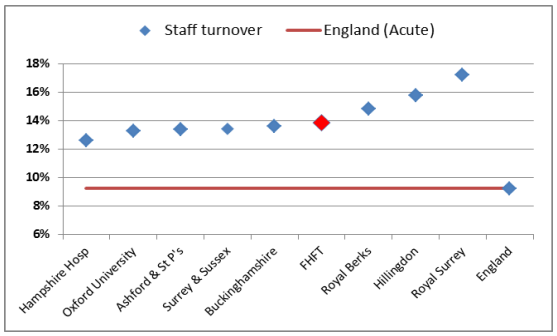






Workforce





***NOTE** – for each graph, the position furthest to the left is the best performing trust*
***Data periods:** A&E (4 hour target) = Aug 2017; RTT (incomplete pathways) = Jul 2017; Diagnostic test waits = Jul 2017; Cancer = Q1 2017/18; Staff FFT (friends & family test) = Q1 2017/18; Staff turnover = Jun 2017*

Activity

	15/16	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	YTD % change
GP and general dental practitioner referrals to all outpatients																	
NHS North East Hants and Farnham	40777	42416	3554	3503	3547	3573	2954	3411	3175	4025	2970	3594	3802	3538	3411	17315	-5%
NHS Slough	37444	41663	3517	3606	3323	3656	3271	3590	3252	3893	3260	3816	3705	3700	3476	17957	5%
NHS Windsor, Ascot and Maidenhead	31293	33384	2567	2818	2837	2886	2590	2905	2714	3068	2437	2883	2934	2811	2580	13645	1%
NHS Bracknell and Ascot	19019	19602	1656	1591	1602	1676	1337	1666	1686	1764	1458	1643	1597	1754	1671	8123	-2%
NHS Surrey Heath	17106	17536	1526	1616	1599	1515	1172	1265	1207	1514	1202	1435	1431	1409	1398	6875	-10%
NHS Chiltern	13931	14576	1203	1346	1150	1264	1101	1207	1160	1435	1118	1272	1194	1214	1207	6005	2%
Other CCG's	15846	15913	1296	1369	1336	1326	1043	1326	1257	1396	1200	1359	1408	1260	1219	6446	-6%
Total GP/GDP referrals	175416	185090	15319	15849	15394	15896	13468	15370	14451	17095	13645	16002	16071	15686	14962	76366	-2%
% change on previous year			19%	3%	0%	7%	-1%	6%	-6%	7%	-14%	5%	-1%	6%	-2%		
Outpatient attendances																	
New attendances	276653	294993	24854	25889	25011	26584	21798	25032	23212	26764	22197	25935	25951	25224	24367	123674	2%
Follow-up attendances	598902	597962	50159	52260	49704	53815	44612	49991	45788	54546	43718	51959	52284	47735	46895	242591	-2%
Total OP attendances	875555	892955	75013	78149	74715	80399	66410	75023	69000	81310	65915	77894	78235	72959	71262	366265	0%
% change on previous year			14%	1%	1%	5%	-3%	5%	-5%	14%	-9%	6%	3%	3%	-5%		
Emergency department (ED) attendances																	
ED attendances (total)	230609	237509	19459	19981	20344	19752	19713	19458	17357	20403	19209	21147	20339	20686	19251	100632	0%
% change on previous year			5%	6%	6%	3%	4%	-1%	-7%	-2%	2%	2%	2%	-4%	-1%		
Non-elective admissions																	
Non-elective admissions (total)	104023	109235	8675	9256	9429	9474	9425	9072	8014	9322	8522	9312	8880	9198	8723	44635	-1%
% change on previous year			4%	8%	8%	9%	4%	0%	-7%	-1%	-2%	1%	-4%	-3%	1%		
Elective admissions																	
Daycase	64340	67810	5529	5978	5868	6188	5030	5855	5407	6024	4860	5910	5584	5473	5323	27150	-1%
Overnight	15567	15412	1248	1321	1251	1363	1143	1221	1198	1411	1126	1312	1248	1188	1181	6055	-7%
Regular day attenders	15820	15897	1301	1329	1186	1477	1176	1377	1250	1537	1322	1524	1515	1422	1437	7220	10%
Total elective admissions	95727	99119	8078	8628	8305	9028	7349	8453	7855	8972	7308	8746	8347	8083	7941	40425	0%
% change on previous year			11%	1%	-1%	14%	-2%	6%	-3%	13%	-11%	10%	1%	0%	-2%		

Activity - ED attendances and emergency admissions (FPH)

	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	YTD % change
Emergency department (ED) attendances																
NHS North East Hampshire & Farnham	51725	4118	4420	4524	4383	4110	4253	3679	4471	4242	4650	4516	4691	4189	22288	2%
NHS Surrey Heath	25190	2161	2084	2078	2105	2100	2035	1856	2088	2042	2239	2201	2181	2114	10777	-1%
NHS Bracknell & Ascot	19326	1578	1722	1635	1675	1569	1650	1362	1724	1524	1701	1728	1687	1535	8175	2%
Other	18410	1646	1558	1606	1534	1561	1442	1360	1558	1516	1623	1661	1821	1612	8233	6%
Total	**114651**	**9503**	**9784**	**9843**	**9697**	**9340**	**9380**	**8257**	**9841**	**9324**	**10213**	**10106**	**10380**	**9450**	49473	**2%**
% change on previous year		6%	6%	4%	3%	2%	0%	-8%	-3%	3%	4%	5%	-1%	-1%		
Emergency department (ED) attendances - by priority																
Majors	43033	3625	3759	3654	3486	3567	3393	3052	3341	3402	3448	3290	3395	3318	16853	-10%
Resuscitation	8489	718	662	653	725	742	821	638	667	663	722	702	792	715	3594	0%
Paeds	33428	3248	2854	2869	2591	2489	2619	2234	2685	2738	3042	3057	3024	3008	14869	-1%
Minors	26306	1737	2291	2351	2548	2062	2012	1882	2558	2008	2432	2339	2359	1723	10861	2%
Not recorded	3395	175	218	316	344	480	535	451	590	513	569	717	831	686	3316	629%
Emergency admissions																
NHS North East Hampshire & Farnham	18191	1342	1521	1636	1523	1577	1557	1329	1523	1328	1476	1533	1613	1524	7474	-1%
NHS Surrey Heath	8696	712	748	690	710	765	761	603	721	690	731	715	737	696	3569	-3%
NHS Bracknell & Ascot	7541	624	671	658	627	600	673	480	658	581	629	641	668	614	3133	-1%
Other	7078	573	578	596	561	640	570	552	644	551	610	575	654	536	2926	0%
Total	**41506**	**3251**	**3518**	**3580**	**3421**	**3582**	**3561**	**2964**	**3546**	**3150**	**3446**	**3464**	**3672**	**3370**	**17102**	**-1%**
% change on previous year		1%	8%	11%	0%	1%	1%	-13%	-8%	-8%	-2%	-1%	1%	4%		

Activity - ED attendances and emergency admissions (HWP)

	16/17	Aug-16	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul	Aug-17	YTD	YTD % change
Emergency department (ED) attendances																
NHS Slough	51,401	4,053	4,168	4,418	4,320	4,272	4,275	3,770	4,508	4,122	4,586	4,268	4,303	3,936	21,108	-3%
NHS Windsor, Ascot & Maidenhead	27,077	2,190	2,249	2,292	2,220	2,256	2,243	2,080	2,284	2,147	2,416	2,291	2,139	2,076	10,964	-4%
NHS Chiltern	28,348	2,210	2,402	2,465	2,346	2,422	2,417	2,186	2,545	2,342	2,517	2,362	2,423	2,370	11,975	3%
NHS Bracknell & Ascot	1,730	145	154	149	132	139	154	103	119	174	166	150	136	111	681	-13%
Other	14,302	1359	1,224	1,177	1,037	1,284	989	960	1,106	1,100	1,249	1,160	1,305	1,308	6,386	-1%
Total	**122,858**	**9,957**	**10,197**	**10,501**	**10,055**	**10,373**	**10,078**	**9,099**	**10562**	**9,885**	**10,934**	**10,231**	**10,306**	**9,801**	**51,157**	**-2%**
% change on previous year		5%	6%	8%	3%	5%	-1%	-6%	-2%	3%	1%	0%	-7%	-2%		
Emergency department (ED) attendances - by priority																
Majors	63624	5043	5137	5444	5352	5443	5616	5242	5795	5363	5985	5640	5697	5734	28421	10%
Resuscitation		Included in Majors														
Minors	30616	3008	2674	2567	2232	2424	2227	1832	2051	2300	2659	2256	2275	2312	11359	-28%
Paeds	28618	1906	2386	2490	2471	2506	2235	2025	2716	2221	2290	2335	2334	1755	11377	-4%
Emergency admissions																
NHS Slough	16,845	1,325	1,385	1,475	1,578	1,489	1,409	1,232	1,462	1,388	1,525	1,363	1,402	1,264	6,885	2%
NHS Windsor, Ascot & Maidenhead	12,570	963	1,030	1,108	1,186	1,097	1,022	1,001	1,067	946	1,118	1,011	949	984	4,944	-1%
NHS Chiltern	11,594	879	1,038	993	1,089	1,082	1,020	920	1,069	951	1,023	925	942	986	4,814	11%
NHS Bracknell & Ascot	909	79	79	69	82	69	81	65	76	80	106	70	68	45	339	-12%
Other	3,125	265	253	287	264	288	236	205	246	270	286	294	272	292	1,412	-8%
Total	**45,043**	**3,511**	**3,785**	**3,932**	**4,199**	**4,025**	**3,768**	**3,423**	**3,920**	**3,635**	**4,058**	**3,663**	**3,633**	**3,571**	**18,394**	**2%**
% change on previous year		13%	16%	11%	21%	9%	3%	1%	6%	7%	12%	0%	-5%	2%		

Appendix A – Methodologies & glossary

Appendix A

Appendix A – Methodologies for calculating the measures

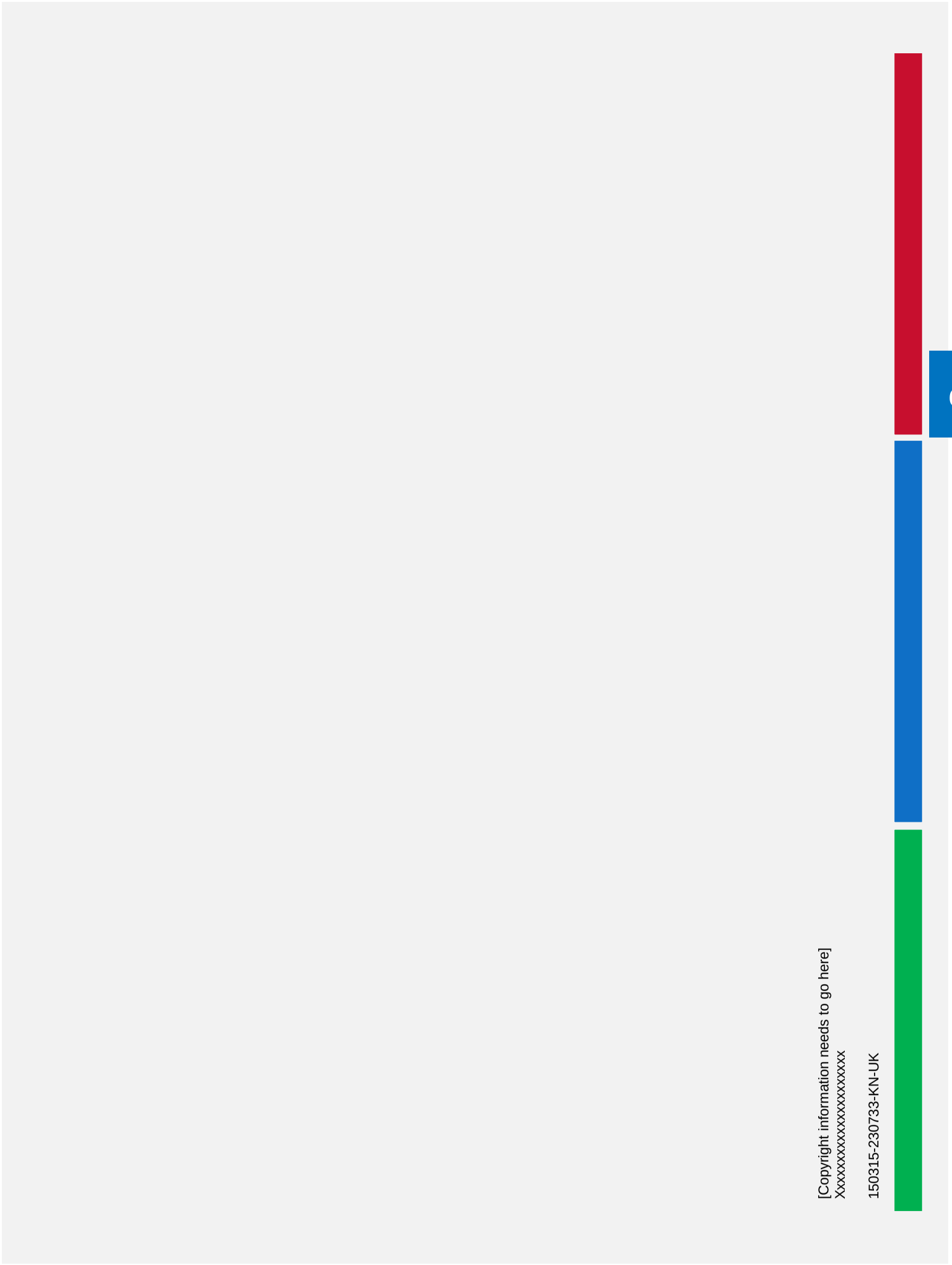
Measure name	Numerator	Denominator	
Length of stay	▪ Total number of bed days occupied ▪ Excludes private patients ▪ Excludes daycases ▪ Based on admission method, split between elective (from a waiting list) and non-elective admissions (includes emergencies and obstetrics)	▪ Total number of discharges in the period	▪ Expressed as a proportion ▪ Measure is consistent with that reported on HED (benchmarking service)
Readmissions	▪ Emergency readmissions to any specialty following an elective or non-elective spell ▪ Readmission length of stay must be at least 1 day ie an overnight stay ▪ Readmission occurs within 30 days of previous discharge	▪ Total number of discharges (completed spells) in the period prior to the last 30 days	▪ Measure is consistent with that used by CQC
Daycase %	▪ Total number of admitted spells where the intended management was daycase, they were admitted electively (off a waiting list) and their spell length of stay was 0 days	▪ Total number of elective spells (admitted off a waiting list)	▪ Expressed as a percentage

Appendix A – Methodologies for calculating the measures

Measure name	Numerator	Denominator	
Outpatient new to follow-up ratio	▪ Number of follow-up outpatient attendances for all referrals and all appointment types (consultant and non-consultant led). Includes ward attenders and private patients	▪ Number of new outpatient attendances	▪ Expressed as a ratio where one new attendance results in "n" follow-up attendances ▪ Measure is consistent with that reported on HED (benchmarking service)
Outpatient DNA rates	▪ Number of outpatient appointments where the patient did not attend. Includes all referrals and all appointment types (consultant and non-consultant led). Includes private patients	▪ Number of outpatient attendances plus the number of appointments where the patient did not attend	▪ Expressed as a percentage ▪ Measure is consistent with that reported on HED (benchmarking service)
Falls resulting in significant injury (rate per 1000 beddays)	▪ Falls recorded on Datix resulting in moderate or severe harm or death	▪ Total number of occupied beddays (including daycases) ▪ Divided by 1000	▪ Expressed as a rate

Appendix A - Glossary

Term	Meaning
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan or Programme
CoSRR	Continuity of Services Risk Rating *As from 1st October 2013 Monitor's new Risk Assessment Framework replaced the old Compliance Framework. Part of the change saw the Financial Risk Rating (FRR) being replace by the Continuity of Services Risk Rating. This measure is designed to describe the risk of a provider failing to carry on as a going concern. The scale is rated from 1 to 4 with 4 being 'No evident concerns' and 1 being 'Significant Risk'*
CQUIN	Commissioning for quality and innovation
CRAB	CRAB (Copeland's Risk Adjusted Barometer) is based on the POSSUM scoring system
EBITDA	Earnings before interest, tax, depreciation and amortization
FHFT	Frimley Health NHS Foundation Trust
FPH	Frimley Park Hospital
HWP	Heatherwood and Wexham Park Hospitals
POSSUM	Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity
YTD	Year-to-date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Frimley Health NHS
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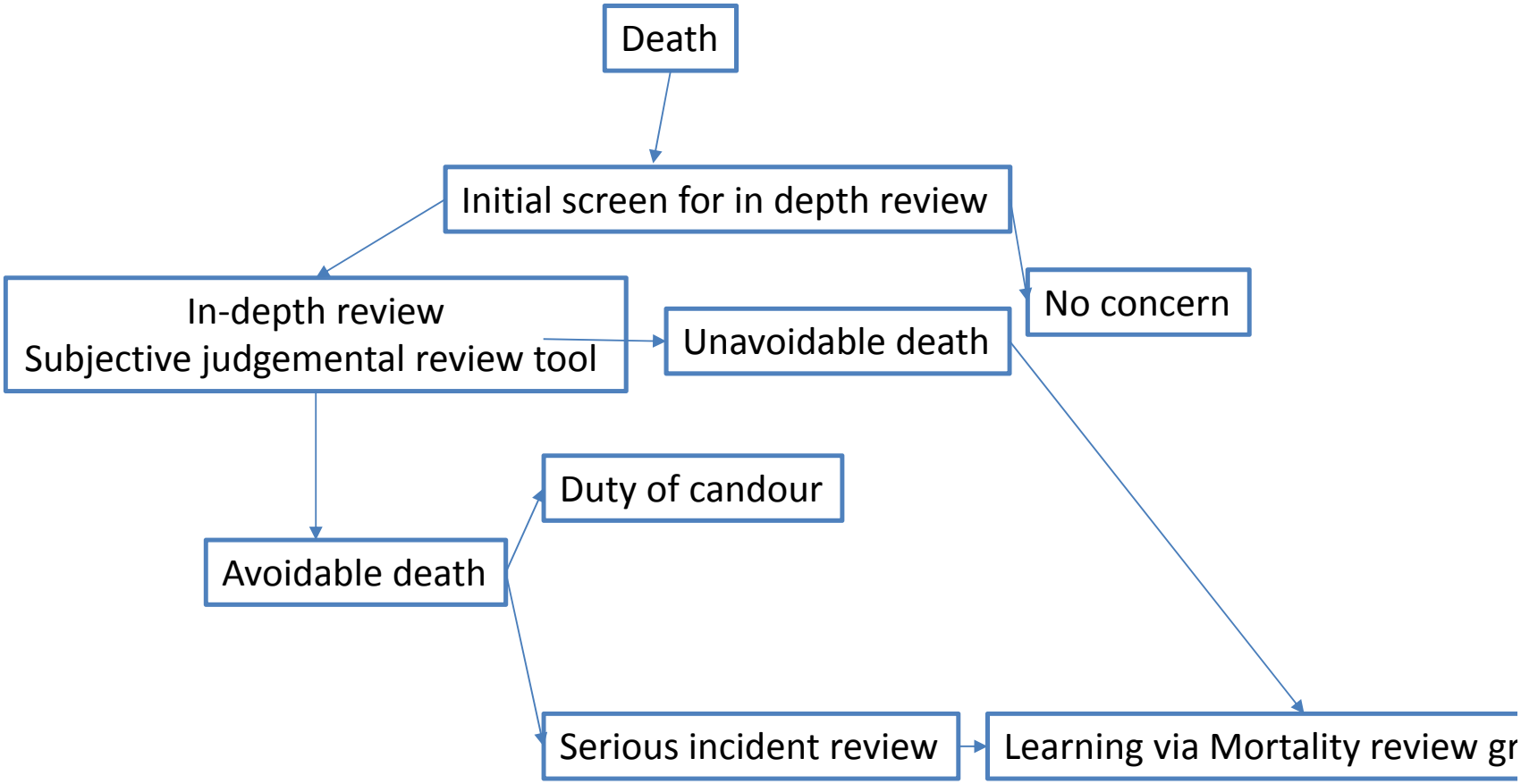
Learning from deaths



Effective - Mortality and morbidity – key measures & messages

In-hospital mortality and summary hospital-level mortality indicator (SHMI)

In-hospital mortality (one month's data)

	16/17	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	YTD
In-hospital deaths	2640	204	189	195	234	239	285	244	193	209	217	206	185	201	1018
Discharges	212501	17003	18338	17997	18943	17006	17822	16300	18629	16140	18408	17588	17570	16968	86674
% deaths	1.2	1.2	1.0	1.1	1.2	1.4	1.6	1.5	1.0	1.3	1.2	1.2	1.1	1.2	1.2

SHMI (rolling 12 months)

	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
Overall	93.3	93.4	92.9	92.6	91.3	91.0	90.9	91.2	91.4	91.0	88.9	87.9	87.4
Non-elective	93.3	93.3	92.7	92.6	91.1	90.7	90.5	90.8	91.0	90.5	88.5	87.3	86.9
Elective	92.6	100.3	99.2	94.8	100.0	103.4	108.8	109.3	110.7	112.9	110.5	118.4	117.9

KEY:	Higher than expected	Within expected range : 90 - 110 (overall and non-elective) 70 - 130 (elective)	Lower than expected

	15/16	16/17	Jul-16	Aug	Sep	Oct	Nov	Dec	Jan-17	Feb	Mar	Apr	May	Jun	Jul-17	YTD	Target	Threshold
Potentially avoidable deaths																		
Total deaths screened(including 30 day post discharge)		New										252	291	290	In arrears		None	
Deeper (RCP)reviews completed		New					This will be published from October 2017					67	59	58	In arrears		None	
Number of deaths of patients with learning disability												1	1	4				
Number of deaths potentially avoidable where RCP score <=3 (definitely, strong evidence or probably avoidable)		New										4	2	2	In arrears		None	

Key messages

Area	Key points	Action taken
Mortality	▪ Trust wide emergency SHMI is as or below expected ▪ Elective SHMI is higher, this effect is from the Wexham site. Deaths of elective patients are all investigated under the SI or mortality review process and learning disseminated.	• Continued monitoring
Potentially avoidable deaths	▪ Cases where deaths were judged more than 50% likely to have been avoidable have or are being investigated under the SI framework	▪ Learning continues to be disseminated trust wide

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Frimley Health NHS Foundation Trust Quality Improvement Plan as at September 2017**
Meeting	Board of Directors
Meeting Date	October 2017
Agenda No.	7.
Report Type	To advise the Board of Directors on the progress against the Frimley Health NHS Foundation Quality Improvement Plan
Prepared By	Debbie Barrow Governance Manager
Executive Lead	Dr Timothy Ho Medical Director
Executive Summary	Attached is the Frimley Health Quality Improvement Plan which was reviewed and agreed at the meeting of the Trustwide Quality Committee in September 2017 The Quality Improvement Plan describes the key quality and patient safety risks identified for Frimley Health and the actions that are being taken to mitigate those risks, current work streams in progress and further work required. Progress against the Improvement Plan is monitored on a monthly basis by the Frimley Health Quality Committee.
Background	The Trust Quality Committee coordinates and monitors the implementation of the responsive actions being taken by the organisation in relation to quality and provides assurance to the Board that the quality agenda is being embedded in line with the quality strategy, and that performance is measured and monitored.
Issues / Actions	• The Trust has recently held a CQC Workshop where the Chiefs of Service, Associate Directors and members of the nursing teams were asked to consider the the key strengths and risks/weaknesses for the organisation against the 5 CQC domains (safe, effective, caring, responsive & well-led). • The risks/weaknesses identified are to be reviewed against the Trust Quality Improvement Plan to ensure that these have been recognised and appropriate actions being taken
Recommendation	The Board of Directors is asked to review the progress against the action plan, to agree the priority areas of concern and trajectories for achieving compliance
Appendices	Quality Improvement Plan September 2017

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Frimley Health NHS
NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

Quality Improvement Plan

as at September 2017

Ragging Key:

Achieved/on target/progress made

In progress but some challenges

Significant difficulty, poor progress

Action achieved, closed

Quality Committee Quality Improvement Plan

as at September 2017

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**Recruitment & Retention** Continue to improve staffing recruitment and retention	The Trust has put in place a robust recruitment plan and this is monitored regularly by Directors and reported monthly to the Board. The Trust will continue to actively recruit and retain staff using all tools and resources possible. National undersupply of qualified clinical staff is resulting in high vacancy rates and over reliance on agency staff. Specific risks in the following occupations: *Band 5 Staff Nurses (General) *Theatre nurses & ODP's *Paediatric Nurses *Sonographers *Radiographers Medical Roles: 1. Paediatrics – middle grade 2. Anaesthetics – middle grade 3. Trauma and orthopaedics – junior and middle grade 4. Acute medicine – junior, middle grade and consultant 5. Care of the Elderly – junior, middle grade and consultant 6. Respiratory Consultant 7. Urology Consultant 8. Dermatology Consultant 8. ED - junior and middle grade	Q4 17/18	Director of HR & Corporate Services / Director of Nursing	Deputy Director of Nursing (WPH) / Assistant Director of Resourcing	Workforce Committee	Actions Detailed recruitment and retention action plan now in place and communicated. Main points include: * New nursing governance group formed in Feb 17 with specific focus on reducing nursing turnover and improving recruitment processes. * 40 nurses recruited from Philippines (via Drake) and will be starting from Mar 17. A further 35 recruited in August. • Revise Open days to increase attendance and experience of potential candidates. Increased attendance at external recruitment open days e.g. RCN careers fairs. • Currently exploring new partnerships with recruitment agencies to increase the supply of staff from Europe and International. *Skype Interviews (Qatar) have taken place in for junior /middle grade positions (7 offers made so far). *local recruitment action plans in place for Theatres and Radiography / Sonography. *ward level recruitment and retention actions plans are being produced to address local risks / concerns.September update: *New 100 day starter survey launched to support local induciton process for nurses. Nurse Staffing paper to BOD Sept 17 Agreement from MDHU for up to 30 military nurses on Wexham site September update: *We have taken a number of actions to respond to the decrease in the number European candidates, including partnering with four new international recruitment agencies (we have 82 nurses in the recruitment pipeline as well as 47 from the Philippines via Drake and a further 47 via Health Perm).

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**E D M S** **Consider the size and organisation of paper health records** **This will remain an ongoing piece of work until such time as all of the records become electronic as part of the EDMS project. Until that time we are continuing to split records each month to meet the size requirement.**	EDMS programme over the next 2 years within pilot specialities due to go live in June 2016	Q4 17/18	Director of Ops (WPH)	Head of Nursing and General Manager Outpatients	OPD HCG	24/07/2017 - All clusters now live and project is in closedown. The revised scanning strategy means that the Trust will be operating with a mix of paper (legacy) and digital (day forward) records for the forseable future. Outstanding issues to be addressed re: consent and speicality specific proformas September update: The Trust is not planning on digitising all legacy records beyond those required for space saving benefits. Legacy notes will remain available on demand or at the request of the clinician. All current and future activity documentation is now being digitised
Frimley Health	**Mandatory Training Data** June update: New system now developed and embedded across the Trust. The system is called MAST and can be accessed via the Intranet on all sites. All Subject Matter Experts (SME's) are reminded of the importance of submitting completed registers to L&OD for reporting onto MAST, this also includes any training that is carried out locally, the information with registers must be sent to L&OD for this to be recorded centrally.	All statutory mandatory training records to be entered on OLM	Q4 17/18	Director of HR & Corporate Services / Director of Nursing	Deputy Director of Nursing (WPH) / Assistant Director of Resourcing Head of Learning and OD/Learning and Development Manager	Workforce Committee Quality committee	• There continues to be a problem with IT infrastructure on the FPH site, which is being looked into. However some of these e-learning subjects have been made into e-assessments which all sites can access on the MAST system. Chief Exec has set an ambition for high priority subject areas and appraisal rates to achieve 85% compliance by 1st October 2017 September Update: All training is now recorded on OLM and pulled through to MAST. Recommendation can now be closed

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**Medical Staffing Out of Hours / Use of Agency** To ensure early identification of potential gaps in medical staffing cover out of hours and minimise the use of agency staff	Each speciality to review medical staffing model and make recommendations to mitigate forthcoming expected gaps in junior doctor rota	Q3 17/18	Medical Director	Deputy Medical Directors FPH & WPH		Workforce Committee sub-group will brief all Directorates in early April regardng the need for a Workforce Plan template to be completed, including likely need for changes in the future. Directorates to present their Workforce Plan at the meeting in September Spend being moniored by Speciality Speciality meetings considering vision for workforce Rotas changed HCAs and non clinical support staff being used in surgery
Frimley Health	**Deteriorating Patient:** To ensure all clinical staff have the right skills & tools to recognise & deliver timely treatment to the deteriorating patient	Learning from SIs and M&M Reviews to be incoporated into training programmes	Ongoing	Medical Director	Lead Nurse for Deteriorating Patient	Resuscitation Committee	Continues to be a theme arising from Morbidity & Mortaility reviews and serious incidents March update: Learning from SIs is shared and disseminated via Directorates and incorporated into ongoing training programs including ALERT In depth review of recent cluster of SIs relating to deteriorating patient to be undertaken Learning from avoidable deaths - led by Trust lead for Mortality & Morbidity, report to Board in October 17 Marked improvement in Cardiac Arrest Audit, FHFT now at 30.60% against national average of 20% patients that survice a cardiac arrest in hospital and go home September update: Introduction of Adult Deteriorating patient study day with assessmnet called ESCALATE (october 2017)
		Observational review of compliance with Hospital at Night arrangements to be undertaken regarding implementation and effectiveness of night-time handover	Q2 17/18				March update: Deputy Medical Director and Chief of Serivce for Medicine currently to undertake an Observational audit Medical & Deputy Medical Directors to attend clinical handover to observe compliance and agree further actions

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**Sepsis** To implement the new NICE guidelines for recognition and Management of Sepsis (NG51)	Monitor compliance of the Sepsis Screening Tool through quarterly audits	Ongoing	Medical Director	Head of Patient Safety	Sepsis Committee	Currently not achieving 90% on either site All specialities to review compliance with sepsis screening at directorate clinical governance meetings Sepsis Roadshows underway Educational Day at WPH New Sepsis video launched Q4 Sepsis Audit show reduction in compliance with Abx within an hour (56%) Sepsis tools launched in adults and children with maternity launching in June. Quarterly audits of the sepsis bundle continue. On HWPH site compliance remains a challenge, weekly ward audits undertaken by the matrons which has improved compliance plus 2 sepsis study days with a 3rd planned 29/6. Both sites have well embedded and attended monthly sepsis meetings and all wards have nominated sepsis champions. June update: Quarterly audits continue, training and education in place. National Sepsis Big Day launch planned for September 2017 July update: Sepsis bundle distributed cross-site July 17. To be attached to obs equipment to promote screening Audit findings shared at Quality Committee & nursing forums Extended Nurse lead for Sepsis on each site until end of March September update: To review Sepsis bundle and update in line with new Sepsis Guidelines launched September 17
Frimley Health	**Do Not Attempt Resuscitation** To ensure there is evidence that DNAR decisions have been appropriately discussed & and are displayed in the medical records (at the front)	To review new national guidance (ReSPECT)	Q2 17/18	Medical Director	Lead Nurse for Deteriorating Patient	Resuscitation Committee	Dr Kelvin Wright now Consultant lead for DNAR. ▪ National Guidance (Respect) currently under review, to be rolled out as part of the End of Life care planning June Update: First ReSPECT workshop held in May. Cross-site DNACPR policy at June HEB. Frimley Health DNACPR policy ratified at HEB. CRoss ite DNACPR form currently under consultation To be audited in Q4

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Park	**Emergency Pressure** To ensure quality of patient care through patient flow	To reduce avoidable admissions through Ambulatory Care pathways and review the threshold for admission by implementing a dynamic response from primary care, social care and community services to support pts at home.	Ongoing	Director of Operations	AD for Medicine	Unscheduled Care	Work with NE Hants on Vanguard scheme to provide integrated care hubs to reduce admissions to FPH. ▪ Opened additional capacity at FPH (G6) in January 2017. ▪ Bed profiling completed, 61-bed deficit on Frimley site. ▪ New Ambulatory Care Unit (ACU) to opened at FPH Jan 2017. ▪ Acquisition of Fleet Hospital Ward (17 beds) + 4 Integrated Care Teams Jan 2017. ▪ FPH have set up a hospital hub for the Integrated Referral Information Service (IRIS). Reviewed use of Ward 1 Heatherwood for medical long stay patients Medical model in ED has delivered reduction in conversation rates
WPH	**Emergency Pressure** To ensure quality of patient care through patient flow						Ambulatory Care majors streaming commenced in ED January 2017. ▪ ESI being implemented 20/04/17. ▪ New medical model will be launched in ED March 2017. ▪ The Urgent Care Steering Group has been re-launched with wider respresentation. Francoise Ticehurst and Prem Premachandran will Chair.
Frimley Health	**Discharge Planning** To ensure there is a robust discharge planning process in place to reduce patients' length of stay, pressure on hospital beds and patient readmission	Discharge planning is a Transformation Workstream supported by the Project Management Office (PMO), currently developing prioritised action plan with 'quick' wins and long term actions to be taken	Q2 17/18	Director of Nursing / Director of Operations		Transformation Group Heads of Nursing	June update: IRIS 'huddle' twice a week in place for NEH&F ICTs to share information on 'known' patients to facilitate early discharge planning. Work underway to engage with Berks & Surrey SPA. Training on electronic systems completed for NEH teams. An IG solution is required for Berks/Surrey teams 2 Deputy Directors of Nursing will be leading discharge groups on both sites with focus on delayed discharges and transfers to community teams

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
		To review the management of private funding for nursing home care and support families who are privately funded	Q2 17/18	Director of Operations	Matron - Patient Access	Urgent Care Board	Funding has been agreed by CCG and lead in post but being used by CCG for other purposes. Director of Ops resolved Social worker to manage and work with private funders to reduce delays & expedite decision making, evoking CHOICE protocol where appropriate Nursing homes to participate have yet to be identified June update: Funding has ceased for this post . Work underway to identify a way forward. Job Description written for new position of Private funding discharge co-ordinator. KPI's and metrics being collated with options being explored for new position Trusted assessors scheme in place to reduce emergency admissions and discharge back to care homes
Frimley Health	**Clinical Handover** To ensure consistency in both medical and nursing handover arrangements & ownership	Observational review of compliance with Hospital at Night arrangements to be undertaken regarding implementation and effectiveness of night-time handover	Q1 17/18	Medical / Nursing Directors	WPH Deputy MD	Quality Committee	Different levels of maturity on each site, more embedded at Wexham Park Hospital Discussed at Critical Care Delivery Group and all Chiefs of Service asked to support attendance at night-time handover to ensure patient safety and priorities are aligned throughout the night Medical Director & Deputy Medical Director on FPH site to liaise with Chief Registrar to format a plan moving forward June update: FPH Chief Registrar had several meetings with ICU, currently H@N at FPH meeting involves medical team and NNP. Site and bed managers attend briefly to give update. Surgery do not attend, ICU attend workload permitting.
		Review weekend handover plans/documents to identify consistent approach	Q3 17/18		Su2S Matron	Quality Committee	July-17 multiple audits and QI projects being run by junior doctors from different specialities to create clearer weekend handovers plans from specialities. Learning from each project to be brought together to create a single consistent approach.

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**Consent / Local Safety Standards for Interventional Procedures** To ensure appropriate checking processes are in place for patients undergoing invasive procedures undertaken outside of Theatres	Recommendations to be considered from national guidance NHS England Patient Safety Alert re: Supporting the introduction of the National Safety Standards for Invasive Procedures published, actions to be taken by September 2016 (progress with implementation)	Sep-16 (The Trust will be expected to demonstrate progress made with implementation by 14th Sept. The deadline for development of all LocSSIPs is still to be confirmed by NHS England)	Medical Director / Director of Nursing	Deputy Medical Director (FPH)	Quality Committee	July - theatres and maternity LocSSIPs are completed and being actioned with new WHO forms being implemeted.Vascular access LocSSIP is in second draft stages and being sent out for comment. Intentionally retained product pathway is currently being reviewed as to how to encorporate the documentation within the patient notes. Paediatric pregnancy testing is being developed by the pre-op matrons in conjunction with the paediatric wards. Cross site development of the emergency department LocSSIPs is underway and the resus team are working on a flashcard for use in emergency invasive procedures.
		Review consent documentation and procedures & implement new process	Q3 17/18			Consent Policy & Implementation Group	• Electronic consent ; a demonstration of an electronic consent package has been well received. Further exploration is required. • Consent Policy; Exiting policy is currently being reviewed and revised Discuss with both Deputy Medical Directors with a view to improving consent prior to the day September update: Obs & Gynae consent forms on order. Orthopedic procedures identified and work has commenced on formatting prepolulated consent forms. PIL has b een gathered for review. Meeting with Urology at Wexham to discuss procedures for review.

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
		Review current patient information with particular focus on risks and benefits to support the consent process for high priority	Q3 17/18			Consent & Implementation Group	The guidance for developing and managing information leaflets is currently being reviewed and will be ratified via the Trust Consent Committee. April update: Obs & Gynae leaflets for top 5 procedures currently being updated in line with current guidance, as part of phase one. June update: Gynae have set up at tracking system for monitoring, reviewing and updating patient information. All Gynae PIL will be looked at in due course. Both Chairs of Consent Groups via Deputy Medical Directors to explain actions being taken September update: Obs & Gynae consent forms on order. Orthopedic procedures identified and work has commenced on formatting prepolulated consent forms. PIL has been gathered for review. Meeting with Urology at Wexham to discuss procedures for review
Frimley Health	**Cancer Pathways** To improve the number of patients treated within the 62 day cancer target and to reduce the number of patients whose diagnosis and treatment takes longer than 104 days To improve cancer patient experience and rationalise referral pathways	Ensure appropriate videoconferencing facilities are in place	Q1 17/18	Directors of Operations	CIO	Cancer Board Executive Board Trust Board	Request made again to Informatics. August update: business case in development by IT. Top Team have not agreed funding, issues continue to arise March update: Top Team approved the outfit of 4 rooms in Dec 16. Currently out to procurement at this time Plan in place, currently out to tender.

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**Management of Patients with Mental Health Issues & Learning Disabilities** To review with mental health colleagues the increase in number and complexity of patients with with mental health needs	The Trust should ensure that staff have clarity around accountability and Duty of Care when managing patients sectioned under the MHA including the use of restraint	Q2 17/18	Director of Nursing	Deputy Director of Nursing FPH		Specialist Simulation training to be provided for key stakeholders including security team Awareness Meeting held with MAYBO to discuss how to provide security staff with next level restraint training Maybo proposal for simulation training to be sustained through train-the-trainer Rapid Tranquilisation Policy in draft Consultant Psychiatrist now delivering Rapid Tranqulisation training and Broadmoor training Maybo Level II training undertaken by all Security staff on both sites 'Managing Challenging Behaviour' incidents roles & responsibilities in-house awareness video being developed On-line roll out anticipated end June 17, dependent on SIM suite availability June update: In-house training video filming has commenced. Paediatric scenario roll out expected by end of July. Delay caused by availability of SIM suite & clinicians Paediatric senario filming completed.
		The Trust should ensure that any patient detained under section 2 of the MHA with a high risk of absconding, self-harm and previous suicidal attempts must be escalated and addressed by the senior nursing staff if a RMN or a 1:1 specialist cannot be provided. All patients requiring 1:1 supervision should receive a daily assessment of their requirement and priority for 1:1care	Q2 17/18	Director of Nursing	Assoc Director for Site Management		All patients sectioned under the Mental Health Act are now highlighted & discussed at the Bed Management Meetings Policy approved at Nursing & Midwifery Board, now at implementation stage Policy to be reviewed in August 17 Discussions with Commissioners & Mental Health providers around Paediatric Mental Health pathway Adults ongoing

Site	Recommendation & Current Risk Rating	Actions	Target Completion Date	Director Lead(s)	Manager	Monitoring Committee	Actions / Current Status
Frimley Health	**Seven Day Services** **To ensure that all specialities meet the 4 key clinical standards required as being 'must do' by 2020 in terms of providing a 7-day service including:** * patients wait no longer than 14 hours to initial consultant review * patients get access to diagnostic tests with a 24-hour turnaround time, for urgent requests (12 hours) and for critical patients, one hour * patients get access to speciality, consultant directed interventions * patients with high-dependency care needs receive twice-daily speciality consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-drected ward rounds	From last national audit of 7-day services the Trust benchamarked well against peers & nationally but below target, actions to be taken include: *Audit findings to be analyzed by site to see where key issues lie *To review and improve access to diagnostics at WPH, i.e echocardiography and MRI out of hours *To reinforce the requirement to Document name & seniority of clinician to provide around who is reviewing patient and when	Q3 17/18	Medical Director	Deputy Medical Directors FPH & WPH	Quality Committee	March update: We have raised awareness of standards and are using a poster pull-up to endorse these. ▪ National audit now underway. Overall achieved better than national average for most indicators Directors of Ops to review audit findings and develop gap analysis
Frimley Health	**Emergency Readmissions** To ensure that the Trust has a good understanding of the number of emergency admissions within 30-days of the original procedure/stay and the associated financial opportunity of reducing this number	All specialities to review their data analysis and coding for emergency readmission to better understand their current position	Q1 17/18	Medical Director	Chiefs of Service	Quality Committee	March update: Each Associate Director is responsible for presenting their data for discussion at the Performance Meeting. ▪ CRAB data to be reviewed by specialties regarding higher incidents of readmission. Monitored through Urgent Care Board Governance Readmission data reviewed at Performance

Report Title	**Month 05 Finance Report to The Board of Directors**
Date of Meeting	Friday, 6th October 2017
Agenda Number	8.
Report type	To receive assurance on the current and forecast financial position of the Trust
Prepared by	Edward John (Director of Operational Finance) / Hugh Cronshey (Assoc. Dir of Finance)
Executive Lead	Nigel Foster (Director of Finance)
Executive Summary	Month 05 shows a £2.3m deficit pre STF which is on plan. The Trust is therefore still at £4.7m adverse YTD. Income has recovered in month 05: there is still an unprecedented level of uncoded episodes at the month end but prior months are being cleared and this will have contributed to the better than average income position. Pay and non-pay continue to be an issue. In particular medical ad-hoc and agency costs are over plan (£1.63m) YTD and bank costs continue to be high. Agency costs are steady at £2m / month and this is within the NHSI cap but pay in total continues to be overspent. The exceptional items booked in M03 of £5.4m mean the STF finance element is achieved and for NHSI reporting purposes the Trust appears ahead of plan YTD*. However, the Board should be aware that it is now considered likely that the A&E targets will not be achieved and so the Trust will lose the STF bonus relating to this element for Q3-4 of £2.8m. CIP is at 99% delivery (86% YTD). The year end forecast has been set to original NHSI plan based on achieving the recovery plan identified last month. * For reporting to NHSI a £2.8m positive variance is reported. This is because the original plan submitted in December 2016 had a level of unidentified CIPs that were prudently phased to be back ended but have since been identified and re-phased in budgets.
Background	The Trust had set a budget of £22.8m surplus for 2017/18 against which this report is monitored. This surplus plan includes £18.6m of STF; £22.6m of DH support inc £6m of Cap-to-Rev, and assumes delivery of £30.5m of cost reduction CIP. The plan is to generate a surplus of £4.2m before STF. This report provides financial performance information in relation to the achievement of both the control total and key dependent indicators including CIP, Cash and Capital.
Issues and Options	Cost containment is not delivering at expected levels and the underlying position is significantly behind plan (£5.2m FYE) The 2017/18 plan is also supported with significant non-recurrent deficit support of £16.6m plus capital to revenue transfer of £6m and now a one-off balance sheet adjustments of £5.4m. In addition A&E STF money is not expected to be achieved for Q3-4 (this does not affect delivery of the control total)
Recommendation	The Board is asked to note the month 05 financial position
Appendices	Finance and Commercial Board Report: Note – all variance are reported against budgets and not original NHSI Plan.

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Finance & Commercial Board Report

Financial Performance

August 2017

M05 / year end at a glance

- The pre STF position is on plan in month £2.3m deficit
- This is £5.9m deficit YTD (£4.7m adverse)
- Clinical income is slightly above plan: although levels of uncoded spells is still very high prior months are being cleared which has contributed to the better position
- Other Income is above plan £0.3m due to overseas patients billing
- Medical Agency / ad-hoc sessions remain the main driver of the adverse position on costs £0.3m
- Month 05 STF of £1.2m accrued because of the stock adjustments in month 03
- Capex behind plan by £11.4m YTD and cash healthy at £93m
- CIP was £2.5m 99% delivered (£10.7m 86% YTD)

Underlying Position and forecast

- I&E Forecast for the year is held to plan assuming cost position is recovered
- Underlying position is still around £5-6m worse than budgeted plan
- The £9.7m improvement identified last month appears to be on track for income but significant risks still exist on the cost recovery programme
- The STF forecast payment has been reduced to reflect A&E operational performance

Summary

In M05 the Trust is on plan at £2.3m deficit (exc STF) and £4.7m behind YTD. The YTD deficit has turned to a surplus due to the one off exceptional items booked in Month 03 (stock £4.7m and £0.7m donated asset). The forecast has been adjusted down due to the risk expected on the A&E element of the STF pf £2.8m. This will not impact on achievement of the control total BUT the underlying position, particularly on pay remains at significant risk due to the lack of reduction in cost base.

Area	Key points	Risks
Income	• Clinical income is above plan but there remains a very high level of uncoded episodes this month (£18m). Other income is above plan driven by overseas visitors income but ytd remains behind by c£1.6m mainly in PPU (£500k) and corporate income (£0.8m).	• Uncoded episodes may not lead to overperformance income when resolved • Other income is significantly below plan YTD
Expenditure	• Operational spend YTD is ££2.6m over plan of £252m (excl. Integration) due mainly to high pay costs (medical agency and a-hoc sessions). Pay costs were overspent in month but agency spend held around £2m. Integration and transaction spend is £2.3m YTD which has been matched to income on a spend-recover basis.	• Underlying costs significantly higher than plan • Urgent recovery action planning required
Net surplus/ deficit	• The Trust is £4.7m adverse YTD against its set budget • one-off exceptional items mean the Trust is showing a positive variance on the bottom line • STF achieved £1.2m for M05 because of the one-off benefits booked in Month 03 but has been adjusted for Q2-4 for the A&E element.	• CIP recovery due mainly to start in M06 must deliver for the Trust to achieve it's plans
CIPs	• In month £2.54m delivery against a plan of £2.57m or 99% (YTD £10.76m 86%)	• CIP is critical to the delivery of the financial plan – all schemes to be forensically reviewed
Cash balance	• Cash closed at £93.4m a positive variance to plan of £16.2m due mainly to STF payments received and Heatherwood Hospital capex slippage means a forecast of £86.9m or £19.8m above plan.	• None
Capital expenditure	• In month £3.7m behind plan of £7.5m (YTD £11.4m behind). Forecast is for a £16.9m underspend which is due to slippage on Heatherwood Hospital	• None

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Frimley Health NHS
NHS Foundation Trust

Income & Expenditure - Month 05 and Year to Date – Summary

Frimley Health	Current Month			Year to Date			Full Year Out-turn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	50.2	50.4	**0.2**	260.8	258.6	**(2.2)**	633.6	632.1	**(1.5)**
Expenditure	(49.9)	(50.1)	**(0.3)**	(249.1)	(251.7)	**(2.6)**	(598.0)	(601.7)	**(3.7)**
Trust Financing	(2.6)	(2.6)	**0.0**	(12.8)	(12.8)	**0.0**	(31.4)	(31.4)	**0.0**
Net Revenue Surplus / (Deficit)	**(2.3)**	**(2.3)**	**(0.0)**	**(1.2)**	**(5.9)**	**(4.7)**	**4.2**	**(1.0)**	**(5.2)**
Exceptional Items	0.0	0.0	**0.0**	**0.0**	**5.4**	**5.4**	**0.0**	**5.4**	**5.4**
Net Position	**(2.3)**	**(2.3)**	**(0.0)**	**(1.2)**	**(0.5)**	**0.7**	**4.2**	**4.5**	**0.2**
STF Funding	1.2	1.2	0.0	5.3	5.3	0.0	18.6	15.8	(2.8)
Integration Funding	0.5	0.4	**(0.0)**	2.3	2.3	**0.1**	5.4	5.4	**0.0**
Integration Costs	(0.5)	(0.4)	**0.0**	(2.3)	(2.3)	**(0.1)**	(5.4)	(5.4)	**0.0**
Net Revenue Surplus / (Deficit) after one-off items	**(1.0)**	**(1.1)**	**(0.0)**	**4.1**	**4.8**	**0.7**	**22.8**	**20.3**	**(2.6)**

Key messages:

STF: The Trust met the control total in month and remains within the YTD plan. Due to the non-recurrent benefit of the introduction of stock in Q1, it is expected that the trust will achieve the financial element of the Q2 STF.

Operating Income: Income slightly over-delivered in month, this was in part due to higher overseas income, but also due to the value of coded activity being higher than previously anticipated. However, there continues to be extremely high levels of un-coded activity, which creates uncertainty in estimating the actual in-month income.

Operating Expenditure: Expenditure in the month was very similar to M04, with pay out-turning at £33.6m and non-pay £19.1m. The budgetary pressures remain in the same areas, notably Medical & Nursing staff costs and clinical supplies.

Forecast: Whilst the Trust is forecasting to stay within the control total, the assessment of income and expenditure has been revised to reflect the year-to-date variances. This has led to a downward revision in income assumptions and a compensating improvement in expenditure.

In order to achieve the forecast, the trust will need to deliver the mitigations highlighted in the M04 Board Report, which anticipate a stepped change in M06.

The STF payment has been forecasted downwards to reflect the current and expected A&E performance.

Please note: The phasing of the internal plan differs from the APR submitted to NHSI. This is largely due to the profile of the CIP plans and the profile of the budgets held in reserves. The NHSI plan is a YTD deficit of £2.8m in M05 (pre-STF).

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Frimley Health NHS
NHS Foundation Trust

Income & Expenditure - YTD month high level variances

Theme	Key Issues	Variance M5 YTD £m
Income		
CCG/NHSE Income	Pass Through Drugs & Devices, Uncoded Activity at average prices	(0.3)
Clinical Income	Delayed commisioner funding for Clinical Schemes (Frality, Ambulatory Care)	(0.3)
Non CCG Income	Private Patient, Overseas, RTA	(0.8)
Corporate Income	Car Park, Accomodation, EDMS Project, Catering	(0.8)
Total Income		**(2.2)**
Pay		
Medical Pay	Agency and Locum Costs above substantive Vacancy	(1.6)
Nursing & Ancillary	Nursing underspends offset through HCA overspends	(1.2)
Prof/Tech & Scientific	Agency Cover above vacancies	(0.3)
Admin & Management	Vacancies not all covered through bank/Agency	1.2
Total Pay		**(1.9)**
Non Pay		
Drugs	Lower overall issues, mostly PbR Excluded, Higher FP10s	1.0
Clinical Supplies	Theatre items, some maintenance contracts	(1.0)
Other Non Pay	Mostly Corporate Areas (Rates, Ulitilities, Maintenance, IM&T,)	(0.7)
Total Non Pay		**(0.6)**

Total Before Exceptional Items		**(4.7)**

Excpetional Items	**Stocktake, Donated Assets**	**5.4**
STF	**Central Strategic Transformation Funding**	**0.0**

Grand Total		**0.7**

I&E Recovery summarised

£m	Rationale	Amount Identified £m
INCOME		
CCG/NHSE Income	Assume recover to plan because: - uncoded at end of month 04 may unwind into overperformance - all but Surrey Heath able to afford plan	3.3
Clinical Income	Delayed commissioner funding for Clinical Schemes (Frailty, Ambulatory Care) - assumed paid	0.9
PPU / Other	RTA and Education income fluctuates around a norm so expect some recovery Action being taken on catering and car park income	0.5
Income Recovery		**4.7**
COSTS		
CIP	Pull back adverse variances on CIP through additional actions, substitutions and re-focus	2.2
Central Mitigations	Those discussed and agreed by exec in addition to the re-focus on CIP	0.7
Costs Recovery		**2.9**
Other		
Stock	Additional stock benefit to be gained as actual stock levels are much higher than the conservative amount pulled onto balance sheet in M03	1.5
Other Recovery		**1.5**
Balance to find	Plans to be agreed	**0.65**
Total Recovery Actions		**9.70**

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Frimley Health NHS
NHS Foundation Trust

CIP Recovery Actions to date

Ref	Sheetname	Directorate	Annual Plan	FOT	Forecast Variance	Mitigations M5	M6	M7	M8	M9	M10	M11	M12	ST	Revised FOT	Revised Var
12.02	Ward Model Adherence	Medicine Frimley	996	498	-498			28	28	28	28	28	28	167	664	-331
3.01	BSPS Integration Savings	Pathology	2379	1927	-452									0	1927	-452
7.17	Medicine Add Medics Prod&agency	Medicine Wexham	350		-350		47	47	47	47	47	47	47	332	332	-18
11.14	Review of Pain Service	Theatres Crit Care & Anaes	300		-300		43	43	43	43	43	43	43	300	300	0
12.04	Medical Locum exit	Medicine Frimley	703	450	-253		12	12	12	12	12	12	12	84	534	-169
11.03	Non-Medics Agency Prem	Theatres Crit Care & Anaes	250	0	-250			17	17	17	17	17	17	100	100	-150
12.11	Exec Endoscopy	Medicine Frimley	200		-200									0	0	-200
7.04	Medcine ED Medics agency saving	Medicine Wexham	196	0	-196			42	42	42	42	42	42	250	250	54
12.03	New ED Rota	Medicine Frimley	405	236	-169		12	12	12	12	12	12	12	84	320	-85
11.06	Pre Op Slots WPH	Theatres Crit Care & Anaes	260	100	-160									0	100	-160
6.05	Overseas Add Data Capture	Private Patients	150	0	-150	0	0	0	0	0	0	0	0	0	0	-150
11.23	Top-Slice of TCCA Budgets	Theatres Crit Care & Anaes	465	315	-150			21	21	21	21	21	21	125	440	-25
17.02	MEDIR Deanery Funding	Medical Director	150	0	-150									0	0	-150
17.04	MEDIR Job Plan	Medical Director	150		-150									0	0	-150
10.01	Removal of PO Services	Orthopaedics & Plastics	157	13	-144	0	0	0	0	0	0	0	0	0	13	-144
10.04	Reduction on Bank B2s	Orthopaedics & Plastics	277	138	-138	17	17	17	17	17	17	18	18	138	276	-0
5.07	MRI Managed Serv Red 2018	Radiology	125	10	-115	14	14	14	14	14	15	15	15	115	125	0
11.24	DSU HWD	Theatres Crit Care & Anaes	200	100	-100			9	9	9	9	9	9	52	152	-48
13.06	Patient Appliances	Therapies	385	289	-96									0	289	-96
19.03	Nursing & Quality CIP Stretch	Nursing & Quality	92		-92									0	0	-92
4.10	Medical Equipment Hire	Surgery	168	84	-84			21	21	21	21	21	21	125	209	41
9.09	Pharmacy Drugs Voriconazole CF	Pharmacy	88	10	-77									0	10	-77
11.20	Pain Windsor	Theatres Crit Care & Anaes	75		-75									0	0	-75
11.19	Pain Aldershot	Theatres Crit Care & Anaes	75		-75									0	0	-75
7.11	Medicine Frailty Unit	Medicine Wexham	139	70	-70			47	47	47	47	47	47	281	351	212
Total			**8734**	**4241**	**-4494**	**31**	**145**	**329**	**329**	**329**	**330**	**331**	**331**	**2153**	**6394**	**-2341**
Central Mitigations																
	Annual Leave C/F	All												0	0	0
	Capitalise staff	Finance; Estates; IM&T						25	25	25	25	25	25	150	150	150
	Non Clinical Recruitment Embargo	All						17	17	17	17	17	17	100	100	100
	Service Developments	All						33	33	33	33	33	33	200	200	200
	Non-pay inflation	All											250	250	250	250
Grand Total			**8734**	**4241**	**-4494**	**31**	**145**	**404**	**404**	**404**	**405**	**406**	**656**	**2853**	**7094**	**-1641**
Actual Mitigation Impact						**0**								-		

CIP Mitigations will be monitored each month to track the impact on the forecast.

Although there were only two schemes that were anticipated to recover in M05, the M05 CIP report reported no improvement on those two items.

The finance team are refreshing the total CIP forecast following M05, which will be included in the CIP Board report.

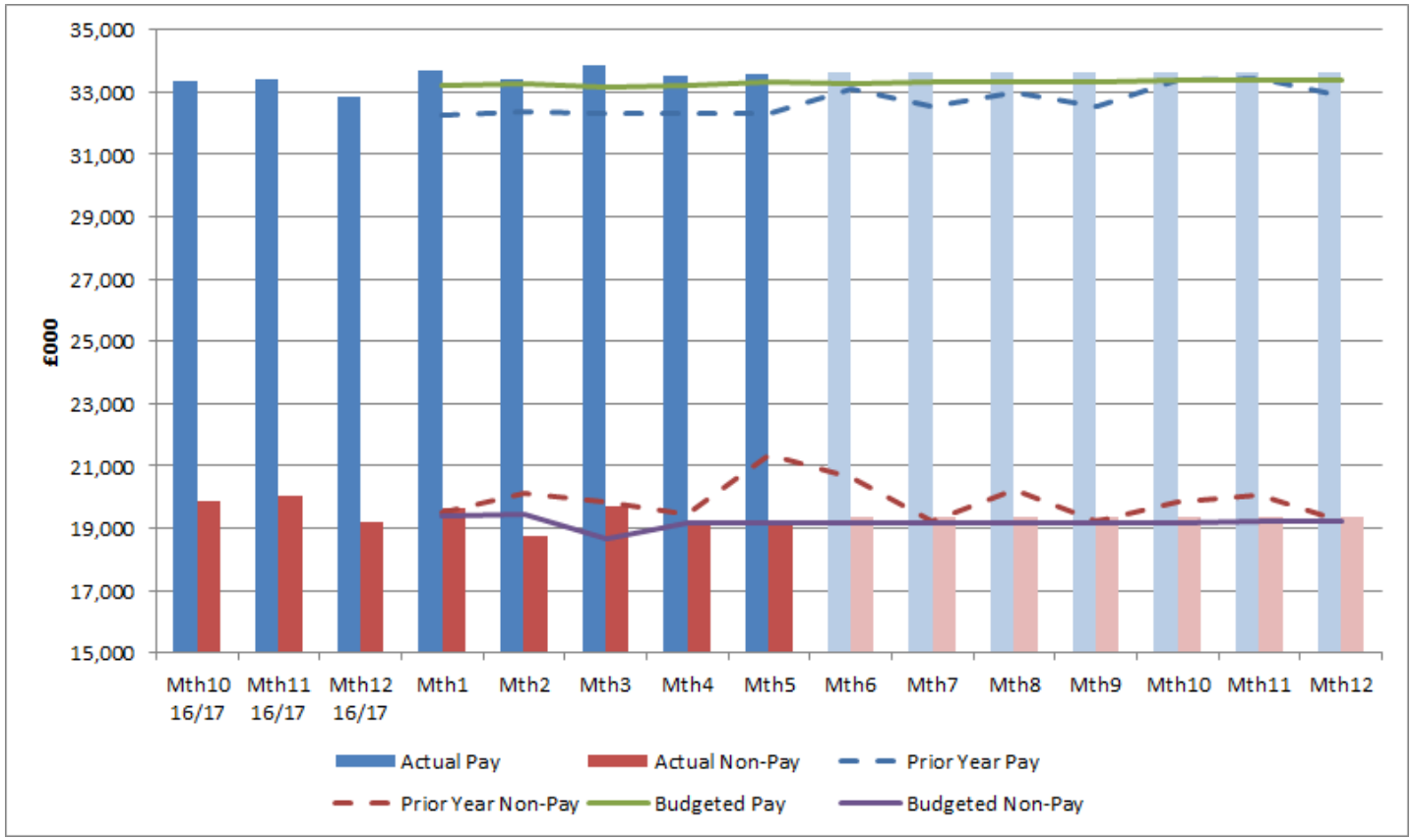
CIP Recovery Agreed Actions

Ref	Sheetname	Directorate	Action Deliver
12.02	Ward Model Adherence	Medicine Frimley	Now managing to budget and plans in place and actioned
3.01	BSPS Integration Savings	Pathology	**TBC: AVM to confirm final outturn figure**
7.17	Medicine Add Medics Prod&agency	Medicine Wexham	Medical Locum Reduction: **Lisa / Helen and Tim to meet with CoS to confirm exit dates**
11.14	Review of Pain Service	Theatres Crit Care & Anaes	Shutdown Theatre 1 HWD plan in place
12.04	Medical Locum exit	Medicine Frimley	**See 7.17 above**
11.03	Non-Medics Agency Prem	Theatres Crit Care & Anaes	Remainder of Theatres Smaller schemes: **DFR's to do line by line on budget**
12.11	Exec Endoscopy	Medicine Frimley	**TBC: Helen to review WLI / 18 weeks and confirm realisable budget**
7.04	Medcine ED Medics agency saving	Medicine Wexham	ED Front Door: **Lisa to lead on clincal model changes**
12.03	New ED Rota	Medicine Frimley	**See 7.17 above**
11.06	Pre Op Slots WPH	Theatres Crit Care & Anaes	
6.05	Overseas Add Data Capture	Private Patients	**TBC**
11.23	Top-Slice of TCCA Budgets	Theatres Crit Care & Anaes	Additional Procurement Savings/Controls: **DFR's to do line by line on budget**
17.02	MEDIR Deanery Funding	Medical Director	Awaiting confirmation from the Board
17.04	MEDIR Job Plan	Medical Director	awaiting plans from Tim Ho
10.01	Removal of PO Services	Orthopaedics & Plastics	None identified at present
10.04	Reduction on Bank B2s	Orthopaedics & Plastics	Recovery plan in place across Ward nursing
5.07	MRI Managed Serv Red 2018	Radiology	Mitigation from further mobile hire reduction & partial Agency removal
11.24	DSU HWD	Theatres Crit Care & Anaes	Additional MOD Nursing
13.06	Patient Appliances	Therapies	
19.03	Nursing & Quality CIP Stretch	Nursing & Quality	
4.10	Medical Equipment Hire	Surgery	Additional Procurement Savings/Controls: **DFR's to do line by line on budget**
9.09	Pharmacy Drugs Voriconazole CF	Pharmacy	
11.20	Pain Windsor	Theatres Crit Care & Anaes	
11.19	Pain Aldershot	Theatres Crit Care & Anaes	
7.11	Medicine Frailty Unit	Medicine Wexham	Additional MOD Nursing & reduction in bank rates
Total			

Central Mitigations

	Annual Leave C/F	All	Needs to be agreed with unions
	Capitalise staff	Finance; Estates; IM&T	Staff in Finance; Estates; IM&T transfer to Capital
	Non Clinical Recruitment Embargo	All	Change recruitment process to include further justified
	Service Developments	All	Service Developments that will not happen
	Non-pay inflation	All	

Expenditure Trend – Excluding Integration & Stock Adjustment



Pay: Pay costs have risen slightly from M04 (<£0.1m).
Temporary staff costs are lower offset by higher employed staff costs.
In order to achieve the forecast, the trust will need to bear down on pay costs, particularly nurse bank and temporary medical staffing.

Non-Pay: Non-pay is marginally lower than M04 (<£0.1m).
The rolling 3mth average would lead to a FOT overspend of £1.9m.
In order to recover this, the trust would need to reduce the monthly run rate by £0.3m.

Income & Expenditure Month 05 – Subjective Analysis – Adjusted to show impact of Exceptional Items

Trust Operations - Excluding Integration

I&E by Subjective Heading	Mth Bud £m	Month Act £m	Mth Var £m	YTD Bud £	YTD Act £	YTD Var £
Income						
Income From Activities	(45.25)	(45.32)	(0.07)	(236.16)	(234.66)	1.50
Other Operating Income	(4.99)	(5.12)	(0.13)	(24.69)	(23.99)	0.69
Income Total	**(50.24)**	**(50.44)**	**(0.20)**	**(260.85)**	**(258.65)**	**2.20**
Pay						
Medical And Dental	8.87	8.45	(0.42)	44.20	42.56	(1.63)
Nursing & Midwifery	10.32	9.53	(0.79)	51.51	48.02	(3.49)
HCAs & Other Support Staff	4.03	4.51	0.48	20.17	22.78	2.62
AHPs, Prof, Scientific & Technical	4.39	4.39	(0.00)	21.80	20.35	1.15
Agency Staff External	0.54	1.99	1.45	2.54	10.23	7.68
Other Staff	5.19	4.72	(0.47)	26.01	24.13	(4.47)
Pay Total	**33.34**	**33.58**	**0.24**	**166.23**	**168.08**	**1.86**
Non-Pay						
Clinical Service And Supplies	9.74	9.45	(0.29)	48.81	48.76	(0.05)
General Supplies And Services	0.80	0.69	(0.11)	4.01	3.56	(0.45)
Premises & Fixed Plant	5.13	5.40	0.27	25.56	26.22	0.66
Other Non Pay	3.47	3.60	0.13	17.43	17.92	0.49
Non-Pay Total	**19.15**	**19.14**	**(0.01)**	**95.81**	**96.46**	**0.65**
Underlying Net Position	**2.26**	**2.28**	**0.03**	**1.18**	**5.89**	**4.71**
Exceptional Items						
Income from Donated Asset	0.00	0.00	0.00	0.00	(0.71)	(0.71)
Stock Adjustment	(0.00)	0.00	0.00	(0.00)	(4.73)	(4.73)
Net Impact of Exceptional Items	**(0.00)**	**0.00**	**0.00**	**(0.00)**	**(5.44)**	**(5.44)**
Grand Total	**2.26**	**2.28**	**0.03**	**1.18**	**0.46**	**(0.73)**
STF Funding	(1.24)	(1.24)	0.00	(5.27)	(5.27)	(0.00)
Net of STF	**1.02**	**1.04**	**0.03**	**(4.09)**	**(4.81)**	**(0.73)**

Income:

Income performed better than plan in the month, with clinical income being on plan, whilst other income was above plan, driven by overseas visitor income. Income from Estates & Facilities, which was a concern earlier in the year, was on-plan in month.

Pay:

As reported earlier, pay costs were very similar to M04. The only notable change being that agency and bank costs have reduced slightly but this has been offset by directly contracted staff. The adverse variance in month is 0.71%, which is marginally lower than M04.

Non Pay:

As with pay, non-pay costs have remained fairly constant from M04, although clinical supplies and services have risen, due to an increase in drug costs, but this has been offset by reductions in all other cost lines. Whilst the in-month adverse variance is less than 0.1%, the year-to-date remains close to 0.7%.

Income & Expenditure Month 05 – Directorate Positions

I&E by Directorate	Pay			Non Pay			TOTAL inc Income						
	YTD Bud £m	YTD Act £m	YTD Var £m	YTD Bud £m	YTD Act £m	YTD Var £m	YTD Bud £m	YTD Act £m	YTD Var £m	YTD Plan	YTD Total	YTD Var	% Var
Directorate: Clinical													
Medicine: Frimley	24.4	25.2	0.8	13.5	13.1	(0.3)	(0.6)	(0.7)	(0.1)	37.20	37.54	0.34	0.90%
Medicine: Wexham	22.7	23.4	0.6	9.6	10.0	0.4	(0.9)	(0.5)	0.4	31.46	32.80	1.33	4.24%
Orthopaedics & Plastics	9.4	9.8	0.4	4.8	4.7	(0.2)	0.0	(0.0)	(0.0)	14.24	14.45	0.21	1.49%
Paeds, Maternity & Gynae	20.0	20.1	0.1	2.4	2.5	0.1	(0.2)	(0.3)	(0.1)	22.18	22.34	0.15	0.69%
Pathology	7.8	8.3	0.5	5.7	6.2	0.6	(2.1)	(2.1)	(0.0)	11.35	12.38	1.03	9.10%
Private Patients	2.4	2.3	(0.1)	0.7	0.7	(0.0)	(4.5)	(4.0)	0.5	(1.39)	(1.05)	0.35	-24.77%
Radiology	6.0	6.1	0.1	3.9	4.2	0.3	(0.2)	(0.2)	0.0	9.66	10.11	0.45	4.66%
Surgery	16.1	15.6	(0.5)	5.3	5.7	0.4	(0.5)	(0.4)	0.1	20.88	20.85	(0.03)	-0.16%
Theatres, Crit Care & Anaes	19.0	19.6	0.7	5.2	5.2	0.1	(0.1)	(0.1)	(0.0)	24.09	24.82	0.73	3.04%
Clinical Total	**127.7**	**130.3**	**2.6**	**51.0**	**52.3**	**1.2**	**(9.1)**	**(8.3)**	**0.8**	**169.67**	**174.2**	**4.56**	**2.69%**
Directorate: Corporate													
Director of Integration	0.7	1.8	1.1	1.5	0.5	(1.0)	(2.3)	(2.3)	(0.1)		(0.00)	(0.00)	
Finance & Strategy	5.7	5.7	0.0	2.1	2.8	0.7	(0.1)	(0.6)	(0.5)	7.60	7.87	0.27	3.53%
HR & Corporate Services	11.2	11.2	0.0	10.3	10.8	0.5	(4.3)	(3.5)	0.8	17.23	18.54	1.31	7.58%
Medical Director	0.4	0.4	0.0	0.5	0.4	(0.2)	(0.8)	(0.7)	0.1	0.06	0.05	(0.01)	-16.79%
Nursing & Quality	2.2	2.5	0.2	0.9	0.6	(0.3)	(0.6)	(0.6)	(0.0)	2.47	2.45	(0.02)	-0.65%
Operations: Frimley	10.2	10.3	0.0	2.9	2.7	(0.3)	(0.8)	(0.8)	(0.0)	12.37	12.15	(0.22)	-1.81%
Operations: Wexham	6.5	6.3	(0.2)	3.2	3.1	(0.1)	(2.7)	(2.3)	0.3	7.02	6.99	(0.03)	-0.41%
Corporate Total	**36.9**	**38.1**	**1.2**	**21.4**	**20.8**	**(0.6)**	**(11.6)**	**(10.9)**	**0.7**	**46.75**	**48.0**	**1.30**	**2.77%**
CCG Income and financing cost	**2.3**	**1.5**	**(0.8)**	**24.9**	**19.2**	**(5.7)**	**(247.7)**	**(247.7)**	**(0.0)**	**(220.50)**	**(227.1)**	**(6.59)**	**2.99%**
Grand Total	**166.9**	**169.9**	**3.0**	**97.3**	**92.2**	**(5.1)**	**(268.4)**	**(267.0)**	**1.4**	**(4.09)**	**(4.8)**	**(0.73)**	**17.79%**

There has been a modest improvement in the YTD variance for clinical areas, however, this has been neutralised by a slightly worsening in the corporate areas.

Notes: In this analysis adverse variances are shown as a positive number

The budget shown in this schedule is the Trust's internal plan. The exceptional items are recorded within CCG income and financing costs

Total Trust Agency Expenditure (Excl. Integration funded spend)

Agency Costs have remained just over £2m this month.

Hospital Agency	2016/17 Q4 Average	M01	M02	M03	M04	M05
Medical	965,811	911,571	794,171	1,018,243	957,827	887,743
Nursing	638,421	603,357	464,634	406,571	485,052	492,876
Prof Tech & Scientific	246,760	195,446	245,999	270,788	270,706	176,202
AHP	362,564	186,418	189,193	212,544	207,516	287,551
Admin	243,534	-23,199	216,811	130,027	95,311	51,081
Ancillary	8,469	12,464	5,833	-2,265	-8,423	5,394
MOD Agency	1	0	0	0	0	0
Other Staff	0	0	0	0	0	0
Total Hospital Agency	**2,465,560**	**1,886,057**	**1,916,642**	**2,035,908**	**2,007,989**	**1,900,847**

Agency costs have reduced from the previous month with both sites reporting lower Medical agency staff costs.

The rise in nursing agency is on the WPH site, whereas the increase in AHPs is mainly at FPH.

The in-month performance means that the Trust continues to be in line with the Agency Ceiling set by NHSI for this financial year.

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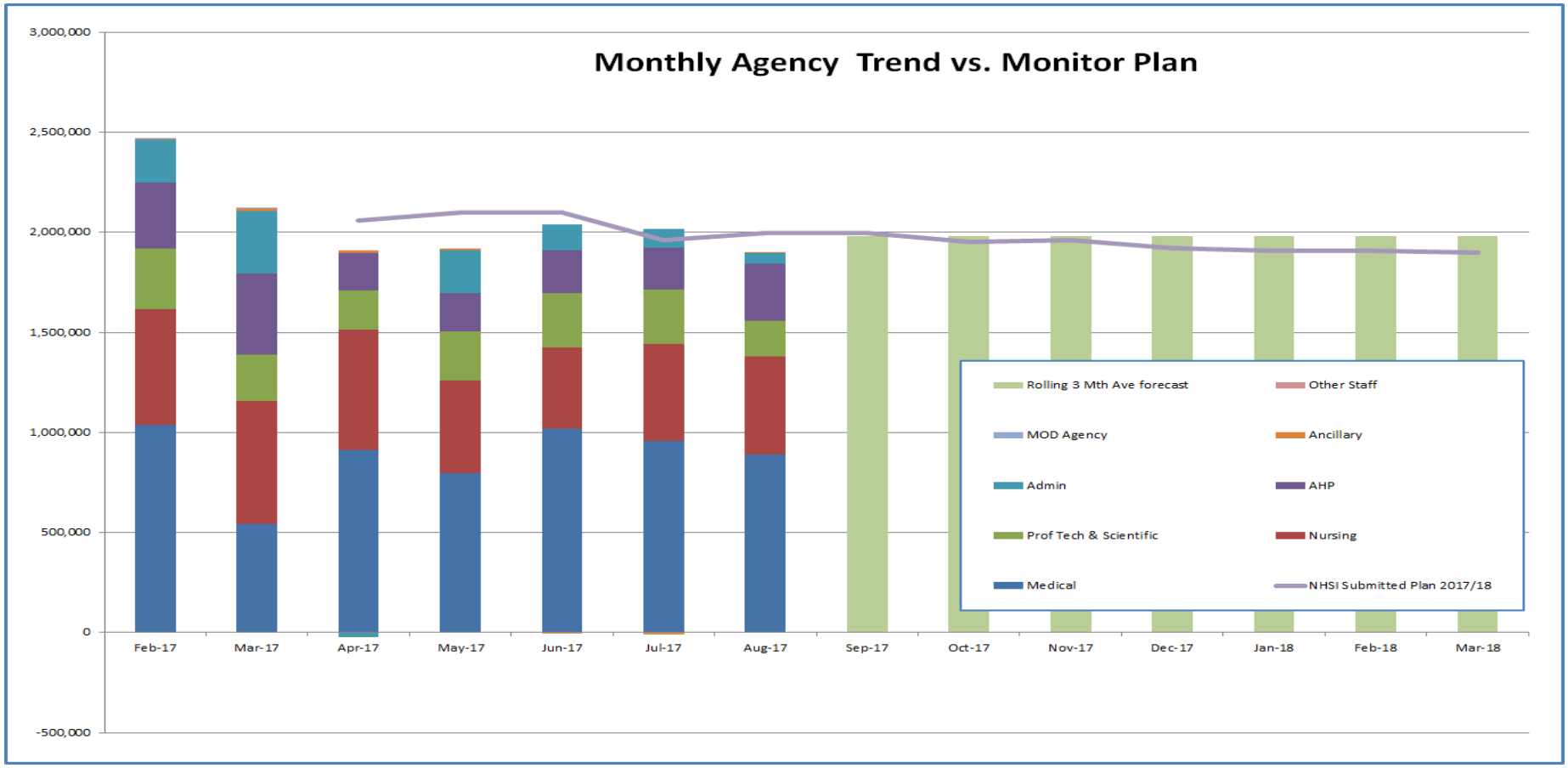
Total Trust Agency Expenditure Trend

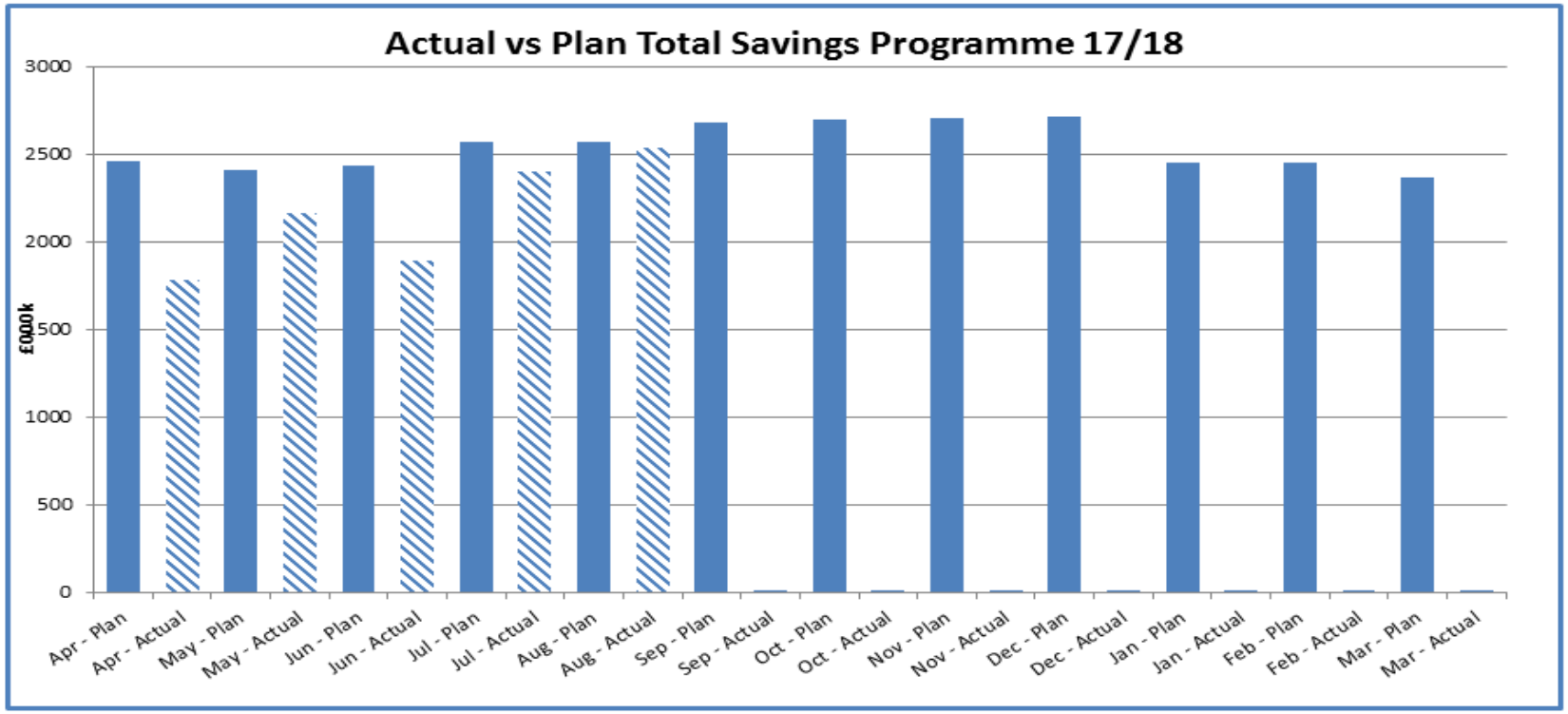


The graph shows the forecasted spend based on a rolling 3 month run rate.

Whilst the expectation is that the NHSI agency cap will be met this year, the trajectory indicates that it is important to remain focussed on maintaining the pressure on the reduction of agency spend and to exit the year with a reducing run rate, rather than stagnating at £2m per month.

Trust Overview – 2017/18 Total Savings Programme

Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
30,500	2,569	2,536	-33	98.7%	12,444	10,763	-1,681	86.5%	26,554	87.1%



The monthly position has increased from 92.3% last month to 98.7% in month 05, due to prior period identification within Pathology and Surgery in month 05.. The YTD position continues to increase to 86.5% achievement. The forecast position is 87.1% delivery before any new mitigating schemes.

All values in £000

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Cash Position Month 5

FRIMLEY HEALTH	Current Month			Year to Date			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Net Cash Increase / (Decrease)	-6.2	3.3	**9.4**	-1.7	6.8	**8.5**	-11.9	0.3	**12.2**
Cash Brought Forward	83.4	90.2	**6.7**	79.0	86.7	**7.7**	79.0	86.7	**7.7**
Cash Carried Forward	**77.3**	**93.4**	**16.2**	**77.3**	**93.4**	**16.2**	**67.1**	**86.9**	**19.8**

Key messages:

- The cash balance for month 5 finished at £93.4m, an increase of £3.3m from M4 against a planned decrease of £6.2m
- The favourable variance of £9.4m is the result of an increase in deferred income having taken receipt of the final indemnity claims against the DH transaction agreement, an element of which is future dated pay protection
- The in year cash movement is now £8.5m ahead of plan and year to date cash position £16.2m above plan
- The year-end position remains forecast to finish £19.8m above plan at £86.9m due to the brought forward variance of £7.7m slippage in capital programme of £16.9m offset by the impact in the change of inventory treatment (£4.7m)

Analysis of Year to Date Variance	£m
Surplus of £4.8m ahead of NHSI plan by £2.4m	2.4
Capital expenditure slippage to programme	11.4
Forecast PDC funding of £8.9m not drawn down	(8.9)
Unplanned increase in inventories and receipt of donated assets	(5.4)
Net working capital position due to rise of deferred income in month whilst trade and other payables remain high	9.5
Other movements in provisions, financial liabilities and non-cash items	(0.5)
	8.5

Capital Month 5

£'m	Month Plan	Month Actual	Diff	YTD Plan	YTD Actual	Diff	FY Plan	FY Forecast	Diff
HWPH									
Heatherwood	1.60	0.08	1.52	5.00	0.55	4.45	26.08	9.18	16.90
Wexham - EDAR	2.18	1.32	0.85	6.58	4.25	2.32	23.75	24.96	(1.21)
Wexham - Women's Services	0.50	0.56	(0.06)	4.25	3.86	0.39	5.37	6.28	(0.91)
Wexham - Estate	1.38	0.50	0.89	6.97	4.60	2.37	16.80	17.52	(0.72)
Information technology	0.25	0.24	0.01	0.95	1.34	(0.39)	3.03	3.03	0.00
Medical equipment	0.27	0.08	0.19	1.35	0.72	0.62	3.23	3.23	0.00
HWPH total	**6.18**	**2.78**	**3.40**	**25.09**	**15.32**	**9.77**	**78.26**	**64.21**	**14.06**
FPH									
Estate	0.73	0.75	(0.02)	2.78	2.26	0.51	11.05	8.21	2.84
Medical Equipment	0.13	0.18	(0.05)	0.63	0.61	0.01	1.50	1.50	0.00
Information Technology	0.32	0.07	0.25	1.31	0.77	0.53	3.85	3.85	0.00
FPH total	**1.17**	**1.00**	**0.17**	**4.71**	**3.65**	**1.06**	**16.40**	**13.56**	**2.84**
Integration capital	**0.23**	**0.08**	0.15	**0.83**	**0.21**	0.62	**2.27**	**2.27**	0.00
Frimley Health Total	**7.57**	**3.86**	**3.72**	**30.62**	**19.17**	**11.44**	**96.94**	**80.04**	**16.90**

Month 5:
- Capital expenditure for month 5 finished behind plan by £3.7m as £3.9m
- The Heatherwood redevelopment (£1.5m) and Wexham estate schemes (£1.7m) continue to be the largest contributors to this underspend due to the delayed planning process and expenditure profile timing differences respectively

Year to Date:
- YTD expenditure of £19.2m now £11.4m behind plan
- Of this; £10.0m can be accounted for by the estates schemes, £0.8m IM&T and £0.6m medical equipment although the latter two are anticipated to recover later in the year

Full Year:
- The annual plan figure of £96.9m has been reduced in the full year forecast to £80.0m, £6.2m under plan
- This reduction is all against the Heatherwood site redevelopment as continued delays with planning approval has held back the programme of works scheduled for the site however planning was approved in month progress on the scheme is anticipated in the second half of the year
- Changes to the profile of expenditure between the remaining estates schemes offset against one another

Balance Sheet M5

	June Actual £m	July Actual £m	August Actual £m	August Plan £m	August Variance £m
Assets, Non-Current					
Intangible Assets	4.351	4.630	4.426	1.475	2.951
Property, Plant and Equipment	325.602	327.021	329.453	351.731	(22.278)
Assets, Non-Current, total	**329.953**	**331.651**	**333.879**	**353.206**	**(19.327)**
Assets, Current					
Inventories	7.989	7.943	7.997	3.500	4.497
Trade and Other Receivables, Current	69.475	55.725	54.393	52.800	1.593
Cash and Cash Equivalents (excluding overdrafts)	75.512	90.167	93.435	77.280	16.155
Assets, Current, total	**152.976**	**153.835**	**155.825**	**133.580**	**22.245**
TOTAL ASSETS	**482.929**	**485.486**	**489.704**	**486.786**	**2.918**
Liabilities, Current					
Trade and Other Payables, Current	(67.021)	(70.104)	(68.857)	(63.333)	(5.524)
Deferred Income, Current	(15.209)	(13.606)	(20.143)	(10.000)	(10.143)
Borrowings, Current	(0.287)	(0.287)	(0.287)	(0.200)	(0.087)
Provisions, Current	(0.335)	(0.247)	(0.240)	(0.400)	0.160
Liabilities, Current, total	**(82.852)**	**(84.244)**	**(89.527)**	**(73.933)**	**(15.594)**
NET CURRENT ASSETS (LIABILITIES)	**70.124**	**69.591**	**66.298**	**59.647**	**6.651**
Liabilities, Non-Current					
Provisions, Non-Current	(0.051)	(0.051)	(0.051)	(0.400)	0.349
Borrowings, Non-Current	(1.692)	(1.656)	(1.634)	(2.000)	0.366
Liabilities, Non-Current, total	**(1.743)**	**(1.707)**	**(1.685)**	**(2.400)**	**0.715**
TOTAL ASSETS EMPLOYED	**398.334**	**399.535**	**398.492**	**410.453**	**(11.961)**
Taxpayers' and Others' Equity					
Taxpayers Equity					
Public dividend capital	226.915	226.915	226.915	235.822	(8.907)
Income and expenditure reserve	60.030	61.231	60.189	51.331	8.858
Taxpayers' equity, total	**286.945**	**288.146**	**287.104**	**287.153**	**(0.049)**
Other Reserves					
Revaluation Reserve	111.389	111.389	111.389	123.300	(11.911)
Total Equity & Reserves	**398.334**	**399.535**	**398.493**	**410.453**	**(11.960)**

Frimley Health total assets employed £398m.

Items to note:

- The combined assets across all 3 sites increased by £4m to £490m in August, £3m above plan.

- Non-current assets of £334m behind plan by £19m primarily due to the b/fwd impact of the 16/17 site valuation and enhanced by the slippage in capital programme

- Current assets remain high, £22m above plan, and increased by £2m in month as cash rose by £3m against a slight decrease of £1m in trade and other receivables

- Current liabilities increased by £5m in month driven by the £6m rise in deferred income having taken receipt of the final claim for DH indemnity funding

- Equity and reserves remains lower than forecast despite higher than planned increase in I&E reserve due to PDC of £8.9m not drawn down

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Report Title	**2017/18 CIP Summary – Month 05**
Meeting	Trust Board
Meeting Date	Friday, 6th October 2017
Agenda No.	9.
Report Type	Note
Prepared By	Michael Laycock, Head of Business Support - Finance
Executive Lead	Helen Coe, Director of Operations, FPH Lisa Glynn, Director of Operations, HWPH
Executive Summary	To brief the Board of Directors on the CIP delivery for M05 and forecasted outturn for the year.
Background	**Annual Savings Programme** • The Trust's combined CIP and synergy target for 2017/18 is **£30.5m**. • YTD delivery to the end of M04 was **83.1%** of the phased plan
Issues / Actions	Performance of CIP schemes are given in the attached paper. **1. CIP Programme Performance Month 5** • At the close of month 5, the Trust delivered **£10.763m** against the plan of **£12.444m**, which is an adverse variance of **-£1.681m** and a delivery of 86.51**%.** This is an **improvement** on the year-to-date postion from M04. The most significant change being the reported Pathology savings months, which is a year-to-date adjustment from prior period performance. • The main areas of underperformance remain in the following areas: - Medicine (FPH) ward staff cost reductions and ED medical staffing - BSPS savings resulting from the incorporation of RBH into the Partnership - Theatre schemes relating to Premium staffing, Pain Service redesign and non-pay reductions

9

	2. Forecasted Outturn • The forecasted outturn has been refreshed for M05 and as a result of the slight improvement in month, the FOT has increased to £27.4m. However, the CIP mitigations are expected to improve significantly in M06, this improvement has not automatically been assumed within the forecast. **3. Action** • The Trust continues to work on delivering both the core CIP schemes and address the mitigating actions agreed in September.
Recommendation	The Board is asked to note the content of this report, progress made, and continued focus on delivery of existing schemes and ensure mitigating items are followed through to delivery.
Appendices	2017/18 CIP Detailed Report – Month 05.

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2017/18 CIP Performance Report M05

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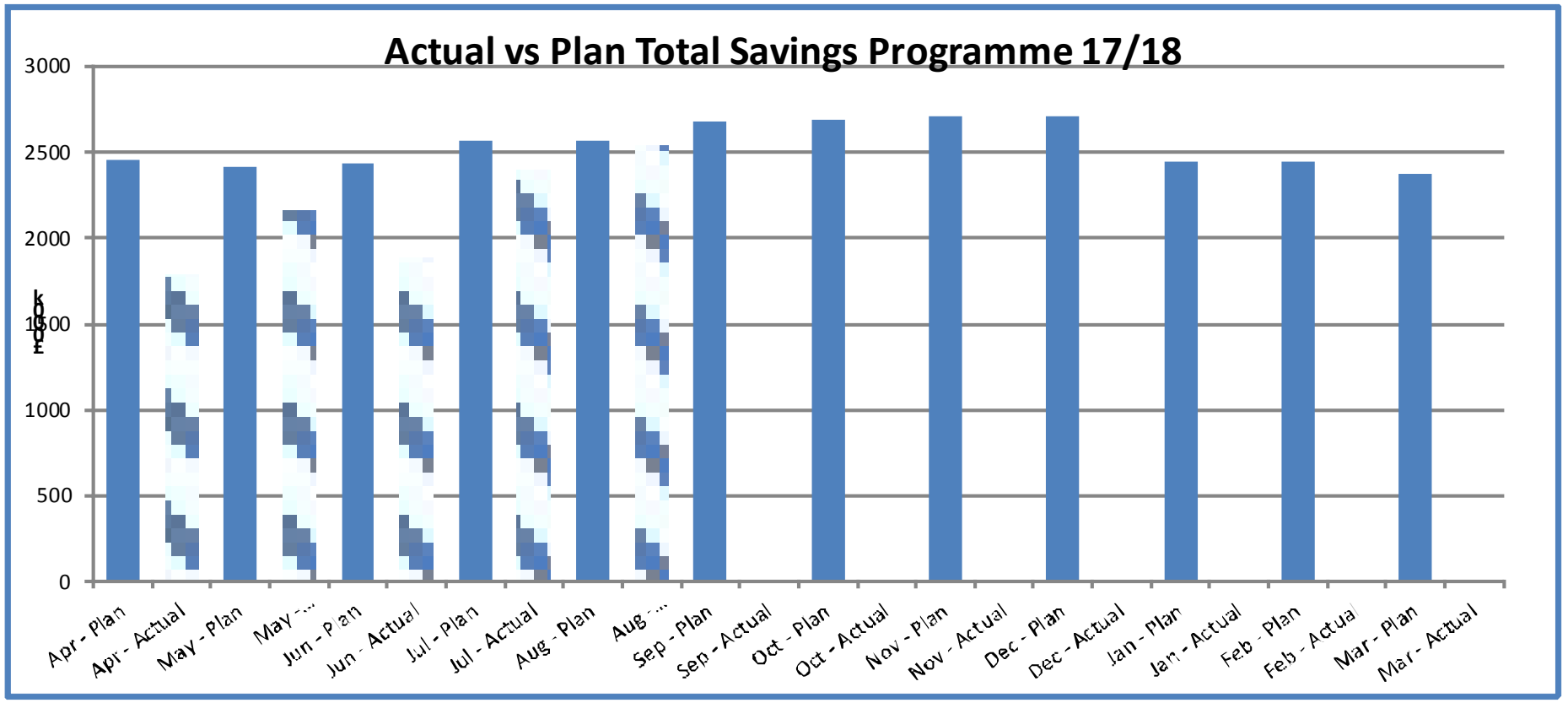
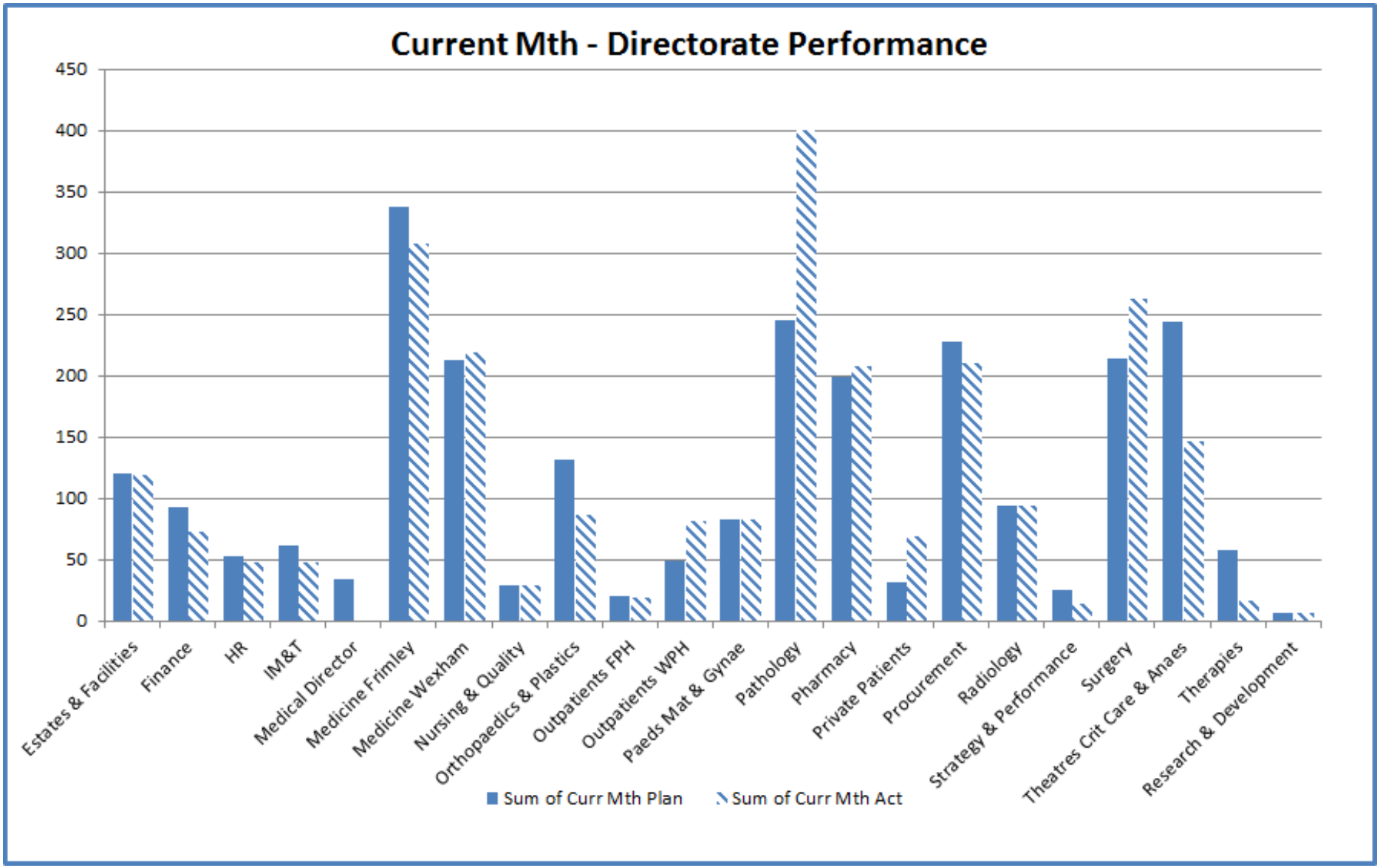
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
30,500	2,569	2,536	-33	98.7%	12,444	10,763	-1,681	86.5%	27,382	89.8%



The monthly position has increased from 92.3% last month to 98.7% in month 05, due to prior period identification within Pathology and Surgery in month 05.. The YTD position continues to increase to 86.5% achievement. The forecast position has increased to 89.8%.

2


Current Mth - Directorate Performance
450
400
350
300
250
200
150
100
50
0
Estates & Facilities
Finance
HR
IM&T
Medical Director
Medicine Frimley
Medicine Wexham
Nursing & Quality
Orthopaedics & Plastics
Outpatients FPH
Outpatients WPH
Paeds Mat & Gynae
Pathology
Pharmacy
Private Patients
Procurement
Radiology
Strategy & Performance
Surgery
Theatres Crit Care & Anaes
Therapies
Research & Development
Sum of Curr Mth Plan
Sum of Curr Mth Act

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In Month Summary

Row Labels	Curr Mth Plan	Curr Mth Act	Curr Mth Var	Comment
Estates & Facilities	120	119	-1	
Finance	93	73	-20	Staffing Restructure, expected to deliver by year end
HR	53	47	-6	
IM&T	61	47	-14	Additional Exec £200k target not being met.
Medical Director	34	0	-34	Deanery funding of additional Pas - being followed up with Tim & Jane
Medicine Frimley	337	307	-30	ED Rota still not achieving,Ward Model Adherance not met again in month, partial mitigation from Hale Ward overdelivery
Medicine Wexham	213	219	7	High Cardiology Non Pay delivery and Ward seasonal reductions offset underachievement within Medics productivity, ED locum and Frailty unit
Nursing & Quality	29	29	0	
Orthopaedics & Plastics	132	86	-45	Removal of Post Op services at Hwd, bankd band 2 staff, Medical additional sessions and PA Reviews not all met.
Outpatients FPH	20	19	-1	
Outpatients WPH	49	81	33	High Private Ambulance recorded in month (again) and Acute Patient Management Team over delivery
Paeds Mat & Gynae	83	83	0	Stretch target overperformance
Pathology	245	400	155	Prior Period achievement recognised - **Matches Pathology Reporting**
Pharmacy	200	207	8	Passthrough overperformance (not cash releasing)
Private Patients	31	69	38	High recorded overseas income in month
Procurement	228	210	-18	Matches Procurement numbers YTD, overperformance
Radiology	94	94	-0	
Strategy & Performance	25	13	-12	
Surgery	214	263	49	Review of WLI position YTD correction
Theatres Crit Care & Anaes	244	146	-98	Unidentified CIP target, which has been flagged up and will continue to be an overspend unless tackled.
Therapies	58	16	-42	Mostly Patient Appliances
Research & Development	6	6	-0	
Grand Total	**2,569**	**2,536**	**-33**	

Top Ten Best Performing (In month)

		Values						
Sheetname	Directorate	Annul Plan	Curr Mth Plan	Curr Mth Act	Curr Mth Var	YTD Plan	YTD Actual	YTD Var
BSPS Integration Savings	Pathology	2,379.16	245.23	400.10	154.87	1,226.16	948.40	-277.76
Medicine Card Device Stock red	Medicine Wexha	340.00	28.33	86.33	58.00	141.67	242.15	100.48
General Surgery WLI	Surgery	300.00	25.00	76.00	51.00	121.00	197.80	76.80
Overseas Add Data Capture	Private Patients	150.00	12.50	63.00	50.50	62.50	63.00	0.50
Hale Ward	Medicine Frimle	1,064.00	88.67	134.00	45.33	443.33	669.67	226.33
Pharm Drugs Caspofungin passthr	Pharmacy	30.00	2.50	34.77	32.27	12.50	141.59	129.09
OPs Wex - Pvt Amb	Outpatients WPI	100.00	8.33	32.53	24.20	41.67	83.80	42.13
CT Mobile Hire reduction WLI	Radiology	50.40	4.20	26.20	22.00	21.00	71.60	50.60
Ophthalmology WLI Specialty Drs	Surgery	200.00	17.00	38.00	21.00	81.00	108.00	27.00
Theatre Utilisation	Surgery	100.00	8.00	28.00	20.00	40.00	80.48	40.48
Grand Total		**4,713.56**	**439.77**	**918.94**	**479.17**	**2,190.83**	**2,606.49**	**415.66**

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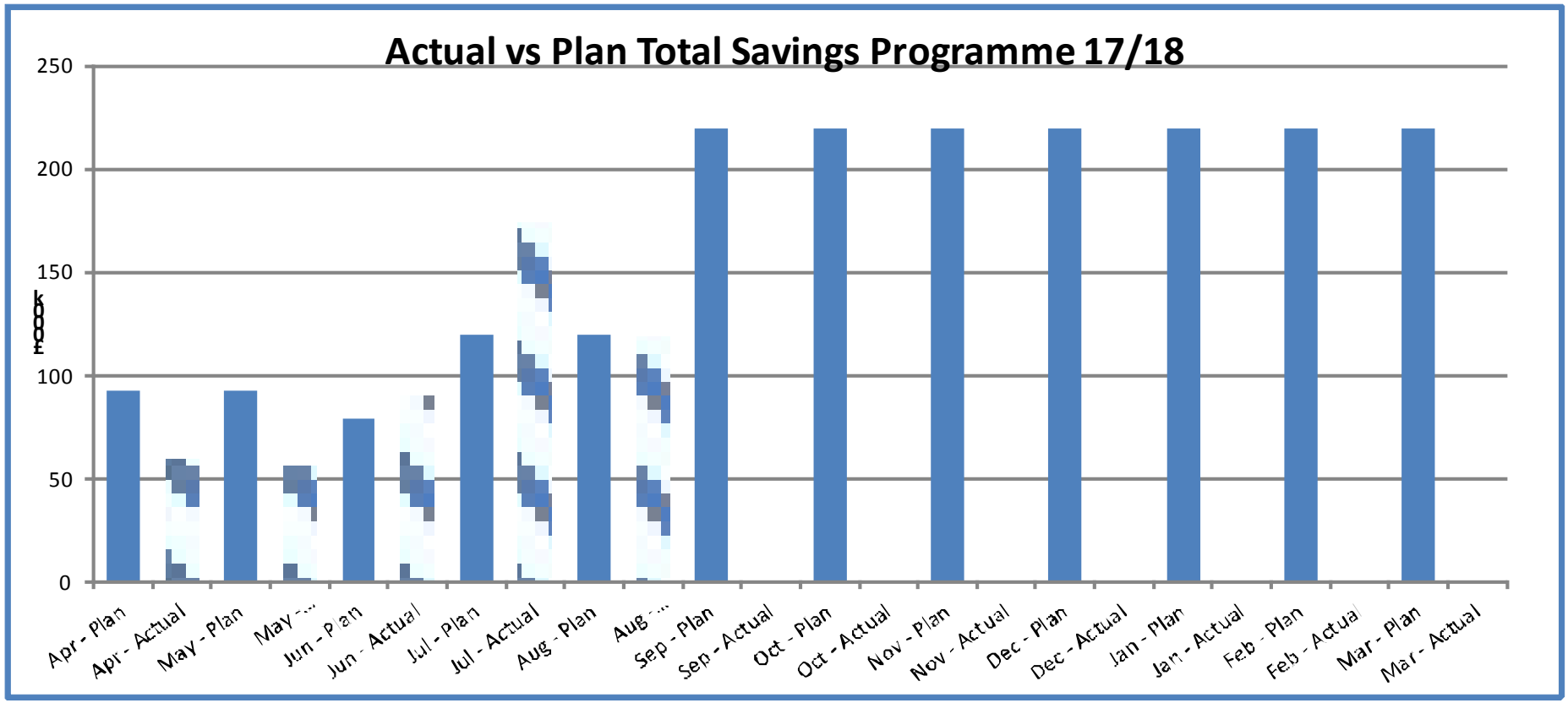
Bottom Ten Worse Performing (In month)

		Values							
Sheetname	Directorate	Annul Plan	Curr Mth Plan	Curr Mth Act	Curr Mth Var	YTD Plan	YTD Actual	YTD Var	FOT
Non Pay Items	Surgery	480.00	40.00	3.85	-36.15	200.00	109.53	-90.47	480.00
Ward Model Adherence	Medicine Frimley	995.76	82.98	47.00	-35.98	414.90	133.00	-281.90	497.88
New ED Rota	Medicine Frimley	405.00	33.75	0.00	-33.75	168.75	0.00	-168.75	236.25
Patient Appliances	Therapies	385.00	32.08	0.00	-32.08	160.42	96.25	-64.17	288.75
Medicine Add Medics Prod&agency	Medicine Wexham	350.00	29.17	0.00	-29.17	145.83	0.00	-145.83	
Review of Pain Service	Theatres Crit Care & A	300.00	25.00	0.00	-25.00	125.00	0.00	-125.00	
Exec Pharmacy	Pharmacy	300.00	25.00	0.00	-25.00	125.00	29.90	-95.10	358.80
Non-Medics Agency Prem	Theatres Crit Care & A	250.00	20.83	0.00	-20.83	104.17	0.00	-104.17	0.00
AHP Agency Premium Reduction	Radiology	335.50	27.96	7.13	-20.83	139.78	129.16	-10.62	335.50
DSU HWD	Theatres Crit Care & A	200.00	20.00	0.00	-20.00	60.00	17.00	-43.00	100.00
Grand Total		**4,001.26**	**336.77**	**57.98**	**-278.79**	**1,643.84**	**514.84**	**-1,129.00**	**2,297.18**

Estates & Facilities

Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,047	120	119	-1	98.8%	506	499	-7	98.7%	1,958	95.7%



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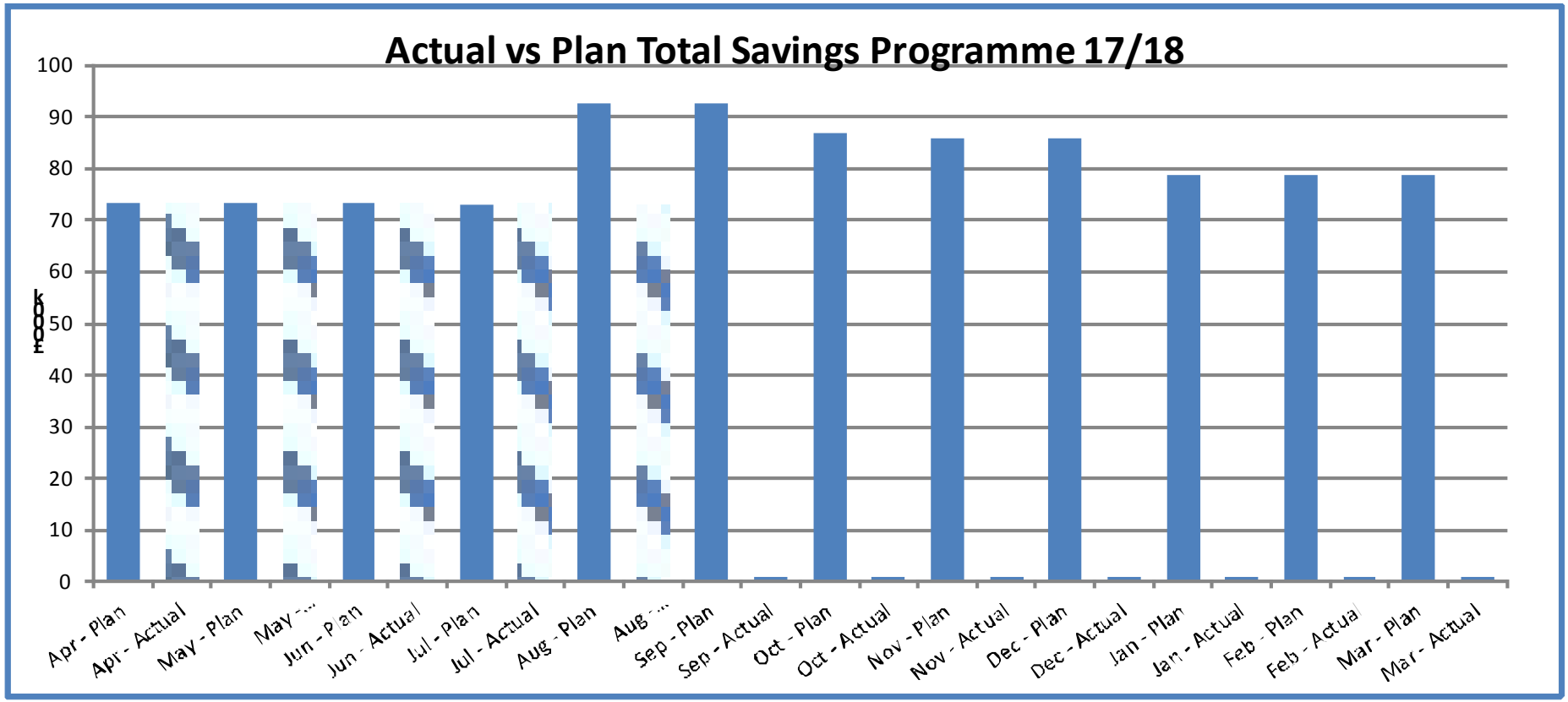
		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Estates & Facilities	**16.01** Introduce Hybrid Mail	200	0	0	0	0	0	0	170
	16.02 Bed Maintenance	90	8	8	0	38	38	0	90
	16.03 Water Management Contract	290	-21	-11	11	-63	-32	32	290
	16.04 Energy Savings-Lighting	70	8	9	1	16	18	2	50
	16.05 Medical Devices Maint	150	17	17	0	33	34	1	111
	16.06 Car Parking Charges	150	17	17	0	33	33	0	150
	16.07 Bus Contract	70	7	7	0	21	21	0	70
	16.08 Linen Management	50	4	4	0	21	21	0	50
	16.09 Capital Estates Team	600	50	51	1	250	246	-4	600
	16.10 Telecoms and Pagers	30	3	0	-3	13	0	-13	30
	16.11 HR Estates TARGET	75	6	0	-6	31	0	-31	75
	16.12 Exec Catering	200	17	17	0	83	120	37	200
	16.13 Synergy E&F	72	6	0	-6	30	0	-30	72
Grand Total		**2,047**	**120**	**119**	**-1**	**506**	**499**	**-7**	**1,958**

Finance

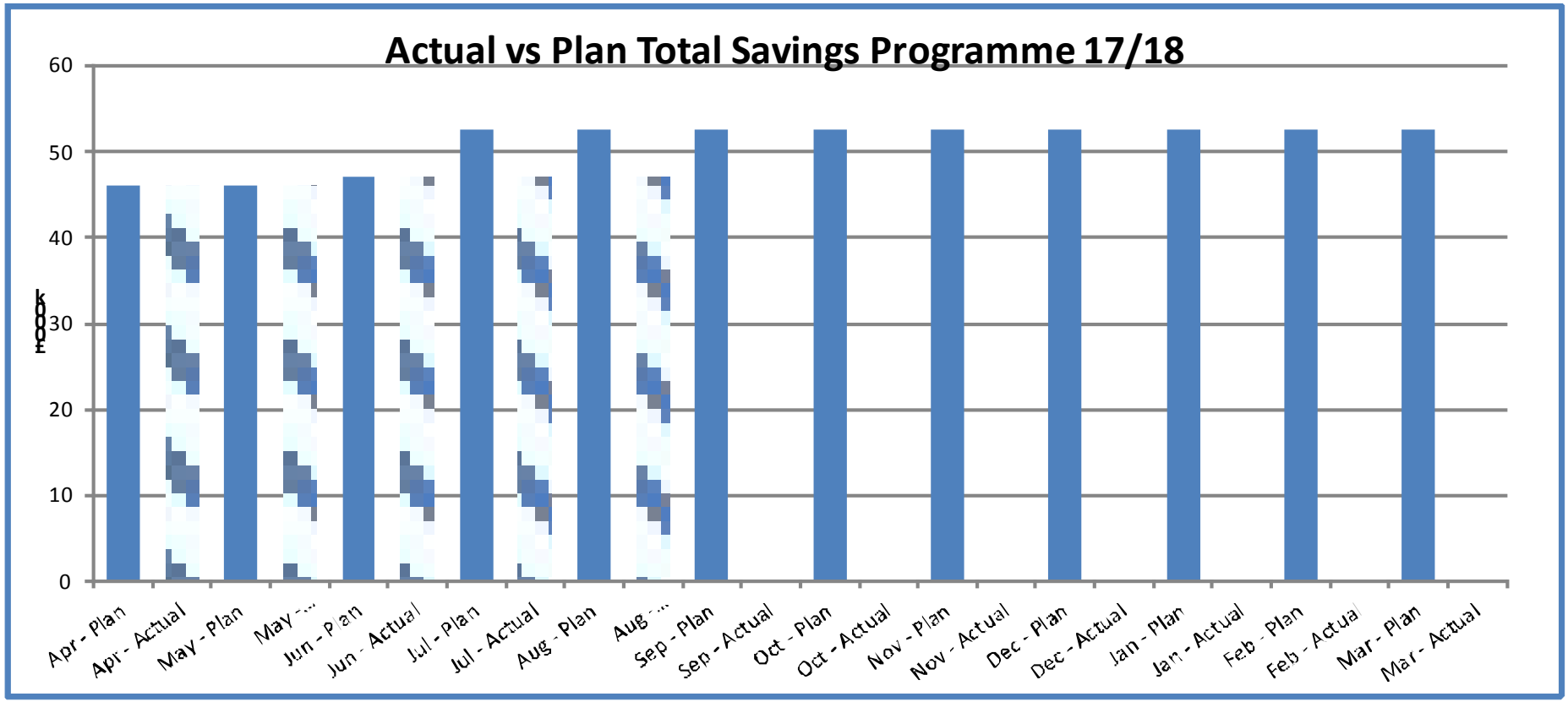
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
974	93	73	-20	78.8%	386	367	-19	95.0%	974	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Finance	**2.01** Agency Reductions	107	14	14	0	71	71	0	107
	2.02 Controllable Non-Pay Top Slice	7	1	1	0	3	3	0	7
	2.03 Late Payment Interest Charges	3	0	0	0	1	1	0	3
	2.04 Charge Capital Acct to Capital	0	0	0	0	0	0	0	
	2.05 Staff Restructure	157	20	0	-20	20	0	-20	157
	2.06 Exec Contingency	700	58	58	0	292	292	0	700
Grand Total		**974**	**93**	**73**	**-20**	**386**	**367**	**-19**	**974**

HR

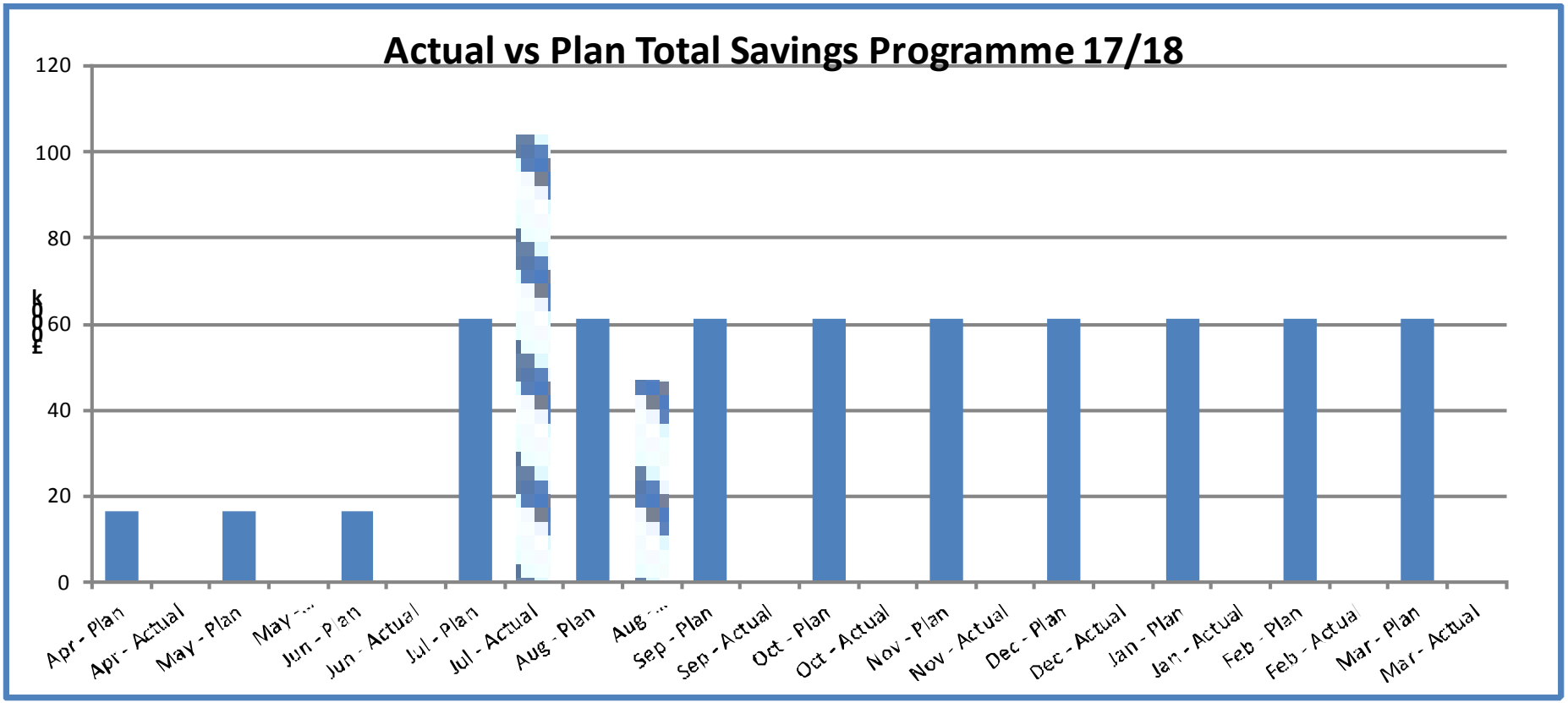
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
613	53	47	-6	89.4%	245	233	-12	95.3%	563	91.8%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
HR	**20.01** HR Staff Reduction	31	3	3	0	13	14	1	31
	20.02 HR Restructure	15	1	1	0	6	5	-1	15
	20.03 HR Nursery Income	5	0	0	0	2	2	0	5
	20.04 HR Pay Budget Savings	52	4	4	0	22	21	-1	52
	20.05 HR Agency Premium	7	1	1	0	3	3	0	7
	20.06 HR Removal Expenses	121	10	10	0	50	50	0	121
	20.07 HR Non-Pay Budget Redn	109	9	9	0	45	45	0	109
	20.08 HR Non-Pay IiP	42	4	4	0	18	18	0	42
	20.09 HR Agency Health & Safety	10	1	1	0	3	3	0	10
	20.10 HR Reorg Comms & Engagement	25	2	2	0	10	10	0	25
	20.11 HR Trust Magazine	25	2	2	0	10	10	0	25
	20.12 HR Payroll	12	1	1	0	5	5	0	12
	20.13 HR Accomodation	9	1	1	0	4	4	0	9
	20.14 Exec Non-Clinical Agency	100	8	8	0	42	42	0	100
	20.15 HR Non Clinical Agency	50	6	0	-6	11	0	-11	
Grand Total		**613**	**53**	**47**	**-6**	**245**	**233**	**-12**	**563**

IM&T

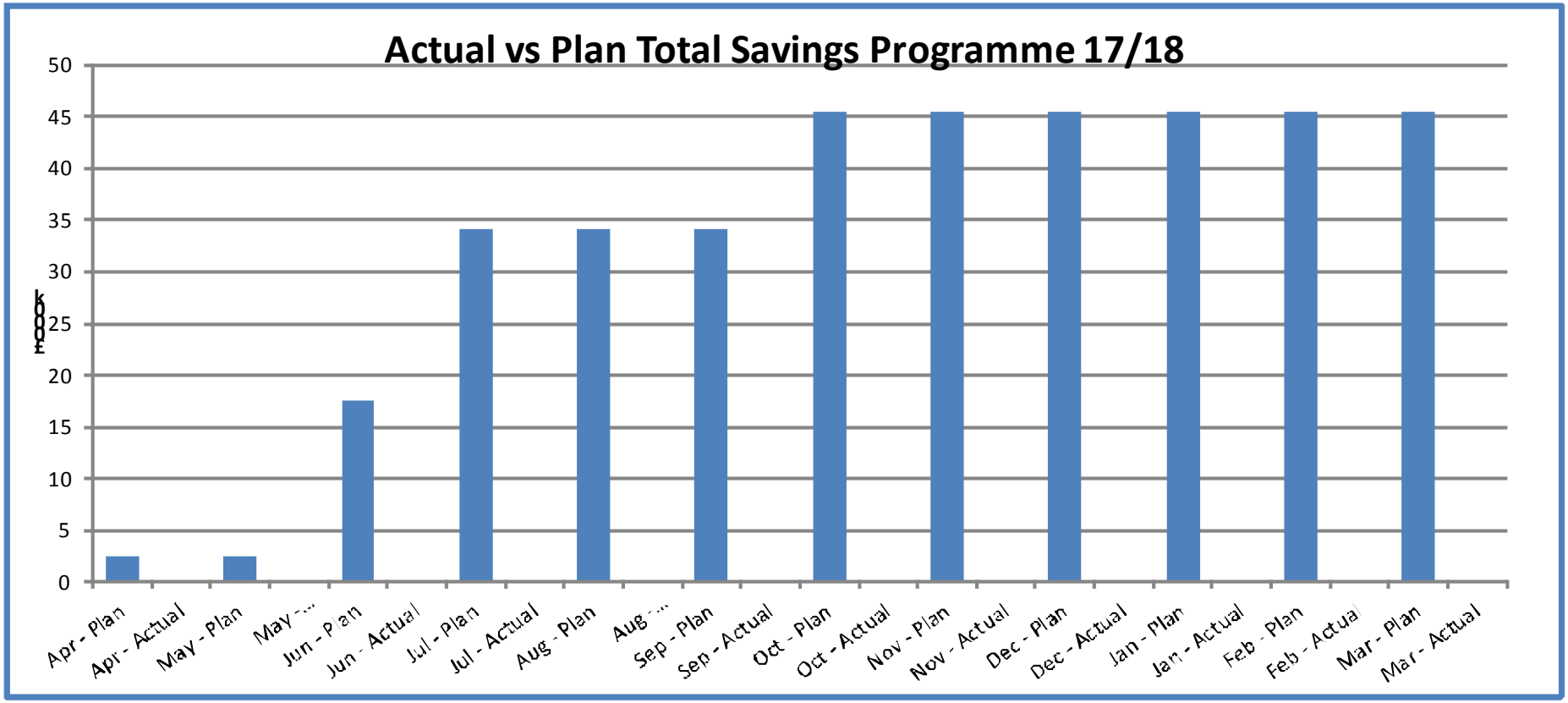
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
613	53	47	-6	89.4%	245	233	-12	95.3%	563	91.8%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
IM&T	**15.01** IM&T Agency reduction	400	44	47	3	89	151	62	400
	15.02 Exec IM&T	200	17	0	-17	83	0	-83	200
Grand Total		**600**	**61**	**47**	**-14**	**172**	**151**	**-21**	**600**

Medical Director

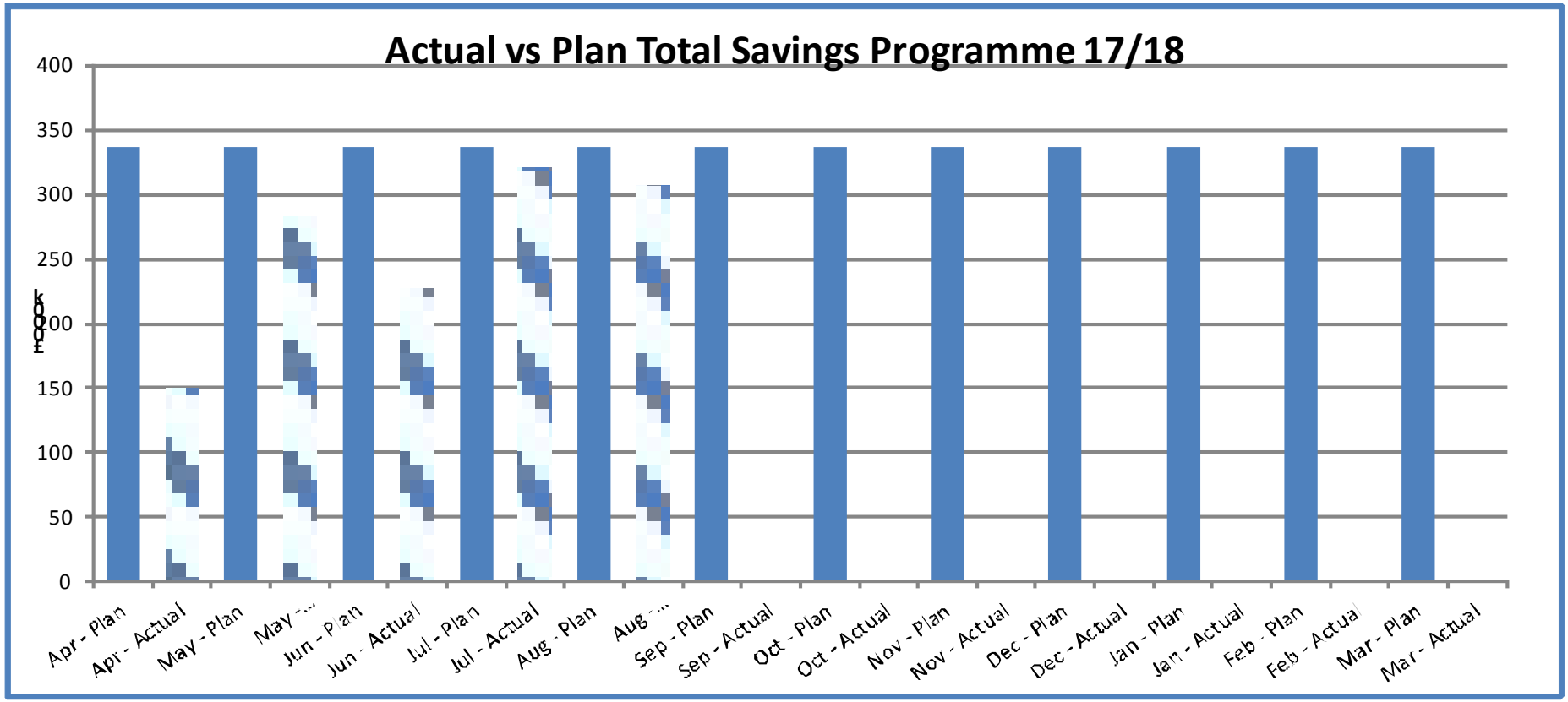
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
600	61	47	-14	76.9%	172	151	-21	87.7%	600	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Medical Director	**17.01** PGEC Restructure	30	3	0	-3	13	0	-13	30
	17.02 MEDIR Deanery Funding	150	15	0	-15	45	0	-45	
	17.03 MEDIR PGEC Catering	68	0	0	0	0	0	0	68
	17.04 MEDIR Job Plan	150	17	0	-17	33	0	-33	
Grand Total		**398**	**34**	**0**	**-34**	**91**	**0**	**-91**	**98**

Medicine Frimley

Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
398	34	0	-34	0.0%	91	0	-91	0.0%	98	24.6%

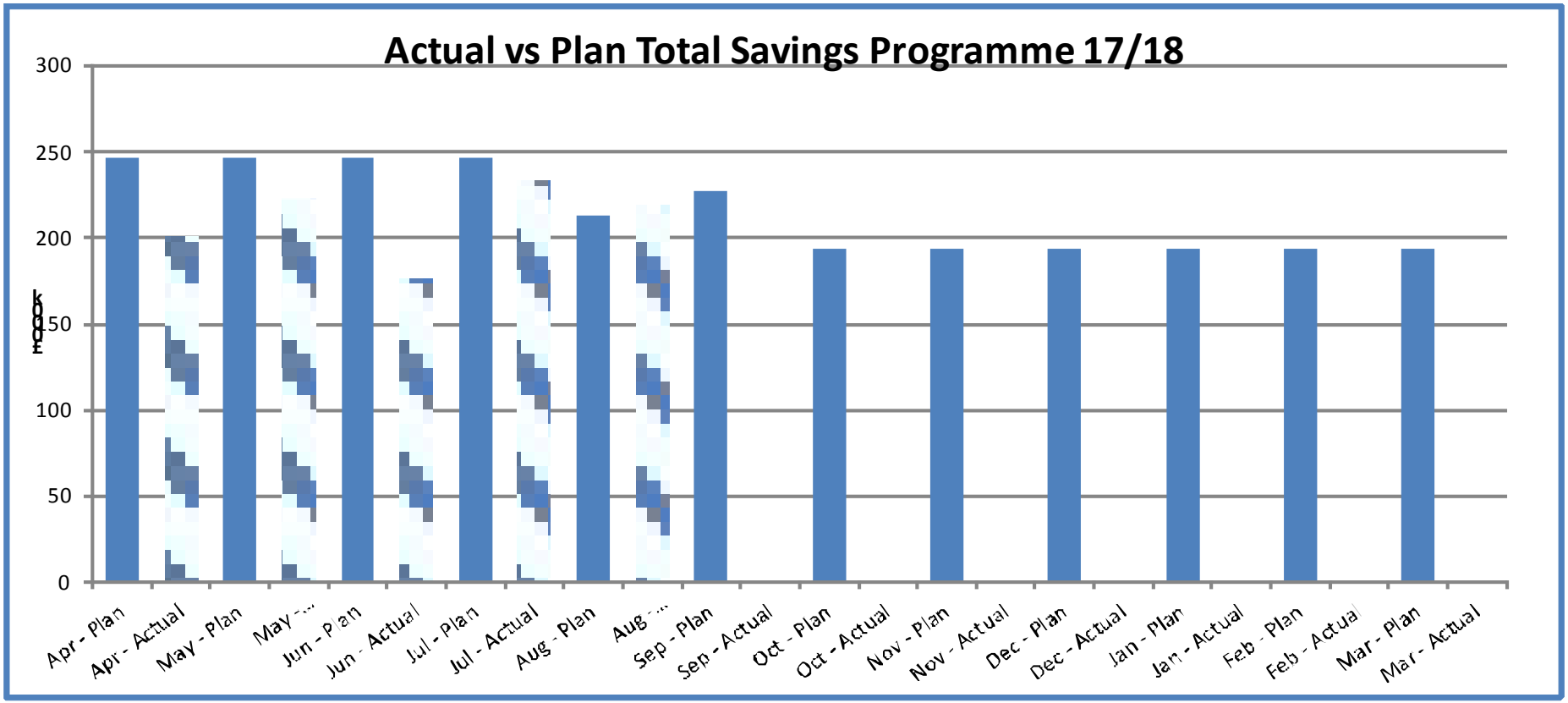


17

		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Medicine Frimley	**12.01** Endoscopy WLI	200	17	11	-6	83	39	-44	200
	12.02 Ward Model Adherence	996	83	47	-36	415	133	-282	498
	12.03 New ED Rota	405	34	0	-34	169	0	-169	236
	12.04 Medical Locum exit	703	59	73	14	293	241	-52	450
	12.05 Non Pay efficiencies	321	27	27	0	134	125	-9	540
	12.06 Cardiac Rehab Post	14	1	1	0	6	6	0	14
	12.07 Health Improvement Post	38	3	3	0	16	16	0	38
	12.08 ED Symphony Post	6	1	1	0	3	3	0	6
	12.09 FORT	100	8	8	0	42	42	0	100
	12.10 Hale Ward	1,064	89	134	45	443	670	226	1,064
	12.11 Exec Endoscopy	200	17	0	-17	83	0	-83	
	12.12 Medical Secretaries	0	0	3	3	0	13	13	30
Grand Total		**4,047**	**337**	**307**	**-30**	**1,686**	**1,286**	**-400**	**3,176**

Medicine Wexham

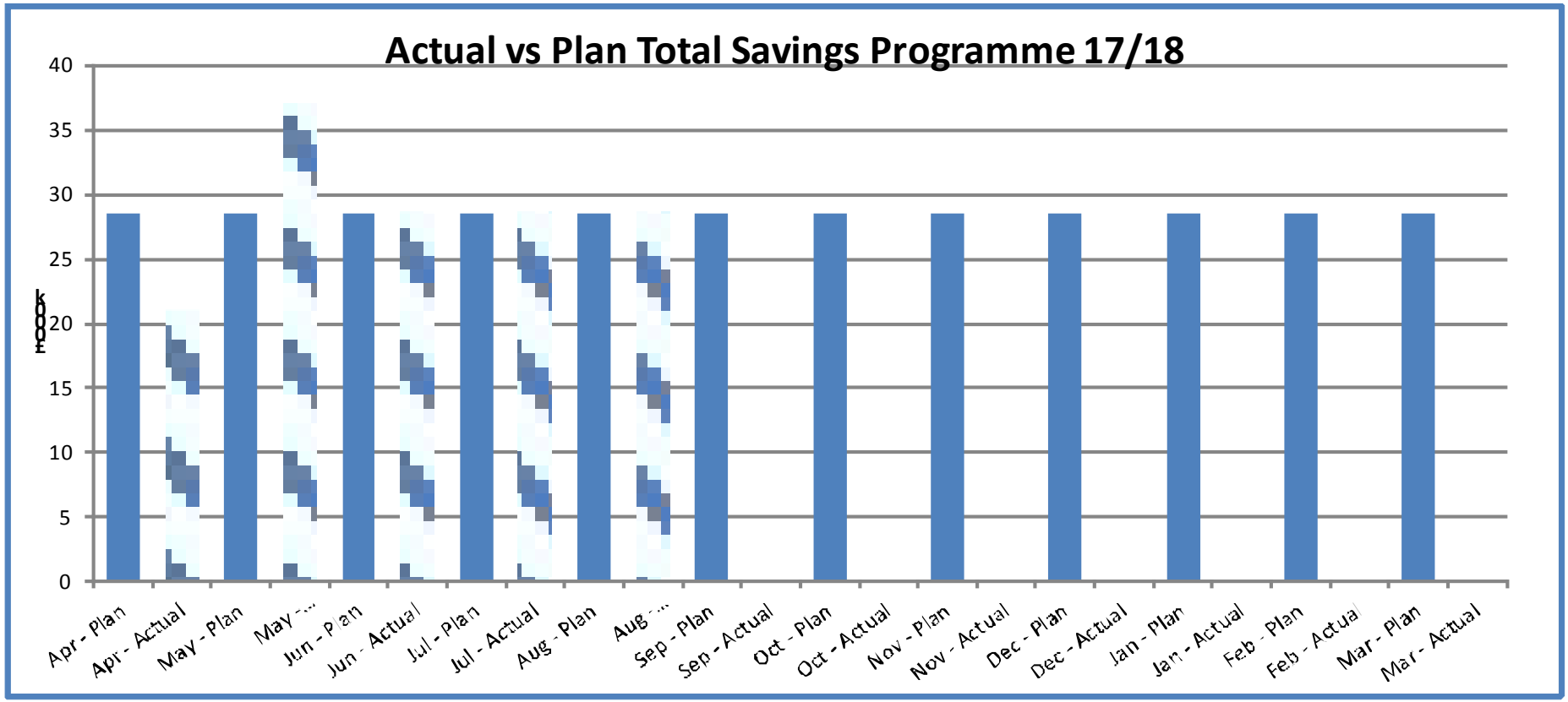
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,587	213	219	7	103.1%	1,198	1,051	-146	87.8%	1,954	75.5%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Medicine Wexham	**7.01** Medicine Nursing Seasonal	200	33	53	20	167	278	112	278
	7.02 Medicine Agency Cap Red. CF	135	0	0	0	135	135	0	135
	7.03 Med - ED Agency reduction CF	68	14	0	-14	68	0	-68	
	7.04 Medcine ED Medics agency saving	196	0	0	0	0	0	0	
	7.05 Medicine Medics Direct Engage	156	13	13	0	65	65	0	156
	7.07 Medicine Decommission Stroke	187	16	16	0	78	78	0	187
	7.08 Medicine CNS Review	90	8	4	-4	38	19	-19	45
	7.09 Medicine Ward 17 Restructure	64	5	5	0	27	27	0	64
	7.10 Medicine Diuretic Lounge	107	9	9	0	45	28	-17	88
	7.11 Medicine Frailty Unit	139	12	0	-12	58	0	-58	70
	7.12 Medicine Card Device Stock red	340	28	86	58	142	242	100	400
	7.13 Medicine Bowelscope	159	13	0	-13	66	0	-66	120
	7.14 Medicine Non-Pay 3%	47	4	4	0	20	20	0	47
	7.15 Medicine Nurse EscalationAgency	100	8	8	0	42	57	15	115
	7.16 Medicine Cardio Non-pay Review	50	4	4	0	21	21	0	50
	7.17 Medicine Add Medics Prod&agenc	350	29	0	-29	146	0	-146	
	7.18 Medicine Stretch on budget	200	17	17	0	83	83	0	200
Grand Total		**2,587**	**213**	**219**	**7**	**1,198**	**1,051**	**-146**	**1,954**

Nursing & Quality

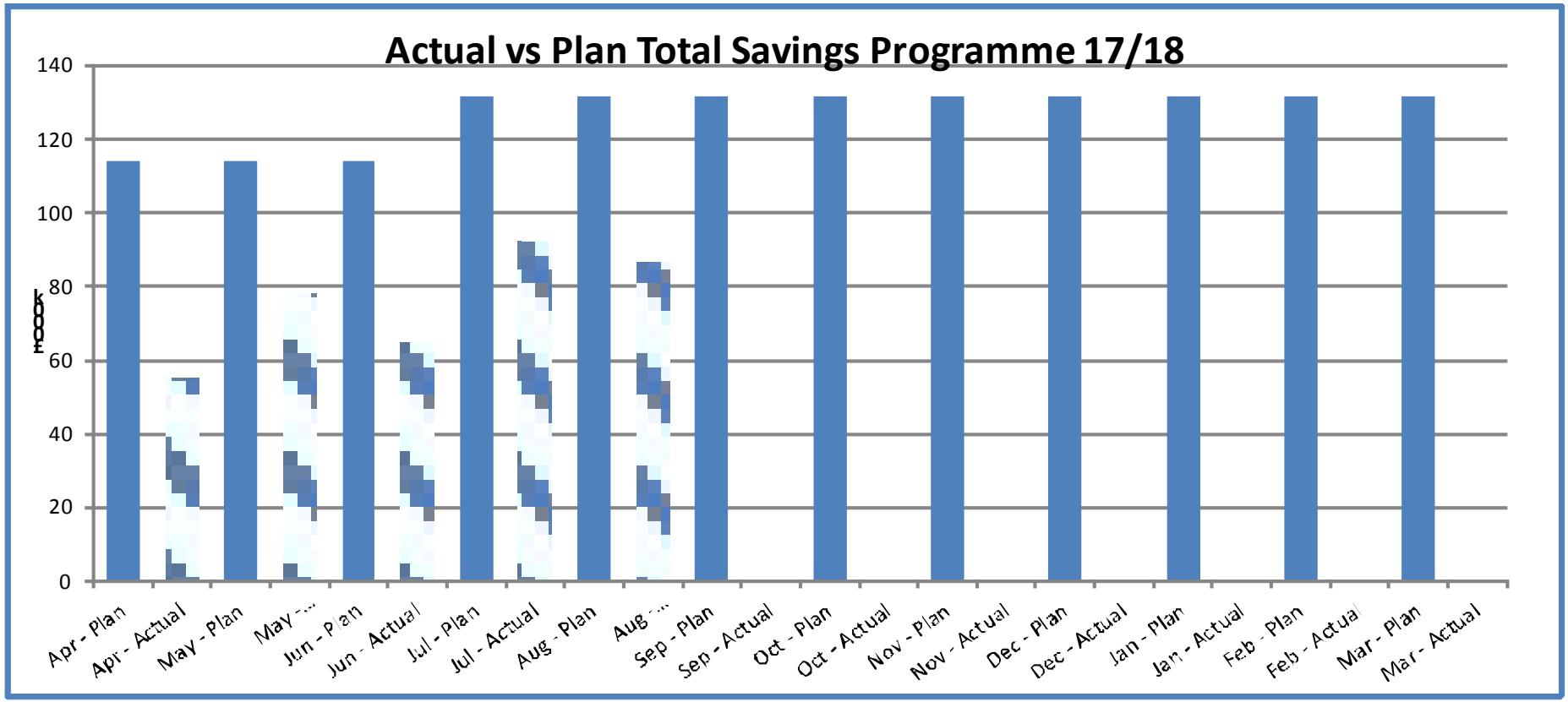
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,587	213	219	7	103.1%	1,198	1,051	-146	87.8%	1,954	75.5%



			Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Nursing & Quality	**19.01**	Nursing & Quality Furn & Fitgs	66	6	6	0	28	28	0	666
	19.02	Nursing & Quality Budget Redn	185	15	16	0	77	78	0	185
	19.03	Nursing & Quality CIP Stretch	92	8	8	0	38	39	0	
Grand Total			**343**	**29**	**29**	**0**	**143**	**144**	**1**	**851**

Orthopaedics & Plastics

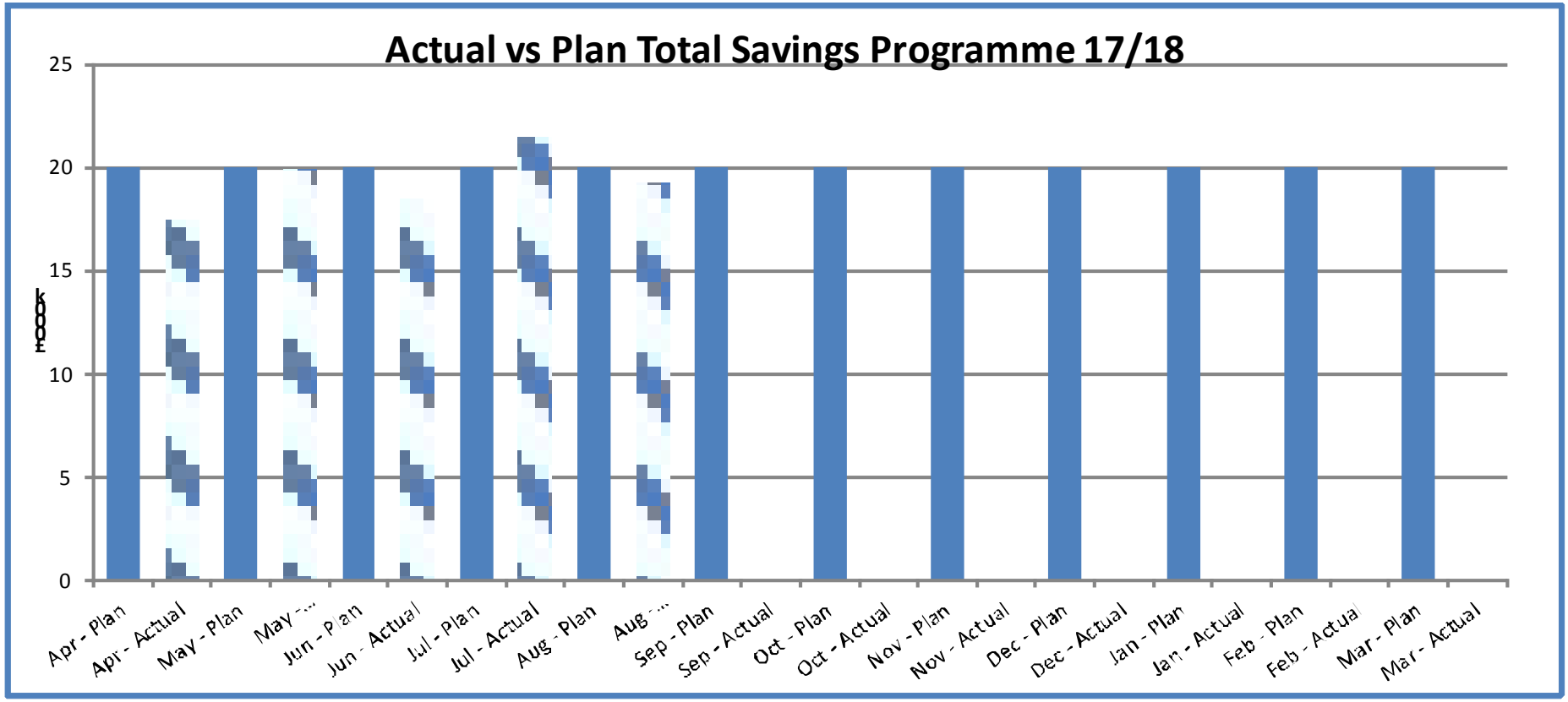
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
343	29	29	0	100.1%	143	144	1	100.6%	851	248.1%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Orthopaedics & Plasti	**10.01** Removal of PO Services	157	17	0	-17	35	0	-35	78
	10.02 Retire & Return Ortho	56	5	5	0	23	24	0	56
	10.03 Medirota Implementation Ortho	30	3	0	-3	13	0	-13	23
	10.04 Reduction on Bank B2s	277	23	9	-15	115	32	-84	221
	10.05 Agency Premium Reduction (2)	90	8	8	0	38	38	0	90
	10.06 Admin Agency Removal	18	2	2	0	8	8	0	18
	10.07 Plastics Locum Consultant	36	3	3	0	15	15	0	36
	10.08 Additional Sessions Controls	126	11	11	0	53	11	-42	63
	10.09 Ward 2 Phased Bed Capacity	69	6	6	0	29	6	-23	69
	10.10 Heatherwood Staffing Models	96	8	8	0	40	51	11	96
	10.11 Reduce Printing & Stationary	8	1	1	0	3	3	0	8
	10.12 Ward Non Pay Controls	25	2	2	0	10	10	0	25
	10.13 Ortho Theatre Orders Control	140	12	12	0	58	58	0	140
	10.14 Cons PAs Review Cross Site	120	10	0	-10	50	0	-50	60
	10.15 Direct Engagements	20	2	2	0	8	8	0	20
	10.16 On Call Reduction 3% to 5%	8	1	0	-1	3	0	-3	8
	10.17 Plastics Rota Reconfiguration	130	11	11	0	54	64	10	130
	10.18 Supplies further Reductions	120	10	10	0	50	50	0	120
Grand Total		**1,526**	**132**	**86**	**-45**	**605**	**377**	**-228**	**1,261**

Outpatients FPH

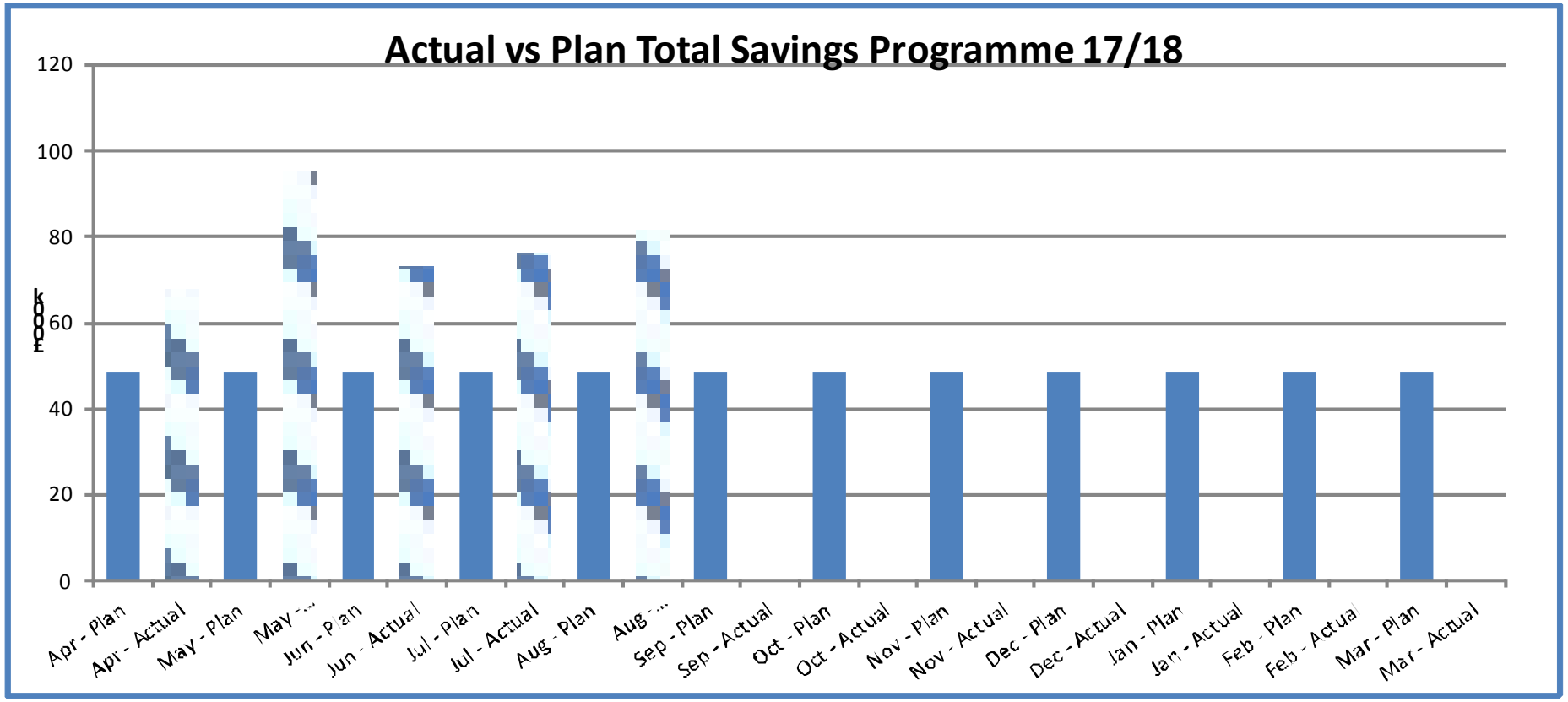
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
240	20	19	-1	96.3%	100	97	-3	96.7%	267	111.3%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Outpatients FPH	**14.01** Outpatients - Agency	75	6	6	0	31	31	0	75
	14.02 Medical Records Overnight	17	1	1	0	7	7	0	17
	14.03 On Call	30	3	3	0	13	13	0	30
	14.04 Courier Costs	13	1	0	-1	5	0	-5	13
	14.05 Headed Paper	5	0	0	0	2	0	-2	5
	14.06 CDC	100	8	8	0	42	42	0	100
	14.07 Medical Records Out of Hours	0	0	0	0	0	0	0	
	14.08 Pay Protection	0	0	1	1	0	4	4	27
Grand Total		**240**	**20**	**19**	**-1**	**100**	**97**	**-3**	**267**

Outpatients WPH

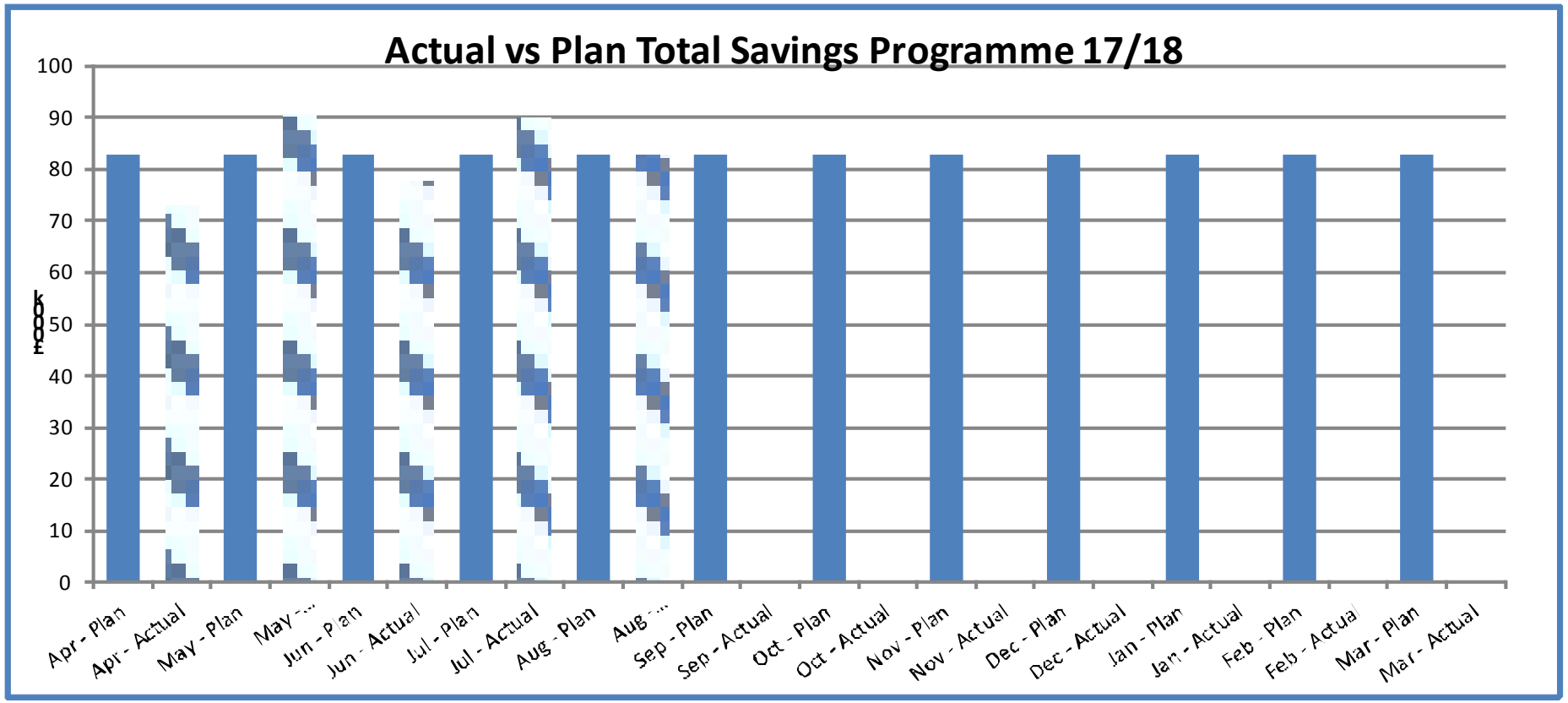
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
585	49	81	33	166.7%	244	393	150	161.3%	634	108.4%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Outpatients WPH	**8.01** OPs Wex - Emergency Planning	6	1	2	2	3	4	2	6
	8.02 OPs Wex - Acute Pat Mgt	39	3	13	10	16	53	37	38
	8.03 OPs Wex - Discharge Lounge	20	2	5	3	8	22	14	20
	8.04 OPs Wex - Dir of OPs cons fees	50	4	4	0	21	21	0	50
	8.05 OPs Wex - OP Choose&Book	24	2	0	-2	10	24	14	24
	8.06 OPs Wex - Pvt Amb	100	8	33	24	42	84	42	150
	8.07 OPs Wex - OP Non-Pay Review	40	3	0	-3	17	62	45	40
	8.08 OPs Wex - OP EDMS	0	0	0	0	0	0	0	
	8.09 Pharm Repackag income growth	10	1	0	-1	4	0	-4	10
	8.10 OPs Wex PP Income	150	13	12	-1	63	63	0	150
	8.11 OPs Wex Pharm Fleet BC	0	0	0	0	0	0	0	
	8.12 OPs Wex Pharm Virgin Care	0	0	0	0	0	0	0	
	8.13 OPs Wex Iron Mountain	22	2	2	0	9	9	0	22
	8.14 OPs Wex Zero Based Review	125	10	10	0	52	52	0	125
Grand Total		**585**	**49**	**81**	**33**	**244**	**393**	**150**	**634**

Paeds Mat & Gynae

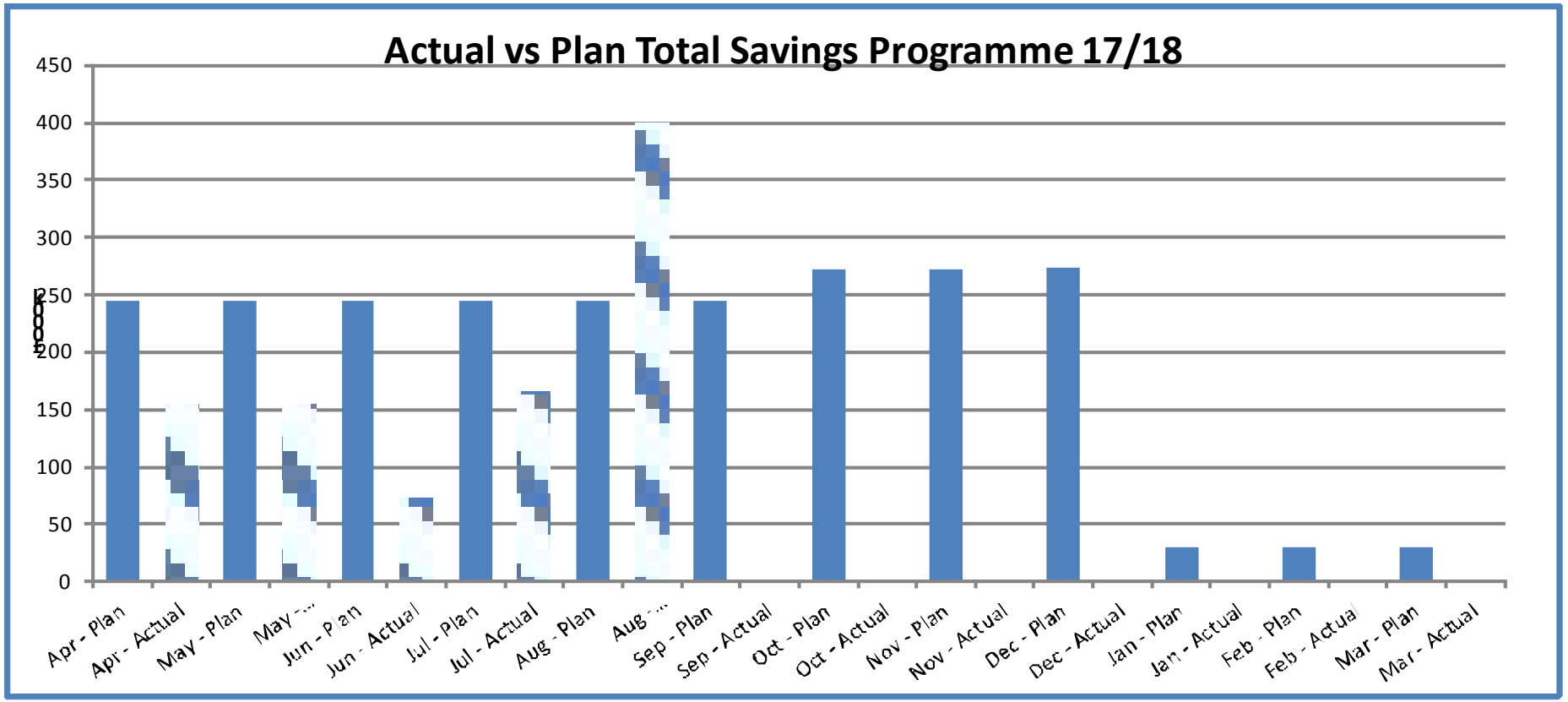
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
993	83	83	0	100.0%	414	414	0	100.0%	993	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Paeds Mat & Gynae	**1.01** Community Paeds Cessation	400	33	33	0	167	167	0	400
	1.02 Gynae Nursing Establishment Rev	93	8	8	0	39	39	0	93
	1.03 Agency Premium Reduction	200	17	17	0	83	83	0	200
	1.04 Non-Pay Review	50	4	4	0	21	21	0	50
	1.05 CIP Stretch Target £250k	250	21	21	0	104	104	0	250
Grand Total		**993**	**83**	**83**	**0**	**414**	**414**	**0**	**993**

Pathology

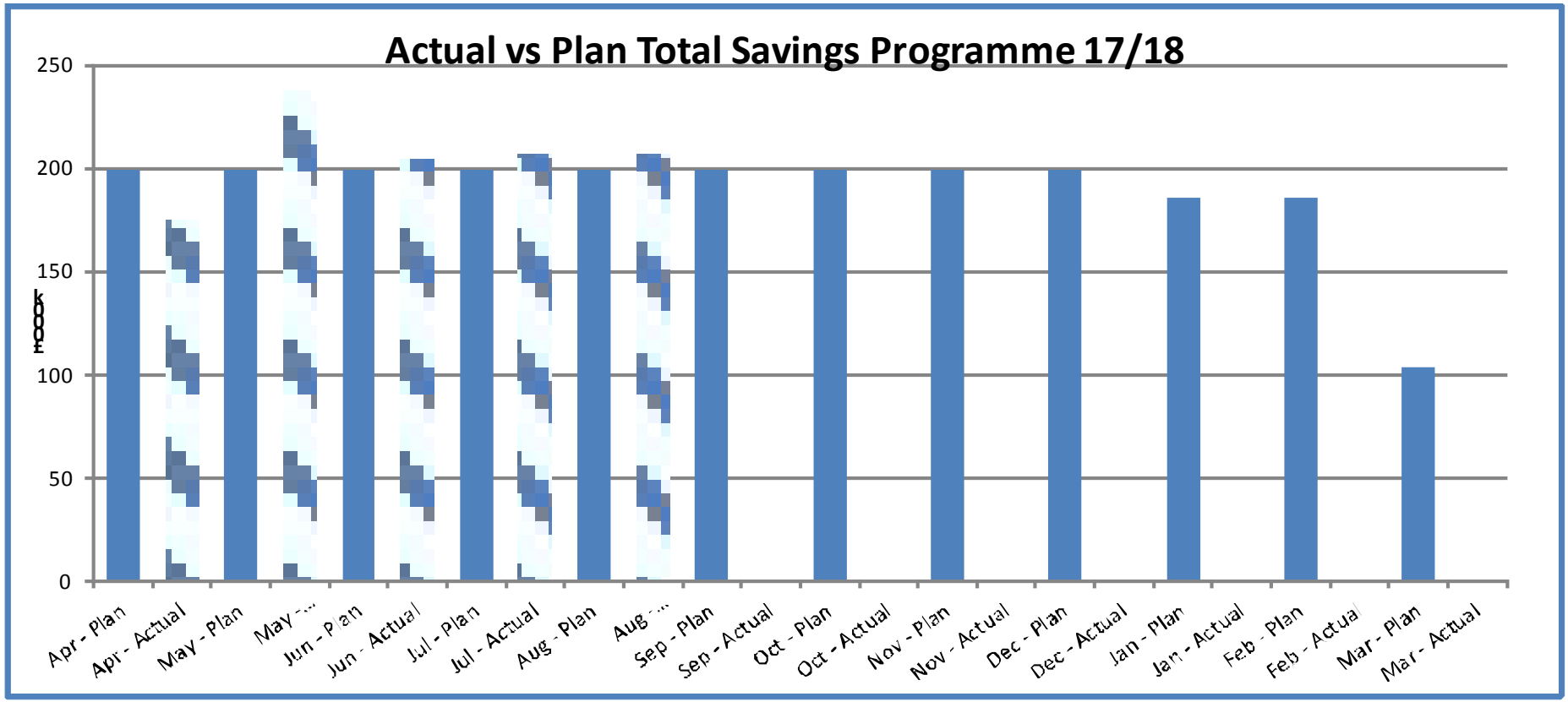
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,379	245	400	155	163.2%	1,226	948	-278	77.3%	1,927	81.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Pathology	**3.01** BSPS Integration Savings	2,379	245	400	155	1,226	948	-278	1,927
Grand Total		**2,379**	**245**	**400**	**155**	**1,226**	**948**	**-278**	**1,927**

Pharmacy

Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,273	200	207	8	103.9%	998	1,031	33	103.3%	2,678	117.8%



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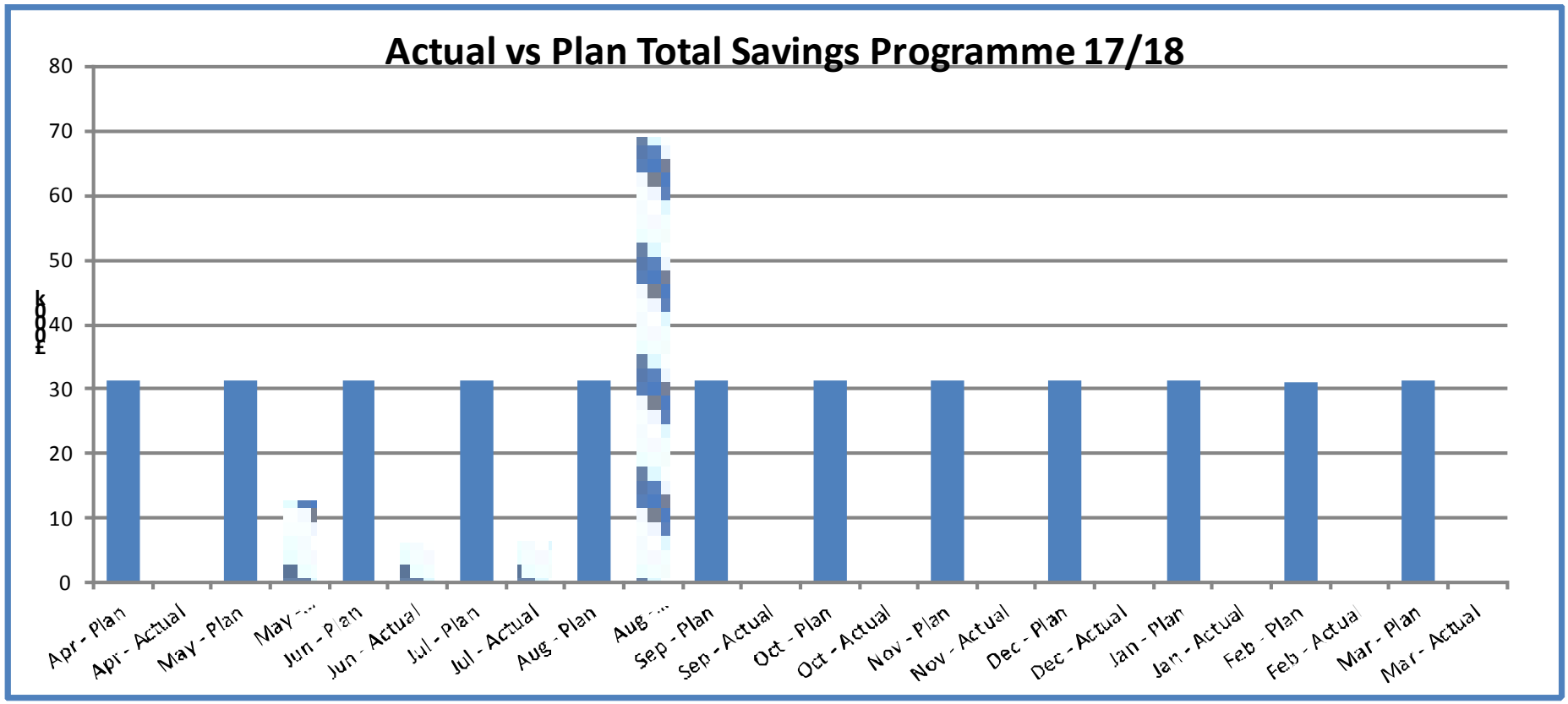
		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Pharmacy	**9.01** Pharm Drugs Imatinib CF	902	82	72	-10	410	370	-40	863
	9.02 Pharm Drugs Carry forward	191	16	22	6	80	102	23	259
	9.03 Pharm Drugs Stock holding	250	21	21	0	104	104	0	250
	9.04 Pharm Drugs Rituximab GS Rhuem	50	4	6	2	21	27	6	69
	9.05 Pharm Drugs Rituximab pass thru	400	33	48	15	167	226	59	400
	9.06 Pharm Drugs Dexamethasone	32	4	4	1	18	21	3	52
	9.07 Pharm Drugs Caspofungin GS	30	3	0	-3	13	-1	-13	
	9.08 Pharm Drugs Caspofungin passthr	30	3	35	32	13	142	129	417
	9.09 Pharmacy Drugs Voriconazole CF	88	10	0	-10	49	10	-39	10
	9.10 Exec Pharmacy	300	25	0	-25	125	30	-95	359
Grand Total		**2,273**	**200**	**207**	**8**	**998**	**1,031**	**33**	**2,678**

Private Patients

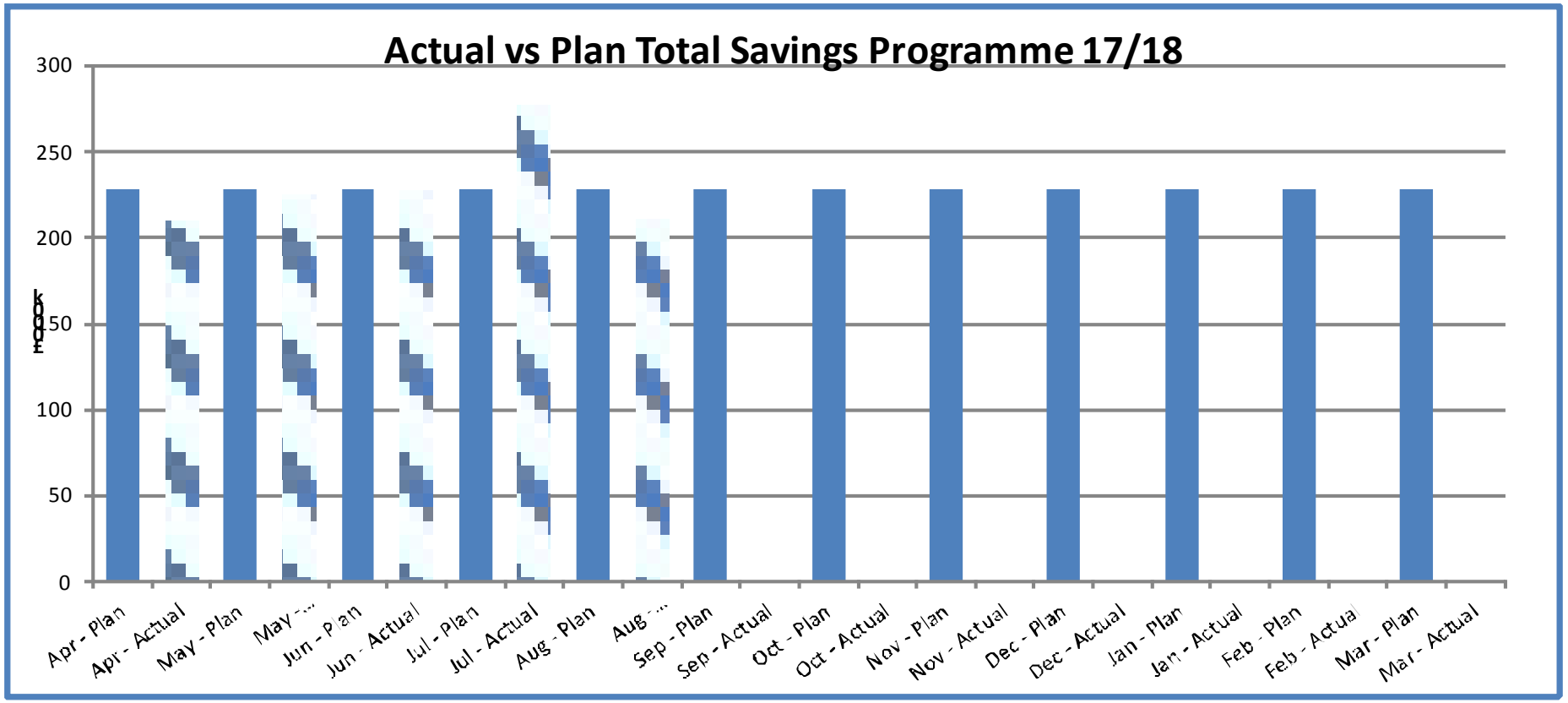
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
375	31	69	38	220.8%	156	94	-63	60.0%	350	93.3%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Private Patients	**6.01** Outpatient Development Inc	75	6	6	0	31	31	-1	75
	6.02 Weekend Operating Lists Inc	0	0	0	0	0	0	0	0
	6.03 Paragon Increased Act (PRefurb)	100	8	0	-8	42	0	-42	100
	6.04 Compucare Billing Efficiency	50	4	0	-4	21	0	-21	25
	6.05 Overseas Add Data Capture	150	13	63	51	63	63	1	150
Grand Total		**375**	**31**	**69**	**38**	**156**	**94**	**-63**	**350**

Procurement

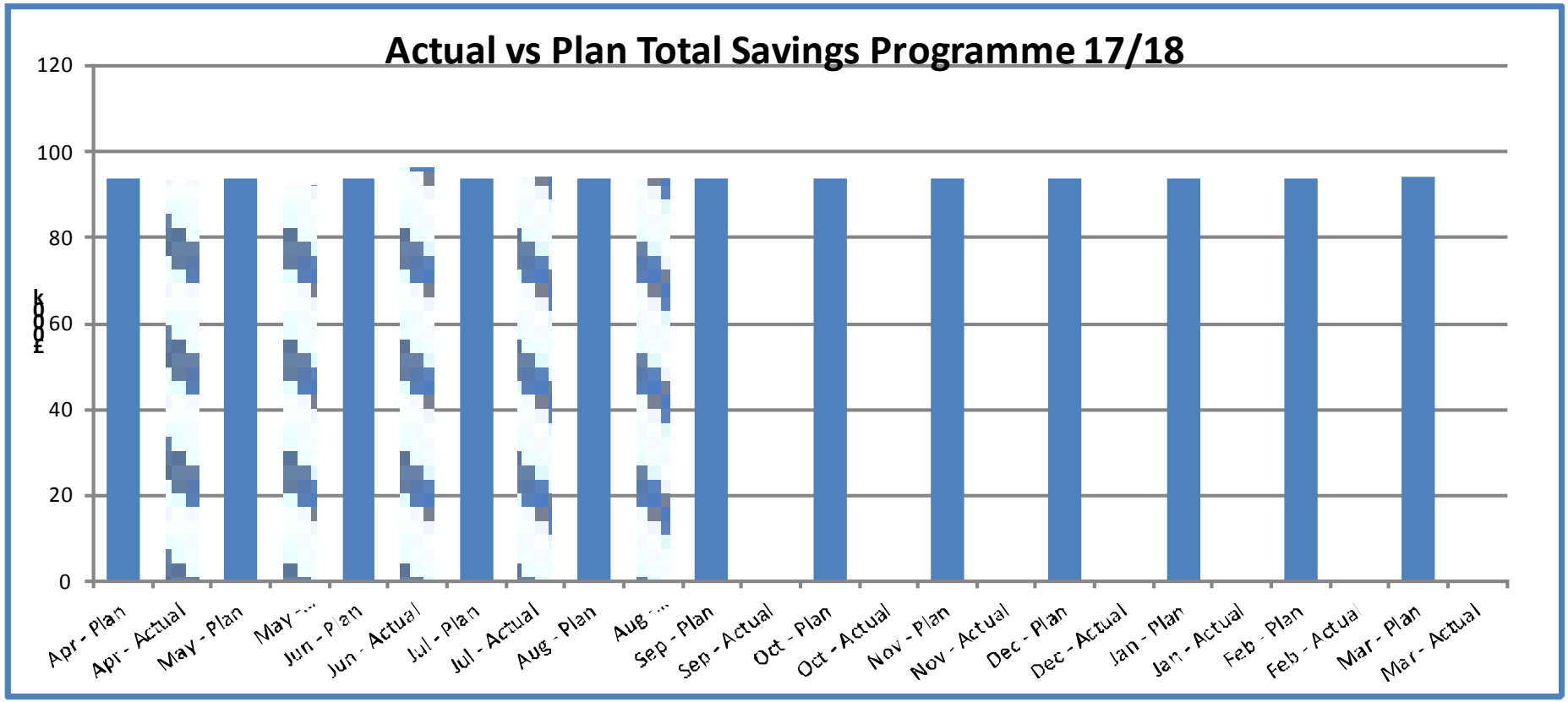
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,741	228	210	-18	92.1%	1,142	1,149	7	100.6%	2,741	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Procurement	**18.01** Procurement	2,141	178	178	0	892	892	0	2,141
	18.02 Synergy Procurement	400	33	32	-1	167	165	-1	400
	18.03 Exec Procurement	200	17	0	-17	83	92	9	200
Grand Total		**2,741**	**228**	**210**	**-18**	**1,142**	**1,149**	**7**	**2,741**

Radiology

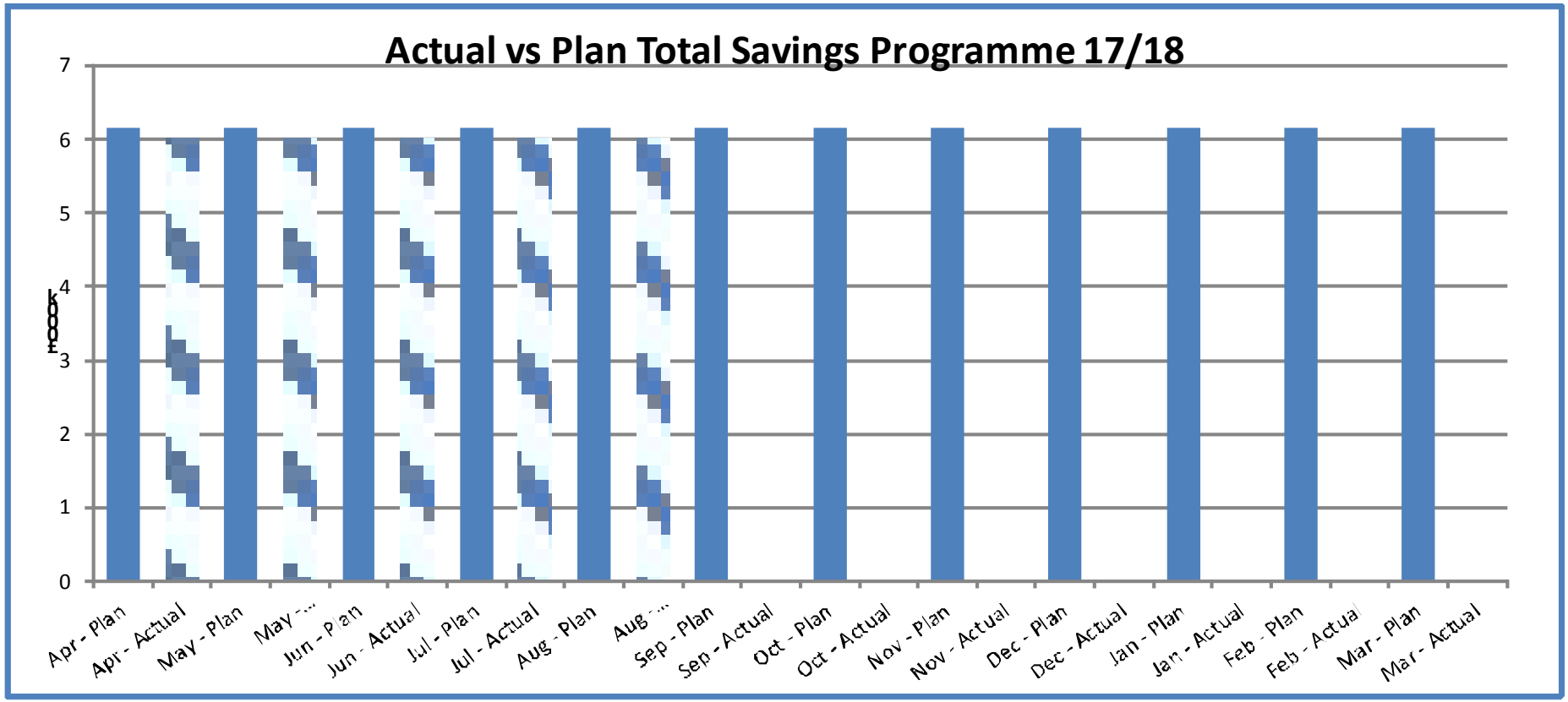
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
1,126	94	94	-0	99.9%	469	469	0	100.1%	1,126	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Radiology	**5.01** AHP Agency Premium Reduction	336	28	7	-21	140	129	-11	336
	5.02 MSSE Stock Reduction	100	8	8	0	42	42	0	100
	5.03 Reduce Cons reporting rates	68	6	6	0	29	29	0	68
	5.04 Reduce Outsourced Reporting	38	3	3	0	16	33	17	38
	5.05 CT Mobile Hire reduction WLI	50	4	26	22	21	72	51	50
	5.06 Reduce Maintenance Cover Levels	223	19	19	0	93	84	-9	223
	5.07 MRI Managed Serv Red 2018	125	10	0	-10	52	10	-42	125
	5.08 Provider Contracts Review	100	8	0	-8	42	19	-23	100
	5.09 Mobile Hire costs reduction WPH	35	3	3	0	15	15	0	35
	5.10 Mobile Hire costs reduction FPH	25	2	20	18	10	28	17	25
	5.11 Reduce Outsourced Reports (TMC)	25	2	2	0	10	10	0	25
Grand Total		**1,126**	**94**	**94**	**0**	**469**	**469**	**0**	**1,126**

Research & Development

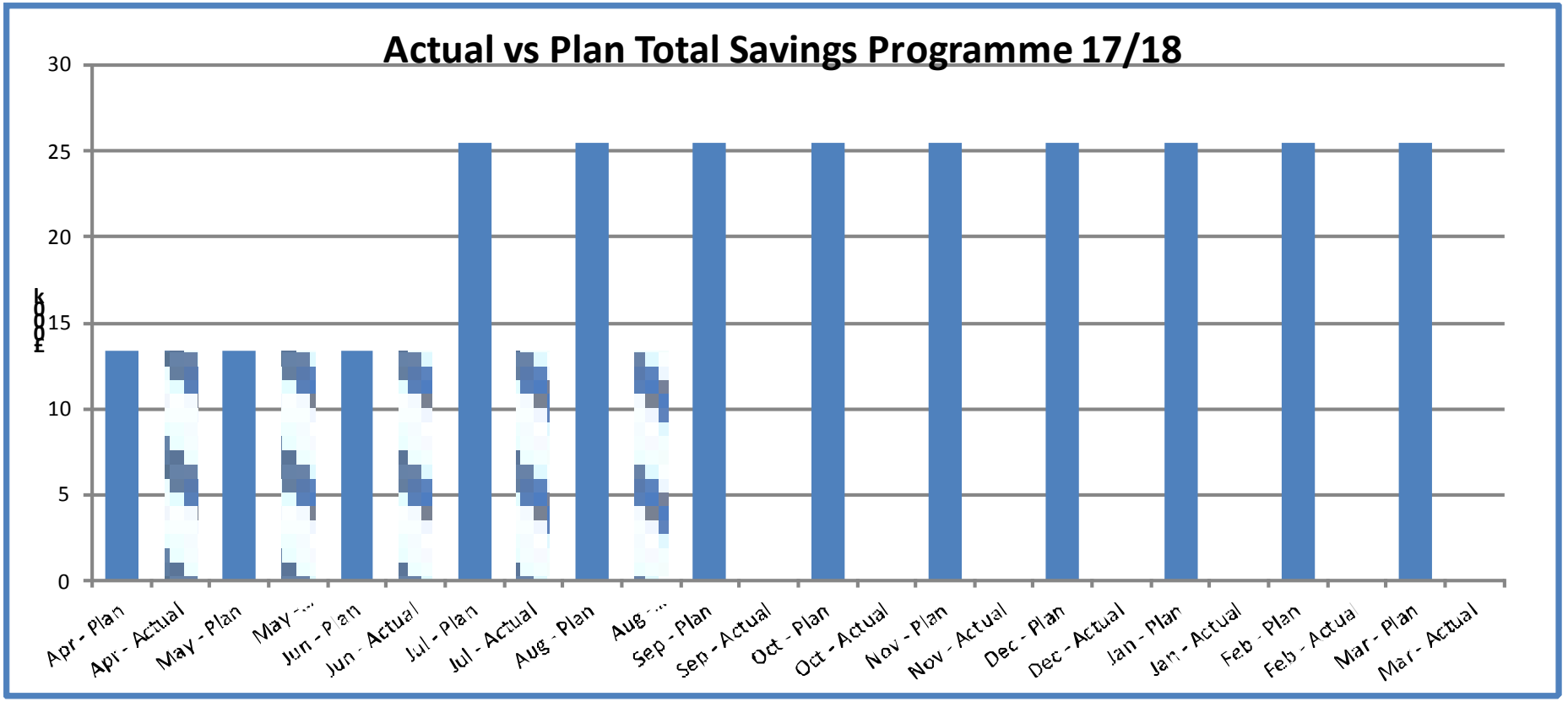
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
74	6	6	-0	97.3%	31	30	-1	97.3%	74	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Research & Developn	**25.01** R&D - Breakeven	74	6	6	0	31	30	-1	74
Grand Total		**74**	**6**	**6**	**0**	**31**	**30**	**-1**	**74**

Strategy & Performance

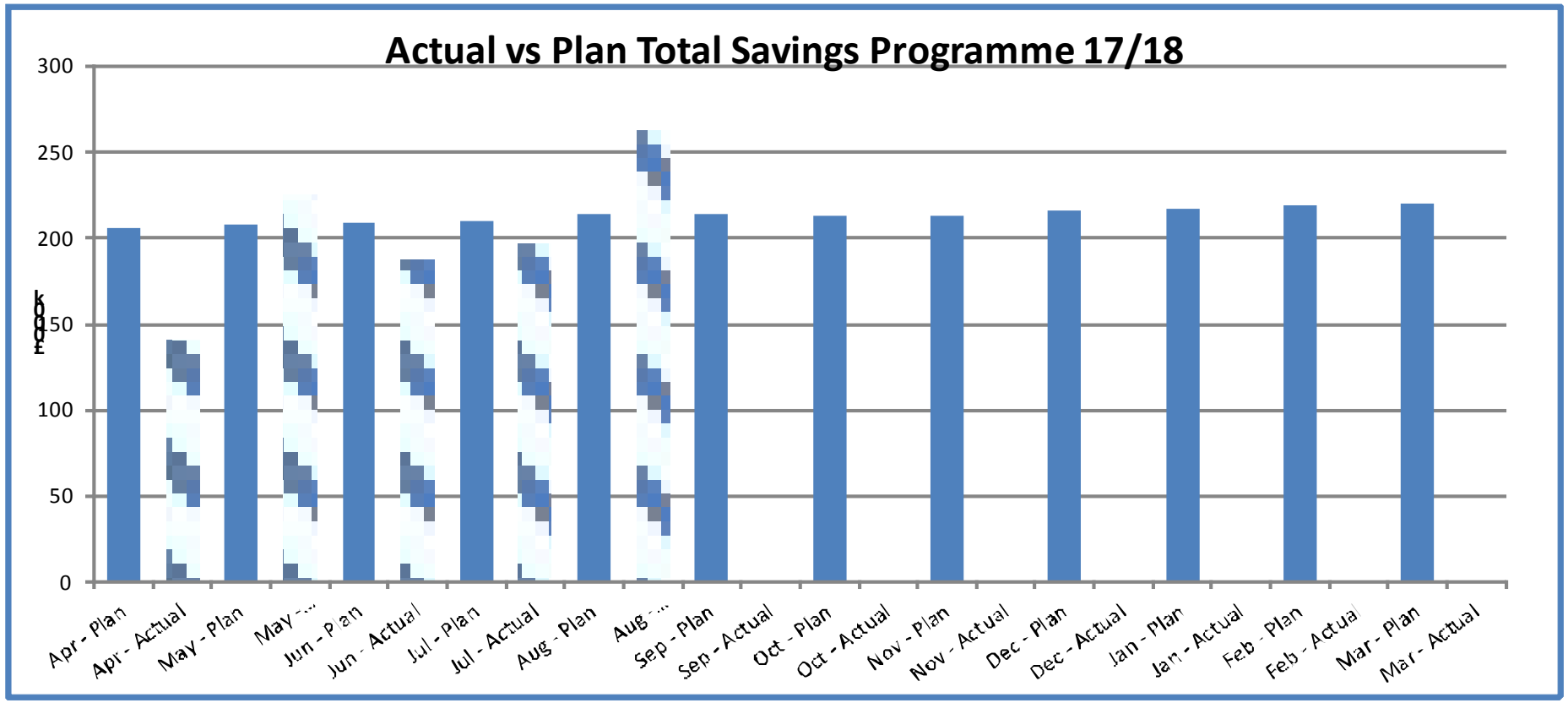
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
74	6	6	-0	97.3%	31	30	-1	97.3%	74	100.0%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Strategy & Performan	**21.01** Strat & Perf - EPS	100	8	8	0	42	42	0	100
	21.02 Strat & Perf - PAY	50	4	4	0	21	21	0	50
	21.03 Strat & Perf - CRAB	10	1	1	0	4	4	0	10
	21.04 Strat & Perf - CIP stretch	109	12	0	-12	24	0	-24	109
Grand Total		**269**	**25**	**13**	**-12**	**91**	**67**	**-24**	**269**

Surgery

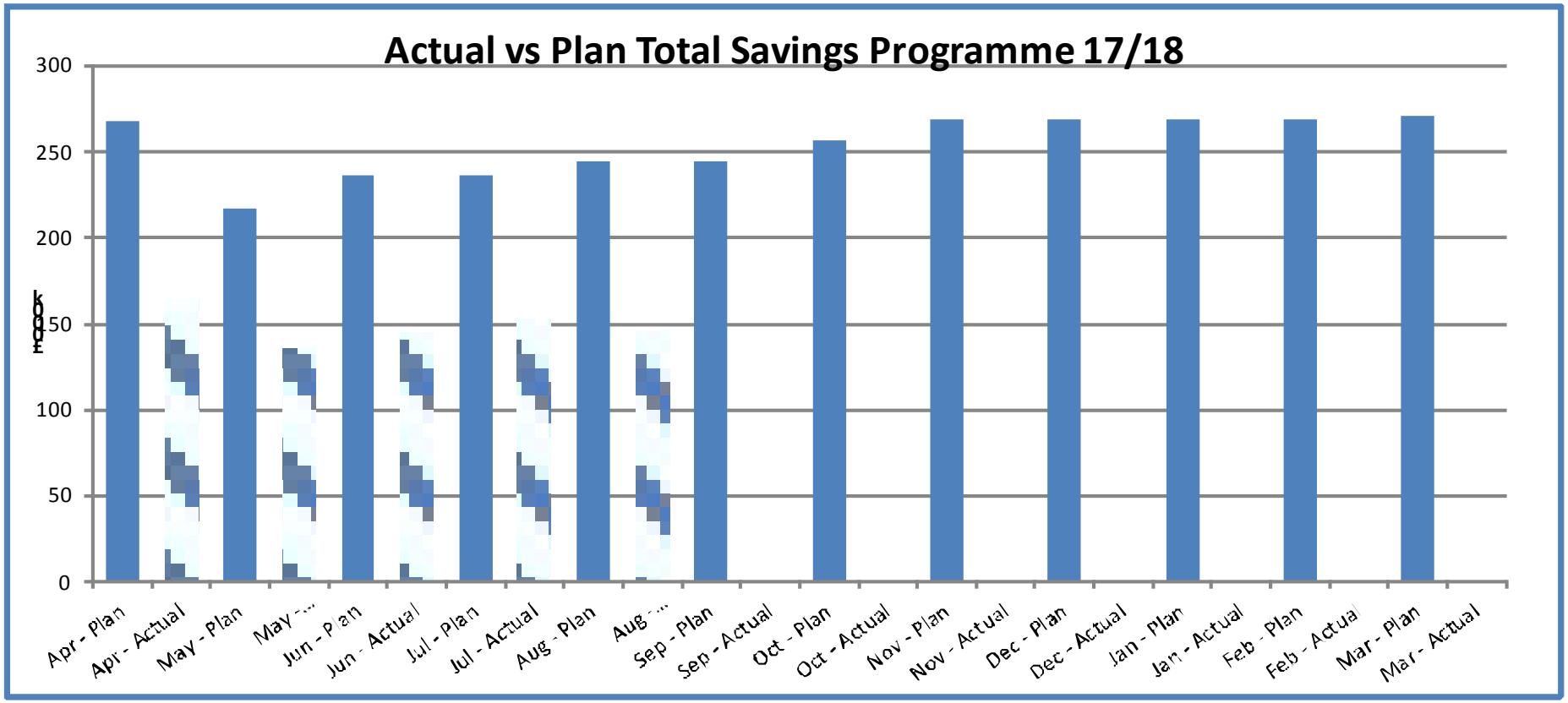
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
2,559	214	263	49	122.8%	1,047	1,013	-34	96.8%	2,271	88.8%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Surgery	**4.01** Retirement of staff	114	10	10	0	50	49	-1	114
	4.02 General Surgery WLI	300	25	76	51	121	198	77	240
	4.03 Hearing Aids	80	7	7	0	31	27	-4	80
	4.04 Non Pay Items	480	40	4	-36	200	110	-90	384
	4.05 Theatre Utilisation	100	8	28	20	40	80	40	100
	4.06 Furniture	38	3	3	0	15	12	-3	38
	4.07 Ophthalmology WLI Specialty Drs	200	17	38	21	81	108	27	200
	4.08 Prostate Biopsy Kit	70	6	0	-6	30	7	-23	70
	4.09 Lasers (BC)	100	8	8	0	40	19	-22	90
	4.10 Medical Equipment Hire	168	14	14	0	70	60	-10	67
	4.11 WD 10 & 11 LD shift reduction	60	5	5	0	25	21	-4	60
	4.12 Dressings & Vasc. dressings	35	3	3	0	14	13	-1	35
	4.13 Tissue Viability	38	3	3	0	15	15	0	38
	4.14 LOS WPH	100	8	8	0	40	40	0	100
	4.15 Pingers	20	2	2	0	6	6	0	20
	4.16 Runners	70	6	5	-1	28	27	-1	49
	4.17 Medical Agency	350	29	29	0	144	131	-13	350
	4.18 Nursing Agency	200	17	17	0	85	78	-7	200
	4.19 Overseas Recruitment	15	1	1	0	5	5	0	15
	4.20 Patients Clothes	21	2	2	0	7	8	1	21
Grand Total		**2,559**	**214**	**263**	**49**	**1,047**	**1,013**	**-34**	**2,271**

Theatres Crit Care & Anaes

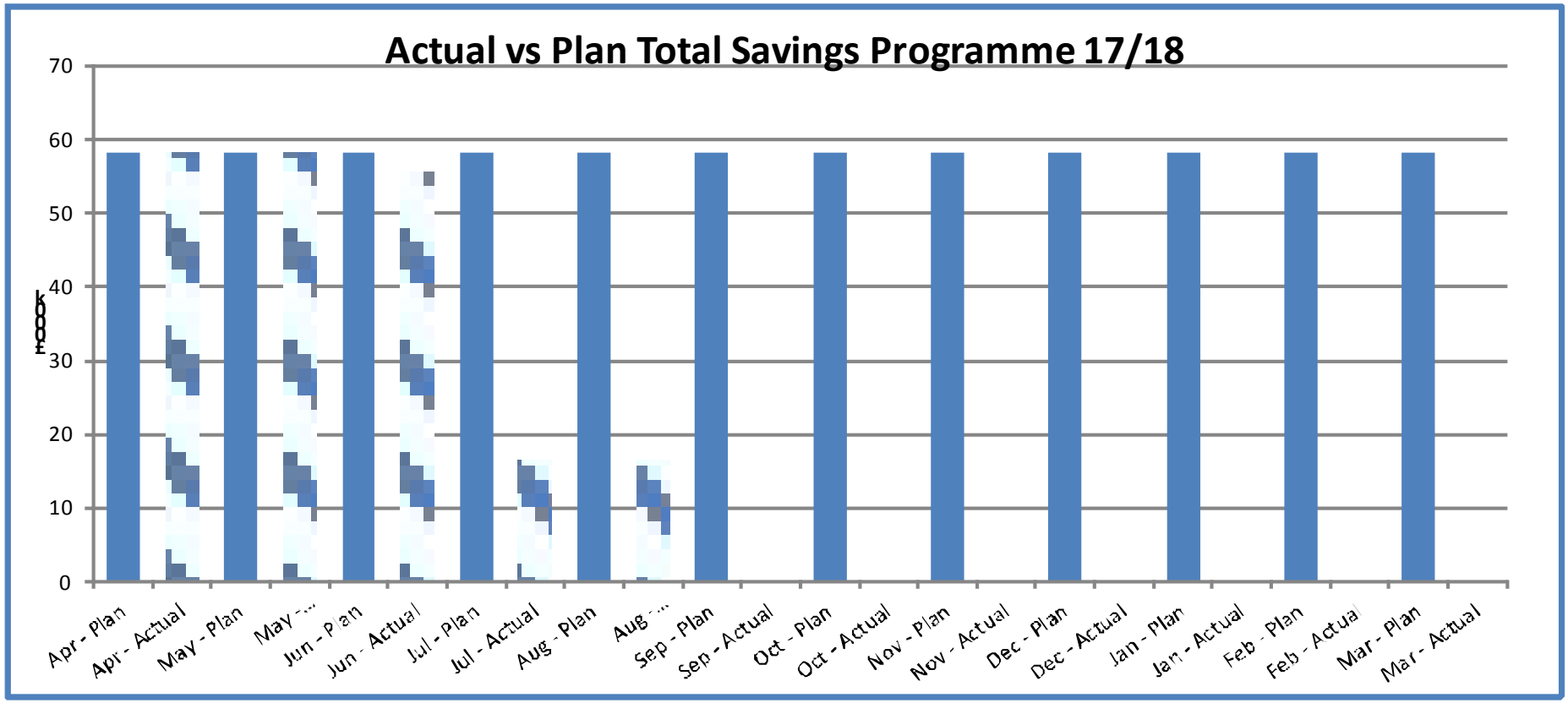
Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
3,052	244	146	-98	59.7%	1,203	744	-460	61.8%	2,012	65.9%



			Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Theatres Crit Care & A	**11.01**	Maintenance Contracts Review	39	0	0	0	39	39	0	39
	11.02	Medics Agency Prem	350	29	29	0	146	146	0	350
	11.03	Non-Medics Agency Prem	250	21	0	-21	104	0	-104	
	11.04	ITU Stock Review	50	4	4	0	21	21	0	50
	11.05	Theatre Stock Review WPH	100	8	8	0	42	42	0	100
	11.06	Pre Op Slots WPH	260	22	4	-18	108	22	-86	100
	11.07	Review of GA and LA Sessions	100	8	0	-8	42	16	-25	70
	11.08	Savings for Non-Op Consumables	100	8	5	-4	42	38	-4	100
	11.09	R&R Savings Year 2	40	3	3	0	17	17	0	40
	11.10	Community Dentals WPH	0	0	0	0	0	0	0	
	11.11	Theatre Utilisation & Rational	0	0	0	0	0	0	0	
	11.12	Admin Mgmnt Restructure	0	0	0	0	0	0	0	
	11.13	Pain WLI	200	17	17	0	83	83	0	200
	11.14	Review of Pain Service	300	25	0	-25	125	0	-125	
	11.15	Consumable Savings FPH Theatres	350	29	29	0	146	146	0	350
	11.16	PD Team Reduction	30	4	4	0	4	4	0	30
	11.17	Office Supplies	5	0	0	0	2	2	0	5
	11.18	Training	3	0	0	0	1	1	0	3
	11.19	Pain Aldershot	75	0	0	0	6	0	-6	
	11.20	Pain Windsor	75	0	0	0	6	0	-6	
	11.21	Band 7 Structure Theatres	30	4	4	0	4	4	0	30
	11.22	Drugs- Des to Sevo	30	3	3	0	13	10	-3	30
	11.23	Top-Slice of TCCA Budgets	465	39	30	-9	194	131	-63	315
	11.24	DSU HWD	200	20	0	-20	60	17	-43	100
	11.25	Mitigating Schemes	0	0	6	6	0	6	6	100
Grand Total			**3,052**	**244**	**146**	**-98**	**1,203**	**744**	**-460**	**2,012**

Therapies

Annual Plan	Curr Mth Plan	Curr Mth Act	Var	%	YTD Plan	YTD Actual	YTD Var	%	FOT	%
700	58	16	-42	28.2%	291	205	-86	70.4%	603	86.2%



		Annual Plan	Curr Mth Plan	Curr Mth Act	Var	YTD Plan	YTD Act	YTD Var	Latest FOT
Therapies	**13.01** Physio Agency	117	10	0	-10	49	27	-22	117
	13.02 SaLT	23	2	2	0	10	10	0	23
	13.03 Dietetics	12	1	1	0	5	5	0	12
	13.04 Physio	64	5	5	0	27	27	0	64
	13.05 OT	99	8	8	0	41	41	0	99
	13.06 Patient Appliances	385	32	0	-32	160	96	-64	289
Grand Total		**700**	**58**	**16**	**-42**	**291**	**205**	**-86**	**603**

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Safeguarding Adults Annual Report**
Meeting	Board of Directors
Meeting Date	6th October 2017
Agenda No.	10.1
Report Type	Safeguarding Adults Annual Report
Prepared By	Mel Martin – Safeguarding Adults Lead
Executive Lead	Duncan Burton
Executive Summary	The summary provides the key points from the attached Annual Report for Adult Safeguarding across Frimley Health for 2016/2017. **Safeguarding Adults Team across Frimley Health** In the last year the safeguarding adult's team have been working together as part of the wider patient safety team with a clear focus on aligning policies, procedures and training across Frimley Health. **Safeguarding Adults Training** The safeguarding adults team have had a significant focus on providing training to all clinical staff as a priority over the last year, which is reflected in the current training statistics against the Training needs analysis: • 98% have received level 1 training • 74% have received level 2 • 65% have received level 3 **Safeguarding Adults Alerts** Frimley Health staff has made 856 adult safeguarding alerts regarding concerns with patients, this is a 56% increase in recognising safeguarding concerns over the last 3 years. This is primarily due to the increase in training and awareness across the organisation. **Safeguarding Adults Alerts raised against the trust** There have been 109 safeguarding alerts raised against the trust with 26 found to be

10.1

	substantiated (23%). 3 of these related to pressure ulcers acquired in hospital, and the remainder relating to poor discharge, poor communication and poor discharge documentation.
Recommendation	The Board of Directors are asked to note the particularly the significant improvement in the training compliance.
Appendices	

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Safeguarding Adults Annual Report
April 2016 – March 2017

1.0 Introduction

The Care Act 2014 Chapter 23 section 42-47 became statute on 1 April 2015 and has set out the first statutory framework for adult safeguarding, and the responsibilities for local authorities and their local partners in protecting adults at risk of abuse or neglect.

This legislation requires the local authority's to establish a Safeguarding Adults Board (SAB) in their area to develop shared strategies for safeguarding and report to their local communities on their progress via an annual report. The core membership of such boards includes the relevant Local Authority, Clinical Commissioning Groups and the Police. Frimley Health NHS Foundation Trust currently has representation on the already well-established Safeguarding Adults Board for Surrey Hampshire, Bracknell Forest Berkshire and Slough

2.0 Governance and Assurance

The Trust has two Adult Safeguarding Lead based at Frimley Park Hospital and another based at Wexham Park Hospital and Heatherwood Hospital. They are each supported by two band 6 Adult Safeguarding Nurses who undertake a large proportion of the training required to meet the statutory requirements for Adult Safeguarding.

The Director of Nursing and Quality is the Trust Executive Lead for Safeguarding, with the Deputy Director of Nursing at Frimley Park Hospital taking responsibility in her portfolio for the safeguarding leadership role in relation to adult safeguarding and represents the Director Of Nursing and Quality at appropriate external meetings.

The Deputy Director of Nursing (Wexham Park and Heatherwood Hospitals) is operationally responsible for a safeguarding on those respective sites and represents the Director of Nursing at the external Safeguarding Boards in Berkshire.

The Trust Safeguarding Adult Leads have responsibility for managing internal alerts raised by staff within the Trust where there are concerns in the community in relation to patients admitted to hospital. They also manage external alerts raised against the hospital from the community where there have been concerns regarding care delivered in the three hospitals which may be safeguarding in nature. This involves reviewing care, assessing patients and working with internal teams and partner agencies such as the local authorities and the police to ensure effective robust investigation and that there is appropriate involvement in the investigation process.

All of the investigations undertaken are person centred using six safeguarding principles that are part of the Care Act 2014 to ensure that appropriate support is offered to individuals concerned. This support is also crucial for staff during the investigative period where allegations may be made against them. The Adult Safeguarding Team completes any relevant section 42 reports that need to be undertaken.

The Trust Adult Safeguarding Leads monitor all activity, ensuring that this is recorded on to the Trust DATIX system to satisfy the CQC requirements for reporting and other databases specifically for adult safeguarding. They are responsible for the writing and collation of all reports and audits that are required both internally for assurance and governance as well as any external reports that may be required for the CQC, Safeguarding Adult Boards and Commissioners. This includes the monthly reports on activity and narrative on the quality aspects of adult safeguarding as per the quality schedule relating to adult safeguarding within the NHS contracts.

They also ensure with any Safeguarding Adult Reviews that learning relevant to the Trust is shared and embedded

3.0 Training

The legislation Under the Care Act 2014 has bought a number of statutory training requirements similar to those outlined in the legislation for safeguarding children. As a result the training needs analysis (TNA) for adult safeguarding has been reviewed for the whole trust a number of times and has prescribed training levels for all staff. The outcome of this is that a larger number of staff required level 2. The intercollegiate document detailing requirements for adult safeguarding training is still to be published, however the TNA for adults has been based on requirements for child safeguarding so will meet the intercollegiate requirements.

Training packages have been reviewed again on the past twelve months for level 1,2,and 3 and are all delivered internally by the Adult Safeguarding Leads and the Adult safeguarding Nurse on all sites. In order to meet the required percentages set contractually by the commissioners, training sessions have been mapped for the twelve months. All new staff to the trust receive level 1 adult safeguarding training on induction and level 2 for those staff it is relevant to. Since January 2017, adult and child level 2 has been combined as the principles are the same. This has meant a reduction of 7 hours training to 3 hours and has received very favourable evaluation from staff attending.

Mental Capacity and Deprivation of Liberty Safeguards (DOLs) has been incorporated in to all of the training packages at the appropriate level for the grade of staff. This has ensured that all staff have awareness of the close links between safeguarding, MCA and DOLS and can report concerns. Those staff that have extra responsibilities have been able to assist in investigations as necessary.

4.0 Monitoring

The Trust has a multi-agency safeguarding group in place in Frimley Park Hospital and Wexham Park Hospital which meet bi-monthly and is chaired by the Deputy Directors of Nursing. These groups have the responsibility for:

- implementing and monitoring current legislation and policy in relation to Safeguarding Adults and Children;
- overseeing the development, implementation and monitoring of systems, processes and policies to ensure Adults and Children are safeguarded whilst in Frimley Health NHS Foundation Trust;
- raising awareness and ensuring staff within the organisation understands the full scope of their responsibilities within the reporting processes for safeguarding adults and children, Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards (DOLs);
- ensuring the Trust works with the Local Authorities in each of the three counties and other agencies to safeguard adults and children by actively contributing to discussions and development of policies and procedures;
- preventing inappropriate deprivation of liberty of all patient throughout the Trust and ensuring that where it is relevant for some patients, the appropriate legislative framework has been used to apply for DOLs;
- ensuring the Trust complies with legislation of the Mental Health Act 2005;
- ensuring appropriate use of the Mental Capacity Act 2005 and accurate assessment by the clinicians is carried out;
- agreeing quality standards, developing audit tools and developing and implementing a training strategy which supports safeguarding adults and children, Mental Capacity Act 2005 and DOLs;
- ensuring that safeguarding adults is incorporated into Clinical Governance throughout the Trust and report regularly to Clinical Risk and Patient Safety Committee's;
- ensuring an Annual Report will be submitted via the Quality Committee to the Trust Board each year;

These groups have broad membership including external key stake holder representation from Local Authorities and Clinical Commissioning Groups (CCG's). The groups also monitor work streams and plan that link to safeguarding to ensure consistency for the Trust.

Both of the group's report to an overarching Safeguarding Executive group which is chaired by the Director of Nursing and Quality. This group's remit is to have oversight and assurance for the strategic elements of Safeguarding and associated work streams and meets quarterly.

4.0 Representation on Safeguarding Adults Boards

The Trust is represented on five Safeguarding Adult Boards across three counties and has contributed to a number of initiatives including review of the multiagency procedures to ensure the requirements of the Care Act 2014 are met, development of an assurance framework for the Board, commitment to the Board with participation and presentation of work and the opportunity to attend training events and conferences. The table below details membership of Safeguarding Adult Boards.

Meeting	Representative	Frequency
Surrey Safeguarding Adults Board	Trust Lead for Adult Safeguarding, Frimley Park Hospital	Quarterly
Hampshire Safeguarding Adults Board	Deputy Director of Nursing, Frimley Park Hospital	Quarterly
Surrey Safeguarding Policy Implementation Group	Trust Lead for Safeguarding Adults, Frimley Park Hospital	Quarterly
Bracknell Forest Safeguarding Partnership Board	Trust Lead for Adult Safeguarding, Frimley Park Hospital	Quarterly
Windsor and Maidenhead Safeguarding Adults Partnership Board	Deputy Director of Nursing/Named Nurse for Safeguarding Adults	Quarterly
Slough Safeguarding Adults Partnership Board	Deputy Director of Nursing/Named Nurse for Safeguarding Adults	Quarterly
Slough Safeguarding Adults Review Panel	Named Nurse for Safeguarding Adults	Quarterly

Resultant to the Care Act 2014, Local Authority Adult Safeguarding Boards have a statutory responsibility to arrange Safeguarding Adults Reviews (SAR) where an adult with care and support needs dies as a result of abuse and neglect and there is concern in relation to multiagency processes. Trust representatives sit on groups for most of the local authorities which undertake the SARs reviews. There have been two SAR that the Trust has participated in. Learning from these has been shared at the Internal Adult and Child Safeguarding Groups

5.0 Adult Safeguarding Governance Arrangements for Surrey, Hampshire and Berkshire

The Trust continues to work within the governance arrangements for Surrey, Hampshire and Berkshire which include attendance at the quarterly Safeguarding Board meetings. This includes completion of the safeguarding self-assessment, assurance tool and submission of safeguarding activity using the frameworks agreed by the Adult Safeguarding Boards. The assurance tools have demonstrated that the Trust is at an effective level for managing safeguarding with no significant concerns around practice or processes.

6.0 Summary of Alerts

The following table demonstrates the number of alerts made by Frimley Health staff which has identified possible concerns in the community. Over the past three years

	Number of Alerts 2014/15	Number of Alerts 2015/16	Number of Alerts 2016/17
Frimley Park Hospital	229	341	412
Heatherwood and Wexham Park Hospitals	146	315	444
Total	**375**	**656**	**856**

Summary of Alerts by category of abuse

The table below demonstrates the category of abuse of the alerts identified from hospital staff and highlights the most frequent occurring type of abuse of 'Neglect or self-neglect'.

Number of Adult Safeguarding Alerts by category		
	Frimley Park Hospital	Heatherwood and Wexham Park Hospitals
Physical	30	72
Neglect including self-neglect	137	279
Financial	14	20
Discrimination	0	0
Physiological	8	36
Institutional	0	33

Sexual	9	4
Domestic Abuse	77	73
Vulnerable	137	0
Total	**412**	**444**

The table below shows the number of alerts made against the hospitals from external agencies and the general public.

	2014/15	2015/2016	2016/2017
Frimley Park Hospitals	41 2 substantiated	63 27 substantiated	87 11 substantiated
Heatherwood and Wexham Park Hospitals	26 0 substantiated	21 10 substantiated	22 15 substantiated
total	67	84	109

7.0 Analysis of Alerts,

There has been a 30% increase in patient alerts for Adult Safeguarding being made by staff compared to the previous year. This is primarily due to a continued increase in awareness and training attended in order to recognise safeguarding concerns.

109 alerts were related to potential safeguarding elements of patient care in hospital of which 83 were found to be unsubstantiated. The themes of the alerts substantiated are summarized below:

- 3 case of pressure sores acquired whilst in care
- 23 cases were related to poor discharge arrangements, poor communication and poor discharge documentation.

The patient survey and complaints support the theme of poor discharge. There are plans in place to improve discharge arrangements, with specific training targeted at relevant staff and areas.

There have been two serious case reviews in the last year which have been led by Slough Local authority. Lessons learned have been shared with the Trust.

8.0 Changes in practice

The Trust has made a number of changes in practice as a result of investigations to improve practice and prevent further allegations under safeguarding. These have included the following:

- Safeguarding training is provided to staff has been specific to their job role, to ensure that this is tailored to meet their individual needs;

- Training has been provided to FY1 and FY2 doctors on induction thus enabling them to identify safeguarding concerns, issues with consent, using the Mental Capacity Act when applicable and recognizing when an IMCA should be used to assist those patients without capacity to make decisions;
- A similar training package has been implemented for all senior grade and consultants;

- There is close working with the HR department whilst undertaking safeguarding investigations where staff members are involved to ensure staff are supported effectively and there are fewer suspensions;

- All complaints are reviewed on a daily basis to ensure any adult safeguarding concerns are identified and managed appropriately;

- All patients admitted to the organisation with grade 3 and 4 pressure sores are reviewed by the Adult Safeguarding leads to establish any safeguarding alerts need to be raised around the presence of these sores;

- All serious incidents requiring investigation are reviewed to ensure any adult safeguarding concerns are identified and managed appropriately;

- All patients with a learning disability who die whilst in hospital have their care reviewed via the mortality and morbidity work stream;

- All mortality and morbidity reviews include reviews for any safeguarding issues to ensure they were raised. In a timely manner;

- Meetings take place on a weekly basis at Frimley Park Hospital with two of the team leaders representing Surry and Hampshire Local Authorities to ensure all information is shared and to discuss progress and next actions. This has led to a very successful working relationship between the trust and the local authorities.

9.0 Deprivation of Liberty Safeguards (DOLS)

The Deprivation of Liberty Safeguards (DOLS) was implemented in April 2009, to provide protection for vulnerable people who are accommodated in hospitals or care homes in circumstances that amount to a deprivation of their liberty, and who lack the capacity to consent to the care or treatment they need. In such cases MCA DOLS provide a lawful way to deprive someone of their liberty, provided that this is in their own best interests or is necessary to keep them from harm.

The table below shows the activity for DOL's and how many were granted after application as a result of assessment by Best Interest Assessors and Doctors

2016/2017	Number of DoLs applications	Granted	Refused	Withdrawn	Discharged/died before local authority could assess
Frimley Park Hospital	70	27	1	0	42
Heatherwood and Wexham Park Hospitals	132	16	24	15	77
Total	**202**	**43**	**25**	**15**	**119**

43 out of the 202 applications made by the Trust were granted by the relevant supervisory bodies. This is a 22% conversion rate as opposed to the national average (2011/12) of 55%. The reason for non-assessment by the local authorities is related to workload and lack of resources as a result of the Supreme Court ruling in 2014.

This clarification of Supreme Court ruling has implications for the organisation in terms of an increase in application for DOLs. This is reflected in the figures for Heatherwood and Wexham Park Hospitals. The Trust has endeavoured to manage the patient under the Mental Capacity Act 2005 and best interest assessment rather than applying for DOL's immediately where appropriate. This has resulted in the number of DOLs applied for remaining reasonably low when benchmarked to some other trusts. The DOLs process will be changing at the end of 2017 following the launch of new national guidance.

10.0 Care Quality Commission Compliance

The Trust is expecting another CQC inspection and is prepared. The Trust has, through its self-assessment process declared compliance with Outcome 7 of the Care Quality Commission (CQC) Quality and Safety standards and will continue to monitor compliance and provide assurance to the Board of Directors on a quarterly basis.

11.0 Training and Awareness on Adult Safeguarding, Mental Capacity Act and DOLS

Safeguarding Adults, Mental Capacity Act training and DOLS is included on corporate Induction of all staff at level 1 along with a Safeguarding Awareness, Protecting Children and Adults from Abuse and Neglect staff information leaflet

Level 1 Safeguarding adults training along with training in Mental Capacity Act 2005 and DOL's has been provided to key groups of staff who are not clinical but have contact with patients e.g. receptionists and domestics.

Level 2 Safeguarding Adults training along with training in Mental Capacity Act 2005 and DOL's has been provided for nursing staff of band3, 4,5 and 6, OT's physiotherapists, doctors and consultants.

Face to face Level 3 Safeguarding Adults Training along with training in Mental Capacity Act 2005 and DOL's has been provided internally for senior ward sisters, Matrons, Heads of Nursing and each manager and deputy in all areas of the Trust.

The table below shows the training figures for the Trust below for 2016/17:

FRIMLEY HEALTH NHS FOUNDATION TRUST WHOLE TRUST ADULT TRAINING	
LEVEL 1	98%
LEVEL 2	74%
LEVEL 3	65%

12.0 Implementation of the Department Of Health Prevent Strategy

Building on the work of the original Prevent strategy and the work of the Contest strategy, the UK Counter-Terrorism and Security Act 2015, gained Royal Assent in February 2015. Within the Act, Section 26 places a duty on certain Bodies, referred to as 'specified authorities' in the exercise of their function, to have 'due regard to the need to prevent people being drawn into terrorism'.

The Prevent Duty Guidance has been produced under section 29 of the Act and states that the authorities subject to the provisions under the Act, must have due regard to the Guidance. 'Health' is key partners in the Prevent Duty and is detailed as specified authorities under the Act. Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism including children and adults. There have been additional examples of healthcare staff been drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, leading to the creation of an atmosphere conducive to terrorism. The key challenge for healthcare is to ensure that where there are signs of such activity, that staff are appropriately trained to recognise the signs and then take the appropriate action. This is particularly pertinent to Wexham Park Hospital.

The Prevent works team and training is managed by the Team for Emergency planning and business continuity and has formal links with the Trust Safeguarding Committee and Group.

All staff in the trust have received a leaflet which has provided awareness of Prevent. Basic awareness training has been rolled across the Trust and WRAP training has been given to those staff who are band & and above.

13.0 Conclusion

The Trust is committed to the safety of adults at risk under our care, and has invested in raising awareness on safeguarding adults for all staff. The Trust is also committed to continuing to deliver the relevant level of training to all staff who work for the Trust.

14.0 Actions for 2017/2018

The following actions have been identified for the coming year:

- To continue to deliver all levels of training to all staff that is relevant to their role.
- To launch Adult Safeguarding Champions in all areas of the Trust to act as an initial point of contact.
- Continue to monitor alerts quarterly at the Safeguarding Adults group and identify any trends or risk issues.
- To identify lessons learnt and improvements in practice required as a result of both Internal and external reviews and investigations completed.
- To monitor compliance against the CQC Safeguarding Outcome 7.
- To maintain and improve as necessary robust systems for recording and reporting alerts;
- Continue to embed the framework provided by the Mental Capacity Act throughout the Trust.
- Develop the work with patients who may need to have restrictions and restraints on their behaviours in their best interests.
- To build on and improve pathways for patients with Learning Disabilities to ensure equity of access and services and negate any safeguarding issues that may arise.
- To continue to share good safeguarding adults practice across Frimley Health NHS Foundation Trust to improve outcomes for patients.
- To continue to provide assurance to the Trust Board, CQC, CCG's and Safeguarding Adults Boards that the processes for managing Safeguarding Adults remain robust and effective and to report all relevant activity.
- The implement the new national guidance for DOLS.

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Safeguarding Children Annual Report**
Meeting	Board of Directors
Meeting Date	6th October 2017
Agenda No.	10.2
Report Type	Safeguarding Children Annual Report
Prepared By	Fran Franks, Deirdre Race & Audrey Carty – Safeguarding Childrens Leads
Executive Lead	Duncan Burton
Executive Summary	The summary provides the key points from the attached Annual Report for Children Safeguarding across Frimley Health for 2016/2017. **Safeguarding Children's Team across Frimley Health** In the last year the safeguarding children's team have been working together across the 3 sites with a clear focus on aligning policies, procedures and training across Frimley Health. **Safeguarding Children's Training** The safeguarding children's team have had a significant focus on providing training to all clinical staff as a priority over the last year, which is reflected in the current training statistics against the Training needs analysis as at end of June : • 96% have received level 1 training • 54% have received level 2 • 73% have received level 3 **Safeguarding Children Alerts** • 699 new referrals for WPH • 786 new referrals for FPH • 33% CAMHS referrals for the Frimley Site • Increase in a trend of violence amongst young people at Wexham Park Hospital including stabbings/involving weapons and children injured

10.2

Recommendation	The Board of Directors are asked to note the increased drive in training is evidenced in an increase in referrals and operational workload.
Appendices	

Section 1: Introduction and Key Achievements

The annual report provides an overview of the continued progress of safeguarding arrangements in place within Frimley Health Foundation Trust to safeguard and protect the welfare of children and young people seen or unseen who come into contact with hospital services.

The report aims to provide assurance to the Board that Frimley Health Foundation Trust is complying with statutory requirements and providing continued quality of care in partnership with health and social care.

- Care Quality Commission
- Children's Act 1989, 2004
- Working Together 2015

To demonstrate the implementation of actions following review and completion of S11 Audits and Serious Case/Partnership Reviews alongside the Local Safeguarding Children's Board (LSCB).

The report acknowledges achievements, service improvements and principal challenges including potential risk in relation to statutory responsibilities. The effectiveness of safeguarding arrangements will continue to be monitored through the local Adult and Children Safeguarding Group and Trust wide Adult and Children Safeguarding Executive Committee.

Key achievements

Staff across the Trust have worked diligently to maintain high standards for Frimley Health to ensure effectiveness in safeguarding arrangements and processes. This has continued to be evidenced and accomplished during this period through robust training of staff groups and collaborative partnership working with external agencies.

Heatherwood and Wexham Park Hospitals

The Named Nurse for Safeguarding Children (Amy Kidd) recognised an increase in a trend of violence amongst young people attending Wexham Emergency Department. The injuries related to stabbings/involving weapons and children injured, ranged between 14-17 years old. Recognition of the trend was shared with multi-agencies (Designated Nurse, Police, Slough Children's Trust) which resulted in further discussion at the LSCB Quality and Assurance Group. The information shared between agencies highlighted important messages and understanding of the current gang situation in Slough which resulted in a commendation from the Home Office and membership on the Slough Youth Violence Group. The positive work was commended and gang violence is now included in safeguarding children training.

Frimley Park Hospital

The number of children requiring referral for CAMHS support has increased by a third in the last year and with the expansion of the safeguarding team, significant work has taken place to build relationships with schools and colleges to liaise and advocate for services for young people predominantly aged 16-18.

Section 2: Demographics

Frimley Park Hospital

Frimley Park hospital site provides district general services for North-East Hampshire, West Surrey and East Berkshire. The estimated number of children within this catchment area is 165,000. The hospital site has involvement with Hampshire LSCB, Surrey LSCB and Bracknell-Forest LSCB.

Heatherwood and Wexham Park Hospital

Heatherwood and Wexham Park Hospitals provide services to a large and diverse population of more than 450,000 which includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire and Windsor. Wexham Park Hospital's foremost LSCB is Slough; with engagement with both the Royal Borough of Windsor and Maidenhead and Bucks.

Section 3: Governance

Corporate Responsibilities

Following the introduction of the Health and Social Care Act (2012) the statutory responsibility for ensuring that organisations safeguard children and young people at risk of abuse or neglect lies with clinical commissioning groups (CCG) and the NHS Commissioning Board (CB). The NHS CB provides oversight and assurance, supporting CCG's in meeting their safeguarding responsibilities.

The accountability and assurance framework for safeguarding vulnerable people (2015) details the responsibilities of NHS organisations and focuses on the statutory requirements to safeguard children. For children and young people the key legislation includes the Children Act 1989 and 2004, the revised edition of Working Together to Safeguard Children (2015) and Statutory Guidance on Promoting the Health and Well-being of Looked after Children.

The Trust is required to demonstrate safeguarding leadership, commitment at all levels of the organisation and to fully engage in the work of the LSCB. To ensure that those who use Trust services are safeguarded and that staff are suitably skilled and supported. It is the Trust responsibility to develop and maintain quality standards and quality assurance, to ensure appropriate systems and processes are in place and to embed a safeguarding culture within the organisation. This is achieved through safe recruitment processes, effective training and learning opportunities, patient experience and feedback, critical incident analysis, audits and annual staff appraisal.

Section 11 of the Children's Act 2004 states the Trust should have in place arrangements that reflect the importance of safeguarding children across the organisation including

- A Senior Board level lead to take responsibility for Frimley Health safeguarding arrangements.
- A clear line of accountability for the commissioning and/ or provision of services designed to safeguard and promote the welfare of children.
- Named professionals who have a key role in promoting safeguarding practice within the Trust, and provide advice and expertise for senior managers, clinical and non-clinical staff.
- The Trust Board/Board of Directors recognises its responsibility of overseeing Safeguarding children arrangements across the Frimley Health Foundation Trust.

Section 11 of the Children Act 2004 guidance places a duty on named agencies to make arrangements to safeguard and promote the welfare of children. The Frimley Health Trust wide Section 11 audit was prepared in May 2016 and was submitted to Hampshire 4 LSCB and the Pan Berkshire Panel. It was also submitted to Surrey safeguarding Children Board although additional work needed to be completed.

The current safeguarding governance structure was agreed at the Trust wide executive meeting. The Trust wide executive meeting takes place on a quarterly basis. A Joint Adult and Children Safeguarding Group is well established for each hospital site; meetings held on a bimonthly basis. Membership includes the safeguarding leads; Deputy Director of Nursing; representatives from each local authority and the Designated Nurse for Berkshire. The role of the Adult and Children Safeguarding group includes the implementation of current legislation and policy, to oversee the development, implementation and monitoring of safeguarding processes and to ensure the Trust works effectively with partner agencies.

Trust staff are required to understand and respond to the full scope of their statutory responsibilities within the following reporting processes:

- Safeguarding Adults and Children
- Children Act 1989, 2004
- Mental Capacity Act (2005) and Mental Health Act (2014)
- Deprivation of Liberty Safeguards
- National Prevent Strategy

Safeguarding Policy

The Safeguarding Children operational policy has been updated in line with Working Together (2015) and was ratified in September 2015. Minor amendments were made in May 2016 following the S11 audit submission. The policy will be reviewed by the Named Nurses annually.

Safeguarding Supervision

Safeguarding supervision continues to be developed across both sites and is being has been delivered and established to the following staff groups:

- Named Professionals
- Neonatal Unit Staff
- Paediatric A & E Staff
- Midwifery staff
- Paediatric Community Staff (WPH)
- Paediatric Liaison Health Visitor (WPH)

Section 4: National and Local Developments in Safeguarding

National and Local Developments

The National Steering Group has been established to implement the accountability and assurance framework, the group has commissioned a number of work streams including health representation on the LSCB; health working group report of Child Sexual Exploitation (CSE); health responsibilities in

responding to Female Genital Mutilation (FGM); the Child Protect Information Sharing (CP-IS) and implementation of the Intercollegiate Guidance 'roles and competencies for health care staff' (2014).

CP-IS is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings, by connecting local authorities' child protection IT systems with those used by staff in NHS unscheduled care settings. Work on this project is held until the local authorities linking to the trust are co-ordinated to share information. When the authorities are live the project will be reviewed.

Hampshire Safeguarding Children's Board - A joint targeted area inspection of children's services took place in December 2016. This has identified some key work-streams in relation to domestic abuse and the trust is contributing to the action plan.

Section 5: Representation at Local Safeguarding Children's Board (LSCB):

Wexham Park

The hospital links to four unitary local authorities, Slough, Windsor and Maidenhead, Bracknell Forest and Buckinghamshire, all of which have an LSCB.

The Trust is represented at Slough LSCB by the Named Nurse for Safeguarding Children. The Trust has in place a joint protocol with Bracknell, Windsor and Maidenhead LSCB to be represented on the Board by a Berkshire Healthcare Foundation Trust representative, and attendance will be by invitation. The Trust safeguarding functions will be reported to Slough LSCB. The Named Nurse has an agreement with the Designated Nurse for Child Protection for Buckinghamshire to report to the Buckinghamshire LSCB on behalf of the trust for any Safeguarding issues.

HWPH has membership of a number of sub-groups that feed into the LSCB:

- Policy and Procedures Group
- Training sub-group
- Serious Case Review
- Quality and Performance Group
- Pan Berkshire Health of Looked After Children
- FGM Sub Group.
- Child Sexual Exploitation Strategic Group
- Slough Youth Violence Group

Frimley Park Hospital

The hospital links to Bracknell Forest, Hampshire and Surrey Safeguarding Children's Boards
FPH has membership of sub-groups as listed below

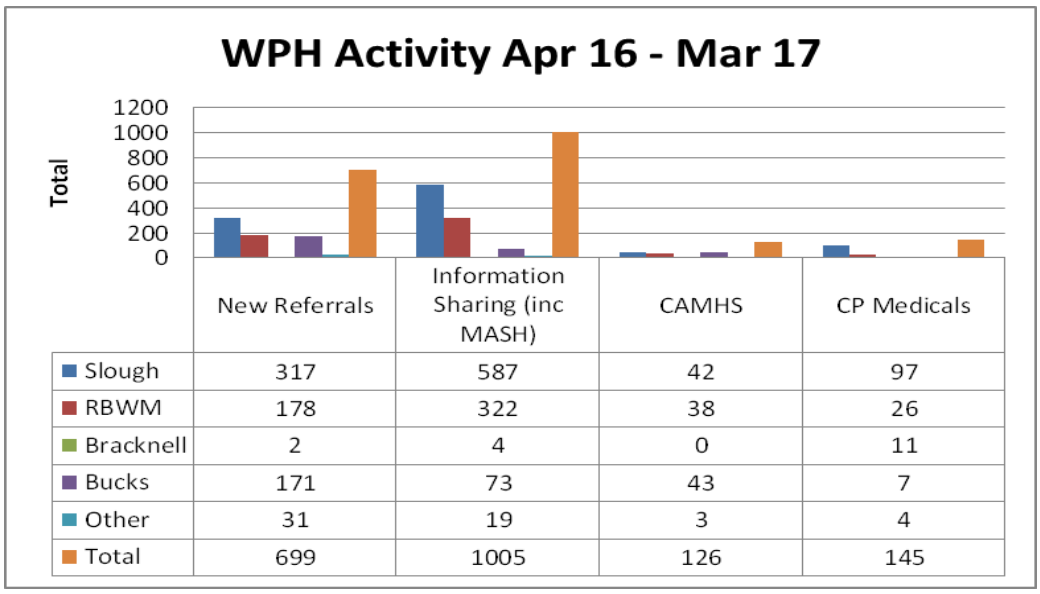
- Bracknell-Forest Learning and Improvement Sub-Group
- Hampshire Health Sub-Group
- HSCB Workforce Development Sub-Group
- FGM Task and Finish Group
- Surrey Health Sub-Group

Section 6a: Paediatric Services HWPH

Safeguarding Notifications

- Safeguarding notifications are monitored through the monthly child protection forum, including the quality and numbers of referrals.
- Referrals from social care for child protection medicals are also reviewed to ensure this is an appropriate and timely response for the child.
- For those children who are already subject to a child protection plan, child in need plan or looked after by the local authority, information regarding their attendance is routinely sent to the allocated social worker.
- The safeguarding team have guidance for referral thresholds to Children's Services and/or Paediatric Liaison Health Visitor (PLHV). Thresholds are based on Berkshire Procedures and Slough Threshold Document to ensure appropriate services are provided for children in need of protection and children in need. This guidance has been approved by the Paediatric Clinical Governance.

Safeguarding Children Activity April 2016 - March 2017



	New Referrals	Information Sharing (inc MASH)	CAMHS	CP Medicals
Slough	317	587	42	97
RBWM	178	322	38	26
Bracknell	2	4	0	11
Bucks	171	73	43	7
Other	31	19	3	4
Total	699	1005	126	145

Table 1: Child Protection activity HW & WPH

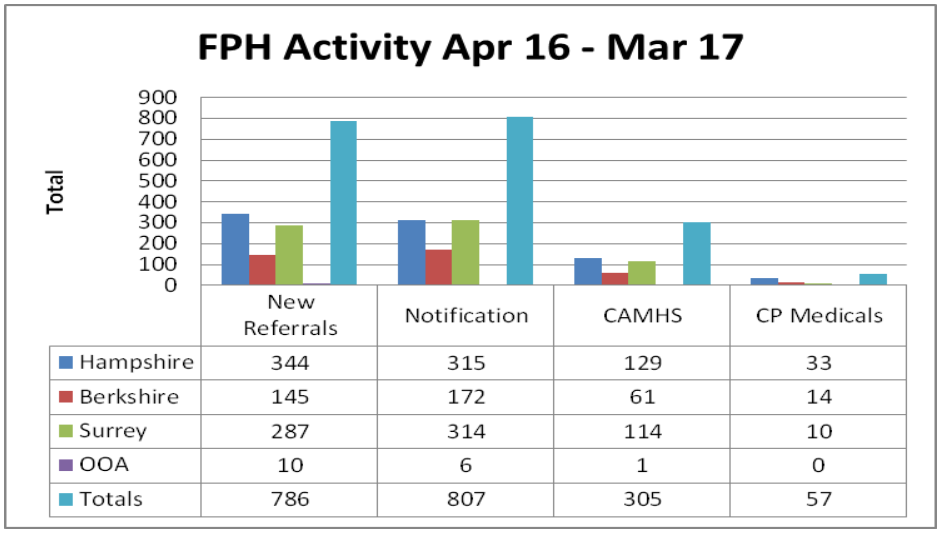
Table 1 shows the number of notifications throughout the year received by the Safeguarding Team.

Each referral made is reviewed and the outcome detailed to ensure appropriate services are being offered to the child and family. The safeguarding team note the outcome for each Local Authority; Slough and the RBWM consistently open more than 50% of the referrals made and the remaining are logged on the system for referral history.

The majority of safeguarding notifications are for children and young people within the boundaries of Slough Local Authority with an annual total of over 600 notifications.

Section 6b: Paediatric Services FPH

Table 2: Child Protection Activity FPH



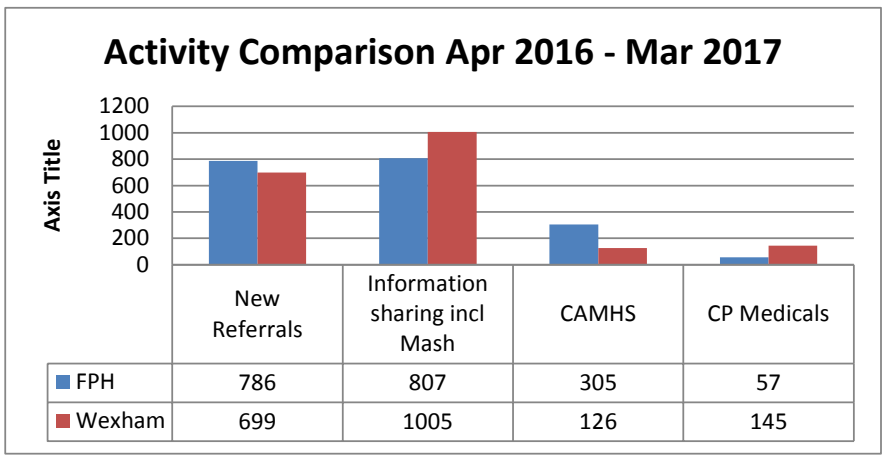
	New Referrals	Notification	CAMHS	CP Medicals
Hampshire	344	315	129	33
Berkshire	145	172	61	14
Surrey	287	314	114	10
OOA	10	6	1	0
Totals	786	807	305	57

Safeguarding referrals and notifications are monitored through a bi-weekly safeguarding meeting, a full review of each notification is made and actions if incomplete are followed up.

Referrals from social care for child protection medicals are peer reviewed quarterly with the Named Doctor for Safeguarding. Numbers of medicals are expected to decrease on Frimley site due to changes in community paediatric services.

As a result of the notification process those children who are already subject to a child protection plan, child in need plan or are looked after by the local authority, information regarding their attendance is routinely sent to the allocated social worker.

There has been a 33% increase in CAMHS activity at Frimley park site.



	New Referrals	Information sharing incl Mash	CAMHS	CP Medicals
FPH	786	807	305	57
Wexham	699	1005	126	145

Referral activity is comparable on both sites, there are different recording processes on each site so full MASH activity and information sharing activity for MAECC and MARAC have not been included in the figures due to differing referring processes. Work will take place to align these processes now the implementation of MASH is consistent across the local authorites. It must be noted that this activity is counted as per contact and not per child/family member. Therefore the totals can correlate to information requests for double or triple that amount, dependant on the number of siblings and extended family members.

Section 7: Serious Case Reviews

Serious Case Reviews (SCRs)/Partnership Reviews

Frimley Health (Heatherwood & Wexham Park Hospital) has contributed to the following serious case reviews, Partnership Reviews or critical case reviews as follows:

- **Surrey and East Sussex Safeguarding Children Board (SSCB) - 2013**

Child M - SCR led by East Sussex Safeguarding Children's Board – published in Nov 16

- **Bracknell-Forest Safeguarding Children Board (BFLSCB) – 2016**

A health learning review has taken place with the Named GP for Safeguarding in Bracknell-Forest and Named Nurse for Safeguarding in Berkshire Healthcare Foundation Trust following the attendance of a 1 month old baby later identified to have a head injury causing significant safeguarding concerns. This is also a criminal investigation resulting in requests for staff involved in the antenatal and postnatal care of mother and baby providing statements to the police.

- **Hampshire Safeguarding Childrens Board (HSCB)**

A referral to the Learning and Improvement Group was made following a Significant Incident investigation in December, where a need for multi-agency learning was identified following historic management of a case. A learning review has taken place and the report is anticipated.

Additional requests for information

Request for chronology of Frimley Health involvement (HW & WPH) to cover a period of 27 years for a family of 11. Family not known to Frimley Health.

Request for chronology of Frimley health involvement (FPH) re a family of 13. Family not known.

Request for information following serious harm to a child from Hampshire Safeguarding Children Board (FPH site). Outcome awaited.

Request for information following serious harm to a child from Surrey Safeguarding Children Board (FPH site). Outcome awaited.

Section 8: Child Deaths Review Process

The purpose of the Child Death Overview Process (CDOP) is to identify areas in which health and social care professionals can learn and improve the provision of care to children in order to help reduce the rates of child deaths.

WPH

During this period 10 rapid response meetings were held for run expected deaths with representation from health; police; social care and education. Two children died unexpectedly who were known to WPH and meetings were co-ordinated.

2016 -17	Q1	Q2	Q3	Q4
Frimley	0	0	0 (2)	0
	Q1	Q2	Q3	Q4
Wexham	1	4	1	4 (2)

Frimley Park Hospital

During this time period there were 0 unexpected child deaths that triggered rapid response procedures with representation as above, although Frimley Park did host the rapid response meeting for the two athletes that were involved in an RTA in Aldershot. Surrey CDOP processes initiate rapid response meetings for neonatal deaths which is not consistent with other local authorities. Therefore figures are not included. All neonatal deaths initiate a serious incident investigation therefore this is a duplication of process.

Section 9: Paediatric Liaison

Wexham Park Site

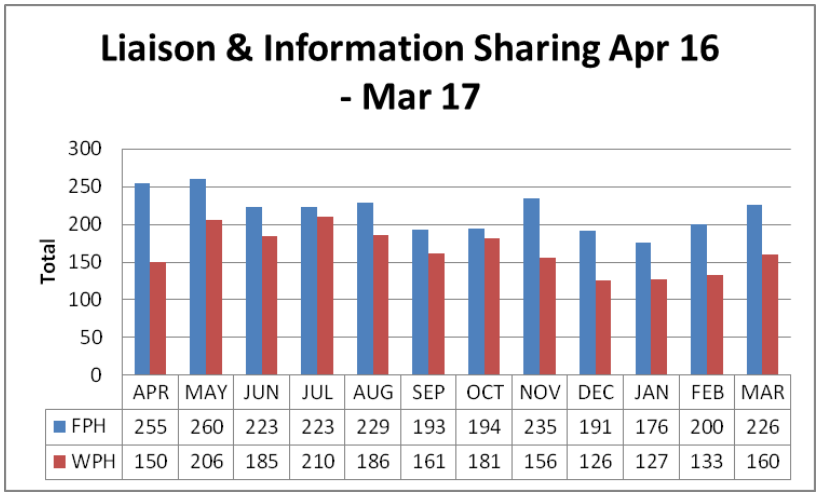
The Paediatric Liaison Service has been developed since March 2016. The aim is to provide holistic support and signposting to other services to ensure the entire families' needs are met during difficult times. Positive relationships have been maintained through collaborative working with community teams. Information is shared with members of the Health Visiting, School Nursing, Complex Needs Childrens Nurses and Looked After Children teams across East Berkshire and South Buckinghamshire to ensure relevant information is shared regarding Paediatric attendances, so additional support may then be offered to families.

Support is on-going for both the Diabetes and Oncology multi-disciplinary teams.

A quarterly meeting with PLHV staff working in surrounding hospitals in Stoke Mandeville, Oxford, Northwick Park, Ealing and Hillingdon has been set up with the aim of developing good practice and improve services.

Information Sharing: Wexham Park hospital contributes on a multi-agency level to

- MARAC – Slough and the Royal Borough of Windsor & Maidenhead
- Child Protection Conferences – Slough, the Royal Borough of Windsor & Maidenhead, Bucks



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
FPH	255	260	223	223	229	193	194	235	191	176	200	226
WPH	150	206	185	210	186	161	181	156	126	127	133	160

Frimley Park Site

A specialist safeguarding liaison nurse post was appointed to in March 2016 to help develop a liaison service, this is a part-time role to build on the work already in progress. Considerable progress has already been made in linking with colleges and NEET teams to ensure that on-going support is in place for the 16 -18 year olds that attend the hospital especially those who have attended with Mental Health issues. The young person attending is asked if they consent to safeguarding notification. Feed-back from colleges is that has been very beneficial as they often do not know who is vulnerable unless approached by the young person or by multi-agency colleagues.

Data has been included within the liaison chart above although there is a difference in referral criteria this is minimal and gives a comparison of activity across both sites.

Information Sharing: Frimley Park hospital contributes on a multi-agency level to

- MARAC - North & East Hants Hampshire, Western Surrey and WK/SH conference
- MAECC – North West and South West Surrey
- Child Protection Conferences – NW Surrey, North & East Hants and Bracknell-Forest, Royal Borough of Windsor & Maidenhead, Wokingham.

Neonatal Services

There is a neonatal lead nurse acting as safeguarding champion within neonatal services. A psychosocial meeting chaired by the Named Midwife is held on a weekly basis. This meeting is joint between acute and community; social work representation for both Slough and the Royal Borough of Windsor and Maidenhead also make a commitment to attend and share information at this meeting.

Frimley Park Site

On Frimley site the safeguarding team work closely with NNU staff and hold a fortnightly psych-social meeting to discuss any case that raises a safeguarding concern or to inform staff of vulnerable pregnancies due that have high risk safeguarding concerns. This also facilitates group supervision to take place.

Section 10: Maternity Services

Wexham Park Site

There is a system in place to flag those mothers whose unborn children are subject to a child protection plan. For historic child protection concerns midwives are reliant on the mother disclosing this at booking or the midwife investigating her suspicions. An update is being proposed to our Maternity Information System for it to include at booking, confirmation from the Mother that the name/s of the child/ren provided are living at home with her. She is also to confirm whether there are current or have been previous Child Protection concerns/Child Protection Plans. The process for listing the names and DOB of children living at home has not yet been finalised and remains ongoing. At booking all women are asked if they have had any previous or if they have current social care involvement but not specified whether CIN or CP involvement. This also is being explored further.

Cross-site achievements

- Cross site work has taken place to implement an assessment process for women who have experienced FGM.

FGM

FGM is recognised as a potential Safeguarding issue and is a direct question that is asked at maternity booking. This is then recorded on CMiS/Euroking and figures reported on a monthly basis to Obstetric Clinical Governance Meeting. However, the accuracy of the information collected from CMiS/Euroking cannot be guaranteed as it is possible for a mother who has been subjected to FGM to have a normal labour and birth without their FGM being detected.

Since October 31st 2015 it is a statutory requirement to report to the Police any under 18's who have undergone FGM and to also identify any children at risk of FGM. Figures below indicate numbers of women currently identified in the antenatal or delivery period who have undergone FGM and required risk assessments to be undertaken on their female infants/children. Reported as per EDD.

2016 - 17	**Q1**	**Q2**	**Q3**	**Q4**
Wexham	21	13	15	16
2016 - 17	Q1	Q2	Q3	Q4
Frimley	1	2	2	1

WPH activity

In 2016/2017, a total of 145 Cause for Concern forms were submitted to the Named Midwife for Safeguarding. The number of referrals represents the total number of maternity patients thought to be requiring additional midwifery social/psychological care throughout the pregnancy; these figures do not always include the information shared from police and social care in relation to families who are suspected to be pregnant potentially requiring support or alerts from local maternity hospitals. From October 2016, a Perinatal Mental Health specialist midwife was employed. If indicated and with consent, women can be referred to the Crystal Team (specialist midwifery team for vulnerable women) for further support. The women benefit from this service as an allocated midwife is provided

for the duration of the pregnancy and this continues through to the postnatal period. There is also provision for a handful of women to be "caseloaded" each month which means that they can be attended to by their allocated Crystal Team midwife during labour/delivery. This maintains continuity for the woman. All midwife visits are convened at the woman's home or a place of their choice, at a time that is convenient to her. The woman and midwife tend to develop over time, a more trusting relationship. This in turn gives the midwife a clearer indication of the robust plans needed to provide appropriate support.

The Crystal Team accepted 542 referrals during this period, which is a decrease of 7% from the previous year. This is due to the fact that 2 of the Crystal Team midwives now have dual roles; 0.4 Perinatal Mental Health midwife/0.4 Bereavement midwife role with both midwives 0.6 Crystal Team role. We are currently recruiting into the Crystal Team so more referrals can be accepted.

2016-17	Q1	Q2	Q3	Q4	Total
Wexham	59	32	28	26	145

Total number of Unborn Babies with serious safeguarding concerns and/or child protection plan **120**

This is an increase of 28% on the year 2016/2017.

Unborn babies subject to Child in Need or Child Protection Plan's activity are reported above. These figures only include high risk vulnerable families' receiving additional support at a statutory level.

Frimley Park Site

In March 2016, 2 midwives were recruited in to the combined roles of Perinatal Mental Health and Safeguarding Lead Midwife. This is part of the services recommended in the Centre for Maternal and Child Enquiries – Saving Mother's Lives (2011), MBRRACE – Saving Lives, Improving Mother's Care (2015), NICE Antenatal and Postnatal Mental Health: Clinical Management and Guidance (2014) and the roles depicted in Maternal Mental Health Alliance: Specialist Mental Health Midwives (2014) endorsed by RCM, RCN, RCOG, NSPCC, Royal College of Psychiatrists, Mind, NCT and other national organisations.

The team are developing the Perinatal Mental Health service; in line with the government mandate to Health Education England (2015) section 2 outlines the importance of maternal health during pregnancy and after birth. The mandate requires specialist mental health staff to be available to support mothers in every birthing unit by 2017. Feed-back has been very positive and links have been developed with perinatal specialist supports services throughout the last year.

FPH Activity

In 2016-17, a total of 560 Families Causing Concern forms were submitted to the safeguarding midwifery team. The number of referrals represents the total number of maternity patients thought to be requiring additional midwifery social/psychological care throughout the pregnancy; these figures do not always include the information shared from police and social care in relation to families who are suspected to be pregnant potentially requiring support or alerts from local maternity hospitals. These figures include the referrals to the perinatal specialist midwives. Work has taken place following learning reviews to create alert prompts onto the booking system to support midwives in identifying historical social care involvement.

Activity for unborn babies subject to Child in Need or Child Protection Plan's or for whom care proceedings have commended following delivery are reported below. These figures only include high risk vulnerable families' receiving additional support at a statutory level.

2016-17	Q1	Q2	Q3	Q4	
	27	20	14	14	75 (+2)

Total number of Unborn Babies with serious safeguarding concerns and/or child protection plan **77**

This is a fall of 6% on the year 2015 - 2016. However, this figure does not include cases which have not reached the threshold for child protection pre-birth but have required a significantly enhanced service being provided in the community. Frimley Park site does not have a specialist community team.

To compare, activity at the statutory level is slightly increased on Wexham park site, demographically there is also increased identification and assessment of FGM as reported above.

Section 11: Safeguarding Training

The Trust has a statutory responsibility to ensure that all staff and volunteers complete the required level of training necessary for them to effectively recognise and respond to the needs of children and young people. Current guidance is provided by 'Safeguarding Children and Young People: role and competences for health care staff, Intercollegiate Document (RCPCH, 2014). The levels are as follows:

- Level 1: Non-Clinical staff working in health care settings
- Level 2: Minimum level required for clinical staff who have some degree of contact with children and young people and/or parents/carers
- Level 3: Clinical staff working with children, young people and/ or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are Safeguarding/child protection concerns

The named professionals also undertake further levels of training as required.

The Trust training strategy was approved in December 2015 and work has continued to take place on to ensure that all staff receive training to the appropriate level of competence. Targeted training has taken place across the organisation with compliance currently reported below as of 10th April 2017.

Child Safeguarding Training for Frimley Health	**Quarter 2**	**Quarter 3**	**Quarter 4**
Level 1	**58.65%**	**61%**	**96%**
Level 2	**72.7%**	**48%**	**54%**
Level 3	**85.9%**	**63.5%**	**73%**

Section 12: LADO Referrals

Every local authority has a statutory responsibility to have a local authority designated officer (LADO), who is responsible for coordinating the response to concerns about an adult may pose a risk to children. Referrals made require joint working with HR and line managers of staff members concerned, to assess if any risk is present for patients. Referrals can also be made following an attendance to the ED/admission if that person is identified as being in a position of responsibility towards children i.e. a child-minder or a teacher.

2016 - 17	Q1	Q2	Q3	Q4
Wexham	3	1	2	6
Frimley	1 (+1 ongoing case)	1 (+1)	1 (+1)	4 (+1)

Section 13: Principal challenges

Working with Local Authority Partner Agencies has provided some challenges in relation to safeguarding processes and building effective working relationships to ensure the safety and well being of children and young people. LSCB priorities are often different which can provide challenge to working practices.

The volume of safeguarding assessments and referrals that are completed by the trust through midwifery services, Paediatric Accident and Emergency and adult admissions across the organisation. Whilst is anticipated that with increased training and awareness that referrals to the teams will increase, this does provide challenges to workloads both emotionally to staff and in when receiving tight deadlines for reporting.

As highlighted by the increase in referrals made, CAMHS services for young people leads at times to prolonged admission, compromising their access to treatment. Ward staff and are often required to manage difficult presenting behaviour and need to request the additional services of registered mental health nurses and the use of security while these young people remain on the Ward.

Section 14: Safeguarding Children Priorities for 2017-18

- Continue to deliver training as per the training trajectories agreed.
- Review Section 11 audit on an annual basis as per schedule.
- Ensure LSCB (Berkshire, Hampshire, Surrey and Bucks) recommendations relevant to health are cascaded across the organisation.
- Implement the CPIS (child protection information sharing) system.
- Streamline safeguarding children practice/processes across Frimley Health.

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Corporate Risk Assurance Framework – September 2017**
Meeting	Board of Directors (Public)
Meeting Date	October 2017
Agenda No.	11.
Report Type	To present Frimley Health NHS Foundation Trust's high level risks to the Board of Directors
Prepared By	Debbie Barrow Governance Manager
Executive Lead	Sir Andrew Morris Chief Executive
Executive Summary	The Frimley Health Risk Assurance Framework (RAF) is the primary mechanism for high level risk management within the organisation. This report summarises the discussions regarding 'high level' risks facing Frimley Health NHS Foundation Trust at the June 2017 meeting of the Corporate Governance Group. The method of scoring risks to categorise them as high, moderate and low risks is based on a '5 x 5' matrix. The risk rating is reached by scoring impact/consequence and likelihood on a scale of 1-5 and multiplying these together.
Background	Frimley Health NHS Foundation Trust is dedicated to establishing an organisational philosophy that ensures risk management is an integral part of corporate objectives, business plans and management systems. Compliance with legislative requirements is only a minimum standard. The specific function of risk management is to identify and manage risks that threaten the ability of the Trust to meet its objectives.
Issues / Actions	In this version of the RAF, there are 2 extremely high graded and 10 'high' graded identified and these are summarised in the attached paper. Two risks were regrrded and no new risks identified
Recommendation	The Board of Directors is asked to note the high level risks included in the Trustwide Risk Assurance Framework
Appendices	Corporate Risk Assurance Framework – September 2017

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Risk Assurance Framework - Risk Scoring Guide

Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on a Impact/Consequence x Likelihood matrix. **Impact/Consequence**- The descriptors below are used to score the impact/ consequence of the risk occurring. If the risk covers more than one column, the highest scoring column is used to grade the risk.

Level	Descriptor	Risk Type			
		Injury/Harm	**Service Delivery**	**Financial**	**Reputation/Publicity**
1	**Negligible**	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Less than £10,000	Rumours
2	**Minor**	Minor injury or illness requiring minor intervention. < 3 days off work if staff	Short disruption to services affecting patient care or intermittent breach of key target	Loss of between £10,000 and £100,000	Local media coverage
3	**Moderate**	Moderate injury requiring professional intervention RIDDOR reportable incident	Sustained period of disruption to services/sustained breach of key target	Loss of between £101,000 and £500,000	Local media coverage with reduction in public confidence
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay.	Intermittent failures in a critical service Significant underperformance of a range of key targets	Loss of between £501,000 and £5M	National media coverage and increased level of political/public scrutiny Total loss of public confidence
5	**Extreme**	Incident leading to death Serious incident involving a large number of patients	Permanent closure/loss of a service	Loss of >£5M	Long term or repeated adverse national publicity Removal of Chair/CEO or exec team

High Risk Tracking Matrix

Likelihood	Consequence				
	Insignificant	Minor	Moderate	Major	Catastrophic
Rare					
Unlikely					
Possible					G H
Likely				A B C D E I J K	
Almost Certain				F L	

11

High Risk Summary September 2017

Chart Ref	Risk Name	Source	Current Score			Target Score	Score Trend			Date Risk Added
			C	L	R		Previous Month	3 months ago	6 months ago	
Corporate Objective 1: Pursuing the highest level of quality, patient experience and clinical outcomes										
A	Nurse Staffing Capacity	FPH/WPH	4	4	16	8				Nov-12
B	Bed Capacity	FPH/WPH	4	4	16	4				Jul-15
C	Recognition of Deteriorating Patient	FPH/WPH	4	4	16	6				Apr-15
D	Critical Care Capacity	FPH/WPH	4	4	16	6				Jun-15
E	PACS/RIS System at WPH	WPH	4	4	16	6				Jan-17
F	A&E 4-hour target	FH	4	5	20	8				Sep-12
G	Medical Staffing Capacity	FH	5	3	15	8				Nov-12
H	Management of Patients with Mental Health issues & Learning Disabilities	FH	5	3	15	4				Oct-16
I	Cardiology	WPH	4	4	16	4				Jul-17
Corporate Objective 2: Transforming our infrastructure										
J	Delivery of Informatics Strategy 2017/18	FH	4	4	16	4				Apr-13
Corporate Objective 3: Developing our Staff and our Culture										
K	Participation in Mandatory Training & Appraisals	HWP/FPH	4	4	16	4				Jan-12
Corporate Objective 4: Breaking through traditional healthcare boundaries										
Corporate Objective 5: Keeping Control of Resources & Delivery Key Standards										
L	Failure to achieve Medium Term Financial Sustainability	FH	4	5	20	4				Sep-11
Corporate Objective 6: Developing sustainable clinical services										

Risk Name	Current Risk Rating	Actions	Assurance
Failure to achieve financial sustainability (FPH/HWPH)		1. Project Initiation Documents to be produced for all remaining savings schemes. 2. Quality Impact assessments to be completed for all remaining schemes. 3. Head of PMO appointed to ensure that all schemes are tracked and remedial actions developed where necessary. 4. Medium-term transformation projects to be developed. 5. CIP under achieving, over spend on medical staff but mitigation agreed to deliver £30m 6. Projected income is now above plan at £2-4m	• Reported to Board through Financial Assurance Committee.
A&E 4-Hour Target Risk to Monitor governance rating due to failure to deliver A&E 4 hour target as per trajectory reaching 95% in March 18, potential 12-hour breaches, and pressures on bed capacity and patient flow with potential to impact ability to deliver routine and critical services, delay in patient treatment, quality of care, and patient safety..		1. Remedial action plan regarding patient flow and discharge 2. Review 7 day provision in line with national requirements 3. Increase the number of pathways applicable to AECU 4. Work needed with social care on delays 5. To finalise the trigger tool and operational directives to take to HEB 6. Monitoring of any 12-hour breaches to ensure patient safety is maintained 7. To put Cardiologist in ED to work alongside clinicians 8. General Medicine consultants to work a late shift 1-10 from July 9. Additional GPs to assist in ED 10. Ambulatory Care Unit to open 7 days a week from Oct 17 11. Physicians now in ED at WPH 12. Target Q2 91.48% to received STF, target March 18 955 13. Establisihing GP streaming at Wexham. Alternative ESI model at FPH, awaiting sign off 16. Potential better staffing with Middle Grades (recruitment in Qatar) 17. Joint A&E Delivery Board established with STP delivery plan. North/South delivery plan in draft to support STP plan 18. Urgent Care Operational Group established on both sites with operational task and finish groups in place	• Weekly performance meetings. • Daily monitoring of breaches of A&E 4 hour target. • Daily alerts to CEO. • Performance on standard reported directly to the Board. • Reviewed by Hospital Executive Board and Quality Assurance Committee on behalf of the Board.
Delivery of Informatics Strategy 2016/17 Risk of failure to deliver the Informatics Strategy 16/17 as a key part of the quality and efficiency objective.		1. Informatics board to confirm programme 2. Clinical Leads identified for each project 3. Transformation suppport to be sought for each major project 4. Clinical IT lead appointed 5. Nurse lead to be appointed. 2nd advert for Nurse lead published, to interview November 16 6. To retest sequencing of various initiatives, to bring combined PAS system forward to mitigate records issues 7. The capacity of the Informatics Team to deliver the IT Strategy is under review.	• Reviewed by Informatics Board with key outcomes reported to the Board via the Hospital Executive Board
Potential risk to patient care due to nursing staff capacity (FPH &HWPH)		1. Multiple retention schemes being explored at Corporate and local level 2. Temporary staffing workstreams 3. Further European recruitment and RR action plan in place 4. Specialist nurses offering support to wards areas and practice development team undertaking clinical shifts. 5. A vacancy trajectory is in place to further decrease the vacancy rate to 11% by Sept 2017 6. Turnover at WP has decreased significantly from 25% to 16%	• Recruitment progress reviewed at Weekly Ward Moves meeting, chaired by Deputy COO • Board will receive assurance via the Quality Assurance Committee • Workforce Group established which monitors management of risk, reporting into Hospital Executive Board

		7. New exit process launched in January to improve intelligence regarding causes of turnover 8. In April the Trust recruited 42 qualified nurses (compared to 25 in April 17). Overall despite a challenging labour market we are on course to reduce nurse vacancy to 9% by the end of the year. 8. New nursing governance group formed in Feb 17 with specific focus on reducing nursing turnover and improving recruitment processes. 10. 40 nurses recruited from Philippines (via Drake) and will be starting from Mar 17. A further 35 recruited in August. 11. Revise Open days to increase attendance and experience of potential candidates. Increased attendance at external recruitment open days e.g. RCN careers fairs. 12 Currently exploring new partnerships with recruitment agencies to increase the supply of staff from Europe and International. 13. Report to BOD September 17 14. Agreement for 30 MOD nurses at Wexham, first 10 due end of September	
Participation in Mandatory Training & Appraisals		1. E-learning packages continue to be rolled out and technical issues being addressed. 2. Alternative delivery methods to be employed, e.g. hosting training in workplace where possible. 3. Development of single metric for inclusion on Trust and divisional balanced scorecards. 4. Follow up paper to Quality Committee with update on progress 5. New Policy now launched - Acheived 6. Temp p/t post to help with system integration. 7. Report scheduled for the Board meeting in November 8. An improvement of 8% observed in apparaisals 9. Subject Training Leads meeting monthly 10. Hot spots and priorities identified and presented at Quality Committee, tatrgetting shortfalls that may impact on patient safety 11. To evaluate e-learning to assess impact on training requirements 12. Monthly report with compliance and RAG status sent to all SME's MAST group now established to include SME's and review training on a regular basis 13. All specialities tasked with achieving 85% by 1/10/17 in high risk submect matter by CEO	• Board will be updated via the Trust Corporate Governance Group • Workforce Group established which monitors management of risk, reporting into Hospital Executive Board
Bed Capacity Risk to patient experience due to potential for lack of sufficient bed capacity to meet demand during Winter months 15/16		1. Work with NE Hants on Vanguard scheme to provide integrated care hubs to reduce admissions to FPH 2. Driving Vanguard & Integrated Care teams to improve flow 3. New working practices being trialled 4. Care Home packages, appointment of 8 care assistants to assist Hants Social Care 5. Emergency workload increase 13% at WPH and 6% at FPH in first 6 months 16/17 6. Nursing home trial to commence on 1/11/16 with 5 beds in conjunction with Hants Social Care at Freelands 7. Ambulatory care to be provided, 7 days a week, 10 hours a day 8. New Abmulatory Care Unit (ACU) to open at FPH Jan 2017. 9. Aquisition of Fleet Hospital Ward (17 beds) + 4 Integrated Care Teams Jan 2017. 10. FPH setting up a hospital hub for the Integrated Referral Information Service (IRIS). 11. Reviewed use of Ward 1 Heatherwood for medical long stay patients	• 6-monthly updates presented to BOD

		12. Submitted bed capacity to NHSI to achieve 87% capacity for winter 13. Schemes being looked at to bridge gap including reducing LOS in ortho, ambulatory care position at 'front door' in an effort to keep conversion rate down	
Critical Care Capacity Risk of poor outcome through failure to provide sufficient flow out of ICU and to generate increased level 2 capacity outside of Critical Care, potentially impacing on flow out of A&E		1. Critical Care Delivery Groups on both sites workstreams 2. Directors of Operations measuring flow 3. Requires discussion with Commissioners regarding support for increasing capacity 4.Data on discharges from Recovery to be captured o performance report and directorate dashboards 5. Launch HDU at WPH Q4 16/17 6. Cross-site Critical Care Strategy to be developed end Q4 16/17, drafted and out for comment 7. Difficulties in recruiting to Critical Care Consultant posts at Wexham 8. New MADU at WPH live June17 9. Critical Care Strategy Meeting met 21/6/17, concluded need more capacity for level 3	• Work of Trustwide M&M Committees monitored through Quality Committee and reported to Board verbally by Medical Director
Medical Staffing Capacity Risk of inadequate, appropriately trained staff, particularly in Middle and Junior Grades in A&E and Middle Grade Surgeons and difficulty in recruiting, with potential to impact on, and cause delays to, patient diagnosis and treatment, and lead to clinic cancellations, gaps in the on-call rota, lack of immediate urgent specialty support and compromise patient care.		1. Recruitment & retention schemes implemented for ED and surgery 2. Specialty doctor grade rota to be reviewed (comparison of numbers per activity needed to compare both sites) 3. Review of Medical Staffing & Manpower Coordinator role completed 4. Trust-wide workforce planning exercise commencing in September 2017 5. Review of high cost locums completed monthly and recruitment plans adjusted accordingly 6. Big push on overseas recruitment especially for ED and general surgery 7. Implementation of latest guidance from NHSI with additional challenges 8. Locum agency bookings are now centralised at FPH apart from ED and anaesthetics; their centralisation is planned for September 2017 9. There are plans to form a shared doctor bank with Ashford and St Peters, Chertsey and the Royal Surrey County Hospital, Guildford and to extend this to cover the North of the FHFT patch – a benefits paper is going to be presented at Top Team 10. There are currently rolling adverts on NHS jobs for both ED and general surgery doctors of specialty doctor level and junior doctor grade 11. IR35 having a greater impact than first envisaged due to locums withdrawing from shifts at short notice 12. Skype Interviews (Qatar) taking place in May for junior /middle grade positions. 9 recruited so far.	• Board will receive assurance via the Quality Assurance Committee. • A Workforce Group established to monitor management of risk, reporting into the Hospital Executive Board.
Electronic Document Management System (EDMS) There is a risk that Trust staff (non IM&T) do not have sufficient IT skills to support an electronic patient record and that the organisation is not ready to move to an electronic solution, for example having multiple manual systems and forms that may need to be streamlined before going electronic		1. EDMS steering group monitoring all major risks to go-live. 2. 'Forms' committee established with clinical leadership to attempt to streamline data capture. 3. Clinicians being briefed through standing item on HEB agenda. 4. 'Go Live' programme to commenced 30/1/17 5. Each speciality to ensure relevant staff have completed EDMS training package & to be clear where they are in EDMS roll out programme 6. Each ward to risk assess position in terms of ward clerks and numbers of discharges each day 7. Floor Walkers to be available to support implementation & to provide out of hours advice via telephone 8. Further work is required in the following areas: consent, legacy notes and availability of IT	• Reviewed by the Informatics Board, with key outcomes reported to the Board via the Hospital Executive Board.

		equipment 9. Phase 1 successfully in place 10. Level of floorwalking and remote support appears to be sufficient to support staff with technical issues. Good quality training has helped mitigate this risk 11. Last phase of roll out, project has progressed well, minor issues arimd scanning and scanning accuracy	
Recognition of the Deteriorating Patient Risk of poor outcome through failure to recognise a patient with a deteriorating condition. To ensure that all clinical staff have the right skills, knowledge and tools to recognise & deliver timely treatment to the deteriorating patient.		1. Resus Team now functioning 8-8 on both sites. 2. To ensure that all relevant staff have received ALERT training 3. Medical Director nominated Exec Lead for Critical Care - November 2016. 4 National Early Warning System (NEWS) launched and implemented across FPH and WPH sites. 5. Training Needs Analysis for the Management of the Deteriorating Patient including Alert course to be reviewed and prioritisation given to senior medical staff in training 6. To review 'Hospital at Night' and make recommendations to standardise arrangements across Frimley Health 7. Cross-site audit of compliance to be undertaken in December 2016. 8. Triggers for high level care increasing on Wexham Park site with failure to escalate deteriorating patient 9. Early sight of audit of NEWS demonstrates escalation significantly improved 10. In depth review of recent cluster of SIs relating to deteriorating patient on Wexham site to be undertaken 11. Reduction in cardiac arrests 12. Marked improvement in Cardiac Arrest Audit, FHFT now at 30.60% against national average of 20% patients that survice a cardiac arrest in hospital and go home	• Work of Trustwide M&M Committees monitored through Quality Committee and reported to Board verbally by Medical Director
PACS/RIS System at WPH The current PACS/RIS system at HWPH is running on unsupported software and obsolete hardware, exposing the Trust to significant risk in the event of a failure. There is no disaster recovery in place, so if the system fails, the service will not be operational (there will be no access to PACS images throughout the Trust and the Radiology department processes will slow down) and the supplier have confirmed that extending any support will be on a best endeavours basis only.		1. Jan 17: PMO continue to work with the Business users to agree the way forward. 2. Decision made to implement Carestream 3. Commercial way forward under review, strategy needs to be agreed following initial meeting with Carestream 4. Further meeting to be held with Carestream 8/6/17 to discuss timescales & procurement approach 5. Once commercials resolved, to review assessment with Carestream to discuss sort term plans and longer term plan for migration with PACs/RIS at Wexham. 6. Digital environment moving to be Cloud based over time and this will be explored 7. Business case being developed	• Reviewed at IOG and IM&T Heads Meeting

Cardiology Interventional Service Potential risk to patient safety and patient experience due to staffing difficulties in maintaining continuity in pPCI 24/7		1. Spike in SIs from Cardiology 2. Lookback exercise of pPCI cases since 24/7 service started, Deputy Medical Director (FPH) reviewing on behalf of Medical Director 3. Temporary staffing changes leading to reduced numbers on pPCI rota 4. External case reviewer appointed	• Mortality Surveillance Group
Management of Patients with Mental Health issues & Learning Disabilities Potential risk to safe management of both adults & children with mental health needs or learning disabilities, to review with mental health colleagues the increase in number and complexity of these patients		1. Mental Health Crisis Group established with representation from Surrey Borders, Safeguarding & ED 2. Dashboard in place - reviewed at Mental Health meeting established with number of referrals, patients requiring sectioning under the MHA and specials, to be further refined 3. Specialist Simulation Training to be provided for key stakeholders including security team around accountability and duty of care when managing patients sectioned under the MHA including use of restraint 4. Ensure Medical Staff have training in MCA, DOLS and restraint 5. All patients sectionunder the MHA now highlighted & discussed at daily Bed Management meetings 6. Current risk assessment documentation under review to include restraint & placement of patient sectioned under the MHA, to form part of new Specials 1:1 Policy 7. Issues regarding weekend provision of CAMHS service 8. Mental health report presented to May Board of Directors 9. 'Managing Challenging Behaviour' incidents roles & responsibilities in-house awareness video being developed. On-line roll out anticipated end June 17 10. On Wexham site, plan to arrange meeting with LA leads to address lack engagement in finding placements for young people with behavioural issues admitted following DSH and deemed not to have MH issues by CAMHS 11. Mental Health post financing through STP 12. Learning Disabilities action plan complete 13. Continued weekend issues with CAMHS at FPH	• Annual Report to Board of Directors

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Report Title	**Senior Information Risk Owner (SIRO) Quarterly Report**
Meeting	Public Board
Meeting Date	Friday, 6th October 2017
Agenda No.	12.
Report Type	Assurance
Prepared By	Victoria Armstrong, Acting Head of Information Governance
Executive Lead	Nigel Foster, Director Finance & IM&T (SIRO)
Executive Summary	• NHS Digital have confirmed that there will be no significant changes to the IG Toolkit submission process this year in preparation for a revamped version in 2018 • IG Training programme is currently underway and training has now been sent out to all those who completed it in September last year. • There were 5 breaches of the 40 day time frame for Data Protection Requests in April and May due to bank holidays and staffing shortages. The team's hours have now been changed to prevent further breaches from happening • Freedom of Information requests continue to rise and increase in their complexity to answer. Key themes have been cyber security after the WannaCry virus, agency spend and charging of overseas patients • Incident reporting is increasing with more actively reported at Frimley site. Current trends have been leaving of telephone messages and patients receiving incorrect information • The department is currently preparing for the changes to the Data Protection Act 1998 and documenting areas of work that will need to be completed in order for the Trust to meet its obligations under the General Data Protection Regulations (GDPR)
Background	This is the quarterly report from the Trust Senior Information Risk Owner (SIRO) to the Trust board as required by the Department of Health. The report details the 6 areas of the IG Work Programme for 2017-2018.

Issues / Actions	There has been an increase of incidents reported to the department in the last quarter, including concerns over staff accessing patient records inappropriately, staff emailing patient information insecurely and patients receiving incorrect information. The department will add details of incidents to training and quarterly Caldicott Bulletin to raise awareness.
Recommendation	None
Appendices	July SIRO Report 2017

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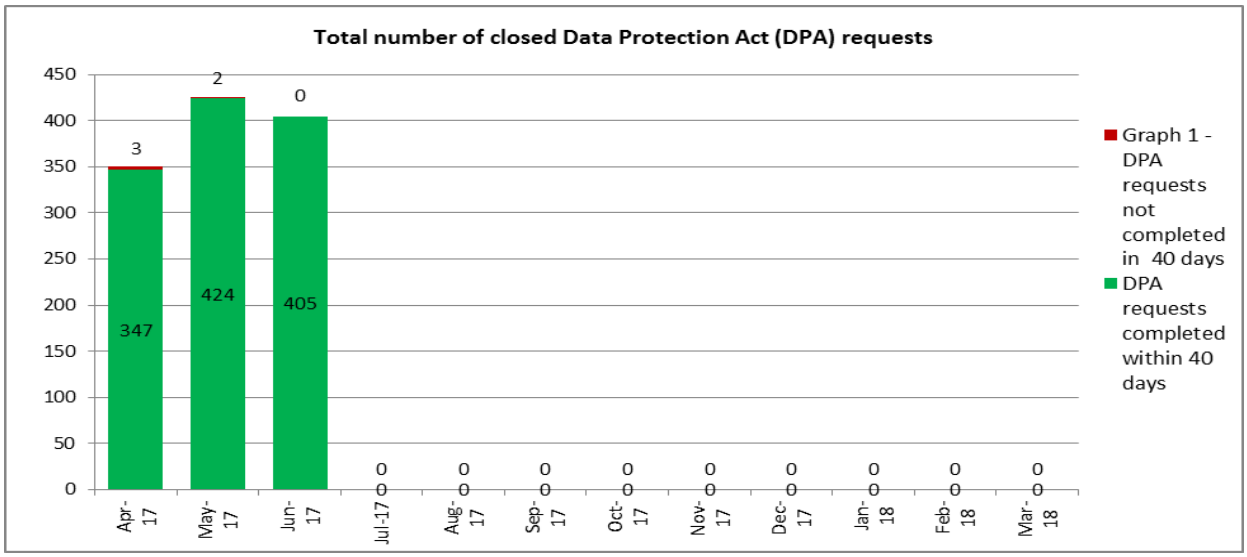
Senior Information Risk Owner (SIRO) Report – July 2017

Below is a report on the first quarter of the financial year – April – June 2017 of the Information Governance Work Programme.

Data Protection Requests



To date there has been a total of 1,181 requests completed by the Access to Medical Records Team across the Frimley and Wexham sites, which equal the number of requests completed for the same period in 2016.

From April 2017, to date there have been a total of 5 cases which have breached the legal 40 calendar day deadline (6 less than 2016 covering the same period). These breaches were at FPH site, each by one day only; three breaches occurred during the Easter holidays (with two bank holidays) and two requests breached when only one member of staff was in. To address this issue, the working hours of the team have been changed to prevent further breaches occurring.

Both sites are now using the same system (Request for Information RFI) system, which was introduced at WPH on the 1st April 2017. Work is continuing to synchronise the working practices on both sites.

12

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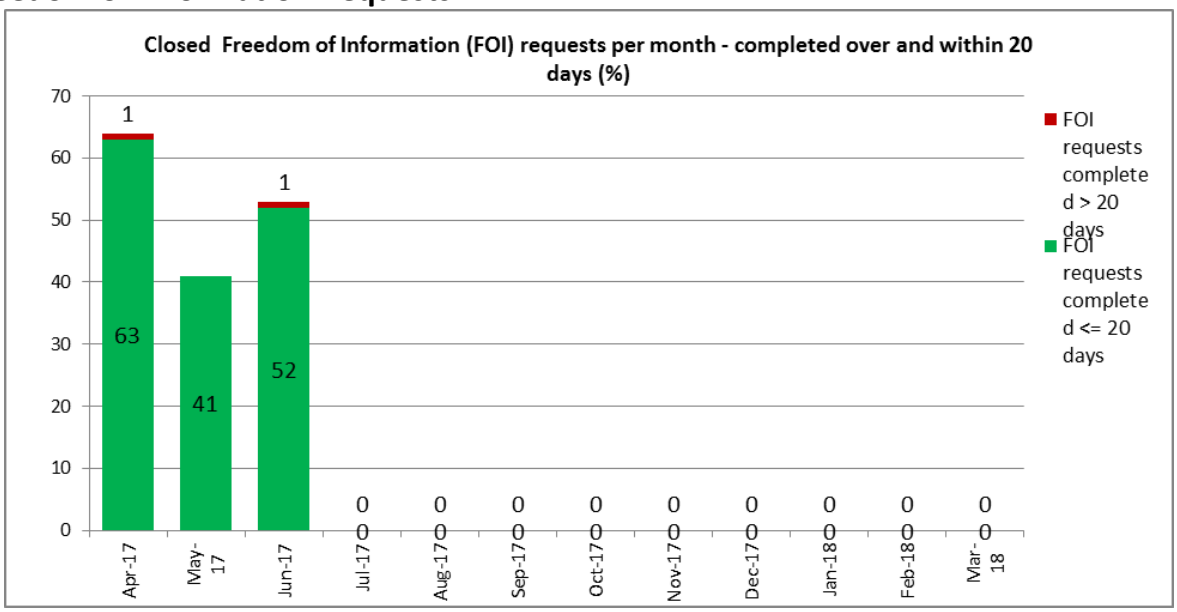
Freedom of Information Requests

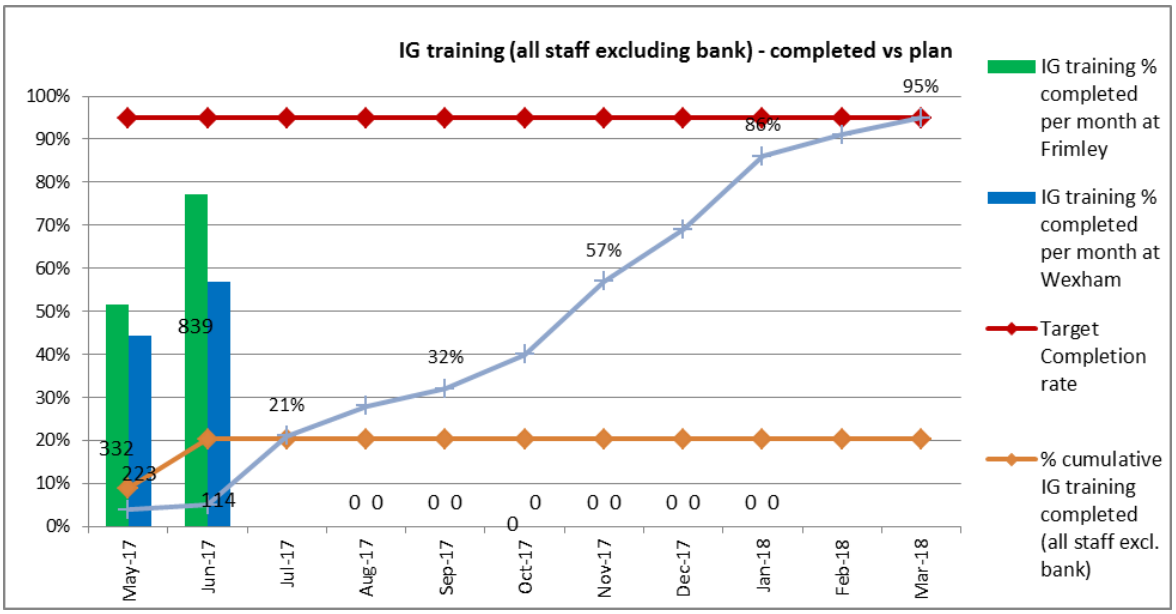


For the financial year 2017-18, there have been a total of 149 FOI requests received. Over the last 6 years the number of FOIs has been increasing; however for the first quarter of 2017-18 this figure demonstrates a fall of 54 requests against the same quarter last year. A large proportion of FOI's relate to current topics or media stories; although there have been a number of requests relating to the recent international cyber-attack, last year there were multiple rolling stories on agency spend, non-EU nurses and charging of foreign patients which likely accounted for the higher figures.

In March 2017, the Information Commissioner's Office (ICO) announced that the target for responding to FOIs within 20 working days was going to be increased to 90% compliance. The table above shows the number of requests closed from April 2017, when the new threshold began. There have been 158 responses sent since April, with only 2 taking longer than 20 working days. This is a compliance rate of 98.7%.

Although the number of FOIs is lower for this period, their complexity continues to rise. However, the FOI Team have managed to maintain the low average number of days to respond to an FOI which was set at the end of the previous year (11 days) and have encouraged transparency with only 6 exemptions being used (3.8%). As a result, during this period there have been no internal reviews and no complaints to the ICO, compared to 3 reviews this time last year.

IG Annual Refresher Training



Each year the Trust is required to train a minimum of 95% of staff in Information Governance. Last year, for the first time in 3 years, the Trust achieved this target.

In order to maintain this performance, the IG training team have developed a strategy for the year which is largely based on last year's successful plan. The majority of training will be completed via PolicyHub, an electronic system which sends out training links to those that are required to do the training. Links were sent to anyone who had not completed the training in over a year, and on a monthly basis, links will be sent anyone who is due to expire within 3 months of the date the training is sent.

One of the big differences for this year was to bring the training approach forward by 2 months to encourage a staggered approach throughout the year rather than the usual push in quarters 3 and 4. The table above shows the number of staff who have completed the training since it was first sent out in May. In total 17% of substantive staff have completed the training – this time last year 5% of staff had completed the training.

Another major change was to use the same training approach for bank staff as substantive staff. Due to the data quality of the bank reports, it is not possible to determine active bank staff. Therefore training has been sent to anyone who has not completed the training for over a year and to anyone expiring within 3 months of the links being sent out. Out of 958 bank staff that training has been sent to so far, only 195 have completed. These are not recorded in the table above.

IG Training of New Starters

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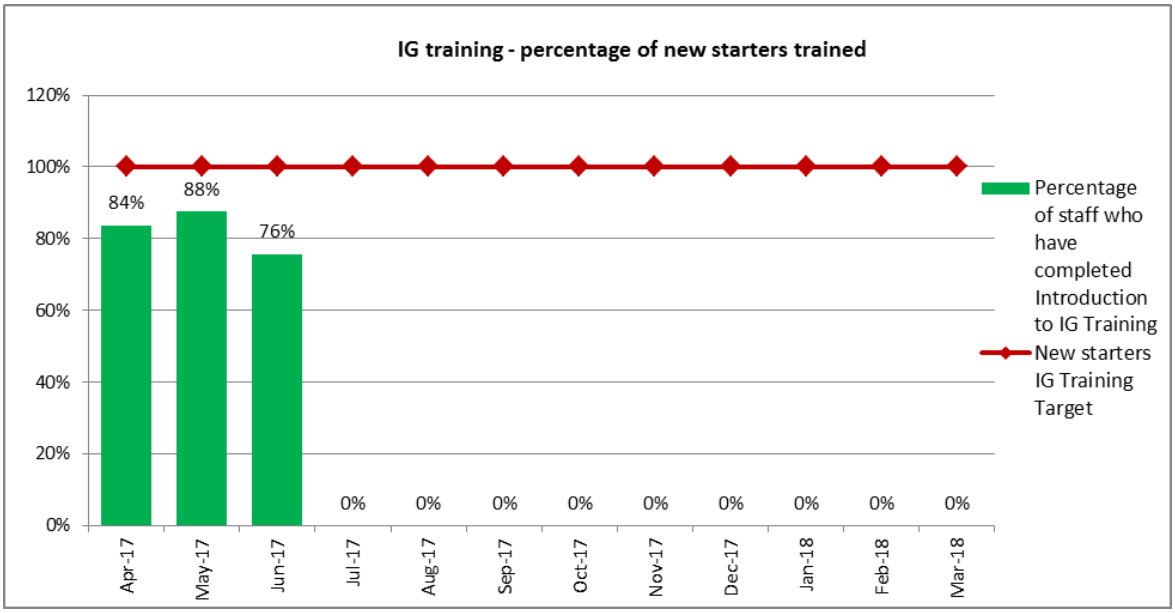
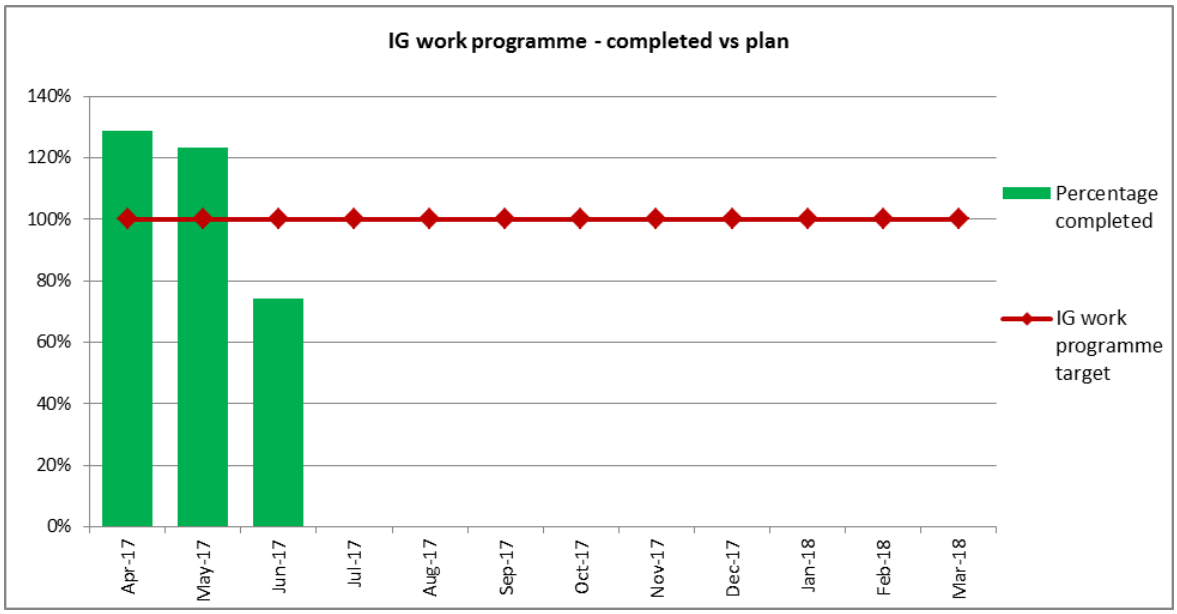


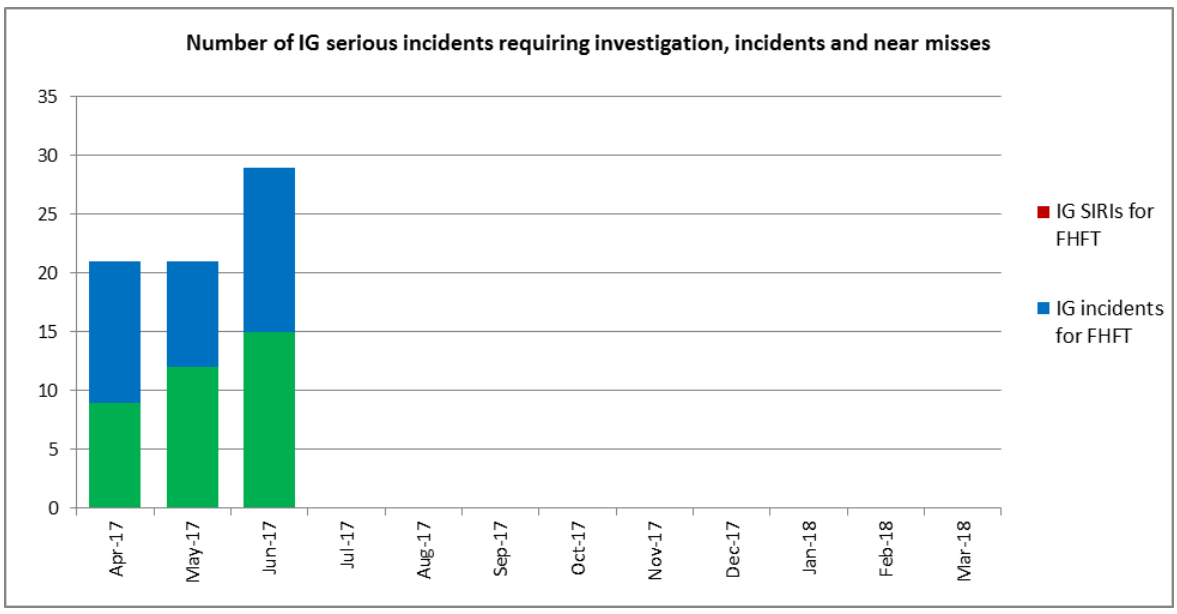
Completion of IG training across the Trust for new starters is running on average about 83%, the table above reflects permanent staff only. Bank staff who are deemed to be new starters are currently running at 54% compliance rate. There are a couple of factors which are resulting in compliance being lower than anticipated; for example, the Trust has recently agreed that any returning member of staff who has previously worked for the Trust in the last 3 years do not need to re-attend Trust Induction. Whilst the staff based at Frimley are being captured by PC Induction process. The IG Department is currently liaising with IM&T to resolve the new starters' process at Wexham to allow us to implement PC Induction.

IG Work Programme



At the end of the 1st quarter, the IG Work Programme is sat at 21% of work that has been already completed. This is due to the completion of some pieces of work that had to be transferred from the 2016-17 work programme due to outstanding actions upon submission of the toolkit, and being able to complete some work that had originally been scheduled for later on in the year. There are currently 2 pieces of work that are on hold due to extenuating factors such as the NHSmail2 project and clarification of the Trust's whiteboard policy to enable the IG Walkabouts to take place.

IG Incidents

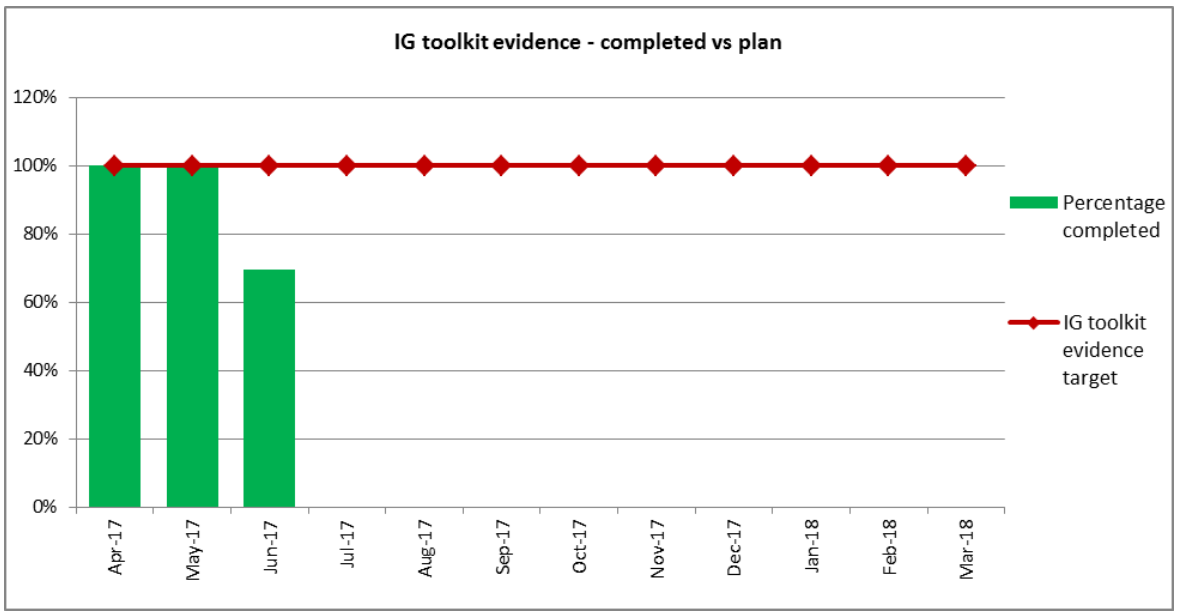


Incident reporting has stayed consistent into the first quarter of the financial year with staff actively reporting incidents, though there appears to be a more proactive culture of staff reporting incident on the Frimley site compared to the Wexham site. Current incident trends that have been identified this quarter are concerns over staff leaving telephone messages on external care provider's voicemail, patients and family's covertly recording care/MDT meeting, staff losing medical information offsite and patients receiving incorrect information.

When an incident is reported it is thoroughly investigated and feedback is provided back to the member of staff, line manager and department to be used to highlight areas of concern and areas identified for improvement. This is also picked up in IG training to educate and remind staff about the importance of confidentiality and the Trust's policies and procedures. The IG Team are also conducting walkabouts in all patient facing areas identifying areas of good practice and where improvements could be made. Each department audited then receives feedback.

The Trust has not reported a Serious Incidents Requiring Investigation (SIRI) during quarter 1. The Trust is required to report any IG incidents that meet NHS Digital's level 2 requirements on the IG Toolkit which automatically notifies NHS Digital and the Information Commissioner's Office (ICO).

IG Toolkit Evidence



At the end of the 1st quarter, the evidence for the toolkit is progressing well, this is due to some evidence from 2016-17 that has been able to be carried forward as it is still relevant such as job descriptions and approved policies. NHS Digital have now confirmed that there will be no significant changes to the toolkit this year and on the 5th July 2017 released version 14.1 of the toolkit to reflect this. They also confirmed that there would no requirement for a July quarterly submission. The toolkit is due to be revamped next year and likely to be focused further on information security and cyber security rather than previous years.

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Report Title	**Changes to Standing Financial Instructions**
Meeting	Trust Board
Meeting Date	Friday, 6th October 2017
Agenda No.	13.
Report Type	Amendment required for approval
Prepared By	Edward John (Director of Operational Finance)
Executive Lead	Nigel Foster (Director of Finance)
Executive Summary	There are minor changes that require to be made to the exisiting SFI's to bring them up to date wrt names, posts and references to Acts of parliament. The changes do not represent significant shifts in processes, systems or internal control. This revised set of SFI's have been to Audit Committee and have been recommended to the Board for approval
Background	There are minor changes that require to be made to the exisiting SFI's to bring them up to date wrt names, posts and references to Acts of parliament.
Issues / Actions	None significant
Recommendation	The Board is asked to approve the proposed changes to the SFIs
Appendices	Report attached highlighting the main changes

13

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Recommended changes to update Trust Standing Financial Instructions

The following table summarises the recommended changes to the SFI's that are required to update the SFI's for changes to names of NHS bodies, Trust posts and structures and to relevant acts of parliament.

The changes are not considered significant and do not represent any material change to systems, processes or procedures of internal control.

Current SFI reference	Recommended change	Notes
1.2.1 (n) Page 2	'Monitor' replaced with 'NHSI'	In the terminology section and then this is also replaced throughout the document where relevant
1.2.1 (t)	'Frimley Park Hospital' replaced with 'Frimley Health'	
2.2	'Fraud and Corruption' replaced with 'Fraud, Corruption and Bribery'	
3.1.3 (b) 3.1.3 (c) 8.2.1	'manpower' replaced with 'workforce'	
3.1.3 (d)	Change 'be prepared within the limits of available funds with regard to the Prudential Borrowing Limit' To 'be prepared within the limits of available funds available to the Trust'	In relation to preparation and approval of budgets by the Board this instruction has been aligned to a general responsibility to spend within available resources.
3.1.3 (a-vii)	Change 'performance against the Prudential Borrowing Limit any permissible borrowing or covenants To 'performance against any permissible borrowing or covenants'	In relation to reporting performance reference to Prudential Borrowing limits removed
5.3.1 (c)	Change 'those authorised to sign cheques or other orders drawn on the Trust's accounts and the limitation on single signatory payments' To 'those authorised to sign cheques or other orders and payments drawn on the Trust's	In relation to preparation of instructions on the operation of bank accounts – seeks to remove any limitation for which procedure notes are

	accounts and the limitation on single signatory payments'	required
6.4.1 (b)	Change 'ordering and securely controlling any such stationery' To 'ordering and securely controlling any such stationery or electronic records'	In relation to Director of Finance responsibilities for recording receipt of monies
9.4.3 Section E 19 (a)	Replaced 'Drugs and Therapeutics Committee' with 'Frimley Health Area Prescribing Committee'	In relation to authorisation powers of introduction new drugs recognises the successor body to the D&TC
14.5 (a)	Replace 'Information Technology Strategy' with 'Information Management and Technology Strategy	
14.5 14.6	Replace 'The Trust IM&T Steering group' with 'IM&T Board'	
17.1.1	Replace 'Corruption acts 1906 and 1916' with 'Bribery Act 2010'	
17.2.1	Refer to company secretary as 'he/she' instead of 'she'	
Appendix 1	Revise table 4.01 which deals with the signing of e-contracts by relevant personnel. Previously this would have been solely the reserve of the FD and CEO but the proposed change is that once correct authorisation procedures have been followed and then the formality of letting a contract (signatures on contracts) may be provided by the Associate Director of Procurement or the Finance Director's Deputy (Director of Operational Finance).	So long as the approvals already detailed in section 3 of Appendix 1 are correctly obtained there is not a requirement for the physical signature of a contract to be made by the FD or CEO.
Appendix 2	Specify 'Minimum level of Officer' instead of 'Officer'	In relation to level at which authorised budgets may be delegated
Appendix 2	Replace 'Head of Management Accounts' with 'Head of Management Accounts or equivalent'	Recognises no such post title exits in present structure
Appendix 4 SFI ref 8	replace 'Remuneration Committee' with 'Performance and Remuneration Committee'	
Appendix 4	Replace 'payroll' with 'Payroll form and adequacy	In relation to responsibilities

SFI ref 8.4	of payroll records and processes'	for payroll processes
Appendix 4 SFI ref 9.2.9	Delete 'ensure that Standing Orders are compatible with Monitor Requirements'	Instruction 9.2.9 was removed in previous SFI updates so is no longer valid
Appendix 4 SFI ref 11	Replace 'Capital investment programme' With 'Managing Capital investment programmes'	In relation to responsibilities to managing the Trusts capex programmes
Appendix 4 SFI ref 11.3.7	Change 'DoF [is delegated to]calculate and pay capital charges' To 'Line or senior managers [are delegated to authorise] use of Trust assets for private use	This is merely to align the appendix with the main body of text
Appendix 4 SFI ref 12.8	Change ref to 12.3 to align with main text	
Section E	Change 'In the absence of the Director of Finance the Deputy Director of Finance may deputise for the Director of Finance' To 'In the absence of the Director of Finance the Director of Finance's deputy may deputise for the Director of Finance'	To recognise current structures most acquisition
Section E 12 (a)	Change 'Duty Manager' to 'AD or Duty Manager'	In relation to reporting incidents to the police to recognise current structures

Frimley Health NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

1 August 2017

FOREWORD

1. **These Standing Financial Instructions (SFIs), together with the Trust's Constitution which contains the Standing Orders, provide a business and financial framework within which all executive directors, non-executive directors and officers of the Trust will be expected to work.** All executive and non-executive directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

2. These documents fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

3. The SFIs have been formally adopted by the Board.

4. Any queries should be referred to the Director of Finance or Deputy Director of Finance as appropriate.

1. INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) shall have effect as if incorporated in the Constitution - Standing Orders (SOs) of the Trust.

1.1.2 These SFIs 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 the requirements of the Independent Regulator in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. 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.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Constitution - SOs.

FAILURE TO COMPLY WITH SFIs and Trust's Constitution IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in the Health Service Act 2006 , or in the Financial Directions made under the 2006 Act shall have the same meaning in these instructions and in addition:

a) "**Act**" means the National Health Service Act 2006;

b) **"Board of Directors"** and (unless the context otherwise requires) "Board", means the executive and non-executive directors of the Trust, including the Chairman, collectively as a body;

c) "**Budget**" means a resource, expressed in financial terms, proposed by the Trust *(Board)* for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

d) "**Budget Holder**" means the director or officer with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

e) "**Chairman**" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole.

f) "**Chief Executive**" means the chief executive officer of the Trust;

g) "**Committee**" means a committee of the Board of Directors;

h) "**Constitution**" means the constitution of the Trust;

i) "**Council of Governors**" means the Council of Governors of the Trust as constituted by the Constitution;

j) "**Director of Finance**" means the chief financial officer of the Trust;

k) "**Funds held on trust**" means those funds which the Trust held at its date of incorporation or subsequently has chosen to accept;

l) "**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice;

m) "**Member of the Board**" means an executive or Non-Executive Director (Member of the Board in relation to the Board of Directors includes its Chairman.)

n) "**NHSI**" means National Health Service Improvement which is the name of the regulator governing NHS Foundation Trusts whose duties were formerly undertaken by Monitor. Any reference to documents, guidance or direction issues by NHSI will refer to either this body or its predecessor body;

o) "**Nominated Officer**" means an officer charged with the responsibility for

discharging specific tasks within Standing Orders and Standing Financial Instructions;

p) "**Non-Executive Director**" means a Member of the Board of Directors who does not hold an executive office of the Trust;

q) "**Officer**" means a member of staff of the Trust;

r) "**SFIs**" means the Standing Financial Instructions of the Trust;

s) "**SOs**" means the Standing Orders of the Trust;

t) "**Trust**" means Frimley Health NHS Foundation Trust.

u) All reference in these instructions to officer shall be deemed to include Consultant Medical staff as appropriate;

v) All references to the Instructions to the masculine gender shall be read as equally applicable to the female gender and vice-versa.

1.2.2 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 director or officers who have been duly authorised to represent them.

1.2.3 Wherever the term "officer" is used and where the context permits it shall be deemed to include officers of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 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 Trust's Constitution - Standing Orders for the Board of Directors.

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation which forms part of the SFIs.

1.3.3 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.

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

1.3.5 It is a duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.6 All directors and officers, severally and collectively, are responsible for:

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

(b) avoiding loss;

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

(d) conforming with the requirements of the Trust's Constitution - Standing Orders and Standing Financial Instructions.

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

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

2. AUDIT

2.1 The Trust shall comply with the directions of NHSI with respect to the standards, procedures and techniques to be adopted in maintaining the Trust's financial records.

2.2 AUDIT COMMITTEE

2.2.1 In accordance with Standing Orders (and as set out in the Audit Code for NHS Foundation Trusts, issued by Monitor now NHSI) the Board shall establish a committee of non-executive directors as an Audit Committee, with formal terms of reference, which will provide an independent and objective view of internal control.

2.2.2 Where the Audit Committee feels there is evidence of ***ultra vires*** transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Monitor.

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

2.2 FRAUD, CORRUPTION and Bribery

2.2.1 The Chief Executive and Director of Finance shall monitor and ensure compliance with good practice to counter fraud,corruption and bribery.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

2.2.3 The Local Counter Fraud Specialist shall report to the Trust's Director of Finance.

2.2.4 The Local Counter Fraud Specialist shall present an Annual Plan to the Audit Committee and periodically report on policies and findings to that Committee.

2.3 DIRECTOR OF FINANCE

2.3.1 The Director of Finance is responsible for:

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

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

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

(i) a clear statement on the effectiveness of internal control;
(ii) major internal control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.3.2 The Director of Finance and appointed auditors (both internal and external) are entitled without necessarily giving prior notice to require and receive:

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

(b) access at all reasonable times to any land, premises or officer of the Trust;

(c) the production of any cash, stores or other property of the Trust under an officer's control; and

(d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of or risk associated with, relevant established policies, plans and procedures;

(b) the adequacy, efficiency and application of financial and other related management controls;

(c) the suitability and effective usage of financial and other related management information and data;

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

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

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

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

2.4.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the *NHS Internal Audit Manual*.

2.5. EXTERNAL AUDIT

2.5.1 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors.

2.5.2 The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by NHSI within the Audit Code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

2.5.3 External Audit responsibilities (in compliance with the requirements of NHSI and Schedule 10 of the Act) are:

(a) to be satisfied that the accounts comply with the directions provided, i.e., the NHS Foundation Trust Financial Reporting Manual;

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

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

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

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

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

(g) to certify the completion of the audit;

(h) to express an opinion on the accounts;

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

2.5.4 External Auditors will ensure that there is a minimum of duplication of effort between themselves, Internal Audit and NHSI. The auditors will discharge this responsibility by:

(a) reviewing the statement made by the Chief Executive as part of the Statement on Internal Control and making a negative statement within the audit opinion if the Statement on Internal Control is not consistent with their knowledge of the Trust;

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

(c) undertaking any other work that they feel necessary to discharge their responsibilities.

2.5.5 The Trust will provide the external auditor with every facility and all information which it may reasonably require for the purposes of its functions under Schedule 10 of the Act.

2.5.6 The Trust shall forward a report to NHSI within 30 days (or such shorter period as NHSI may specify) of the External Auditor issuing a public interest report. The report shall include details of the Trust's response to the issues raised within the public interest report.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive and Director of Finance will compile and submit to the Board an annual business plan. 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.

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

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

(a) be in accordance with the aims and objectives set out in the annual business plan;

(b) accord with workload and workforce plans;

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

(d) be prepared within the limits of available funds available to the Trust; and

(e) identify potential risks.

3.1.4 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them and report to the Board.

3.1.5 Officers shall provide the Director of Finance with all financial, statistical and other relevant information as necessary, for the compilation of such budgets, plans, estimates and forecasts.

3.1.6 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 successfully.

3.1.7 Operating surpluses may be used to:

(a) spend on revenue;

(b) meet locally determined health needs;

(c) build cash reserves for future investments;

(d) finance an investment or purchase;

(e) make payments on a loan.

Operating surpluses may not be distributed to members.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive on the advice of the Director of Finance may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

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

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement (Appendix 2).

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

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

(iii) summary cash flow and forecast year-end position;

(iv) summary balance sheet;

(v) movements in working capital;

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

(vi) explanations of material variances that explain any movements from the planned retained surplus/deficit position at the end of the current

month;

(vii) performance against any permissible borrowing or covenants;

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

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and workforce budgets;

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

(e) arrangements for the authorisation of budget transfers.

3.3.2 Financial reports shall be received monthly by the Board of Directors.

3.3.3 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the 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;

(f) no permanent officers are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board;

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

3.4 CAPITAL EXPENDITURE

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 11.) All items of capital expenditure must be referred to the Director of Finance for inclusion in the capital planning and approval processes.

3.5 MONITORING RETURNS

3.5.1 The Chief Executive is responsible for ensuring that:

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

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

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

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

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

4. ANNUAL ACCOUNTS AND REPORTS

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

(a) keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHSI may, with the approval of the Treasury, direct;

(b) ensure that, in preparing annual accounts, the Trust complies with any directions given by NHSI with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared;

(ii) the information to be given in the accounts.

(c) ensure that a copy of the annual accounts and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHSI.

4.2 The Trust's Audited Annual Accounts must be presented to the Board for approval and received by the Council of Governors at a public meeting.

4.3 The Trust will prepare an annual report as required by NHSI. This will be presented to the Board for approval and received by the Council of Governors at a public meeting. A copy will be laid before Parliament and copies forwarded to NHSI.

5. BANK ACCOUNTS

5.1 GENERAL

5.1.1 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.

5.1.2 The Board shall approve the banking arrangements.

5.2 BANK ACCOUNTS

5.2.1 The Director of Finance is responsible for:

(a) bank accounts;

(b) establishing separate bank accounts for the Trust's unregulated funds;

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

5.3 BANKING PROCEDURES

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

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

(b) the limit to be applied to any overdraft;

(c) those authorised to sign cheques or other orders and payments drawn on the Trust's accounts and the limitation on single signatory payments.

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

5.3.3 All funds shall be held in accounts in the name of the Trust. No officer other then the Director of Finance shall open any bank account in the name of the Trust.

5.4 TENDERING AND REVIEW

5.4.1 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.

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

6.1 INCOME SYSTEMS

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

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

6.1.2.2 The Trust will carry on activities for the purpose of making additional income available in order to better carry on the Trust's principal purpose, subject to any restrictions in NHSI's authorisation and as stated in the Constitution.

6.2 FEES AND CHARGES

6.2.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice on matters of valuation shall be taken as necessary.

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

6.3 DEBT RECOVERY

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

6.3.2 Income not received should be dealt with in accordance with losses procedures.

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

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 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 or electronic records;

(c) the provision of adequate facilities and systems for officers 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.

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

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

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

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

6.4.6

6.4.7 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. Any loss or surplus of cash should be immediately reported to the Director of Finance.

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

7. CONTRACTS WITH COMMISSIONERS

7.1 The Chief Executive is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the Business Plan.

7.2 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) billing systems and cash flow management;

(d) any other matters of a financial nature;

(e) the contract negotiation process and timetable;

(f) the provision of contract data;

(g) amendments to contracts.

7.2 Contracts with commissioners shall comply with best costing practice and shall be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract, should be considered.

7.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

7.4 The Trust will maintain a public and up-to-date schedule of the authorised goods and services which are being currently provided, including non-mandatory health services.

8. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND OFFICERS

8.1 REMUNERATION AND TERMS OF SERVICE

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

8.2 FUNDED ESTABLISHMENT

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

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

8.3 STAFF APPOINTMENTS

8.3.1 No director or officer may engage, re-engage, or regrade officers, 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; and

(b) within the limit of his approved budget and funded establishment.

8.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for those officers outside of Agenda for Change.

8.3.3 A signed copy of the contract/appointment form and other such documents as she may require shall be sent to the Director of Human Resources (HR) and Facilities within one week of the officer commencing duty.

8.3.4 A termination of employment form and such other documents as the Director of HR and Facilities may require shall be submitted in the prescribed form immediately upon the effective date of an officer's resignation, retirement or termination being known. Where an officer fails to report for duty in circumstances which suggest that he has left without notice the Director of HR and Facilities shall be informed immediately.

8.3.5 The Director of HR and Facilities shall be notified immediately upon the effective date of any change in state of employment or personal circumstances of any officer being known.

8.3.6 All time records, pay sheets, and other pay records and notifications shall be in a form approved by the Director of HR and Facilities and shall be certified and submitted in accordance with the relevant instructions.

8.4 PROCESSING OF PAYROLL

8.4.1 The Director of HR and Facilities is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay;

(c) making payment on agreed dates;

(d) agreeing method of payment.

8.4.2 The Director of HR and Facilities will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of officers. All officers shall be paid by bank credit transfer, unless otherwise agreed by the Director of HR and Facilities;

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

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of officer;

(h) procedures for payment by cheque, bank credit, or cash to officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) separation of duties of preparing records and handling cash;

(l) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 The Director of Finance will issue instructions regarding the maintenance of regular and independent reconciliation of pay control accounts.

8.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of HR and Facilities's instructions and in the form prescribed by the Director of HR and Facilities;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an officer's resignation, termination or retirement. Where an officer fails to report for duty in circumstances that suggest they have left without notice, the Director of HR and Facilities must be informed immediately.

8.4.5 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4.6 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

8.5 CONTRACTS OF EMPLOYMENT

8.5.1 The Director of HR and Facilities is responsible to the Trust Board for:

(a) ensuring that all officers are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

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

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

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

9.1.2 The Chief Executive will set out in the Scheme of Delegation:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted. Wherever appropriate, the supply of goods and services shall be covered by a contract following a tender exercise.

9.2.2 Where the item to be supplied is medical equipment, the Medical Director is responsible for ensuring that adequate procedures are in place to enable managers and clinicians to establish specifications and select equipment that provides the best value for money.

9.2.3 The Trust's Head of Procurement shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

9.2.4 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds (whole life costs) should be incorporated in standing orders and regularly reviewed (see Appendix 1);

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts due. The system shall provide for:

(i) A list of directors/officers authorised to certify requisitions, orders, goods receipts or invoices. This should include specimens of their signatures and/or lists of their unique computer generated login codes in the case of on-line requisitions and orders.

(ii) Certification by either hard copy or electronic means that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to officers regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.5 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits;

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

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.6 Official Orders, either hard-copy or electronically generated, must:

(a) be consecutively numbered;

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

(c) state the Trust's terms and conditions of trade;

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

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

(a) all contracts other than for a simple purchase permitted within the Scheme of Delegation or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

(c) no order shall be issued for any item or items to any supplier that has made an offer of gifts, reward or benefit to directors or officers, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(iii) where the Chief Executive has approved the order, in writing, being

satisfied that the supplier represents the most appropriate choice.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order, either in hard copy or electronic media, except works and services executed in accordance with a contract or purchases from petty cash and purchases using a purchasing card;

(g) verbal orders are only issued in specific instances, the first being by an officer designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". The second being in the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Director of Finance

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of directors/officers authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

9.2.8 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Director.

9.3 LEGALLY BINDING AGREEMENTS (e.g. leases)

9.3.1 Any leases or rental agreements must be vetted by the Director of Finance prior to final agreement, to enable insurance issues and technical accounting treatment to be determined.

9.3.2 All lease agreements must be signed on behalf of the Trust by the Director of Finance (or his deputy) in addition to being accompanied by the usual order and duly authorised in accordance with SFIs.

9.4 EXPENDITURE ON DRUGS

9.4.1 All drugs should be purchased by Pharmacy and not direct with suppliers.

9.4.2 A procedure for the introduction of new drugs was introduced in October 1995. This contained clinical criteria for the introduction of new drugs, but also included that for any new drugs which would cost more than £5,000 per annum (full year effect), the Hospital Executive Board must review the criteria and make a decision on whether the drugs can be authorised for use. Any expenditure on drugs outside of this limit without prior purchaser approval is not authorised and is a contravention of Standing Financial Instructions.

9.4.3 The introduction of new drugs costing less than £5,000 per annum (full year effect) may be authorised by the Frimley Health Area Prescribing Committee, providing such costs can be met from within existing budget.

10. EXTERNAL BORROWING AND INVESTMENTS

The Director of Finance will be responsible for the management of the Trust's cash flow.

10.1 EXTERNAL BORROWING

10.1.1 The maximum borrowing limit will be calculated using the Prudential Borrowing Code formula based on projected cash flows.

10.1.2 The Trust will secure the most preferential interest rates for borrowing.

10.1.3 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing. The Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts and associated interest.

10.1.2 Any application for new borrowing will only be made by the Director of Finance or by an officer so delegated by the Board.

10.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by the Independent Regulator.

10.1.3 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance.

10.1.4 All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

10.1.5 Assets protected under the authorisation agreement with the Independent Regulator shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

10.2 INVESTMENTS

10.2.1 Temporary cash surpluses must be held only in such investments and with such financial institutions as approved by the Board and within the terms of guidance issued by the Independent Regulator.

10.2.2 The Director of Finance is responsible for advising the Board on investment strategy and shall report periodically to the Board concerning the performance of investments held.

10.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

10.3 FOREIGN EXCHANGE CONTRACTS

10.3.1 Foreign exchange contracts can only be entered into for the purpose of obtaining best value for money when contracts are taken out in foreign currencies. Foreign exchange contracts will not be entered into for the purpose of trading for profit in foreign currencies.

10.3.2 Foreign exchange contracts can only be entered into with the direct knowledge and authorisation of the Director of Finance. All contracts must be signed on behalf of the Trust by the Director of Finance (or in his absence his deputy). The goods or services which are being purchased with the foreign exchange currency will have the appropriate order and duly authorised in accordance with SFIs.

10.3.3 The Board will be informed of any such foreign exchange contracts entered into.

11. CAPITAL INVESTMENT, ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 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 the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal to be funded from the Trust's own resources, exceeding £0.5m estimated cost, the Chief Executive shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case;

(c) that the Chief Executive has certified to indicate endorsement of the operational assumptions.

(d) that the business case is submitted and approved by the Board (or Investment Committee, subject to delegated powers);

(e) that all proposals to lease, hire or rent fixed assets have been subject to appraisal of their impact on the Trust's ability to achieve its financial targets and subject to legal advice, from the Trust's legal adviser, on the terms of the proposed contract.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management.

11.1.4 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.

11.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

11.1.6 The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.1.7 The Chief Executive will issue a scheme of delegation for capital investment and the Trust's Standing Orders.

11.1.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 ASSET REGISTERS

11.2.1 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 once a year.

11.2.2 The Trust shall maintain a publicly available property register recording protected property, in accordance with the guidance issued by the Independent Regulator.

11.2.3 The Trust may not dispose of any protected property without the approval of the Independent Regulator. This includes the disposal of part of the property or granting an interest in it. Where protected property is lost or disposed of, the value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The Director of Finance shall approve procedures for reconciling balances on protected property accounts in ledgers against balances on protected property registers.

Non-protected assets may be used to raise funds for the development of services.

11.3 SECURITY OF ASSETS

11.3.1 The overall control of all assets is the responsibility of the Chief Executive.

11.3.2 Asset control procedures (including protected property, non-protected assets, cash, cheques, negotiable instruments and donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

11.3.3 All discrepancies revealed by verification of physical assets to the asset register shall be notified to the Director of Finance.

11.3.4 Whilst each officer has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior officers in all disciplines to apply such appropriate routine security practices in relation to property of the Trust as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

11.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by officers in accordance with the procedure for reporting losses.

11.3.6 Where practical, assets should be marked as Trust property.

11.3.7 Private use of the Trust's assets

Use may only be made of the Trust's assets in the pursuance of the Trust's business unless use of the assets for private or other business is explicitly approved in writing. No such use is implied by previous practice. Approval to use the Trust's assets shall be granted as appropriate by the relevant line manager or a member of senior management of the Trust, dependent upon the value of the asset and the use requested.

12. STORES AND RECEIPT OF GOODS

12.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him 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 oil of a designated estates manager.

12.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as property of the Trust.

12.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns and losses.

12.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

12.5 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNATIONS

13.1.1 The Director of Finance shall prepare detailed procedures for the disposal of assets including condemnations, scrap materials and items surplus to requirements and ensure that these are notified to managers. The Trust may not dispose of any protected property without the approval of the Independent Regulator. These procedures shall comply with all appropriate Standing Orders and Standing Financial Instructions in addition to the requirements specified in the Trust's Policies and Procedures Manual.

13.1.2 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.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an officer (the Condeming Officer) authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

13.1.4 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.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

13.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately, or without any undue delay depending on the seriousness of the loss, inform the Chief Executive (material amounts only) and the Director of Finance. Where a criminal offence is suspected, the Director of Finance must immediately inform the Local Security Management Specialist and the police if theft or arson is involved. For minor break-ins etc. the appropriate Duty Manager or Security Officer is responsible for informing the police and thereafter the Director of Finance.

13.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board, and

(b) the Local Counter Fraud Manager and

(c) the Local Security Management Specialist.

13.2.4 Within limits established by the Trust the Board, or Audit Committee through its delegated authority, may consider and if thought fit, shall approve the writing-off of losses.

13.2.5 The Director of Finance shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made against insurers.

13.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14. INFORMATION TECHNOLOGY

14.1 The Chief Executive, 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, having due regard for the Data Protection Act 1984;

(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 systems (including those obtained by external agency arrangements) and that such computer audit reviews as he/she may consider necessary are being carried out.

14.2 The Director of Finance shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3 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.

14.4 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.

14.5 Where computer systems have an impact on corporate financial systems the Chief Executive shall satisfy him/herself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Management and Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(d) Director of Finance staff have access to such data;

(e) such computer audit reviews as are considered necessary are being carried out;

(f) any changes to such systems shall be notified to and approved by the Director of Finance;

(g) appropriate disaster recovery and contingency arrangements are in place to ensure continuity in execution of the Trust's business.

14.5 The Trust IM&T Board is responsible to the Board for setting the Trust IM&T Strategy and monitoring progress towards implementing that strategy.

14.6 All new systems must be approved by the IM&T Board as to their suitability, value for money and compliance with any set strategy.

15. PATIENTS' PROPERTY

15.1 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.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

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.

15.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16. CHARITABLE FUNDS - FUNDS HELD ON TRUST

16.1 INTRODUCTION

16.1.1 The discharge of the Charitable Fund's corporate trustee responsibilities are distinct from its responsibilities for corporate funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. In particular, the purchasing rules and delegated financial limits that apply to Trust purchasing also apply to charitable funds purchasing. These delegated limits, including the associated authorisation requirements, are summarised at Appendix 4 of these SFIs. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

16.1.2 This Section of the SFIs shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

16.1.3 The Board hereby nominates the Director of Finance to have primary responsibility to the Board for ensuring that these SFIs are applied.

16.1.4 The Charitable Funds Committee (CFC) is a Committee of the Corporate Trustee of the Charitable Funds (the Trust's Board of Directors). Its purpose is to undertake the routine management of the Charitable Funds and to give additional assurance to the Trustee that the Trust's Charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales. The CFC on behalf of the Charitable Trustee is responsible for fundraising in compliance with all statutes and regulations. The Directors with responsibility for Fundraising and Finance will advise the CFC.

16.2 EXISTING CHARITABLE FUNDS

16.2.1 The Director of Finance shall arrange for the administration of all existing chariable funds. He shall ensure that a governing instrument exists for every charitable fund and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and officers. Such guidelines shall identify the restricted nature of certain funds where applicable.

16.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Charitable Fund's corporate trustees regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The Director of Finance may recommend an increase in the number of funds where this is consistent with the Charitable Funds corporate trustee policy for ensuring the safe and appropriate management of restricted funds, eg, designation for specific wards or departments.

16.3 NEW CHARITABLE FUNDS

16.3.1 The Director of Finance shall arrange for the creation of a new charitable fund where funds and/or other assets, received in accordance with the Charitable Funds corporate trustee's policies, cannot adequately be managed as part of an existing fund.

16.3.2 Where no fund matches a donor's specific purpose the advice of the CFC should be sought to establish if a new fund is required or whether the donation should be rejected if the donor's wishes cannot be accommodated.

16.4 SOURCES OF NEW FUNDS

16.4.1 In respect of Donations, the Director of Finance shall:

(a) provide guidelines to the Charitable Fund corporate trustees as to how to proceed when offered funds. These to include:

(i) the identification of the donors' intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice;
(v) treatment of offers for personal gifts.

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Charitable Funds and that the donor's intentions have been noted and accepted.

16.4.2 In respect of Legacies and Bequests, the Director of Finance shall:

(a) provide guidelines to officers of the Charitable Funds covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Charitable Funds are the beneficiary;

(c) be empowered, on behalf of the Charitable Funds corporate trustees, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;

(d) be directly responsible for the appropriate treatment of all legacies and bequests;

(e) be kept informed of all enquiries regarding legacies and keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Director of Finance, who alone shall be empowered to give an executor a good discharge.

16.4.3 In respect of Fund-raising, the Director of HR and Facilities shall:

(a) deal with all arrangements for fund-raising by and/or on behalf of the Charitable Funds and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Body and provide them with an adequate discharge. The Director of HR and Facilities shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) be responsible for alerting the Board to any irregularities regarding the use of the Charitable Fund's name or its registration numbers; and

(d) be responsible for the appropriate treatment of all funds received from this source.

(e) be required to advise the Board on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

16.4.4 In respect of Charitable Fund's Trading Income, the Director of Finance shall:

(a) be primarily responsible, along with other designated officers, for any trading undertaken by the Charitable Fund's as corporate trustee;

(b) be primarily responsible for the appropriate treatment of all funds received from this source.

16.4.5 In respect of Investment Income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.5 INVESTMENT MANAGEMENT

16.5.1 The Director of Finance shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he shall be required to provide advice to the Charitable Fund's corporate trustees, or the Charitable Funds Working Group, shall include:

(a) the formulation of investment policy within the powers of the Charitable Funds under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Director of Finance shall agree the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive or a duly

authorised officer;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by the Charitable Funds corporate trustees in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

16.6 DISPOSITION MANAGEMENT

16.6.1 The exercise of the Charitable Funds dispositive discretion shall be managed by the Director of Finance in conjunction with the Charitable Funds corporate trustees. In so doing he shall be aware of the following:

(a) the objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of Trust funds to discharge Charitable Fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Trust shall be discharged by Charitable Funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Charitable Funds;

(f) the definitions of "charitable purposes" as agreed with the Charity Commission.

16.7 BANKING SERVICES

16.7.1 The Director of Finance shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the Charitable Funds as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 ASSET MANAGEMENT

16.8.1 Assets in the ownership of or used by the Charitable Funds as corporate trustee,

shall be maintained along with the general estate and inventory of assets of the Charitable Fund. The Director of Finance shall ensure:

(a) that appropriate records of all assets owned by the Charitable Fund as corporate trustee are maintained and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for.

16.9 REPORTING

16.9.1 The Director of Finance shall ensure that regular reports are made to the Charitable Funds corporate trustees with regard to, inter alia, the receipt of funds, investments and the disposition of resources.

16.9.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Charitable Funds corporate trustees within agreed timescales.

16.9.3 The Director of Finance shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Independent Regulator and the Charity Commission for adoption by the Charitable Funds corporate trustees.

16.10 ACCOUNTING AND AUDIT

16.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

16.10.3 The Charitable Funds corporate trustees shall be advised by the Director of Finance on the outcome of the Charitable Funds annual audit. The Chief Executive shall submit the Management Letter to the Charitable Funds corporate trustees.

16.11 ADMINISTRATION COSTS

16.11.1 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Charitable Funds Working Group, shall charge such costs to the appropriate trust accounts.

16.12 TAXATION AND EXCISE DUTY

16.12.1 The Director of Finance shall ensure that the Charitable Funds liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17. INDUCEMENTS and DECLARATION OF INTERESTS

17.1 ACCEPTANCE OF GIFTS AND HOSPITALITY

17.1.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. Staff must comply with national guidance 'Standards of Business Conduct for NHS Staff' and any guidance and directions issued by the Independent Regulator.

17.1.2 Where offers of goods and services do not involve inducement or reward officers should not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If such gifts arrive unsolicited, the advice of the Director of Finance should be sought.

17.2 DECLARATION OF INTERESTS

17.2.1 The Company Secretary shall be advised of declared pecuniary interests of members of the Board for recording in a register he/she will maintain for that purpose.

17.2.2 All other officers should declare any relevant interest in accordance with the standards of Business Conduct.

17.3 PRIVATE TRANSACTIONS

17.3.1 Officers having official dealings with contractors or other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for defining retention periods and maintaining archives for all documents required to be retained.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

18.4 The Trust's arrangements for disclosure under the Freedom of Information Act shall be maintained by the Director of Finance.

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 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;

(a) contingency plans to offset the impact of adverse events;

(b) audit arrangements including: internal audit; clinical audit; health and safety review;

(c) decisions on which risks shall be insured through arrangements with either the NHS Litigation Authorities Pooling Schemes or commercial insurers;

(d) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts.

19.3 The Chief Executive in consultation with his designated officer(s) shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board of Directors.

APPENDIX 1. PURCHASING AND TENDERING

1.0 INTRODUCTION

1.1 The Trust's Standing Financial Instructions (SFI's) set out procedures to be adopted in obtaining goods and services.

1.2 This supplementary procedure note deals with the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and detailed procedures in relation to purchasing and tendering and considers the correct authorization procedures for the four stages of procurement:

1. Identification of requirement to commit expenditure
2. Procurement activity (Section 2)
3. Trust Approvals (Section 3)
4. Purchase Order and/or Contract raising (Section 4)

1.3 The Director of Finance (or Deputy in his absence) must personally authorise any request which commits the Trust to expenditure between £10,000 and £100,000. The Chief Executive (or Director of Finance in his absence) must authorise all expenditure from £100,000 to £500,000.

1.4 Any commitment on behalf of the Trust in respect of all capital projects and financial commitments, including leases, costing between £0.5m and £1.5m, in their entirety if included in the Trust's Annual Plan or Capital Plan must be approved by the Trust's Commercial Development and Investment Committee (CDIC). Any proposals above £0.5m and below £1.5m which have not already been approved in the Trust's Annual Plan or Capital Plan must be submitted to CDIC for review and recommendation to the Board. The costs are whole life costs. All expenditure in excess of £1.5m requires approval of the Board.

1.5 In addition to the Trust delegated tendering limits, attention must be paid to the regulations governing procurement within the European Union. In all cases advice should be sought from the Associate Director of Procurement to ensure compliance with appropriate thresholds.

1.6 If the purchase has an IM&T component (this may include access to the Trust network, a provision of software or hardware) then authority for approval must also be given by the IM&T Operational Group or IM&T Board. If in doubt advice from the IM&T department should be sought.

2.0 PROCUREMENT ACTIVITY

The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most competitive price.

Tendering activity will depend on the whole life costs and will follow the route summarised in table 2.01

Table 2.01

Whole life costs	£0 £10,000	£10,001 £50,000	£50,001 £100,000	£164,176* and above
Minimum Three Written Quotations		Yes		
Full Tendering Process			Yes	
EU Tendering Process or Framework				Yes

**Current 2016-7 EU threshold for Supplies and Services. Threshold for Works currently £4,104,394. Note that these values are set every 2 years on 1st January.*

2.1 COMPETITIVE TENDERING (Over £50,000)

2.1.1 The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most economically advantageous price. The standard method of procurement will be by competitive tender for goods or services expected to cost in excess of £50,000; this may be waived under the following circumstances:

a. where the requirements are ordered under existing contracts or where in the opinion of the relevant director:

b. there is only one supplier and no reasonably satisfactory alternative product/service;

c. competition would be impractical, impossible or not beneficial;

d. the requirement is to be ordered under existing contracts;

e. the work for practical reasons must be of the same manufacture, for instance repairs/spare parts for existing equipment;

f. where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the Associate Director of Procurement or nominated Deputy in confirmation of such circumstances.

2.2 COMPETITIVE AND NON-COMPETITIVE QUOTATIONS (£50,000 and under)

2.2.1 Three competitive quotations must be obtained for all contracts and services where the value is not expected to exceed £50,000.

2.2.2 Non-competitive quotations in writing, or electronically, may be obtained for the following purposes:

(a) where the supply of goods (or related goods) is of a special character and does not exceed £10,000;

or where in the opinion of the relevant director:

(b) there being only one supplier and no reasonably satisfactory alternative product/service;

(c) competition would be impractical, impossible or not beneficial;

(d) the requirement is to be ordered under existing contracts;

(e) the work for practical reasons must be of the same manufacture, for instance, repairs/spare parts for existing equipment;

(f) where it is known that a marked financial advantage will accrue to the Trust from making a spot purchase of products subject to quickly changing market conditions.

In any of these circumstances the detail should be documented and the authorisation counter-signed by the Associate Director of Procurement or nominated Deputy in confirmation of such circumstances.

2.2.3 Officers should involve the Associate Director of Procurement or nominated Deputy in choice of supplier, price negotiation and in the procurement process for all goods and services.

2.2.4 Where the supplier being used is nationally or regionally approved, and/or they are providing a continuous supply in operational terms, it may be appropriate to use annual orders duly authorised as appropriate. Annual orders must include a clear schedule of the items being ordered, their agreed individual prices, an estimate of the volumes required of each item for the period of the order and hence an agreed total cost which must not be exceeded. The advice of the Associate Director of Procurement or nominated Deputy should be sought when establishing such annual orders to ensure that the correct format is applied and that value for money is obtained.

2.2.5 No single supplier or single annual order should be used for a period in excess of 12 months, where the costs incurred during that period exceed £25,000, without the requisitioner demonstrating value for money. The advice of the Associate Director of Procurement or nominated Deputy should be sought. Where this advice is not sought or not acted upon the requisitioner must advise the Chief Executive in writing seeking waiver of this rule.

2.3 TENDERING PROCEDURES

2.3.1 Wherever possible tenders shall be advertised, issued and submitted on the Trust's e-tendering system.

2.3.2 Where not practical or possible tenders may be received as hard copies. In this case all written tenders shall be addressed to the Chief Executive.

2.3.3 All invitations to tender on a competitive basis shall state that no written tender will be accepted unless submitted in either:-

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or the word "Tender", followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

b) in a special envelope supplied by the Trust to prospective tenders, and that tender envelopes/packages shall not bear the names or marks indicating the sender.

2.3.4 Every tender for building and engineering works, except any tender for maintenance work only, where Estmancode guidance should be followed, shall embody or be in the terms of the current Edition of the Standard Form of Building Contract Local Authorities Edition with (or, where appropriate, without) quantities or the Agreement for Minor Building Works issued by the Joint Contract Tribunal as appropriate or (when the contents of the works is primarily engineering) the General Conditions of Contracts recommended by the Institute of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institution of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These base documents should be modified and amplified to accord with current Departmental guidance forms of contract may be used after prior consultation with the Department.

2.3.5 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package. Tenders submitted via e-tendering will be electronically date and time stamped.

2.3.6 The Trust shall designate an officer or officers, not from the originating department, to be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

2.3.7 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two officers at least one of which must be an Executive member of the Board.

Tenders submitted via e-tendering shall be opened by senior Procurement staff. The system shall automatically record the date, time and member of staff opening the tender.

2.3.8 Every tender received shall be recorded to show for each set of competitive tender

invitations despatched: -

(a) the names of all firms invited;

(b) the names of and the number of firms from which tenders have been received, and the amount for each tender;

(c) the date the tenders were opened; and

(a) the record shall be signed by the persons present at the opening.

For tenders received via e-tendering this information will be electronically recorded.

2.3.9 Except as in paragraph 2.3.11 below a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, the final price shown shall be recorded. The record shall be initialled by two of those present at the opening.

Alterations to tenders submitted via e-tendering will be electronically marked.

2.3.10 A report shall be made in the record if on any one tender price alterations are so numerous as to render the procedure at paragraph 2.3.9 above unreasonable.

2.3.11 Tenders received after the due time and date may be considered only if the Chief Executive decides that there are exceptional circumstances, e.g. where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenderers concerned. The Chief Executive shall decide whether such tenders are admissible and where re-tendering is desirable.

2.3.12 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

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

2.3.14 Necessary discussion with a tenderer of the contents of his tender, in order to elucidate technical, etc, points before the award of a contract, need not disqualify the tender.

2.3.15 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall be kept strictly confidential and held in safe custody by an officer designated by the Chief Executive.

For tenders submitted via e-tendering, the tenders will remain electronically unopened.

3.0 TRUST APPROVALS

Approval for expenditure is summarized in tables 3.01 and 3.02 below

A Trust official Purchase Order should be raised following approval.

Summary of Delegated Approval Limits

Table 3.01 – Pre-Procurement Approval

Whole life costs	£0 £500,000	£500,000 £1,500,000	£1,500,001 upwards
No Pre-approval required	Yes		
CDIC (Investment Committee)		Yes	Yes
Board of Directors			Yes

Table 3.02 – Procurement (Contract) Approval

Whole life costs	£0 £10,000	£10,001 £50,000	£50,001 £100,000	£100,001 £500,000	£500,001 upwards
Budget Holder	Yes	Yes	Yes	Yes	
Director of Finance		Yes	Yes	Yes	
Sub Committee of the Board				Yes	
Chief Executive				Yes	
CDIC (Investment Committee)					Yes
Board of Directors					Yes

In addition authorisation may also be required at the following Groups:

Product Selection Group	Yes[1]	Yes[1]			
IM&T Operational Group	Yes[2]	Yes[2]			
IM&T Board			Yes[2]	Yes[2]	Yes[2]

[1] *For appropriate procurement falling under the Product Selection Group remit*
[2] *For appropriate procurements falling under the IM&T remit*

3.1 Pre-Procurement Approval

Any commitment on behalf of the Trust in respect of all capital projects and financial commitments, including leases, costing between £0.5m and £1.5m, in their entirety if included in the Trust's Annual Plan or Capital Plan must be approved in advance of any Procurement activity by the Trust's Commercial Development and Investment Committee (CDIC). Any proposals above £0.5m and below £1.5m which have not already been approved in the Trust's Annual Plan or Capital Plan must be submitted to CDIC for review and recommendation to the Board. The costs are whole life costs. All expenditure in

excess of £1.5m requires approval of the Board

3.2 Procurement (Contract) Approval

3.2.1 Where tenders for goods and services exceed £100,000 (whole life costs), a Sub-committee of the Board should be formed comprising, as a minimum, two Executive Directors, which would have responsibility for adjudicating the tenders.

3.2.2 Where tenders for goods and services exceed £500,000 and also where the requirement has previously been pre-approved by the CDIC, a tender report should be submitted to the CDIC for final approval.

3.2.3 In all cases the most economically advantageous tender/quotation must be accepted. Any proposal to waive this rule would need the approval of:

a)	goods/services between £50,000 and £100,000	Director of Finance
b)	goods/services in excess of £100,000 and up to £500,000	Chief Executive
c)	goods/services in excess of £500,000	Board / CDIC

3.2.4 Officers with any doubts concerning the appropriateness of competitive tendering in particular circumstances must seek formal clarification from the Director of Finance. The Trust will not be responsible for officers committing costs other than in accordance with the above procedures.

3.2.5 Where only one tender/quotation is sought and/or received, the Trust shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

3.2.6 The most economically advantageous tender/quotation, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary; such reasons shall be set out in a permanent record.

4.0 PURCHASE ORDER AND CONTRACT RAISING

4.1 A Trust official order or Contract document should be raised for all committed expenditure. A purchase order for committed expenditure shall only be placed once the approvals process relevant to the spend requirement has been properly completed. The Director of Finance shall delegate this responsibility to appropriate Procurement staff.

4.2 Purchase Orders and Contract documents should be raised under standard NHS Terms and Conditions.

4.3 Every contract for building and engineering works, except measured term contracts where Estmancode guidance should be followed, should be embodied in a formal contract document which should conform to these Standing Financial Instructions. These formal contract documents should reflect any change in the terms and conditions of contract agreed following receipt of tenders.

4.4 No goods, services or works other than works and services, executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, which may be in hard copy or electronic media. Contractors shall be notified that they should not accept orders unless in an official format. Verbal orders shall be issued only in specific instances, the first being by an officer designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". The second being by the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Director of Finance.

4.5 The physical signing and e-signing of contracts may only be made by personnel in accordance with table 4.01 and only on completion of all approvals detailed in 3.2

Table 4.01

Whole life costs	£0 £10,000	£10,001 £100,000	£100,001 £500,000	£500,001 upwards
Budget Holder	Yes			
Associate Director Procurement or Deputy Director Finance	Yes	Yes	Yes	Yes

APPENDIX 2. HIERACHY OF DELEGATED BUDGETARY AUTHORITY

Budgets of Authorised	**(£) Limit**	**Minimum level Officer**
Virement between non-pay budget lines within same core or equivalent	£all	Budget holder or appropriate delegated budget manager(s) together with authorisation from Head of Management Accounts
Virement between non-pay lines across cores or equivalent	£all	Mutual agreement of budget holders or budget manager(s) together with authorisation from Head of Management Accounts
Any virement involving pay lines	£all	Budget holder or appropriate delegated budget manager(s) together with authorisation from Head of Management Accounts or equivalent; any establishment change to be authorised by the Director of Finance.
Pay Expenditure Delegated Limits		
Commitment to incur costs as a result of a contract of employment (including temporary contracts), existing post	£all	AD or Head of Service (with reference to authorised establishment)
Commitment to incur costs as a result of a contract of employment (including temporary contracts), new post	£all	DOF and Chief Executive (by authorising change to establishment)
Commitment to incur costs via agency, consultancy or other means, for any continuous period fulfilling same duties, even if undertaken by different individuals	up to £10,000	Budget holder or appropriate delegated budget manager
	£10,001 and over	Director of Finance upon receipt of request authorised by the Budget holder.

APPENDIX 3. SUMMARY OF DELEGATED APPROVAL LIMITS

For all Revenue and Charitable Contracts and Purchases

Pre-Procurement Approval

Whole life costs	£0 £500,000	£500,000 £1,500,000	£1,500,001 and above
No Pre-approval required	Yes		
CDIC (Investment Committee)		Yes	Yes
Board of Directors			Yes

Supplier Selection Method

Whole life costs	£0 £10,000	£10,001 £50,000	£50,001 £100,000	£164,176* and above
Minimum Three Written Quotations		Yes		
Full Tendering Process			Yes	
EU Tendering Process or Framework				Yes

Procurement (Contract) Approval Limits

Whole life costs	£0 £10,000	£10,001 £50,000	£50,001 £100,000	£100,001 £500,000	£500,001 upwards
Budget Holder	Yes	Yes	Yes	Yes	
Director of Finance		Yes	Yes	Yes	
Sub Committee of the Board				Yes	
Chief Executive				Yes	
CDIC (Investment Committee)					Yes
Board of Directors					Yes

* Or Prevailing OJEU Threshold value.

APPENDIX 4

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.6	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.7	DIRECTOR OF FINANCE (DOF)	Responsible for: Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.8	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.10	DOF	Form and adequacy of financial records of all departments.
2.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	DOF	Carry out all work to counter fraud and corruption in accordance with NHSI Directions.
2.3.1	DOF	Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption in accordance with NHSI Directions.
2.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.5	AUDIT COMMITTEE	Ensure cost-effective external audit.
3	CE CE CE DOF DOF DOF	Overall responsibility for business plans and budgets. Delegate budget to budget holders and submit monitoring returns. Ensuring compliance with NHSI requirements and ensuring adequate system of monitoring. Submit budgets. Monitor performance against budget, submit to Board financial estimates and forecasts. Devise and maintain systems of budgetary control.

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
4	DoF	Annual accounts and reports.
5	DoF	Banking arrangements.
6	DoF	Income systems.
7	CE CE DoF	Negotiating contracts for provision of patient services. Negotiating NHS contracts Regular reports of actual and forecast contract income.
8	BOARD CE REMUN. COMMITTEE	Agree terms of reference of Performance and Remuneration Committee Variation to funded establishment of any department. Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
8.4	DoHR&F	Payroll form and adequacy of payroll records and processes
9.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
9.2.3	DoF	Prompt payment of accounts.
9.2.6	CE	Authorise who may use and be issued with official orders.
10	DoF	Advise Board on borrowing and investment needs and prepare procedural instructions.
11	CE	Managing Capital investment programmes
11.1	DoF	Monitoring the capital programme.
11.1.2	CDIC	Approval of schemes in the Annual and Capital Plan between £.5m and £1.5m and recommendation to the Board

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
		on those not included within the plans.
11.3	CE	Maintenance of asset registers.
11.3.7	LINE OR SENIOR MANANGERS	Use of Trust assets for private use.
11.4.1	CE	Overall responsibility for fixed assets.
11.4.4 / 5	ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
12	DOF	Responsible for systems of control over stores and receipt of goods.
12.3	CE	Identify persons authorised to requisition and accept goods from Supplies stores.
13.2	DOF	Prepare procedures for recording and accounting for losses and special payments
14	CE	Responsible for accuracy and security of computerised data.
15.2	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
16	DOF	Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Charitable Funds Committee if any).
18	CE	Retention of document procedures
19	CE	Risk management programme
19.3	DOF	Insurance arrangements

FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST - DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.
In all cases in the absence of the Chief Executive the Director of Finance may deputise. In the absence of the Director of Finance the Director of Finance's deputymay deputise for the Director of Finance.

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.	**Management of Budgets**		SFIs Section 3
	Responsibility of keeping expenditure within budgets		
	a) At individual budget level (Pay and Non Pay)	Budget Manager	
	b) At service level	Associate Director/ Head of Service	
	c) For the totality of services covered by Clinical / Executive Director	Clinical/Executive Director or Chief Executive	
	d) For all other areas:	Director of Finance or Appropriate Delegated Manager	
	e) Approving expenditure up to £100,000	Director of Finance	
2.	**Maintenance / Operation of Bank Accounts**	Director of Finance	SFIs Section 5

3.	**Non Pay Revenue and Capital Expenditure/Requisitioning/Ordering/ Payment of Goods & Services**		SFIs Section 9
a)	• up to £10,000	Budget Manager	
	• from £10,001 to £100,000	Director of Finance	
	• from £100,001 to **£500,000**	Tender Committee, report to Chief Executive	
	• all requisitions OVER **£500,000**	Trust Board or Investment CDIC under delegated powers.	
b)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive and Director of Finance	
c)	Orders exceeding 12 month period	As (a) above for whole life of contract.	
d)	All contracts for goods & services and subsequent variations to contracts	As (a) above for whole life of contract	
4.	**Capital Schemes**		
a)	Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Director of HR and Facilities	
b)	Financial monitoring and reporting on all capital scheme expenditure	Director of Finance or Nominated Deputy or Director of HR and Facilities	
c)	Granting and termination of leases	Director of Finance	

5. Quotation, Tendering & Contract Procedures		
a) Evaluating quotations for goods/services up to £100,000	Budget Manager /Purchaser	SFIs Appendix 1 & Standing Orders Section 9 & Annex
b) Evaluating competitive tenders for goods/services over £100,000	Tender Evaluation Committee	
c) Waiving of Tenders on competitive quotations subject to SFIs		SFI's Appendix 1
below £100,000	Director of Finance	
£100,000 to £500,000	Chief Executive	
Over £500,000	Trust Board	
6. Setting of Fees and Charges		SFIs Section 7
a) Private Patient, Overseas Visitors, Income Generation and other patient related services.	Director of Finance	
b) Price of NHS Contracts	Director of Finance	

7. Engagement of Staff Not On the Establishment	Chief Executive	SFIs Section 8
a) Engagement of Trust's Solicitors	Nominated Executive Director	
b) Authorising engagement of Bank or Agency Staff • Medical Locums • Nursing • Clerical	Associate Director / Head of Service	

8. Expenditure on Charitable and Endowment Funds	Same rules as Trust Funds, with authorised signatories from fund acting as budget manager.	SFIs Section 16
9. Agreements/Licences		
a) Preparation and signature of all tenancy agreements/licences with staff subject to Trust Policy on accommodation for staff	Accommodation Manager	
b) Agreements with landlords on behalf of the Trust	Director of Finance/Director of HR and Facilities	
c) Extensions to existing leases	Director of Finance/Director of HR and Facilities	
d) Letting of premises to outside organisations	Director of Finance/Director of HR and Facilities	
e) Approval of rent based on professional assessment	Director of HR and Facilities	

10.	**Condemning & Disposal**		SFIs Section 13
a)	Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively		
	i) with current/estimated purchase price <£50	Associate Director / Head of Service	
	ii) with current purchase new price >£50	Associate Director / Head of Service	
	iii) disposal of x-ray films (subject to estimated income of £1,000 per sale)	Head of Radiology	
	iv) disposal of x-ray films (subject to estimated income exceeding £1,000 per sale)	Head of Radiology and AD	
	v) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)	Director of HR and Facilities	
	vi) disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)	Director of HR and Facilities and Director of Finance	
11.	**Losses, Write-off & Compensation**		SFIs Section 13
a)	Losses and Cash due to theft, fraud, overpayment & others Up to £10,000	Director of Finance (report to Audit Committee)	
b)	Losses and Cash due to theft, fraud, overpayment & others £10,001 to £50,000	Chief Executive and Director of Finance (report to Audit Committee)	
c)	Losses and Cash due to theft, fraud, overpayment & others over £50,000	Trust Board	
d)	Fruitless Payments (including abandoned Capital Schemes over £50,000)	Trust Board	
e)	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other	As a) b) & c) above	

f)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (eg fraud, theft, arson) or other	As a) b) & c) above	
g)	Compensation payments made under legal obligation, or ex gratia payments for clinical negligence in line with legal advice	Director of Finance	
h)	Extra Contractual payments to contractors Up to £50,000	Director of Finance	
i)	Ex-Gratia Payments (except clinical negligence in line with legal advice)	As a) b) & c) above	
j)	Patients and staff for loss of personal effects	As a) b) & c) above	
k)	For clinical negligence up to NHSLA Excess Limit (negotiated settlement) in line with legal advice.	Director of Finance	
l)	For personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to NHSLA Excess Limit	Director of Finance	
m)	Other, except cases of maladministration where there was no financial loss by claimant Up to £50,000	Director of Finance	

12.	**Reporting of Incidents to the Police**		SFIs Section 2 & 13
a)	Where a criminal offence is suspected i) criminal offence of a violent nature ii) other	AD or Duty Manager	
b)	Where a fraud is involved	Director of Finance or nominated Local Counter Fraud Specialist (LCFS)	
13.	**Petty Cash Disbursements**		
a)	Expenditure up to £50 per item	Petty Cash Holder	SFIs Section 9
b)	Reimbursement of patients monies	Petty Cash Holder	SFIs Section 15
14.	**Receiving Hospitality** Applies to both individual and collective hospitality receipt items. In excess of £25.00 per item received	Declaration required in Trust's Hospitality Register	SFIs Section 17
15.	**Implementation of Internal and External Audit Recommendations**	Appropriate Executive Director	SFIs Section 2
16.	**Maintenance & Update on Trust Financial Procedures**	Director of Finance	SFIs Section 1
17.	**Investment of Funds (including Charitable & Endowment Funds)**	Director of Finance	SFIs Section 16

18.	**Human Resources & Pay**		SFIs Section 8
a)	Authority to fill funded post on the establishment with permanent staff.	Associate Director/Heads of Service	
b)	Authority to appoint staff to post not on the formal establishment.	Chief Executive and Director of Finance	
c)	<u>Additional Increments</u>		
	The granting of additional increments to staff within budget	Director of HR and Facilities or deputy	
d)	<u>Upgrading & Regrading</u>		
	All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure	Director of HR and Facilities or deputy	
e)	<u>Establishments</u>		
	i) Additional staff to the agreed establishment with specifically allocated finance.	Chief Executive and Director of Finance	
	ii) Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive and Director of Finance	

f)	<u>Pay</u>		
	i) Authority to complete standing data forms effecting pay, new starters, variations and leavers	HR Advisor	
	ii) Authority to complete and authorise positive reporting forms	Associate Director/Head of Service	
	iii) Authority to authorise overtime	Associate Director/Head of Service	
	iv) Authority to authorise travel & subsistence expenses	Associate Director/Head of Service/Budget Manager	

	v) Approval of Performance Related Pay Assessment(not Executive Directors)	Executive Directors / Chief Executive	
g)	<u>Leave</u>		
	i) Approval of annual leave	Line/Departmental Manager	
	ii) Annual leave - approval of carry forward (up to maximum of 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service).	Line/Departmental Manager	
	iii) Annual leave - approval of carry over in excess of 5 days but less than 10 days.	Executive Director	
	iv) Annual leave - approval to carry forward 10 days or more.	HR Director	
	v) Special leave arrangements	Associate Director/Head of Service and Director of HR and Facilities in certain circumstances	Special Leave Policy
h)	<u>Sick Leave</u>		
	i) Extension of sick leave on half pay up to three months	Executive Director in conjunction with Director of HR and Facilities	
	ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with Director of HR and Facilities	
	iii) Extension of sick leave on full pay	Director of HR and Facilities or Chief Executive	
i)	<u>Study Leave</u>		
	i) Study leave outside the UK	Chief Executive	
	ii) All other study leave (UK)	General Manager/Head of Service/Executive Director	

j) Removal Expenses, Excess Rent and House Purchases Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) per the policy i) up to £5,000 ii) over £5,000	 Head of HR / Head of Employee Services Director of HR and Facilities	
k) Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Human Resources officer must be sought when the grievance reaches the level of General Manager	Director of HR and Facilities	Trust Grievance Procedure
l) Authorised Car & Mobile Phone Users Requests for new posts to be authorised as car users Requests for new posts to be authorised as mobile telephone users	 Associate Director Associate Director	
m) Entering into Fixed Term Contract	Director of HR and Facilities / Head of HR and Facilities	
n) Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	 Associate Director	Retirement Policy
o) Redundancy	Director of HR and Facilities	Redundancy Policy

q)	Dismissal	Dismissing Officers	Disciplinary Procedures

19.	**Authorisation of New Drugs**		SFI's Section 9
	a) Estimated total yearly cost up to £5,000	FrimleyHealth Area Prescribing Committee	
	b) Estimated total yearly cost above £5,000	Hospital Executive Board	
20.	**Authorisation of Sponsorship deals**	Chief Executive, Medical Director, R & D Committee	
21.	**Authorisation of Research Projects**	Chief Executive, Medical Director, R & D Committee and Director of Finance	
22.	**Authorisation of Clinical Trials**	Ethics Committee, Chief Executive and Medical Director	
23.	**Insurance Policies and Risk Management**	Chief Executive & Director of Finance	SFIs Section 19
24.	**Patients & Relatives Complaints**		
	a) Overall responsibility for ensuring that all complaints are dealt with effectively	Director of Nursing	

	b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly. c) Medico - Legal Complaints Co ordination of their management.	Associate Director/Head of Service/Executive Director Associate Director/Head of Service/Executive Director	
25.	**Relationships with Press** a) Non-Emergency General Enquiries • Within Hours • Outside Hours b) Emergency • Within Hours • Outside Hours	 Media and Communications Officer Admin on Call or Executive Director Chief Executive or Executive Director Admin on Call or Executive Director	
26.	**Infectious Diseases & Notifiable Outbreaks**	Admin on Call or Control of Infection Lead	
27.	**Extended Role Activities** Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	Chief Executive or Director of Nursing, Quality and Patient Services	Nurse/Midwives/ Health Visitors Act Midwives Rules / Code of Practice UKCC Code of Professional Conduct

28. Patient Services		
a) Variation of operating and clinic sessions within existing numbers	Chief Executive or Medical Director	
• Outpatients		
• Theatres		
• Other		
b) All proposed changes in bed allocation and use		
• Temporary Change	Bed Manager	
• Permanent Change	Chief Executive	
• Contract monitoring & reporting	Director of Finance	
29. Facilities for staff not employed by the Trust to gain practical experience		
Professional Recognition, Honorary Contracts & Insurance of Medical Staff.	Director of HR and Facilities	
Work experience students	Director of HR and Facilities	
30. Review of fire precautions	Director of HR and Facilities	
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Head of Facilities/Director of HR and Facilities	
32. Review of Medicines Inspectorate Regulations	Director of Nursing, Quality and Patient Services	

33.	**Review of compliance with environmental regulations, for example those relating to clean air and waste disposal**	Clinical Director / Director of HR and Facilities	
34.	**Review of Trust's compliance with the Data Protection Act**	Chief Executive	
35.	**Monitor proposals for contractual arrangements between the Trust and outside bodies**	Chief Executive	
36.	**Review the Trust's compliance with the Access to Records and Freedom of Information Acts**	Chief Executive	
37.	**Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60**	Chief Executive	
38.	**The keeping of the Register of Directors' Interests.**	Company Secretary	SOs Section 6
39.	**Attestation of sealings in accordance with Standing Orders**	Chief Executive	SOs Section 12
40.	**The keeping of a register of documents sealed.**	Company Secretary	SOs Section 12
41.	**The keeping of the Hospitality Register**	Chief Executive	
42.	**Retention of Records**	Chief Executive	SFIs Section 18
43.	**Clinical Audit**	Chief Executive	SFIs Section 19

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Frimley Health NHS
NHS Foundation Trust

Report Title	Quarterly Report from Frimley Health Infection Prevention & Control Teams (the Frimley Park Hospital Infection Control Committee, and Heatherwood & Wexham Park Hospitals Infection Control Committee)
Meeting	Board of Directors
Meeting Date	Friday 6th October 2017
Agenda No.	14.
Report Type	Governance and compliance report. Meeting in Public
Prepared By	Dr T Ho (Director of Infection Prevention and Control FHFT), Amanda Walker (Infection Prevention & Control Nurse Consultant FHFT), Vicky Gentry (Infection Prevention & Control Nurse Specialist FPH), & Jenny Wyeth (Lead Infection Prevention & Control Nurse HWPH)
Executive Lead	Dr T Ho
Executive Summary	This report provides the Board with an update on Trust healthcare-associated infection performance for 2017/18 to date, and the feedback on agenda items presented at the FPH and HWP infection control committees in the current quarter
Background	A regular report to Board with assurance of healthcare-associated infection performance is a requirement of the *Health & Social Care Act 2008: Code of practice for the NHS on the prevention & control of healthcare associated infections and related guidance*.
Issues / Actions	Actions to note from the report are: • Need to ensure local ownership to continue improvement in hand cleaning compliance by staff of all grades and to ensure clinical staff are dressed appropriately for carrying out clinical care • Due to changes made to the mandatory training programmes at FHFT, attendance at Learning & OD-organised Staff & Patient Safety (SaPS) updates at the beginning of the year was very low, and is only slowly catching up resulting in high numbers of staff out of date. • A need to highlight the requirement to involve IPCTs in the planning stage of new builds and refurbishments to ensure an understanding of compliance with national standards to improve the number of *en suite* single rooms for isolation of infectious patients (which will align the Trust with bench marked peers) and ensure an understanding of compliance with National guidelines for spaces between beds. Infection Control advice is not always followed in refurbishments and new builds and plans are not always signed off by the Trust's qualified Infection Control specialists. • Clinical Medical Lead attendance has been low at HICC on both sites. Attendance is reported as part of the "Ward to Board" reports. • There have been two Trust-apportioned MRSA bacteraemia cases to date, one in June 2017 at FPH (which was agreed to have been "avoidable", and one at WPH in August (which was agreed to have been "unavoidable").
Recommendation	Members are asked to discuss and note this Report.
Appendices	NA

14

MRSA bacteraemia

There has been one Trust-apportioned case in August at WPH. At the formal Post Infection Review on 29/6/17, it was agreed there was no lapse in care. The root cause was unknown but may be related to nasal packing for epistaxis following a facila injury in a patient colonised with MRSA, or possibly due to an IV device *in situ* prior to the bacteraemia.

Clostridium difficile infection (CDI)

There have been 20 Trust-apportioned cases to date against the objective of 31 cases: 11 at WPH, 9 at FPH (summary of cases below). All cases undergo formal root cause analysis at meetings attended by CCG infection control representatives so that robust challenge and discussion can take place, and any lapse in case can be identified and agreed. There have been two 'lapses in care' identified to date at WPH: one case where antimicrobial prescribing did not follow Trust guidance, and one case in which there was a delay in stool sample collection, which delayed treatment of the patient. A period of increased incidence is currently being investigated on Ward 10 at WPH, after two cases were identified wthin a week.

A cluster of community-onset CDI cases was identified in postpartum ladies (7 cases in 6 months in the FHFT catchment area), considered to be unusual as only 3 cases had been previously identified in the past 10 years in this patient group at FPH. An investigation has been completed with support from Public Health England to identify any potential risk factors, and a report written for publication. There have been no further cases observed since July 2017, but awareness of potential CDI in this patient group has been raised with clinicians both in acute Trusts and the community.

Summary of Trust-apportioned CDI cases

Month	Consultant	Avoidable/ Unavoidable	Root Cause (including severity of CDI)	Comments (including discussion of lapses in care if present)
April 2017 FPH F8	Mr Gerrard	Unavoidable	This was considered to be a **moderate** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition, both on this admission, and at a neighbouring Trust.	No lapse in care
April 2017 WPH W5	Dr Akavarapu	Unavoidable	This was considered to be a **mild to moderate** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care
April 2017 WPH W18	Dr Thaite	Unavoidable	This was considered to be a **moderate** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care
May 2017 FPH G9	Dr Clarkson	Unavoidable	This was considered to be a **Severe** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care
June 2017 FPH SSS	Mr Dowson	Unavoidable	This was considered to be a **moderate** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care
June 2017 FPH F8	Mr Gerrard	Unavoidable	This was considered to be a **mild** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care
June 2017 WPH Eden	Dr Philpott	Unavoidable	This was a **severe** case in a high risk patient who was immunosuppressed/neutropaenic. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care
June 2017 FPH G2B	Dr Gupta	Unavoidable	This was considered to be a **mild** CDI case. The root cause was antibiotic	No lapse in care

			treatment required for the patient's underlying condition.	
June 2017 WPH W4	Dr Metaxa	Avoidable	This was considered to be a **mild** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	Due to coamoxyclav prescription having no stop/review date or indication (on two occaisions), no urine sample being sent for suspected urosepsis, hand hygiene score of 80% and commode cleanliness audit score of 50% it was agreed there was a **lapse in care**
July WHP ITU	Dr Tamm	Unavoidable	This was considered to be a **moderate** CDI case. The root cause was antibiotic treatment required for the patient's complex underlying condition.	No Lapse in care
July FPH Bourne	Dr Gupta	Unavoidable	This was considered to be a **severe** CDI case. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in care. All antibiotic treatment was given prior to transfer to Bourne. All prescribing on F2 was in line with Trust guidance.
July FPH G2B	Dr Gupta	NA	This was considered to be Cdiff **colonisation** only - the result was not clinically significant, and the patient did not require treatment.	No lapse in care. This was the second CDI case in a month on G2B - The ribotype of the two cases was different (Sporadic and 015), so no evidence of cross-infection.
July WPH W18	Dr Thet	Unavoidable	This was agreed to be a **moderate** case. The root cause was unknown	No lapse in care.
Aug FPH F9	Dr Anwar	Unavoidable	This was agreed to be a **mild** case in a high risk patient. The root cause was unknown.	No lapse in care. No Antibiotics prescribed in community or Trust before CDI positive
Aug WPH W5	Dr Mohammedi	Avoidable	This was agreed to be a **severe** case. The root cause was unknown and patient had diarrhoea on admission	There was a delay in sending stool sample when diarrhoea commenced with a resultant delay in commencement of CDI treatment it was agreed there was a **lapse in care**
Aug WPH Eden	Dr Philpott	Unavoidable	This was a second **severe** case in a high risk patient who was immunosuppressed/neutropaenic. The root cause was antibiotic treatment required for the patient's underlying condition.	No lapse in Care
Aug WPH W10		A/W RCA (20/09/2017)		
Aug WPH W10		A/W RCA (11/10/2017)		

Aug WPH W11		A/W RCA (11/10/2017)		
Sept FPH G1	Dr Rees	A/W RCA (28/9/17)		

Meticillin sensitive Staphylococcus aureus bacteraemia

There have been 21 Trust-apportioned MSSA bacteraemia cases to date, with no objective set for 2017/18. A summary of the cases shown below:

Month	Ward	Root cause	Healthcare-associated?
April	WPH W9	Hospital-acquire pneumonia	Yes
April	FPH F10	Unknown	No
April	FPH G5	Peripheral cannula	Yes
April	WPH W17	Endocarditis	Yes
April	WPH W4	Unknown	No
April	FPH MAU	Unknown	No
April	FPH G5	Parotitis	No
May	FPH F9	Upper GI bleed	No
June	WPH ITU	Infected thrombus	Yes
June	FPH SAU	Dermatitis	No
June	FPH G2A	Peripheral cannula	Yes
July	WPH Stroke Unit	Skin and Soft tissue	No
July	FPH F10	Hospital-acquired pneumonia	Yes
July	FPH G9	Community-acquired pneumonia	No
August	WPH NNU	Peripheral cannula	Yes
August	FPH F8	Osteomyelitis	No
August	WPH W8	Skin/ Soft tissue	No
August	WPH W4	Unknown	No
August	FPH F9	PICC	Yes
September	WPH ICU	Unknown	No
September	WPH Eden	PICC	Yes

Glycopeptide-Resistant Enterococci (GRE)

There have been 3 GRE-positive blood cultures, with no objective set for 2017/18. Two cases at WPH (Paragon and W6), and one case at FPH (F8).

The number of new GRE-colonised or infected patients identified at FPH has been maintained at baseline since May 2016. The majority (54%) of patients who have acquired GRE in sterile sites, have been under Diabetic foot/ Vascular care, or had Gastro-intestinal surgery.

Escherichia coli bacteraemia

Cases are now being apportioned to Trust and CCG, as with MRSA and MSSA bacteraemia cases. There have been 63 Trust-apportioned cases to date (39 at FPH, 24 at WPH). 10 of the 39 cases (26%) at FPH have been sourced to urinary catheters.

The IPCT continue to work closely with colleagues in the local CCGs Leads, identifying and addressing actions which can assist the CCGs in the 2017/18 objective to reduce the number of Ecoli bacteraemia cases by 10%, and the number of Gram-Negative Bacteraemia cases by 50% by 2021. The actions are focussing on:

Prompts given for clinicians to review the need for any invasive devices (including urinary catheters) on a daily basis.

- Improvements in sending, looking up results of, and interpretation of urine samples is needed (both in hospital and community).
- Development of a catheter care passport, which will improve care across local healthcare establishments.
- Public education on hydration and hygiene for those both with, or without a urinary catheter.

Since August 2017, the local CCGs are permitted to make additions and changes to risk factor data for Gram-Negative Bacteraemia cases that the acute Trust enter on the Data Capture System, for up to a year after the data was already signed-off by the CEO. The IPCNs have written to Public Health England to express concerns over the loss of governance of this information.

Klebsiella spp bacteraemia

Reporting of *Klebsiella* bacteraemia cases began in April 2017. There is no objective for 2017/18, and cases are not apportioned to Trust or CCG. There have been 77 cases to date (35 at FPH, 42 at WPH).

Pseudomonas aeruginosa bacteraemia
Reporting of *Pseudomonas aeruginosa* bacteraemia cases began in April 2017. There is no objective for 2017/18, and cases are not apportioned to Trust or CCG. There have been 26 cases to date (11 at FPH, 15 at WPH).

Antimicrobial Prescribing Stewardship
No audit data has been presented since the cross-site audit in June 2017.
AMU ward rounds occur twice a week with the Consultant on AMU and the Antimicrobial Consultant and Antimicrobial Pharmacist. Antimicrobial therapy is discussed and advice given on possible further tests to be carried out or alternative treatments. Antibiotics were stopped in 25% of patients seen during August, alternative treatments suggested in 13% and alternative tests in 9%. This has also allowed the opportunity to advise on standard tests, ensuring that urine samples and blood cultures are sent in relevant patients.

Death certificates with MRSA or CDI recorded as Primary or Secondary Cause
There has been one death certificate with CDI (Part Ib) from a patient at Wexham Park Hospital (RCA to be undertaken on 20/09/17) No MRSA related deaths have been recorded on death certificates to date.

Short term, non-tunneled CVC infections
There have been no CVC-associated blood stream infection to date.

TPN related Peripherally inserted Central Catheter infections
There has been one TPN-related PICC infection to date on FPH F9, which was one of the MSSA bacteraemia cases for the Trust.

Orthopaedic Mandatory Surgical Site Infection Surveillance
FPH: There was one superficial SSI of a primary total hip replacement in the April-June 2017 quarter. Data for July-Sept 2017 continues to be collected.
Heatherwood: There was one organ/ space SSI reported for April-June 2017 quarter. Data for July-Sept 2017 continues to be collected.
WPH: There was one joint SSI in a primary total hip replacement in the April to June 2017 quarter. Data for July-Sept 2017 continues to be collected.

Mandatory Infection Control Training
Due to changes made to the Staff and Patient Safety (SAPS) programme in early 2016 the overall percentage of Trust staff in date with infection prevention & control training has fallen steadily during the year from 83% in February 2016 to 64% in July 2017. The IPCNs have been carrying multiple additional clinical-based training sessions between July and September, but despite providing around 30 formal traning sessions per month, and training staff in lcinical and ward areas, still the percentage of staff recorded as in date with training on MAST continues to fall. Learning & OD have reported that some attendance sheets have gone missing and that there is a 2 month back-log of attendance sheets to input onto OLM.

Hand Hygiene
A summary of the hand hygiene audits completed in the July-September 2017 quarter by the Infection Prevention & Control Nurses:
FPH: Overall compliance = 94%. The Unregistered nursing staff group compliance has improved, whereas Ancillary staff (eg. Housekeepers, Porters, Ward waitresses) has reduced to below 80%.
HWP: Overall compliance = 87%. Housekeepers are also scoring the lowest compliance.
As an attempt to create healthy competition, a league table of wards' hand hygiene results (those carried out by the IPCNs) has been produced. At Nursing Midwifery Board in September, senior nursing staff have been asked to urgently formulate local plans to improve hand hygiene and to consider a disciplinary rounte for those who demonstrate sub optiomal complaicne.

Hospital Infection Control Committee (HICC)
Monthly HICC meetings are held for FPH and WPH, chaired by the Director of Infection Prevention and Control. Clinical Medical Lead attendance has been low at both sites due to operational pressures on clinical staff.

Facilities and Estates Issues

The Infection Control Doctors and Lead Nurses attend the Environment Group meetings held at Heatherwood, and have reviewed and agreed the updated Trust standard for sanitary fittings.

FPH:

- High legionella counts have been identified for a number of months in the Neonatal Unit and ENT Outpatients. High *Pseudomonas* counts have also been found in Neonatal Unit and Labour Ward. Estates have reported that taps have either been de-scaled or changed, but on IPCN visits to the departments, there was still heavy scaling on taps, and ward staff had not been made aware that they should be running the outlets daily (as they were just labelled stating not to be used), so water was not being flushed through).
- There have been high legionella counts also associated with Capital Projects works in Parkside and ED Minors (which has led to high counts in Paediatric ED).
- The Hydrotherapy pool in Physiotherapy was closed in June, due to high TVCs on water testing. It required an inspection from an external expert to identify that some of the system had been connected incorrectly and that filters required changing, as this was not identified by Estates or Aegis.
- Estates reported at the Built Environment Committee in May, that there is no documented testing of water at Calthorpe Unit, Fleet Hospital by Southern Health, and no evidence provided that it has ever been tested. To minimise the risk to patients we are recommending that ***no immunosuppressed patients*** are admitted/ transferred to Calthorpe, fitting any of the following criteria, until FHFT Estates Team have tested and received satisfactory water results:
  - Neutropenia (neutrophils <1)
  - High dose steroids (eg. >40mg prednisolone/day), or other immunosuppressive treatment

  In addition, it was advised that patients who have had recent surgical procedures (with open wounds) or who have central venous catheters in place, are also included in this group.

WPH:

- The theatre annual maintenance programme is well underway.
- Water quality issues have been identified in the Endoscopy unit at Wexham Park. Remedial actions have been identified which in the immediate term have resolved the majority of issues. Further input is being sought from the equipment manufacturers to ensure that a long term solution is achieved.
- The hydrotherapy pool at Wexham Park was closed temporarily in August due to high TVCs on water testing. Investigations were undertaken and recent test results indicate that the remedial actions taken to date have been successful in resolving the problem.
- Water testing from the Neonatal Unit continues to demonstrate the presence of Pseudomonas. An investigation undertaken by the Estates team has identified the need for considerable work to be carried out on the water distribution pipework in order to deliver a long term solution. Protocols are in place to protect the users of this unit (by using alcohol hand sanitser to clean hands and sterile water to bath babies).

Heatherwood:

- Heatherwood Theatres The annual maintenance program has been delayed due to poblems associated with Theatres 1 and 2 which have taken longer to rectify than originally anticipated.
- Routine water quality results have identified issues specifically relating to the supply to Apollo ward, but it was queried with Estates why these outlets were still being tested when the ward has been closed to any use.

The process for communicating theatre ventilation results has been reconfirmed to ensure these are sent to the infection control team in a timely manner and include microbiology results.

<u>Routine Programme of 6-monthly Deep Cleans</u>

A programme of routine 6-monthly deep cleans for wards was implemented in the UK in 2007 and 2008. At FPH patients are moved to “decant areas” (ie endoscopy or day surgical areas that are not used during weekends) so that ward beds, lockers and furniture get a thorough clean, alongside items that are not easily accessible such as vents and radiators. Due to bed pressures the decant areas are now frequenbtly unavailable resulting in the deep clean programme for side-rooms is behind schedule, and the deep clean of wards has reduced to annually from 6-monthly.
At HWP there was no programme of routine 6-monthly deep cleans implemented in 2008, although areas can have enhanced cleaning on a case by case basis.

<u>Siderooms</u>

At FPH continues to be concerns about the sustained national increase in number of patients colonised with multi-drug resistant organisms (MDRO) occupying beds in open bays on surgical wards since January 2016, and there has been an increase in the number of DATIX reports coming through about this matter. This is likely to be an continuing problem (the number of FPH inpatients (on any given day) colonised with MDRO has increased five-fold in the past 6 years), so actions are needed to reduce the risk of onward transmission of the organisms to these high risk patient groups (especially within implant surgery).

- Compliance with the Trust Hand Hygiene policy.

- Housekeeping staff must change cloths after cleaning each bed space.
- Bedspaces must be cleaned thoroughly after each patient discharge.
- Single-patient-use equipment should be used where possible for patients in bays with MDRO (such as blood pressure cuffs and hoist slings).
- Where patients with MDRO are unable to be isolated due to side-room capacity, staff should contact the Infection Prevention & Control Team for advice, to ensure patients are placed in as low risk bays as possible (eg. no recent surgery or CVCs).
- Drs must be made aware of patient's MDRO status prior to prescribing antibiotics, as it may have an impact on the antibiotic choices for that patient.

The IPCT has expressed concerns about the loss of an *en-suite* side-room for F15 Gynae (converted into a scanning room), for Cardiology in the G8/ Renal Unit plans, and insufficient side-room capacity being planned in to new builds. The lack of increase in provision of *en suite* siderooms has placed additional strain on the infection ontrol nurse resource due to the need for additional monitoring and advice to ensure wards remain free from outbreask/ can remain open.

Capital Projects

The number of Capital Projects is placing a demand on the Infection Prevention and Control Team (IPCT) resource due to the large number of meetings to attend (some of which are off-site). Despite attending meetings Infection Control advice is not followed in the majority of projects as evidenced by works not being signed off by a qualified infection control specialist as recorded below.

Current involvement is with:

- FPH Renal Unit – **these plans were not signed off by the IPCT** due to concerns raised about insufficient storage for the ward, lack of a treatment room, and lack of partitioning between bed spaces in line with National Guidelines for prevetion of blood bourne Viruses. A treatment room was requested by the infection control team for IV line insertion was built into the plan only after the Renal Consultants supported this requirement .
- FPH F9 – **these plans were not signed off by the IPCT** due to a reduction in bed spacing, insufficient toilet facilites and lack of storage room.
- Heatherwood – meetings held on FPH site which places additional strain on infection control resource
- Wexham ED – **1:200 plans not signed off by infection control** as bed spacing in 4-bedded bays does not comply with National standards. Meetings held to discuss how to ensure these comply.The infection Control Team have requested copies of the most up to date plans to be made available.
- Wexham Maternity - **Not signed by the IPCT** as plans did not comply with National standards for bed spacing. Building work due to complete by the end of 2017.
- Wexham Paedatrics – Refurbishment is now complete on W24, Paediatric Assessment and Children's Clinic with the addition of ensuite WC's to the single bed isolation cubicles on W24
- Wexham Radiograpy - Refurbishment plans are being drawn up and will include the provision of a designated bed-waiting area
- Heatherwood - Lithotripsy unit being developed in the old minor injuries unit.
- FPH & WPH Parkside Refurbishment - Work is underway to refurbish Parkside, including installation of clinical hand wash basins in the rooms.
- FPH New Diagnostic Building – **these plans were no signed off by the IPCT**. Despite this being a new build, the plans do not comply with guidance set by the Department of Health, including:
    - Bed spacing is 3m (non-compliant with the 3.6m recommendation)
    - Only one Dirty Utility is available for 36 beds (recommendation is for one Dirty Utility per 15 beds)
    - 30% single rooms (recommendation is for new builds to have at least 50% single rooms).
    - Insufficient storage for patient equipment.
    - Lack of Housekeeping cupboard.

Staffing

There is a Band 7 IPCN vacancy at WPH. Post has been unsuccessfully advertised on two occasions.

There has been a reduction in nursing staff at FPH following acquisition and additional wards added at community hospital sites.

The Nurse Consultant post will be advertised following the resignation of the current post-holder.

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Update Summary from the Charitable Funds Committee, (CFC)**
Meeting	Public Board
Meeting Date	Friday, 6th October 2017
Agenda No.	15.1
Report Type	Information
Prepared By	Mike O'Donovan, Chair of the CFC and Kevin Jacob, Asst. Company Secretary
Executive Leads	Nigel Foster, Director of Finance and IM&T and Janet King, Director of Human Resources and Corporate Services.
Executive Summary	This report briefs the Board on the main items discussed at the 4th September 2017 meeting of the Charitable Funds Committee.
Background	**1. Charitable Funds Significant Income and Expenditure 2017/2018 M1-4** The Committee **noted** a report on: • Recent income received from individual donations over £5,000 and details of individual purchases from charitable funds in excess of £10,000 highlights of which included income of £150,000 and expenditure of £513,000 for the purchase of X-Ray equipment funded by the Frimley Breast Care Appeal **2. Charitable Fund Balances and Treasury Management Report** The Committee **noted** a report on: • The current combined fund which as of 31st July had a combined total of £3.9 million • How investments had been made in line with the Charitable Funds Investment Policy together with an update on the current case position and future commitments. **3. Final Draft Charitable Funds Annual Report and Accounts** The Committee noted that following review by the Trust's external auditor KPMG no significant issues had been identified or changes required to the Charitable Funds Accounts. The annual report, account and auditors opinion would be presented to the Audit Committee on the 14th September prior to formal sign off by the Charitable Fund Trustees on 6th October.

15.1

	4. Fundraising Activity Report The Committee considered a comprehensive report setting out an update on the Trust's major appeals the Stroke Appeal at Frimley and the Children's Critical Care Appeal at Wexham and other charity fundraising activities. It was highlighted that the Charity Team was now fully staffed at both Wexham Park and Frimley Park and there were a number of new fundraising activities which were planned or had taken place at Wexham including Film Wexham at Pinewood Studios and Race Wexham to be hosted by Windsor Racecourse. The Committee also noted that a fundraising pack including a fundraising agreement had been developed to support those wishing to raise money for the charity. The report was noted. **5. Fundraising Strategy 2017/2020** The Committee considered a new Fundraising Strategy for 2017/2020 which set out what the charity hoped to achieve over the next three years and how it planned to build on the successful legacy of fundraising campaigns at Frimley and Wexham to develop income streams in all areas. The Committee discussed the strategy in detail and provided challenge to the Head of Fundraising that the goals and challenges set out in the strategy were aspirational but also reasonable and achievable. The Committee was satisfied that it was reasonable and achievable and agreed to **recommend** to the Charitable Fund Trustees that it agree the strategy.
Recommendation	This Board is asked to note the issues highlighted in the reports and agree any further action as required.

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Frimley Health NHS
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Report Title	**Update Summary from the Audit Committee**
Meeting	Public Board of Directors Meeting
Meeting Date	Friday, 6th October 2017
Agenda No.	15.2
Report Type	For Information
Prepared By	Dawn Kenson, Chair of Audit Committee Kevin Jacob, Assistant Company Secretary
Executive Lead	Nigel Foster, Director of Finance and IM&T
Executive Summary	This report briefs the Board on the main items discussed at the 14th September Audit Committee.
Background	**1. Internal Audit Progress Report** The Committee considered internal audit reports in respect of the following areas: • Waiting List Management – Reasonable Assurance • Private Patient Income – Reasonable Assurance • Estates Compliance – Reasonable Assurance • NICE Guidance Implementation – Reasonable Assurance • HR Performance Data Quality – Reasonable Assurance • MAST Training – Reasonable Assurance In respect of HR Performance Data Quality the Committee provided challenge on the importance of staff appraisal and probation records being updated and improvements to compliance in this area. In respect of Mandatory and Statutory Training compliance the Committee, whilst recognising the progress made provided challenge that this was a recurring theme that needed constant focus and attention. The Committee **noted** the report. **2. Update on Recruitment Retention Audit** The Committee received an update on the implementation of actions arising from the internal audit of recruitment and retention undertaken in autumn 2016 In discussion, the Committee made the point that the introduction of improved recruitment guidance and processes was to be very much welcomed, but compliance could not be assumed. The Committee sought assurance that sufficiently robust measures were in place to identify where the processes were not being followed and by whom. The Committee was informed that the TRAC recruitment system allowed this to be identified and for stronger controls to be in place. For instance payroll would not set up payment details for a new starter unless the previous stages of the

recruitment process had been fully completed.

The Committee noted the report.

3. Risk Assurance Framework – August 2017

The Committee considered a report which set out the corporate risks faced by the Trust as reviewed by the August meeting of the Corporate Governance Group, (CGC) and as previously considered by the Board at the 2nd September meeting.

The Committee discussed how it might further improve and deepening its consideration of the Risk Assurance Framework on the Board's behalf.

It was noted that the risk rating for the management of patients with mental health issue or learning disabilities had increase to red. The Committee explored the reasons behind this and the challenges for the Trust in meeting the growing number of patients with such needs. The Committee learned of initiatives with partners such as Broadmoor Hospital to provide mutual support and the training of staff.

The Committee also discussed the risks to the organisation around financial stability which it was felt would become more challenging in 2017/2018.

The Committee **noted** the report.

4. Local Counter Fraud Service Progress Report

The Committee considered a report from RSM, the Trust's Local Counter Fraud Service provider which updated it on progress in respect of on-going counter fraud training and investigations.

The Committee **noted** the report.

5. Diagnosis Fraud – NHS Benchmarking Report.

The Committee received a report from RSM bench marking reactive fraud referrals across the RSM NHS client base in 2016. The number of reactive referrals in the 2016/2017 financial year for Frimley had been above average for the RSM client base with the type of allegations being very much consistent with those of other trusts. Very few allegations concerning Frimley Health amounted to criminal conduct.

The Committee **noted** the report.

6. Losses and Write Offs – Quarter 1 2017/2018

The Committee considered a report setting out losses and write offs for the period April to June 2017.

As part of the report the Committee considered benchmarking information on the level of Trust income and bad debts for overseas visitors and private patients in comparison to other foundation trusts.

- 2016/2017 level of bad debts vs. income was 10% less than the national average

	although mid-rank when compared locally against other trusts. • There had been significant improvement from 2015/2016 when the Trust was ranked worst against local foundation trusts and 20% above the national average. Processess had now been tightened significantly. The Committee **noted** the report. 7. **Review of Standing Financial Instructions** The Committee considered minor proposed amendments and agreed to recommend them to the Board for Approval. **8. Policies** The Committee reviewed and approved the following policies. • Treasury Management Policy • Anti-Fraud Policy • Financial Redress Policy **9. Frimley Health Annual Report and Accounts** The Committee considered the Frimley Health Charity Annual Report and Accounts. It was highlighted that the charity currently had net assets of £4 million, an increase of approximately £1 million from the previous financial year. It was noted that the Trust's external auditors KPMG had given the financial statements an unqualified opinion. It was noted that the accounts would be presented to the Charitable Trustees on 6th October. **10. Policy Integration Update** The Committee received an update on progress on the project to update and review the Trust's policies and noted that whilst there was still more work to do a total of 72 policies had been updated and this represented good progress. The Committee noted the report. **11. Review of Terms of Reference** The Committee undertook its annual review of its terms of reference and discussed the nature of its role in reviewing the work of other board sub-committees. **12. Audit Committee Self-Evaluation Questionnaire Results** It was noted that the questionnaire results were positive indicating the committee was undertaking the right enquiries in providing assurance to the Board and meeting the right number of times to meet its workload.
Recommendation	This Board is asked to note the issues highlighted in the reports and agree any further action as required.

15.2

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NHS Foundation Trust

Report Title	**Update Summary from the Commercial Development and Investment Committee (CDIC)**
Meeting	Public Board
Meeting Date	Friday, 6th October 2017
Agenda No.	15.3
Report Type	Information
Prepared By	Mark Escolme, Chair of the CDIC and Kevin Jacob, Asst. Company Secretary
Executive Lead	Janet King, Director of Human Resources and Corporate Services
Executive Summary	This report briefs the Board on the main items discussed at the 15th September meeting of the Commercial Development and Investment Committee.
Background	**1. Berkshire & Surrey Pathology Service – Award of contract for the supply of blood glucose and ketone point of care testing systems** The Committee considered a paper setting out the results of a tender exercise to supply blood glucose and ketone point of care testing systems across the Berkshire and Surrey Pathology network. The Committee agreed to **recommend** to the Board that it agree the award of the contract to the supplier set out in the report. **2. Replacement of PACS and RIS systems at Heatherwood and Wexham Hospitals.** The Committee considered a report setting a business case for the replacement of the Picture Archiving and Communications System and Radiology Information System on the Heatherwood and Wexham Park sites. It was noted that replacement of the existing systems which dated from 2007 had been identified within the Trust's risk assurance framework as a major risk. The Committee agreed to **recommend** to the Board that it approve the replacement of the systems to the provider set out in the report subject to a number of report clarifications. **3. Standby Generator Expansion – Wexham Park Hospital** The Committee considered a report setting out the case for the replacement of standby generators at the Wexham Park site in order to provide improved emergency

15.3

	electrical backup in the event of a power failure. It was noted that the hospital had been built to have a combination of essential, (generator back up) and non-essential supplies which meant that in the event of a power failure a limited number of circuits would be provided to maintain critical services. Since that time the power demands and service requirements of the hospital had grown to the extent that further and refreshed generator provision was necessary. The Committee agreed **recommend** that the Board approve the cost of delivering the phases to the project and award contracts for the phases as set out in the report. **4. Redevelopment Programme Progress Report** The Committee was updated on the progress of redevelopment capital projects in respect of all three hospital sites including: • the redevelopment of the Wexham Emergency Department and Assessment Unit which was progressing to programme and within budget. • The Heatherwood Redevelopment - Following the decision of the Royal Borough of Windsor and Maidenhead, (RBWM) to approve planning permission for the redevelopment of the site subject to legal agreement and Secretary of State approval, the Committee noted the work being undertaken to progress the project including negotiation around the agreement of planning conditions with RBWM and work to progress the business case. • The construction of the new Women's Services scheme at Wexham Park which was progressing well overall although there had been some challenges with the handover of the labour ward. **5. Review of Terms of Reference** The Committee considered an annual review of its terms of reference prior to submission to the November Board Meeting. The Terms of Reference had been slightly updated to remove reference to the Trust's Transformation Plan that was now being reviewed at the new Finance committee. The Committee **recommended** that the Terms of Reference of the Committee be approved by the Board. **6. CDIC Annual Effectiveness Self-Evaluation Results** The Committee considered the results of a self-evaluation of its effectiveness. It was noted that the Committee was felt to be operating effectively. A number of changes to the questionnaire were agreed to remove reference to transformation and financial planning.
Recommendation	This Board is asked to note the issues highlighted in the reports and agree any further action as required.

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Frimley Health NHS
NHS Foundation Trust

Report Title	**Update Summary from the Quality Assurance Committee, (QAC)**
Meeting	Public Board
Meeting Date	Friday, 6th October 2017
Agenda No.	15.4
Report Type	Information
Prepared By	Mike O'Donovan, Chair of the QAC and Kevin Jacob, Asst. Company Secretary
Executive Leads	Duncan Burton, Director of Nursing and Tim Ho, Medical Director
Executive Summary	This report briefs the Board on the main items discussed at the 15th September 2017 meeting of the Quality Assurance Committee.
Background	**1. Briefing on Learning, Candour and Accountability – Investigation of Deaths of Patients** The Committee received a detailed presentation from the Trust's Mortality Lead on the Trust's mortality review process for the identification of potentially avoidable deaths. The Committee was informed of how the Trust's existing processes for identifying and learning from avoidable deaths had been further strengthened and amended in light of the CQC Report on Learning, Candour and Accountability in 2016 and the National Quality Board paper on learning from deaths. It was noted that there was now a two stage review process, deaths in hospital and deaths within 30 days of discharge and that trusts were now required to report the number of potentially avoided deaths to their boards on a quarterly basis from October 2017. In discussion, the Committee whilst recognising that potentially avoidable deaths would occur, stressed the importance of capturing and embedding the learning from any potentially avoidable deaths across the whole organisation in order to all that possibly could be done to minimise the number. The Committee requested that it regularly receive information on themes and how learning was being embedded and shared. The Committee felt it was important to maintain an open, honest and learning culture where staff felt able to recognise and share when things went wrong and where supported, there should also be clear accountability as appropriate.

15.4

The Committee was reassured that appropriate and robust processes were in place and **noted** the report.

2. Duty of Candour Update

The Committee received a verbal update from the Deputy Director Nursing and Quality (Frimley) on the duty of candour. The Trust had a clear policy in place and appropriate discussions and debate would continue to take place within the Trust to further improve the culture of candour and to learn from incidents, not just those triggering a Serious Incident.

An audit of duty of candour compliance had indicated a higher number of candours on the Frimley Park site than at the Wexham Park or Heatherwood sites. The Committee explored possible explanations for this and was informed of the measures being put in place across all sites to boost staff confidence in reporting, but that it was recognised that the sites had come from different historical starting points.

The report wa**s noted.**

3. Serious Incidents Requiring Investigation and Quality Assurance Committee Review

The Chairman updated the Committee re ongoing discussions around the best way to manage the reporting of Serious Incidents at board meetings whilst using the Quality Assurance Committee to undertake more detailed, periodic reviews to provide assurance that learnings were being embedded in order to reduce the risk of re-occurence. The next such review was scheduled for the December meeting.

4. Complaints – Status on Key Issues

The Committee received an update on key issues around the complaints service and PALS contacts across the Trust including the detail of the processes of how such complaints were handled and areas of improvement. A key message was that in considering the Trusts complaint's performance, a wider view had to be taken than time taken to respond to complaint alone which was a Trust performance indicator only. It was also important to include qualitative indicators such as the quality of response, percentage of reopened complaints and outcomes from complaints to the Parliamentary and Health Service Ombudsman.

Discussion took place on how themes from complaints could be identified and learning shared and embedded to help prevent future complaints and the links between the complaints and PALs processes and other quality processes such as the serious incident review process. The Committee also discussed how the process for complaints and PALs might need to adapt in light of the development of a wider health system view through the Accountable Care System.

5. Progress on Quality Improvement Priorities for 2017/2018

The Committee's consideration focussed upon the mental health quality improvement priority and it considered an updated action log setting out progress in respect of recommendations to improve the way in which the Trust responded to mental health issues.

The Committee was informed of the work being undertaken by the Trust's Mental Health Group to respond to the increase in patients attending the Trust with a mental health need and to support staff who were not specialists so they were better able to respond to such patients. Initiatives included working with local NHS mental health partners to exchange training and skills.

	Challenges faced were brought to the Committee's attention particularly with regard to the commissioning of CAMHS services for Berkshire patients for patients attending the Frimley Park site. The Committee **noted** the report. **6. Clinical Governance Committee, (CGC) Reports** The Committee noted the reports from the Clinical Committee with no significant issues being brought to its attention. **7. Patient Safety Committee and Patient Experience Forum** The Committee was updated on key issues arising from meetings of the Patient Safety Committee and Patient Experience Forum.
	This Board is asked to note the issues highlighted in the report and agree any further action as required.

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Frimley Health NHS
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Report Title	**Summary report from the Performance & Remuneration Committee**
Meeting	Board
Meeting Date	15th September 2017
Agenda No.	15.5
Report Type	For information
Prepared By	Susanne Nelson-Wehrmeyer, Company Secretary
Executive Lead	Dawn Kenson, Non-Executive Director
Summary	The Committee met on 15th September and discussed the following items; **1. Report on Appraisal Performance August 2016-July 2017** A progress report was presented to the committee designed to ensure that appraisal ratings were fair and consistent. This was the first time this data had been collated using the ESR system and the Committee asked that an annual report be prepared for consideration in September of each year. **2. PRC Executive Director Remuneration Policy** The Executive Remuneration [policy was reviewed and approved with no major amendments. **3. Review progress with Organisation Development-workforce plan update** A progress report had been provided for assurance by Eleanor Shingleton-Smith on the trust's objectives for workforce planning. There had been work undertaken with directorates to support development of local workforce plans with the aim to have an organisation-wide workforce plan by the end of Q3. There was a workforce group considering recruitment and retention and how a passport system would work to enable people to change roles within the STP footprint. The MD at the Royal Borough of Windsor & Maidenhead led this group, which JK attended and the group had just begun a high level analysis for the area. **4. NEDs - review end of terms of office and skills required for recruiting** The Committee discussed the position of the NEDs who were approaching the end of their current terms and agreed recommendation to make to the NERC in respect of these. **5. PRC Meeting Planner** The Committee reviewed the annual planner for its meetings to ensure a timely and balanced agenda for the year ahead.

15.5

	6. Terms of Reference There was an annual requirement for each of the board's sub-committees to review their terms of reference all of which would be reported to the board in December or January to enable an overview. The Committee agreed the wording to add oversight of the work of the workforce planning committee to its terms of reference. **7. Review Board objectives** The board objectives along with the individual executive director objectives are regularly considered by the committee to ensure objectives are kept up to date. Some minor amendments were recommended and this included referencing business continuity.
Recommendation	For noting.

Frimley Health NHS
NHS Foundation Trust

Report Title:	**Summary of Nominations Committee held on 15th September, 2017.**
Meeting date:	Friday 15th September 2017
Agenda number:	15.6
Report Purpose:	For information
Prepared by:	Susanne Nelson-Wehrmeyer
Executive Lead:	Pradip Patel - Chairman
Summary:	The Nominations committee met to consider an update report from the Chairman to consider the recruitment of new CEO for Frimley Health Foundation Trust. A small team had met and produced some high quality work which was handed over to Odgers Berndtson for the creation of a high quality brief. He asked the committee to note appendices 1, 2, 3 and 4 and requested feedback on appendices 4, 5 and 6- the risk register, timetable and communications plan. He was also keen to ensure that key internal and external stakeholders were kept informed of progress and indicated he was reflecting on how best to ensure engagement of the governors. He would be reporting to the NERC on 3 October and the governors and public at the upcoming CoG and AMM on 26th September. The Committee discussed minor changes to the risk register, timetable and communications plan and noted the report.
Recommendation:	Board to Approve

15.6

Frimley Health NHS
NHS Foundation Trust

Report Title:	**Summary of Nominations Committee**
Meeting date:	Tuesday 26th September 2017
Agenda number:	15.7
Report Purpose:	For information
Prepared by:	Susanne Nelson-Wehrmeyer
Executive Lead:	Pradip Patel - Chairman
Summary:	The Nominations Committee started the process to appoint a new chief executive for the trust on 16th August. The advertisement had gone out with a closing date of 11th October. Candidates applying would undergo a long and short listing process and the committee met to discuss and determine the principles and selection process for the shortlisted candidates. Long-listing would be conducted on 13th October with short-listing taking place on Monday 6th November. The formal interview process would be conducted over two days beginning on Wednesday 22nd November, with final interviews taking place on Thursday 23rd November. It was agreed that there would be presentation on day 1 in the morning, followed by an informal lunch then carousels of small stakeholder groups in the afternoon. Candidates would then finish for the day and return for the main interview in the morning for day 2. Candidates would be required to complete any psychometric tests beforehand. Involvement in the process with the NERC would be discussed at the next meeting on 3rd October and the relevant governor meetings would be determined at that time and reported accordingly.
Recommendation:	To Note.

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Acronym 'Buster'

A

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting / Annual Governance Meeting
- AHP - Advanced Health Professional
- AKI - Acute Kidney Injury
- AMM - Annual Members Meeting
- AMR - Antimicrobial Resistance
- AMU - Acute Medical Unit
- AOS - Acute Oncology Service
- ANP - Advanced Nurse Practitioner
- AR - Annual Report
- ASPH - Ashford and St. Peter's Hospital

B

- BAU - Business As Usual
- BBE - Bare Below Elbow
- BME - Black and Minority Ethnic
- BCF - Better Care Fund
- BMA - British Medical Association
- BMI - Body Mass Index
- BoD - Board of Directors

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CAU - Clinical Assessment Unit
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- CDI - Clostridium Difficile Infection
- CDIC - Commercial Development and Investment Committee
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CFO - Chief Finance Officer
- CHC - Continuing Health Care
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Continuous Improvement Plan
- CoG - Council of Governors
- CoS - Chief of Service
- CoSRR - Continuity of Service Risk Rating
- CPA - Care Programme Approach
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRAB - Copeland's Risk Adjusted Barometer
- C.Section - Caesarean Section
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography
- CVC - Central Venous Catheter

D

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DoN - Director of Nursing
- DoO - Director of Operations
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

E

- E&D - Equality and Diversity
- EAU - Emergency Assessment Unit
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ECIST - Emergency Care Intensive Support Team
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EDMS - Electronic Document Management System
- EEG- Electroencephalogram
- EHR - Electronic Health Record
- EHRC - Equality and Human Rights Commission
- EIA - Equality Impact Assessment
- ELSCS - Elective Caesarean Section
- EM - Emergency Medicine
- EMLSCS - Emergency Caesarean Section
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EOLCA - End of Life Care Audit
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record
- ETP - Electronic Transmission of Prescriptions
- EEA - European Economic Area

F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FH - Frimley Health
- FOI - Freedom of Information
- FPH - Frimley Park Hospital
- FRR - Financial Risk Rating
- FT - Foundation Trust
- FTE - Full Time Equivalent
- FPH - Frimley Park Hospital
- FYE - Financial Year End

G

- GI - Gastrointestinal
- GMC - General Medical Council
- GMS - General Medical Services

- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEB - Hospital Executive Board
- HED - Healthcare Evaluation Data
- HEKSS - Health Education Kent, Surrey and Sussex
- HETV - Health Education Thames Valley
- HICC - Hospital Infection Control Committee
- HoN - Head of Nursing
- HSE - Health and Safety Executive
- HSMR - Hospital Standardised Mortality Ratio
- HTC - Hospital Transfusion Committee
- HWB - Health and Wellbeing Board
- HWD - Heatherwood
- HWP - Heatherwood and Wexham Park
- HWPH / H&WPH - Heatherwood and Wexham Park Hospitals

I

- I&E - Income and Equity
- IC - Information Commissioner
- ICM - Integrated Case Management
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPCN - Infection Prevention and Control Nurse
- IPCT - Infection Prevention and Control Team
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LINAC - Linear Accelerator
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

M

- M&M - Morbidity and Mortality
- MAU - Medical Assessment Unit
- MDT - Multi-Disciplinary Team
- MHPS - Maintaining High Professional Standards
- MIDU - Medical Investigations Day Unit
- MiG - Medical Interoperability
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Methicillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director
- NHS FT - NHS Foundation Trust
- NHSE - NHS England
- NHSLA - NHS Litigation Authority
- NHSP - NHS Professional
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OLM - Oracle Learning Management
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy

P

- PACS - Picture Archiving and Communications System
- PACU - Post-Anesthetic Care Unit
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PAU - Paediatric Assessment Unit
- PbR - Payment by Results
- PCI - Percutaneous Coronary Intervention
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PEAT - Patient Environment Action Team
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PILS - Patient Information Leaflets
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMS - Personal Medical Services
- PMO - Programme Management Office
- POD - Pre-Operative Department

- POSSUM - Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity
- PPE - Personal Protective Equipment
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

Q

- QA - Quality Assurance
- QAC - Quality Assurance Committee
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAF - Risk Assurance Framework
- RAG - Red Amber Green
- RBH - Royal Berkshire Hospital
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RSCH - Royal Surrey County Hospital
- RTT - Referral to Treatment

S

- SADU - Surgical Day Unit
- SAU - Surgical Assessment Unit (FPH) / Surgical Assessment Unit (WPH)
- SCAS / SCAmb - South Central Ambulance Service
- SDIP - Service Development and Improvement Plan
- SHMI - Summary Hospital-level Mortality Indicator
- SHO - Senior House Officer
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO - Serious Incident Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SME - Subject Matter Expert
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SPS - Surrey Pathology Service
- SSI(S) - Surgical Site Infections (Surveillance)
- SSNAP - Sentinel Stroke National Audit Programme
- SSS - Short Stay Surgical Unity
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

- TIA - Transient Ischaemic Attack
- TLC - Turn off, Lights out, Close doors
- TMG - Theatre Management Group
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UCB - Urgent Care Board
- UI - Untoward Incident
- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WLI - Waiting List Initiative
- WPH - Wexham Park Hospital
- WTE - Whole Time Equivalent

Y

- YTD - Year to Date