Extra Ordinary Board Meeting of both BUSH and WSHFT to held concurrently

Wednesday 24 April 2019

12.30 – 13.30
Boardroom Trust HQ, Royal Sussex County Hospital, Brighton

AGENDA

1	12.30	**Welcome, Apologies and Confirmation of Quoracy**		Chair
2	12.30	**Declarations of Interest**		Chair
3	12.35	**BSUH and WSHFT SFIs** for approval	Enc 1	Karen Geoghegan
4a	12.45	**WSHFT Risk Management Strategy** for approval	Enc 2	Glen Palethorpe
4b	12.55	**BSUH Risk Management Strategy** for approval	Enc 3	Glen Palethorpe
5	13.00	**Charitable Funds use for Staff support for both BSUH Charity and WSHFT Charity** for discussion	Verbal	Marianne Griffiths
	13.30	**Meeting close**		

Agenda Item:	2	**Meeting:**	Board	**Meeting Date:**	24 April 2019
Report Title:	**BUSH and WSHFT SFIs**				
Sponsoring Executive Director:	Karen Geoghegan, Chief Financial Officer				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:	Finance and Investment Committees of both BSUH and WSHFT in March 2019				
Purpose of the report:					
Information	☐		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	✓	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					
These documents have been considered by the Finance and Investment Committees of both BSUH and WSHFT in March 2019					
Executive Summary:					

Introduction

It is recommended that the SFIs are reviewed on a periodic basis; at an interval of no more than three years. There may be a requirement to update more frequently as a result of internal or external drivers for change.

A task and finish group was constituted, comprising members of the finance teams of both organisations, for the purpose of reviewing, updating and aligning the financial governance documents contained herein (Appendix 1 and 2). In addition, Trust subject matter experts were also consulted as appropriate i.e. Corporate Governance, HR, Estates and the Local Counter Fraud Specialist.

Given the management contract arrangements, the sharing of a number of executive and non-executive directors and the benefits expected from employing a consistent approach, the ambition was to align as much of the content as possible whilst recognising the differences between each organisation; particularly WSHT status as a Foundation Trust.

Standing Financial Instructions (Appendix 1)

The SFIs for both Trusts are included in one document to allow an easy read across between the two Trust's with the specifics recognising that WSHFT is a Foundation Trust are in red text, the specifics

for BSUH as a NHS Trust are in blue. (Please note that once approved each Trust will have these as separate documents containing the text only relevant to their Trust)

With respect to the SFIs, there were no material changes to the content; the amendments largely focussing on language and style.

In terms of key variations between BSUH and WSHT, the following should be noted:

- Introduction (Para 2) – Inclusion of Foundation Trust Specifics related to WSHT (This distinction is repeated throughout the document for the Trust and Foundation Trust status of both organisations)
- Bank and GBS accounts (Para 6) – WSHT have less restrictions on cash management based on additional guidance from NHSI
- Appointment of Officers of the Trust Board and Executive Committee (Para 10) – Different roles for Secretary of State for Health and Social Care (BSUH) and Council of Governors (WSHT)

Delegated Financial Limits (Appendix 2)

Like the SFIs, the Delegated Financial Limits were also reviewed with a number of proposed changes identified. In the main these changes are to a) ensure consistency in approach and decision making between BSUH and WSHT b) recognise the organisational structures and, in particular, the trust and group director roles and c) amend and align financial limits to ensure decision making is at the appropriate levels.

Key amendments are detailed below with the full list shown in Appendix 2:

- Award of a legal contract:
  - Trust & Group Directors – up to £10,000 (new entry)
  - Trust Finance Director – up to £250,000 (new entry)
  - Chief Financial Officer/Chief Executive – up to £500,000 (increase from £90,000/£250,000)
  - Trust Executive Committee – up to £1,000,000 (increase from £500,000)
  - Finance & Investment Committee – between £1,000,000 and £3,000,000 (increase from up to a £1,000,000)
  - Trust Board – over £3,000,000 (increase from over £1,000,000)
- Approve a business case
  - Limits as above for the award of a legal contract
  - Applies to the value of the business case over the project term
- Authorise a spend against a charitable fund
  - BSUH to align with WSHT delegated limits
  - Fund-holder – up to £2,500
  - Trust Finance Director/Chief Financial Officer – up to £10,000
  - Charitable Funds Committee – between £10,000 and £50,000
  - Corporate Trustee/Trust Board – over £50,000
  - All charitable fund applications, as confirmation of public interest benefit, will require approval of the Charity Director

Consideration by Finance and Information Committees

At the March meetings of both the BSUH and WSHFT Finance and Investment Committees they received, considered and recommended to the Board for approval the revisions proposed to the both Trust's SFIs and Delegated Financial Limits.

Key Recommendation(s):

To approve the revised SFIs and Delegated Financial Limits for each Trust.

WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
[WSHFT]

BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST
[BSUH]

STANDING FINANCIAL INSTRUCTIONS (SFI)

March 2019

CONTENTS Page

CONTENTS Page

1. INTERPRETATION AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Board of Directors of the Trust shall be the final authority on the interpretation of Standing Financial Instructions (about which they should be advised by the Chief Executive).

1.2 In these Standing Financial Instructions, unless the context otherwise requires, all references to the masculine gender shall be read as equally applicable to the feminine gender and words importing the singular shall import the plural and vice-versa.

1.3 References to any statutory body shall be deemed to include any successor body or bodies which may from time to time assume all or substantially all of the functions of that original statutory body.

1.4 References to any statute or statutory provision shall be deemed to include any instrument, order, regulation or direction issued under it and shall be construed to include a reference to the same as it may have been, or may from time to time be, amended, modified, consolidated, re-enacted or replaced.

1.5 Any expression to which a meaning is given in the National Health Service Act 2006, Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions and in addition:

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

1.5.2 [WSHFT]: **"Board"** means the Chair, officer and non-officer members of the Trust collectively as a body.

1.5.3 [BSUH]: **"Board"** means the Board of Directors, comprising a non-executive Chair, up to six non-executive directors (excluding the Chair) and up to five executive directors.

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

1.5.5 **"Budget holder"** means the director, officer or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.5.6 **"Chair of the Board (or Trust)"** is the person appointed by NHS Improvement on behalf of the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust, if there is one, if the Chair is absent from the meeting or is otherwise unavailable.

1.5.7 **"Chief Executive"** means the chief officer and Accountable Officer of the Trust.

1.5.8 **"Chief Financial Officer"** means the Executive Board Member in charge of Finance in the Trust.

1.5.9 **"Clear days"** means all the days in the relevant timeline except the day of commencement and day of completion.

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

1.5.11 **"Committee"** means a committee, created and appointed by the Board.

1.5.12 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

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

1.5.14 **[WSHFT]: "Council of Governors"** means the body that represents the interests of trust members and the public.

1.5.15 **"Deputy Chair"** means the [WSHFT]: person / [BSUH]: non-executive director appointed by the [WSHFT]: the Council of Governors /[BSUH]: Board of Directors to take on the Chair's duties if the Chair is absent for any reason.

1.5.16 **"Executive director"** means a director who is an employee of the trust and includes the Chief Executive and other executive directors appointed by the relevant committee in accordance with the Membership and Procedure Regulations, or by virtue of regulation 5 of those regulations.

1.5.17 **"Finance and Performance Committee"** means a committee whose functions are concerned with strategic financial matters and also review significant operational performance maters for which the Trust has responsibility.

1.5.18 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept on trust in accordance with powers derived from Part II of the NHS Act 2006 or otherwise. Such funds may or may not be charitable.

1.5.19 **"Member"** means an executive or non-executive director of the Board as the context permits. Member in relation to the Board does not include its Chair.

1.5.20 [BSUH]: **"Membership and Procedure Regulations"** means the most up to date National Health Service Trusts (Membership and Procedure) Regulations.

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

1.5.22 **"Non-Executive director"** means a Non-Executive director, independent member of the Trust Board and is not a member of the executive management team. Non-Executive Directors are not employees of the Trust unlike Executive Directors. Non-Executive Directors do have the same legal duties, responsibilities and potential liabilities as their executive counterparts on the Board.

1.5.23 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.5.24 [WSHFT]: **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Trust constitution, NHSI and Department of Health guidance.

1.5.25 **"SFI"** means Standing Financial Instructions.

1.5.26 **“SO”** means Standing Orders.

1.5.27 **“Trust”** means [WSHFT]: Western Sussex Hospitals NHS Foundation Trust / [BSUH]: Brighton and Sussex University Hospitals NHS Trust.

1.5.28 **"In writing"** includes references to communications sent by email, except where explicitly stated otherwise.

1.5.29 **“NHSI”** means NHS Improvement. The NHS Trust Development Authority and Monitor are collectively referred to as NHS Improvement.

2. INTRODUCTION

2.1 General

2.1.1 [WSHFT]: Western Sussex Hospitals NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on the 1st July 2013, following authorisation by "NHSI", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

2.1.2 [WSHFT]: These Standing Financial Instructions (SFI's) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SO's) of the Foundation Trusts Board of Directors (note the SOs are a statutory requirement for Foundation Trusts (FT's) but SFI's are not termed as such, although an equivalent set of rules is required by NHSI, which this document represents).

2.1.3 [WSHFT]: The NHSI risk assessment framework elements which are relevant to financial matters include *The Audit Code for NHS Foundation Trusts, the Prudential Borrowing Code for NHS Foundation Trusts, Risk Assessment Framework* and the *NHS Foundation Trust Annual Reporting Manual*, all as updated, replaced or superseded from time to time. Other relevant guidance may be issued.

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

2.1.5 These SFI's identify the financial responsibilities which apply to everyone working for the Foundation Trust and its constituent organisations including any trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Trust's Finance & Investment Committee.

2.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFI's then the advice of the Chief Financial Officer must be sought before acting. The user of these SFI's should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors [WSHFT]: (as well as the separate Standing Orders of the Council of Governors).

2.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can, in certain circumstances, be regarded as a disciplinary matter that could result in an employee's dismissal.

2.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All officers and employees of the Trust have a duty to disclose any non-compliance with these SFI's to the Chief Financial Officer as soon as possible.

2.2 Responsibilities and delegation

2.2.1 [WSHFT]: The Council of Governors' statutory responsibilities are set out in the National Health Service Act 2006 and the Health and Social Care Act 2012. The financial duties are as follows:

2.2.2 [WSHFT]: From the National Health Service Act 2006:

(a) decide the remuneration and allowances, and the other terms and conditions of office, of the chair and non-executive directors;

(b) appoint and, if appropriate, remove the trust's external auditor;

(c) receive the trust's annual accounts, any report of the auditor on them and the annual report;

2.2.3 [WSHFT]: From the Health and Social Care Act 2012:

(a) approve, by a majority voting, "significant transactions" as defined within the trust constitution;

(b) approve, by a majority of all, an application by the trust to enter into a merger, acquisition, separation or dissolution;

(c) decide whether the trust's private patient work would significantly interfere with the trust's principle purpose, i.e. the provision of goods and services for the health service in England or the performance of its other services;

(d) approve, by a majority voting, any proposed increases in private patient income of 5% or more in any financial year;

2.2.4 **The Trust Board:** The Board exercises financial supervision and control by:

(d) formulating the financial strategy, [WSHFT] having regard to the views of the Council of Governors;

(e) requiring the submission and approval of budgets within approved allocations/overall income;

(f) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(g) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

2.2.5 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, other committees as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

2.2.6 **The Chief Executive and Chief Financial Officer:** The Chief Executive and Chief
2.2.7 Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.8 Within the SFI's, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to [WSHFT] NHSI / [BSUH] the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within

the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

2.2.9 It is a duty of the Chief Executive to ensure that officers of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFI's. [WSHFT] Also that the Council of Governors have the skills and knowledge required to undertake their role.

2.2.10 **The Chief Financial Officer:** The Chief Financial Officer is responsible for:

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

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

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

And, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer include:

(d) the provision of financial advice to other members of the Board and employees;

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

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

2.2.11 **Board Officers and Employees:** All officers of the Board and employees, severally and collectively, are responsible for:

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

(b) avoiding loss;

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

(d) conforming with the requirements of the Trust constitution, Standing Orders, Standing Financial Instructions, Financial Procedures, the Scheme of Delegation [WSHFT]: the Terms of Authorisation and NHSI.

2.2.12 **Contractors and their employees:** Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

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

3. AUDIT

3.1 Audit Committee

3.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2005), which will provide an independent and objective view of internal control by:

(a) monitoring the independent external auditors' qualifications, independence and performance;

(b) monitoring the performance of the Trust's Internal Audit function;

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

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

(e) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board, the adequacy of all risk and control related disclosure statements and advising the Board accordingly;

(f) [BSUH]: monitoring compliance by the Trust with legal, regulatory and code of conduct requirements;

3.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

3.1.3 It is the responsibility of the Chief Financial Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

3.2 Chief Financial Officer

3.2.1 The Chief Financial Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function. An Internal Audit function is required in line with prevailing guidance set out by NHSI and DHSC.

(b) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption (subject to the provisions of SFI 3.5 in relation to fraud and corruption);

(c) ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit Committee and the Board. The report(s) must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control

criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit Committee;
(ii) any major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed work-plan for the coming year.

3.2.2 The Chief Financial Officer and designated auditors are entitled without necessarily giving prior notice to require and receive:

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

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

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

(d) explanations concerning any matter under investigation.

3.3 Role of Internal Audit

3.3.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

3.3.2 Internal Audit will review, appraise and report upon:

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

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

(c) the suitability of financial and other related management data including internal and external reporting and accountability processes;

(d) the efficient and effective use of resources;

(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 (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist);
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.
(iv) any form of risk, especially business and financial risk but not exclusively so.

(f) the adequacy of follow-up actions by the Trust to internal audit reports;

(g) any investigations/project work agreed with and under terms of reference laid down by the Chief Financial Officer;

(h) the Trust's "Assurance Framework Statements" in accordance with guidance from the Department of Health and Social Care;

(i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

3.3.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately and, in the case of alleged or suspected fraud, the LCFS must be notified.

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

3.3.5 The Head of Internal Audit, or equivalent title shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in prevailing guidance from NHSI and DHSC. The reporting system shall be reviewed at least every three years.

3.4 External Audit

3.4.1 The External Auditor is appointed by the [WSHFT]: Council of Governors/ [BSUH]: Trust Board with advice from the Audit Committee.

3.4.2 The Audit Committee must ensure a satisfactory and cost-effective service is provided and agree audit work-plans, except statutory requirements.

3.4.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

3.4.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

3.4.5 If there are any problems relating to the service provided by the External Auditor then this should, in the first instance, be raised with the External Auditor with a view to be resolved in accordance with the Audit Code. Otherwise it should be referred on to the Audit Committee if the issue cannot be resolved.

3.4.6 Prior approval must be sought from the Audit Committee [WSHFT]: (the Council of Governors may also be notified) for each piece of additional audit work (i.e. work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the Chief Financial Officer is required to authorise expenditure.

3.5 Fraud, Bribery and Corruption

3.5.1 In line with their responsibilities, the Trust Chief Executive and Chief Financial Officer shall monitor and ensure compliance with prevailing guidance from the relevant authority charged by DHSC on the subject of NHS fraud and corruption.

3.5.2 [BSUH]: In addition they will ensure the Trust complies with the NHS Standard Contract in respect of counter fraud and security management and provide commissioners with appropriate assurances.

3.5.3 The Chief Financial Officer is the executive board member responsible for counter fraud and corruption in the Trust.

3.5.4 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist in accordance with prevailing guidance.

3.5.5 The Local Counter Fraud Specialist (LCFS) shall report to the Trust Chief Financial Officer and shall work with staff in NHS Counter Fraud Authority (NHS CFA) in accordance with prevailing guidance.

3.5.6 An LCFS work-plan must be agreed annually; this must include activity relating to the four main NHS CFA standards: Strategic Governance, Inform and Involve, Prevent and Deter, and Hold to Account.

3.5.7 [BSUH]: The Chief Financial Officer/ [WSHFT]: The LCFS shall regularly report progress with the annual work-plan to the Audit Committee.

3.5.8 [WSHFT]: The Chief Financial Officer will consult with the LCFS as to involvement of the police in cases of fraud and corruption and the LCFS will follow the prevailing guidance in this respect.

3.5.9 [BSUH]: Investigations will be carried out where appropriate within the context of the Bribery Act 2010 and the Fraud Act 2006.

3.6 Security Management

3.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with directions issued by the Secretary of State for Health (best practice for FT's) and any guidance from NHSI on NHS security management.

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

3.6.3 The Trust shall nominate a [WSHFT]: Non-Executive Director/ [BSUH]: Executive sponsor to be responsible to the Board for NHS security management.

3.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3.6.5 [BSUH]: The Chief Financial Officer will report progress at least annually to the Audit Committee, on counter fraud and security management activities within the Trust.

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

4.1 Preparation and Approval of Plans and Budgets

4.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Board [WSHFT]: and the Council of Governors an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual 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;

(c) the financial plan for the year;

(d) [WSHFT] such other contents as may be determined by NHSI.

4.1.2 [WSHFT]: The annual plan must be submitted to NHSI in accordance with NHSI's "Risk Assessment Framework" in a format as described in that framework.

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

(a) be in accordance with the aims and objectives set out in the Trust Annual Plan;

(b) accord with workload and manpower plans;

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

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

(e) identify potential risks;

(f) be based on reasonable and realistic assumptions; and

(g) [WSHFT]: enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

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

4.1.5 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

4.1.6 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

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

4.2 Budgetary Delegation

4.2.1 The Chief Executive, through the Chief Financial Officer, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

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

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. Budgets should only be used for the purpose for which they were provided.

4.2.3 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.

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

4.3 Budgetary Control and Reporting

4.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing sufficient information to allow the Board to ascertain the financial performance of the Trust, this may include:

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

(ii) movements in working capital;

(iii) movements in cash and capital;

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

(v) explanations of any material variances from plan;

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

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

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

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

(e) arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

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

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

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan

4.4 Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in SFI 16. Accounting for fixed assets must comply with the prevailing guidance issued by NHSI and DHSC.

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation. The performance figures to the Board should reflect the same figures, though not necessarily in the same format.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Chief Financial Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Treasury, the Trust's accounting policies , international financial reporting standards (IFRS) and prevailing guidance from NHSI and DHSC;

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

5.1.1 The Trust's annual accounts must be audited by an auditor appointed by the [WSHFT]: Council of Governors / [BSUH]: Trust. The Trust's audited annual accounts must be presented to [WSHFT]: the Council of Governors at the Members' annual meeting / [BSUH]: a public meeting and made available to the public.

5.1.2 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it to [WSHFT]: the Council of Governors at the Members' annual meeting / [BSUH]: a public meeting. The document will comply with prevailing guidance issued by NHSI and DHSC.

6. BANK AND GBS ACCOUNTS

6.1 General

6.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. [WSHFT]: This advice will take into account guidance/ directions issued from time to time by NHSI.

6.1.2 The Board shall approve the banking arrangements.

6.2 Bank and GBS Accounts

6.2.1 The Chief Financial Officer is responsible for:

(a) bank accounts and Government Banking System (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

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

(e) monitoring compliance with prevailing guidance on the level of cleared funds;

(f) Ensuring covenants attached to bank borrowings are adhered to.

6.3 Banking Procedures

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

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

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

6.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4 Tendering and Review

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

6.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

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

7.1 Income Systems

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

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

7.2 Fees and Charges

7.2.1 The Trust shall follow the Department of Health and Social Care's advice in relevant prevailing guidance in setting prices for NHS service agreements.

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

Sponsorship – Ethical standards in the NHS, or any successor guidance, shall be followed.

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

7.3 Debt Recovery

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

7.3.2 Income not received should be dealt with in accordance with the losses and special payments procedures.

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

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Chief Financial Officer is responsible for:

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

(b) ordering and securely controlling any such stationery;

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

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

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

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

7.4.4 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.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

8.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions. The Trust will ensure compliance with the Public Contract Regulations 2015 (as may be amended from time to time) and relevant NHS guidance on procurement (including but not limited the Principles Rules for Cooperation and Competition, and the Procurement Guide for Commissioners of NHS-funded Services).

8.2 EU Directives Governing Public Procurement

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

8.3 Reverse eAuctions

8.3.1 In the event that eAuctions are undertaken the Trust should have policies and procedures in place for the control of all tendering activity carried out through such activities. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk/ www.cabinetoffice.gov.uk

8.4 Capital Investment and other Department of Health and Social Care Guidance

8.4.1 Capital investment and estate and property transactions

The Trust shall comply as far as is practicable with the requirements set out in prevailing guidance on capital investment and the management of the Trust Estate in respect of capital investment and estate and property transactions .

8.4.2 Management consultancy contracts

In the case of management consultancy contracts the Trust shall comply as far as is practicable with prevailing guidance on the Procurement and Management of Consultants within the NHS. Any proposal to engage management consultants must be submitted to the Chief Financial Officer in advance for consideration as to whether it represents value for money. The Chief Financial Officer's decision shall be final.

8.5 Formal Competitive Tendering

8.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

8.5.2 Health Care Services

The Public Contracts Regulations 2015 encompass contracting for Healthcare Services and these Standing Financial Instructions shall apply for any tendering procedure for such services and need to be read in conjunction with Standing Financial Instruction No.18 and No.19.

8.5.3 Exceptions and instances where formal tendering need not be applied

As determined by the Chief Executive or nominated officer, formal tendering procedures may not need to be carried out where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set by the Trust;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No.18;

(d) the requirement is covered by an existing locally convened contract resulting from a competitive tender;

(e) National agreements established by NHS Supply Chain and the Government Procurement Service (or equivalent bodies) are in place and have been approved where appropriate by the Board;

(f) a consortium / Hub arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members.

Formal tendering procedures **may be waived** in the following circumstances:

(g) where the requirement is covered by an existing contract;

(h) where Government Procurement Service agreements are in place and have been approved by the Board of Directors;

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

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

(k) where specialist expertise is required and is available from only one source;

(l) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

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

(n) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work;

(o) where allowed and provided for in the requisite capital guidance issued by DHSC and NHSI .

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

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

8.5.4 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 9.1 and 9.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than [WSHFT] three / [BSUH] two firms/individuals (unless demonstrated to be a restricted market), having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.5.5 **List of Approved Firms**

Where appropriate the Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. The approved lists shall not be maintained in contravention of procurement law and guidance and entry onto the approved list shall be open to all providers. Where in the opinion of the Chief Financial Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 9.6.8 List of Approved Firms).

8.5.6 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with CONCODE) without Departmental of Health approval.

All tender processes will be conducted in accordance with the requirements in respect of contracts for Works under Public Contract Regulations 2015 (as may be amended from time to time), EU procurement principles and Department of Health and Social Care guidance on procurement.

8.5.7 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

8.6 Contracting/Tendering Procedure

8.6.1 **eTendering**

[WSHFT]: Where an e-tendering system is not being used to manage the tender process, the following procedure shall apply. Any e-tendering system used shall replicate the level of assurance provided for by the following procedure.

[BSUH]: The Trust has adopted the eSourcing Managed Service eTendering service from Due-North to conduct all tender activities electronically.

8.6.2 **Invitation to tender**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders;

(ii) [WSHFT]: All invitations to tender shall state that no tender will be accepted unless:

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

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

(iii) [BSUH]: No tender shall be considered for acceptance unless submitted through the appropriate process as instructed within the relevant tender document. This will be done electronically using the eTendering service.

(iv) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(v) Every tender for building or engineering works (except for maintenance work, when Estate Code guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with CONCODE; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

8.6.3 **Receipt and safe custody of tenders**

[WSHFT]: The Chief Executive or his/her nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

[BSUH]: An auditable date/time stamp of all actions is automatically created through the eTendering service. This record is available for review in real-time by all staff with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

8.6.4 **Opening tenders and Register of tenders**

[WSHFT]:

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department;

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £1,000,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation. The Trust's company secretary will count as a Director for the purpose of opening tenders;

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender;

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

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department;

The Trust's Company Secretary will count as a Director for the purposes of opening tenders;

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening;

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

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the persons to be involved in the evaluation (this will be cross referenced with the list of declarations of interest);
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Financial Instruction No. 9.6.5 below).

[BSUH]:

The buyer will access the tender once the closing time and date for opening has passed. Once the tender documents are opened the buyer can share them electronically with members of the evaluation panel. This can either be done through the eTendering service or downloaded and sent via email.
An auditable log of actions, which may not be edited, is created including, but not limited to:

Procurement actions:

- Time/ date stamp of 'publication' of tender by buyer.
- Time/date stamp of any amendments to a 'published' tender (e.g. if any buyer tender document attachments are added/ amended during the process).
- Time/date stamp of any buyer messages communicated via the integrated messaging area (including the content, which suppliers received the message

and when it was opened). All messages are delivered in a “blind copy” format to ensure suppliers cannot view who else has received a message.
- Time/date stamp of opening information including (buyer name by time/date stand by individual response envelope).
- Time/date stamp of confirmation of buyer acceptance of supplier bids.
- Time/date stamp of confirmation of buyer acceptance of supplier evaluation scores.
- Time/date stamp of confirmation of buyer award decisions.

Supplier actions:

- Time/date stamp of initial registration within the eTendering service.
- Time/date stamp by supplier of when the specific tender was first accessed.
- Time/date stamp of any supplier messages communicated via the integrated messaging area (including the content, which buyer received the message and when it was opened).
- Time/date stamp of any individual components of a ‘published’ tender accessed (e.g. buyer tender document attachments).
- Time/date stamp of official ‘submission’ of tender response.

8.6.5 **Admissibility**

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.6.6 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

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

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

8.6.7 **Acceptance of formal tenders**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The most economically advantageous tender (MEAT), 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 (for example, evaluation criteria) shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;
(b) understanding of client's needs;
(c) feasibility and credibility of proposed approach; and
(d) ability to complete the project on time.

Where these reasons are applied, in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

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

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;
(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained in an appropriate and suitable facility for inspection. Such retention shall apply to both active and expired contracts.

8.6.8 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8.6.9 **List of approved firms**

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. Suppliers who are not on such lists but are proven to be technically competent to deliver the required goods / services, shall not be precluded from being invited to tender. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

8.6.10 **Exceptions to using approved contractors**

If in the opinion of the Chief Executive and the Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

8.7 Quotations: Competitive and non-competitive

8.7.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure is reasonably expected to exceed £10,000 but not exceed £50,000 including VAT. For income the threshold shall be £5,000. All competitive quotations where the value is reasonably expected to exceed £25,000 excluding VAT shall comply with the relevant DH guidance on transparency. The Trust shall comply with EU procurement principles where contracts are to be awarded outside of a formal tendering process.

8.7.2 **Competitive Quotations**

(i) Wherever possible Quotations should be obtained from at least [WSHFT]: 3 / [BSUH]: 2 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing [BSUH] utilizing the eTendering service unless the Chief Executive or his/her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is

not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

8.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (i) and (ii) of this SFI) apply.

8.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer.

8.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by those staff as identified and recorded by the Chief Executive or nominated officer.

The levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use the NHS Supply Chain for procurement of all appropriate goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Logistics - where tenders or quotations are not required, because expenditure is below £10,000 the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

(c) the Trust shall use National/Collaborative/Locally (competitively tested) contracts/agreements for the procurement of all appropriate goods and

services unless the Chief Executive or nominated officer deem it inappropriate.

8.10 Private Finance for capital procurement

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by [WSHFT] NHSI / [BSUH] Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;
(b) EU Directives and other statutory provisions;
(c) any relevant directions including prevailing guidance on capital investment, the Trust's Estate and guidance on the Procurement and Management of Consultants;
(d) such of the NHS Standard Contract Conditions as are applicable.

Contracts with other Foundation Trusts must be in a form compliant with appropriate NHS guidance.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

8.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. Where required by law, the Trust shall undertake a formal tender process to appointment such employment agencies.

8.13 Healthcare Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with another Foundation Trust, being a Public Benefit Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

8.14 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated Officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DHSC/ [WSHFT] NHSI guidance has been issued but subject to compliance with such guidance.

8.15 In-house Services

8.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering or soft market testing.

8.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated Officer(s) and specialist(s).

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies Officer and a Chief Financial Officer representative. For services having a likely annual expenditure set out in the Scheme of Delegation a non-executive member of the Board should be a member of the evaluation team.

8.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.15.4 The evaluation team shall make recommendations to the Board.

8.15.5 The Chief Executive shall nominate an Officer to oversee and manage the contract on behalf of the Trust.

8.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

These Instructions shall not only apply to expenditure from exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

9. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

9.1 Service Level Agreements (SLAs)

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

9.1.2 All SLAs should aim to implement the agreed priorities contained within the Service Delivery Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

9.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.3 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF OFFICERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

10.1 Appointments and Remuneration

[WSHFT]:

10.1.1 In accordance with the Trust constitution, the Board shall establish an Appointments 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. This will be separate from any committee established by the Council of Governors in relation to the appointment and remuneration of the Chair and other non-Executive directors, and the appointment of the Chief Executive including terms of service.

10.1.2 The Committee will:

(a) advise the Board about appropriate remuneration for the Chief Executive, other officers of the Board employed by the Trust and other senior employees including:
  (i) all aspects of salary (including any performance-related elements/bonuses);
  (ii) provisions for other benefits, including pensions and cars;
  (iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officers of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officers (and other senior employees);

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

10.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

10.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and Officers not covered by the Committee, other than those for which the Council of Governors preside.

10.1.5 The Trust will pay allowances to the Chair and non-Officer members of the Board in accordance with instructions issued by the Council of Governors.

[BSUH]:

10.1.6 In accordance with the Standing Orders, the Board shall establish a Nomination 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.

10.1.7 The Nomination and Remuneration Committee's role is to appoint and, if necessary, dismiss the executive directors, establish and monitor the level and structure of total reward for executive directors, ensuring transparency, fairness and consistency. The terms of reference shall be set out in full in the Rules of Procedure.

10.1.8 The Committee shall receive reports from the Chairman of the Board of Directors on the annual appraisal of the Chief Executive, and from the Chief Executive on the annual appraisals of executive directors, as part of determining their remuneration.

10.1.9 The Trust will pay allowances to the Chairman and non-executive members of the Board of Directors in accordance with instructions issued by the Secretary of State for Health.

10.2 Funded Establishment

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

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

10.3 Staff Appointments

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

(a) unless authorised to do so by the Chief Executive;
(b) within the limit of their approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

10.4 Processing Payroll

10.4.1 The Chief Financial Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

10.4.2 The Chief Financial Officer will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act;
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheque, bank credit, or cash to employees and officers;
(i) procedures for the recall of cheques and bank credits;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash;
(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to

fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

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

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an Officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;
(b) dealing with variations to, or termination of, contracts of employment.

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 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.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;
(b) the maximum level of each requisition and the system for authorisation above that level.

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

11.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

11.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust in line with the Procurement Strategy and Code. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

11.2.2 **System of Payment and Payment Verification**

The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

11.2.3 The Chief Financial Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

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

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

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

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

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

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

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

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

11.2.4 **Prepayments**

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

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

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

(c) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

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

11.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Chief Financial Officer;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");

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

(f) all goods, services, or works are ordered on an official order except purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

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

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

(j) changes to the list of employees and Officers authorised to certify invoices are notified to the Chief Financial Officer;

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

(l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

11.2.7 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE (or any relevant guidance related to the Trust Estate). The technical audit of these contracts shall be the responsibility of the relevant Director.

11.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

11.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

12. EXTERNAL BORROWING

12.1.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the [WSHFT]: risk ratings included within NHSI's Risk Assessment Framework for Foundation Trusts / [BSUH]: within the limits set by the Department of Health and Social Care. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

12.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer.

12.1.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Business Plan and be approved by the Trust Board.

12.2 Investments

12.2.1 Cash surpluses must be held only in such public or private sector investments as [WSHFT]: notified by NHSI and authorised by the Board.

12.2.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.2.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual* is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; the involvement of appropriate Trust personnel and external agencies;
(ii) appropriate project management and control arrangements;

(b) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations in prevailing DHSC guidance related to the management of the Estate.

13.1.4 The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.1.5 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

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

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

(a) specific authority to commit expenditure;
(b) authority to proceed to tender (see overlap with SFI No. 9.6);
(c) approval to accept a successful tender (see overlap with SFI No. 9.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with prevailing DHSC guidance related to the management of the Estate and the Trust's Standing Orders.

13.1.7 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes issued by the Department of Health and Social Care.

13.2 Private Finance

13.2.1 When considering a capital procurement, the Trust should market-test for PFI (Private Finance Initiative funding) unless the Chief Financial Officer considers it inappropriate to do so. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;
(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care or in line with any current guidelines;
(c) The proposal must be specifically agreed by the Board.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified by accounting standards.

13.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets held under a finance lease and capitalised.

13.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the prevailing guidance relating to Capital Accounting issued by the Department of Health and Social Care.

13.3.7 The value of each asset shall be depreciated using methods and rates as specified by accounting standards.

13.3.8 The Chief Financial Officer of the Trust shall calculate and pay capital charges as specified by the NHSI.

13.4 Security of Assets

13.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

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

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

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

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

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

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

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

14. STORES AND RECEIPT OF GOODS

14.1 General position

14.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

14.2 Control of Stores, Stocktaking, condemnations and disposal

14.2.1 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation

being entered in a record available to the Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

14.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

14.2.3 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

14.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

14.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.3 Goods supplied by NHS Supply Chain

14.3.1 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy him/herself that the goods have been received before accepting the recharge.

15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 **Procedures:** The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

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

15.1.4 The Condemning Officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 **Procedures:** The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments in accordance with prevailing guidance and prepare a register.

15.2.2 Any employee or Officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an Officer charged with responsibility for responding to concerns involving loss. This Officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer must inform the relevant LCFS and NHS Counter Fraud Authority regional team in accordance with Secretary of State for Health's directions.

15.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

15.2.4 Within limits delegated to it by the Department of Health and Social Care, the Board shall approve the writing-off of losses.

15.2.5 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.6 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

15.2.7 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

15.2.9 All losses and special payments must be reported to the Audit Committee at every meeting.

16. INFORMATION TECHNOLOGY

16.1 Responsibilities and duties of the Chief Financial Officer

16.1.1 The **Chief Financial Officer**, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

16.1.2 The Chief Financial Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.1.3 The Company Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

16.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.3 Contracts for computer services with other health bodies or outside agencies

16.3.1 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

16.4 Risk Assessment

16.4.1 The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

16.5 Requirements for computer systems which have an impact on corporate financial systems

16.5.1 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:

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

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

(c) Chief Financial Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

17. PATIENTS' PROPERTY

17.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.1.2 The Trust will comply with guidance issued by NHS Counter Fraud Authority.

17.1.3 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; *(notices are subject to sensitivity guidance)*
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

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

17.1.5 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

17.2 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.3 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.4 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18. FUNDS HELD ON TRUST

18.1 Corporate Trustee

18.1.1 Standing Order No. 2.7 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

18.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.1.3 The Chief Financial Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.2 Accountability to Charity Commission and Secretary of State for Health

18.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to funds held on Trust

18.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 9.16).

18.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

19.1 The Chief Financial Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Financial Instructions.

20. RETENTION OF RECORDS

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with latest prevailing guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive. Proper detail shall be maintained of records so destroyed.

21. RISK MANAGEMENT AND INSURANCE

21.1 Programme of Risk Management

21.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board and its delegated committees with responsibility for Risk Management

21.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the risk management programme.

These matters shall be defined in more detail in the Risk Management Strategy. The existence, integration and evaluation of the above elements will assist in providing a basis for the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

21.2 Insurance: Risk Pooling Schemes administered by NHSLA

21.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.3 Arrangements to be followed by the Board in agreeing Insurance cover

21.3.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

21.3.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self- insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.3.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Western Sussex Hospitals NHS Foundation Trust

Brighton and Sussex University Hospitals NHS Trust

Delegated Financial Limits

This document should be read in conjunction with the Trust constitution, Standing Financial Instructions and the supporting notes on the following page.

Nothing in this document should be taken as obviating the need for sound financial control and budgetary management.

Where ✓ is shown this means that no upper financial limit to the delegated authority from the Trust Board. In all cases the additional information column should be reviewed to identify any additional criteria that must be complied with.

				Committees/Groups					Role within Trust											Finance Directorate (see Note d)																Other Directorates (see Note d)		
	Action	Additional Information	Council of Governors	Trust Board	Finance and Performance Committee	Remuneration Committee	Charitable Funds Committee	Trust Executive Committee	Chief Executive	Chief Financial Officer	Finance Director	Executive Team Directors (see Note a)	Trust & Group Directors (see Note b)	Director / Chief of Service (see Note b)	Deputy Director	Assistant Director/ Associate Director	Head of Service	Care Group Manager	Budget Holder	Non Budget Holder (See Note c)	Deputy Director of Finance	Assistant Director of Finance (Income)	Assistant Director of Finance	Asst Director of Commissioning	Finance Manager (Income)	Finance Analyst (Income)	Head of Financial Systems	Financial Services Manager	Financial Services Team Leader	Head of Procurement	Deputy Head of Procurement	Divisional Proc Lead	Ad-Hoc Buying/ Materials Mgt Team Leaders	Buyer/ Proc Systems TLI Materials Mgt Officer	Capital Development Director	IMT Director	Head of Charity Operations
Budget Setting	Review and Recommendation of Annual Budget		*Note 1*		✓			✓																													
	Approval of Annual Budget		*Note 1*	✓																																	
Procurement of Goods and Services	Authorise a tender waiver	Subject to EU Public Procurement Directives	*Note 2* *Note 3*						✓	✓	✓																											
	Award a legal contract	Subject to Public Procurement Regulations AND Compliance with Trust requirements for formal quotations and tenders (see note e) AND Appropriate budgetary approval, in line with delegated financial limits, being in place prior to award	*Note 2* *Note 3*	£3,000,000 and above	£1,000,000 - £3,000,000			up to £1,000,000	≤£500,000	≤£500,000	≤£250,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £5,000	≤ £200									≤ £50,000	≤ £50,000						
	Granting and Termination of Leases	Total cost for primary lease period		£3,000,000 and above	£1,000,000 - £3,000,000			up to £1,000,000	≤£500,000	≤£500,000	≤£250,000																											
	Authorise a requisition	Within budget (subject to contract award and tender waiver limits above)							≤£500,000	≤£500,000	≤ £250,000	≤ £100,000	≤ £50,000	≤ £50,000	≤ £30,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £5,000	≤ £200																	
	Authorise a purchase order									✓	✓																		✓	≤ £250,000	≤ £100,000	≤ £50,000	≤ £25,000				
	Authorise a non purchase order invoice	For defined exceptions to PO requirement AND Within budget							≤£500,000	≤£500,000	≤ £250,000	≤ £100,000	≤ £50,000	≤ £50,000	≤ £30,000	≤ £10,000	≤ £10,000	≤ £10,000	≤ £5,000	≤ £200																	
	Authorise spend against a charitable fund	Must be an authorised signatory for fund in question		≥ £50,000			< £50,000		< £2,500	<£10,000	<£10,000	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500																		
Capital	Review and recommendation of Capital Programme		*Note 1*		✓			✓																													
	Approval of Capital Programme		*Note 1*	✓																																	
	Virement of approved capital budgets	Subject to requirements set out in Virement Policy						✓		✓	✓																								≤ £150,000	≤ £150,000 (for IT capital)	
	Acquisition of land and property		*Note 2*	✓																																	
	Disposals of land and property		*Note 2*	✓																																	
	Disposals and condemnations of equipment	Based on estimated current market value							✓	✓	✓	<£1,000	<£1,000	<£1,000	<£1,000	<£1,000	<£1,000	<£1,000	<£1,000																		
Charitable Funds	Authorise spend against a charitable fund	Must be an authorised signatory for fund in question		≥ £50,000			< £50,000		< £2,500	<£10,000	<£10,000	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500	< £2,500																		
	Signing cheques (charitable funds)	Where these are not part of an automated payment run AND Countersignatory required for amounts over £1,000							✓	✓	✓										✓		✓														✓
	Set-up a Charitable Fund									✓	✓										✓		✓														
Pay Related Activity	Approval annual staffing (WTE) plan		*Note 1*	✓																																	
	Authority to fill or advertise a funded post		*Note 5*						✓	✓	✓	✓	✓	✓																							
	New Starters								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Contractual Changes								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Leavers								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Attendance Returns								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Timesheets								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Travel and Subsistence Claims								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Severance Business Cases	Subject to DH delegated limits				✓																															
	Compromise Agreements	Subject to DH delegated limits				✓																															
Business Cases	Approve a business case	Total value of business case over project term	*Note 2*	£3,000,000 and above	£1,000,000 - £3,000,000			up to £1,000,000																													
	Authorisation of New Drugs	Also requires approval from Drugs and Therapeutics Committee Estimated cost per annum										≥ £25,000	<£25,00	<£25,000																							
Income	Invoice Request/Sales Order Request for Non Contract Invoice								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																	
	Invoice Request/Sales Order Request for Contract Invoice	Invoiced sums to be covered by approved SLA or Contract							✓	✓	✓										✓	✓	✓	✓	✓	✓											
	Authorise the raising of a credit note	See note f for definition of credit note vs debt write-off								✓	✓										✓	≤ £500,000		≤ £50,000	≤ £50,000		≤ £500,000	≤ £50,000	≤ £1,000								
	Authorise a debt write-off	See note f for definition of credit note vs debt write-off	*Note 2*		≥ £50,000					< £50,000	< £5,000										≤ £1,000																
	Authorise submission of expression of interest								✓	✓	✓	✓	✓	✓																							
	Authorise submission of a bid	Chief Exec and DoF may authorise in exceptional circumstances only where timings genuinely preclude consideration by Exec Team AND subject to business case approval if required						✓	✓	✓	✓																											
	Sign a legal contract	Subject to business case approval if required							✓	✓	✓										≤ £500,000	≤ £500,000		≤ £500,000													
	Sign a service level agreement	Subject to business case approval if required							✓	✓	✓										≤ £500,000	≤ £500,000		≤ £500,000													
	Agree variations to a contract or service level agreement	Subject to business case approval if required							✓	✓	✓										≤ £500,000	≤ £500,000		≤ £500,000													
	Setting of fees and charges	Items not subject to National Tariff								✓	✓										✓	✓															
Banking and Cash	Authorisation of Payment Runs (BACs, Cheque or RFT)	Individual payment run items to be have been authorised in line with parameters in Procurement of Goods and Services section								✓	✓										✓		✓				✓										
	CHAPS or Faster Payment	Expenditure to have been authorised in line with delegated financial limits								✓	✓										✓		✓				✓										
	Opening Bank Accounts									✓	✓																										
	Signing cheques (exchequer funds)	Where these are not part of an automated payment run AND Expenditure to have been authorised in line with delegated financial limits AND Countersignatory required for amounts over £5,000 or amount over £500 where cheque is made payable to cash							✓	✓	✓										✓		✓				✓	✓									
	Approval of Loan Applications	Subject to Cash Management Policy	*Note 2*	✓																																	
	Investment of Funds	Subject to Cash Management Policy	*Note 2*							✓	✓										✓		✓														
	Petty Cash								< £50	✓	✓	< £50	< £50	< £50	< £50	< £50	< £50	< £50	< £50		✓						✓										
	Return of Patients' Monies	Previously formally deposited by Trust							< £500	✓	✓	< £500	< £500	< £500	< £500	< £500	< £500	< £500	< £500	< £500	✓						✓										
Losses and Special Payments	Ex-Gratia, Extra-contractual payments and Fruitless Payments	Includes settlements recommended by PHSO	*Note 2*	>£5,000						≤ £5,000	≤ £5,000										≤ £1,000		≤ £1,000														
	Payments made under legal obligation for clinical negligence and personal injury claims	Includes settlements negotiated by NHSLA								✓	✓										≤ £30,000		≤ £30,000														
	Debt Write-off and Claims Abandoned	See note f for definition of credit note vs debt write-off	*Note 2*		≥ £50,000					< £50,000	< £5,000										≤ £1,000		≤ £1,000														

Western Sussex Hospitals NHS Foundation Trust

Brighton and Sussex University Hospitals NHS Trust
Delegated Financial Limits - Notes

Note 1: In approving forward plans, the trust board must have regard to the views of the Council of Governors

Note 2: Significant transactions must be approved by the Council of Governors

Note 3: Limits must take into account total value of contract awards made within the last 12 months and known future award recommendations within the next 12 months

Note 4: items that might be considered sensitive or have a reputational risk must be approved at Trust Board

Note 5: The Council of Governors appoint the Chair and Non-Executive directors and approve the appointment of the Chief Executive

Note a: Executive Team Directors means a member of the Trust Board

Note b: Trust Director means HR Director, Nursing Director, Medical Director. Group Director means those Director roles that form part of the management contract between WSHT and BSUH. Director includes Divisional Directors and other Director roles that report to an Executive Director

Note c: Section Heads must be identified and authorised by the relevant budget holder

Note d: These sections identify authority that is delegated to specific posts within the organisation. This authority is in addition to any authority delegated to a role of the same level in the section "Roles within the Trust"

Note e:

Value of Goods/ Services	**Quotation/Tender Requirements**
< £10,000	No formal quotations required but should be able to demonstrate that value for money has been considered, proportionate to the value of the contract
£10,000 - £49,999	Minimum of 3 written quotes
≥ £50,000	Competitive Tenders

Note f: A credit note is issued where there has been an error in the original invoice e.g the wrong customer has been invoiced, the wrong price has been charged or the customer did not receive the goods or services.

A debt write-off occurs where the original charge is correct but debt recovery will not be pursued e.g. the Trust wishes to waive part of the charge, debt recovery is considered uneconomic or the customer cannot be traced or has insufficient funds.

NHS
Western Sussex Hospitals
NHS Foundation Trust

Agenda Item:	3.1	**Meeting:**	Board	**Meeting Date:**	24 April 2019
Report Title:	**WSHFT Risk Management Strategy**				
Sponsoring Executive Director:	George Findlay, Chief Medical Officer				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:					

Purpose of the report:			
Information	☐	Assurance	☐
Review and Discussion	☐	Approval / Agreement	✓
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	☐	Staff confidentiality	☐
Patient confidentiality	☐	Other exceptional circumstances	☐
Link to Trust Strategic Themes:			
Patient Care	✓	Sustainability	✓
Our People	✓	Quality	✓
Systems and Partnerships	✓		

Any implications for:	
Quality	
Financial	
Workforce	

Link to CQC Domains:			
Safe	✓	Effective	✓
Caring	✓	Responsive	✓
Well-led	✓	Use of Resources	✓

Communication and Consultation:

Executive Summary:

Introduction

An effective governance framework relies on a robust system for managing risk. In support of this the Trust has developed risk management structures, systems and processes that will ensure that the Trust meets its strategic and operational objectives and delivers safe, sustainable, high quality care.

The Trust has codified this within its Risk Management Strategy which sets out the Trust's approach to risk management which includes the identification assessment, reporting and management of risk. The Strategy also defines the contribution to be made by key parts of the Trust's governance structures. By managing risk effectively, the Trust aims to:

- ensure that risk management is an integral part of open culture
- identify risks to achieving the Trust's objectives requiring intervention, and
- drive a standardised, strategic, and accessible approach to risk management

It should be noted that the Strategy defines the Trust's risk appetite which will allow the Trust to maximising opportunities to achieve objectives, as well as reducing risks.

Risk Appetite

When the Risk Management Strategy includes the Board's stated risk appetite which was developed in September 2018. (this is reproduced for ease of review as an appendix to this report).

The Board have used this appetite statement when determining target scores for the board Assurance Framework and in reviewing significant business developments. The Board over 2018/19 found this statement to be clear and relevant to the delivery of the Trust's objectives.

Update

At the end of March 2019 the Trust Board approved revisions to two of its Committee's terms of reference, these being that the Quality Risk Committee would become the Quality Assurance Committee and the Finance and Investment Committee would become the Finance and Performance Committee from April 2019.

The attached Risk Management Strategy has been updated to reflect these changes (within table 1 and appendix 3)

Key Recommendation(s):

The Board is recommended to consider and endorse there is no change to the Risk Appetite statement included within the Strategy that was developed in 2018

To Board is recommended to approve the Risk Management Strategy.

Appendix A

Risk Appetite Statement

The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Western Sussex Hospitals NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

Patient Care: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

> We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

Safety: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

> We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

> We have a **low** appetite for risks that may jeopardise patient safety.

> We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

> We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

Sustainability: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

People: We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

Systems and Partnerships: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

Western Sussex Hospitals
NHS Foundation Trust

RISK MANAGEMENT STRATEGY

Version:	8
Status:	Update to Risk Management Strategy v 9
Category and number:	P5
Approved by:	Trust Executive Committee Board
Date approved:	September 2018
Name of author:	Interim Group Company Secretary
Name of responsible committee/individual:	Chief Medical Officer
Date issued:	December 2018
Review date:	December 2021
Target audience:	All staff including: Governors, Executive and Non-Executive Directors, Clinical Divisions, Corporate Directorates and Divisional Management Teams
Accessibility	This document is available in electronic format only
Linked documents	Risk Management Policy Incident Management Policy Complaints Policy

Reference Number:	S1

Version	**date**	**Author**	**Status**	**Comment**
1.0	March 2010	Deputy Director of Nursing	Archived	Strategy updated in relation to the changes in Governance Structures and setup of the Trust Board's Sub-Committees.
2.0	February 2011	Company Secretary	Archived	Annual review of Strategy. Updated to reflect current practice and plans for development
3.0	December 2011	Deputy Company Secretary	Archived	Governance Structure updated to include new Quality Standards Group.
4.0	March/April 2012	Company Secretary	Archived	
5.0	September 2012	Company Secretary	Archived	Section 8 amended and references to Committees reviewed
6.0	January 2013	Company Secretary and Director of Nursing & Patient Safety	Archived	Regular review
7.0	July 2015	Company Secretary	Archived	Full review explicit reference to risk appetite and BAF
8.0	September 2018	Interim Company Secretary	Archived	Update for change in names of two committees (finance and performance and quality assurance committee) plus reconfirmation of Board's risk appetite
9.0	April 2019	Group Company Secretary	Live	

Table of Contents

1 Introduction

1.1 The Board of Western Sussex Hospitals NHS Foundation Trust (WSHFT) is committed to ensuring that risks to the quality, safety, effectiveness and sustainability of it services are identified and managed so that they are reduced to an acceptable level or eliminated as far as reasonably practicable. This Risk Management Strategy sets out the Trust's intentions and approach to risk management. It should be read in conjunction with the Trust's Risk Management Policy which sets out the methods and responsibilities for delivering this strategy.

1.2 The successful management of risk in all aspects of the Trust's business and by all those working within the Trust is fundamental to delivering the Trust's strategic and operational objectives. It also ensures the Trust is resilient and able to deal with unanticipated exposure to risks that could threaten our success. Therefore, the Trust will ensure that effective risk management is an integral part of everyday working practice in all aspects of the Trust's business as part of its overarching strategy and approach to delivering its strategic objectives.

1.3 The Trust is committed to an integrated risk management system, which incorporates all aspects of risk including strategic, clinical, financial, workforce, infrastructure, health and safety, operational, compliance and reputational risk.

1.4 The Trust's governance framework relies on a robust system for managing risk. This strategy describes how the Trust's risk management structures, systems and processes will ensure that the Trust meets its strategic and operational objectives and delivers safe, sustainable, high quality care. This will involve maximising opportunities to achieve objectives, as well as reducing risks.

1.5 The strategy sets out the Trust's approach to risk management which will include the identification assessment, reporting and management of risk. It defines the contribution to be made by key parts of the Trust's governance structures. By managing risk effectively, the Trust aims to:

- ensure that risk management is an integral part of open culture
- identify risks to achieving the Trust's objectives requiring intervention, and
- drive a standardised, strategic, and accessible approach to risk management

1.6 In addition to this Risk Management Strategy there are a range of policies that support the identification and management of risk within the Trust. These include the following policies:

- Risk Management Policy
- Incident Management Policy
- Complaints Policy

2 Scope

2.1 The risk management approach described in this strategy applies to all areas and activities of the Trust and to all individuals working within the Trust. The Trust will work in partnership with its staff, service users and stakeholders to ensure it takes a comprehensive approach to risk management and that all opportunities for the identification and management of risk are fully exploited including risk management approaches that can only be delivered in partnership with others.

3 Risk Management approach

3.1 Risk is inherent in all the Trust's activities: for example, treating patients, determining service priorities, project management, record-keeping, communication, staffing, service design, and setting strategy. Equally, there is also risk associated with not taking any action at all.

3.2 The Trust supports a dynamic and proactive approach to risk management, with the aim of identifying and managing potential threats and hazards before adverse events occur. The identification and assessment of risk should be seen as opportunities to improve care quality.

3.3 The Trust's strategy for the management of risk is to integrate the identification, assessment, and control of risk into all areas of the Trust's business so that risk is routinely identified by all staff and appropriate action is taken to reduce risks to acceptable levels. The Trust will support all staff to take an active role in the identification and management of risk and to take responsibility for the health, safety, and wellbeing of patients, visitors, staff and others accessing and using the Trust's facilities and services. This approach will also enable staff to make an active contribution to the management of risks associated with the delivery of services in line with the NHS Constitution, and with the delivery of the Trust's objectives.

3.4 While the Trust Board carries overall responsibility for risk management, the key to success is local leadership. The Trust's divisional structure is fundamental to the risk management system, and divisional leaders and their teams will work with colleagues holding specialist Trust-wide governance remits, and the Trust's Executive directors to ensure it is successfully implemented.

3.5 It is the responsibility of all staff to identify risk and report concerns that may affect the quality, safety and effectiveness of service provision. The Trust aims to work in partnership with staff and support them with their responsibilities by creating a culture of openness and willingness to admit mistakes. The Trust is committed to learning from mistakes, incidents, near misses, complaints and claims and using this learning to improve systems. The Trust is committed to a just culture where the reporting of incidents and concerns is encouraged and staff are supported in delivering their responsibilities for safe care.

3.6 This strategy sets the objectives for risk management within the Trust as follows:

- to take all reasonable and appropriate steps in the management of risk in order to protect patients, staff, the public, its assets and reputation
- to meet statutory, regulatory and legal obligations
- to develop and maintain an effective system to identify, assess, manage and review

risks across the Trust
- to offer staff appropriate training and support in the principles and practice of risk assessment and management
- to provide assurance to the Board via the Audit Committee regarding the effectiveness and robust implementation of the Risk Management Policy and its associated systems and processes
- to manage risk within the risk appetite that has been agreed by the Trust Board

4 Risk Management System

4.1 The risk management system will be an integral part of the Trust's framework for assuring and delivering good governance. It will enable the Trust to identify and monitor risks to its strategic objectives, supports the appropriate management and escalation of these risks and informs the Board whether the systems and process in place are providing effective controls and assurances.

4.2 The key components of the Trust's risk management system will be the risk appetite statement, the Board Assurance Framework, the Corporate Risk Register and local risk registers. The production of these components is supported by the Trust's risk management processes

Risk Appetite Statement

4.3 Risk appetite can be defined as the amount of risk or the level of potential impact that an organisation is willing to accept in pursuit of the achievement of its strategic aims and objectives. Risk appetite therefore is at the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

4.4 The amount of risk an organisation is willing to accept can vary from one organisation to another and between one type of risk and another depending upon the specific organisational and risk circumstances. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

4.5 In order to transfer, treat, terminate, or tolerate risks those staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the Trust's Board

4.6 The risk appetite of the Trust will be defined by the Board. The Board will make a decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, the Trust's risk appetite will address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

4.7 Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and should be used to determine the target risk rating throughout the risk management

process.

Risk Appetite

4.8 The following risk appetite levels, adapted from those developed by the Good Governance Institute (see Appendix 1), form the background to the Board's discussion and decision when defining the Trust's risk appetite. Using this model as guidance the Trust Board will agree an appetite statement that aligns to the Trust's strategic aims. The statement should be then be considered when assessing risk target and tolerances in the Board Assurance Framework, Corporate and Local (Divisional) Risk Registers.

Appetite Level	Description:
None	Avoid: There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low	Minimal: There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	Cautious: There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.
High	Open: There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.
Significant	Seek: There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is Mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

Risk Appetite Statement

4.9 The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Western Sussex Hospitals NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

4.10 The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

4.11 Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

4.12 **Patient Care**: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is

required to achieve patient safety and quality improvements.

4.13 We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

4.14 **Safety**: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

4.15 We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

4.16 We have a **low** appetite for risks that may jeopardise patient safety.

4.17 We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

4.18 We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

4.19 **Sustainability**: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

4.20 We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

4.21 We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

4.22 We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

4.23 We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

4.24 **People:** We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their

roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

4.25 We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

4.26 We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

4.27 We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

4.28 We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

4.29 We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

4.30 **Systems and Partnerships**: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

4.31 We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. . A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

4.32 We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

Risk Tolerance

4.33 Risk 'tolerance' is the minimum and maximum risk the Trust is willing to accept as reflected in the risk appetite themes above. All risks with a total risk score of 12 and above and those with a consequence/impact score of 5 will be considered as Corporate Risks and as such require executive oversight by the Trust Executive Committee (TEC). TEC will be responsible for ensuring that Corporate Risks are managed and controlled in accordance with the risk appetite defined by the Board and with the Risk Management Policy.

Board Assurance Framework

4.34 The Board Assurance Framework (BAF) will set out the strategic risks which may threaten the achievement of the Trust's strategic objectives. It will enable the Board to monitor progress in achieving the strategic objectives, attend to key accountability issues, ensure the right issues are debated and that remedial actions are taken to reduce risk, strengthen controls and assurances. All NHS bodies are required to sign a full Annual Governance Statement, and must have the evidence to support this. The BAF brings together a significant part of this evidence

4.35 The BAF will be designed to assess the strength of the internal control measures that are intended prevent these risks occurring and to identify and evaluate sources of assurance. It supports the identification of gaps in control and assurance and enables the Board to monitor progress on the actions being taken to address these gaps.

4.36 The BAF will also describe the assurances and sources of assurance the Board has agreed are necessary to assess the achievement of the Trust's strategic objectives, and will thus drive the cycle of Board and Board Committee work and reporting to the Board.

4.37 The BAF also describes the controls that the Trust's Executive must ensure are effective in order to manage strategic and operational risks and to assess that the adequacy and strength of these controls are aligned to the Board's risk appetite for individual strategic risks.

4.38 The BAF will be regularly review by the Board, Board Committees and TEC as determined by their roles and responsibilities set out in Section 7 and defined in the Risk Management Policy.

4.39 The assurance alignment within the Trust is shown diagrammatically by Good Governance Institute, see Appendix 2.

Corporate Risk Register

4.40 The corporate risk register (CRR) will be comprised of all risks with a score of 12 or above or that has an impact score of 5, and will be compiled from divisional and corporate directorate risk registers. It will be the key tool for the management of risk and will be informed by the Trust's risk escalation process.

4.41 The CRR will be routinely reviewed by TEC and the Management Groups as determined by their roles and responsibilities as set out in their Terms of Reference. This will ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk
- these actions have been effective in reducing the risk level
- risks to strategic objectives are identified
- gaps in control are identified and included in the BAF
- the ongoing integrity of the risk management system

4.42 In addition the CRR will be routinely reviewed by the Audit Committee in order to assess the adequacy and effectiveness of the Trust's risk management systems and processes so that the Committee can provide the relevant assurance to the Board.

4.43 The Audit Committee will also assess whether the linkages between the CRR and the BAF are robust and enable the Board to effectively identify gaps in control and assurance. Risks on the CRR may indicate a gap in control or identify that the Board is receiving inadequate, insufficient or incomplete assurances.

Local Risk Registers

4.44 The local Risk Registers (RR) will be held at divisional and corporate directorate level and are the mechanism and management tool through which identified risks, controls and actions to mitigate or manage risks are recorded, monitored and managed. RR will follow the same format as the CRR.

4.45 Divisional RR will be routinely reviewed and monitored through the divisional governance structure. Corporate directorate RR will be routinely reviewed and monitored by Executive Directors and their teams.

4.46 In addition the CRR and RR will be reviewed as required by TEC and Management Groups to ensure consistency between all RR in the identification, assessment and rating of risks and to ensure effective management action is being taken to mitigate and control risks.

5 Risk management processes

5.1 The Trust's risk management processes will be described in the Risk Management Policy and will be determined in line with NHS and regulatory requirements and best practice. They will govern how risk is contextualised, identified, analysed for likelihood and impact, prioritised and managed and how risks will be communicated, reported, recorded, monitored and reviewed.

5.2 The Trust's risk management processes will ensure that risk is identified from a wide range of sources both proactively (for example through audit or assessment of provision against clinical guidelines) and reactively (for example through complaints, incidents and claims).

5.3 The Trust will manage identified risk through one of the following approaches:

- **Treat**: control or reduce by taking action
- **Terminate**: remove altogether by stopping practices, or
- **Tolerate**: accept where appropriate and in line with risk appetite
- **Transfer**: move to another organisation or service

6 Governance Structure

6.1 The Trust's governance structures will support the ward to Board management of risk throughout the organisation. The Trust's Governance structure is set out in Appendix 3.

6.2 The Board's is responsible for setting the objectives and strategy for risk management, setting the Trust's risk appetite and assessing the outputs and outcomes of the Trust's Risk Management Systems to ensure that they deliver appropriate levels of assurance

and demonstrate that the risks to the Trust's strategic objectives are being effectively managed and controlled The Board delegates some of its responsibilities to its Committees as described below. The BAF is the key tool used by the Board in fulfilling its responsibilities.

6.3 The Trust's management structures will have the responsibility to ensure risk is managed and controlled in line with the Trust's Risk Management Strategy and Policy. Gaps in control will be identified through the management structures, and actions to strengthen controls or address gaps in control will be defined and monitored.

6.4 TEC will be the principal governance forum for the management of risk and will delegate some of its responsibilities to other management groups in order to ensure appropriate levels of scrutiny and action to manage risk. The Risk Management Policy CRR and RR will be the key tools used by the Executive and Trust managers in fulfilling their responsibilities.

6.5 Assurances on the effectiveness of the Trust's risk management system will be developed through the Trust's management systems and will be assessed and scrutinised by the Board and its Committees. The Board and TEC will agree the format and content of management and Board reporting that supports the provision of robust assurance.

Risk escalation

6.6 In order to successfully monitor and manage operational and strategic risk it is essential that high risks, areas of escalating risk, gaps in control and delays in implementing actions to strengthen controls or address control gaps are escalated through the risk management governance structure. The risk escalation process will be described in the Risk Management Policy. In addition to regular reporting to provide assurance it is expected that all component parts of the Trust's risk management governance structure will identify and escalate risks in a timely manner, reporting concerns to ensure awareness and the implementation of strengthened actions.

Learning from the management of risk

6.7 The Trust is committed to continuously developing as a learning organisation and ensuring that it can learn from the outcomes and processes of its risk management system. Learning will include the identification of improvement actions that will enable incremental improvement in the effectiveness of the risk management system, the implementation of effective controls and risk mitigations and the development and delivery of assurance. Learning opportunities will be identified throughout the Trust's risk management process and highlighted to the Board. Plan for risk management improvement will be incorporated into the Risk Management Strategy, Policy and practice.

7 Organisational responsibilities

7.1 In line with the governance structure illustrated in Section 6, Table 1 below describes the key responsibilities of the Board and its Committees. Table 2 describes the roles and responsibilities of the Trust's key management groups for the delivery of the Trust's risk management systems and processes and the development of assurances in relation to the management.

8 Strategy Implementation and monitoring

8.1 The Trust's Risk Management Strategy will be implemented through the mechanisms described in Section 7 and through the Risk Management Policy. The Board will review the Risk Management Strategy at least annually making any changes required to reflect national and regulatory standards, best practice and learning and improvement opportunities identified by the Trust including through internal or external reviews the of risk management systems.

Table 1: Responsibilities of the Board and Board committees

Group and responsibilities
The **Trust Board** is accountable for • Agreeing the Trust's Risk Management Strategy • Agreeing the key risks to the achievement of the Trust's strategic objectives • Agreeing the Trust's risk appetite in relation to the strategic objectives and the types of risk1the trust is managing • Agreeing the BAF; defining the controls, assurances and gaps in control and assurance for each of the key risks that will be the focus of the Board's assurance assessment activity • Ensuring the BAF informs the business of the Board and drives the Board agenda • Scrutinising and testing the assurances received on the effectiveness of controls and actions to address gaps in control through the annual cycle of business • Challenging the risk controls and sources of assurance described within the BAF to ensure they are effective and robust • Considering the wider strategic implications of the risks identified, and making recommendations to improve management of risk by taking a strategic corporate approach
The Board delegates responsibility to the **Audit Committee** for**:** • Assessing the quality and strength of the assurances received on the Trust's risk management, quality and financial governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) and that this supports the achievement of the Trust's objectives • Testing the integrity and completeness of the risk management system through reviewing the strength of operational and strategic risk management and internal control. • Assessing the accuracy, adequacy of the assurances provided on the effectiveness of controls and the actions being taken to address gaps in control processes that indicate the effectiveness of the management of principle corporate and clinical risks. • Identifying gaps in assurance, assessing the adequacy and robustness of the actions being taken to address these gaps and the progress being made to close them • Regularly reviewing and testing the contents of the BAF, CRR,and local RRs in pursuit of the above responsibilities • Regularly reviewing and testing the contents of the Trust's Risk Management Strategy, Risk Management Policy and associated policies in pursuit of the above responsibilities. • Ensuring there is independent scrutiny of the Trust's risk management and governance systems and processes and of the strength and adequacy of related assurances through internal and external audit work programmes • Making recommendations to the Trust Board on the development and implementation of the Risk Management Strategy and Policy • Reviewing and testing all risk and control-related disclosure statements (e.g. the Annual Governance Statement) to provide assurance to the Board that they are accurate and adequate. • Reviewing the Trust's Risk Management Annual Report, and agree recommendations on actions for improving the Trust's risk management systems and processes

The Board delegates responsibility to the **Quality Assurance Committee** for

- Assessing the quality and strength of the assurances received on the Trust's quality and clinical governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of quality and clinical governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives
- Testing the integrity and completeness of the quality governance system through reviewing the strength of operational and strategic management and internal control of quality and clinical risks.
- Assessing the accuracy and adequacy of quality reporting and the assurances developed through the Trust's quality management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic;
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Assessing the effectiveness of the controls implemented through the Trust's quality management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic
- Escalating concerns about areas of inadequate control to the Board
- Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for quality improvement
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Reviewing and testing all clinical and quality related statements (e.g. the Quality Account) to provide assurance to the Board that they are accurate and adequate.
- Making recommendations to the Trust Board on the development and implementation of the Quality Strategy
- Regularly reviewing and testing the contents of the Quality Improvement Plan, Clinical Governance Annual Report and associated policies in pursuit of the above responsibilities.

The Board delegates responsibility to the **Finance and Performance Committee** for**:**

- Assessing the quality and strength of the assurances received on the Trust's financial and operational performance governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of financial and operational performance governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives
- Assessing the accuracy and adequacy of financial reporting and the assurances developed through the Trust's financial management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic objectives
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Assessing the effectiveness of the controls implemented through the Trust's financial management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic
- Escalating concerns about areas of inadequate control to the Board
- Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for financial improvement
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Reviewing and testing all financial statements (e.g. the Financial Accounts) to provide assurance to the Board that they are accurate and adequate.
- Reviewing and testing the reported performance of the Trust to provide assurance that the information reported is accurate and adequate.
- Making recommendations to the Trust Board on the development and implementation of the Trust's Financial Strategy

Table 2: Responsibilities of the Trust's management groups and divisions

The **Trust Executive Committee** is responsible for**:**

- Ensuring the effective identification, evaluation and management of operational and strategic risk in all aspects of the Trust's business and providing effective and proactive leadership of risk management within the Trust by implementing the Trust's Risk Management Strategy and Policy and the associated framework of processes, procedures and controls that enable risks to be managed directly and through delegated powers and ensure the Trust meets its strategic objectives
- Ensuring the Trust's Risk Management Strategy and Policy and the annual risk management improvement plan are developed, regularly reviewed and updated taking into account recommendations for improvement arising from internal and external scrutiny and recommending these to the Board for approval.
- Developing and providing assurance to the Board and its Committees on the effectiveness of the Trust's risk management systems
- Reviewing the local RR, CRR and Board Assurance Framework routinely to ensure risks and controls are described clearly and accurately, rated consistently, and managed appropriately to reduce risks to the agreed target level. Recommending the BAF to the Board for approval.
- Identifying gaps in assurance or control and ensuring actions to address these gaps are agreed and delivered in a timely fashion to make the necessary improvements, taking action as required to address delays and enable and support successful delivery
- Escalating risks, gaps in control or gaps in assurance to the Board
- Promoting continuous quality improvement with regard to the management of clinical and non-clinical risk and the control environment throughout the Trust by examining and challenging action plans developed to control risks, and assessing their wider impact.
- Assessing the quality and strengths of the assurances developed through the Trust's quality management system and its sub-groups to provide evidence of the effectiveness of quality risk management within the Trust, taking action to strengthen assurances as required
- Assessing the quality and strengths of the assurances developed through the Trust's performance management system to provide evidence of performance risk management within the Trust, taking action to strengthen assurances as required
- Assessing the quality and strengths of the assurances developed through the Trust's financial management system to provide evidence of financial risk management within the Trust, taking action to strengthen assurances as required
- Considering the wider strategic implications of risks and themes arising, and opportunities to improve management of risk by taking a corporate approach
- Delegating powers for the management of risk to the appropriate management groups as set out in their approved Terms of Reference.

Appendix 1: Risk Appetite for NHS Organisations

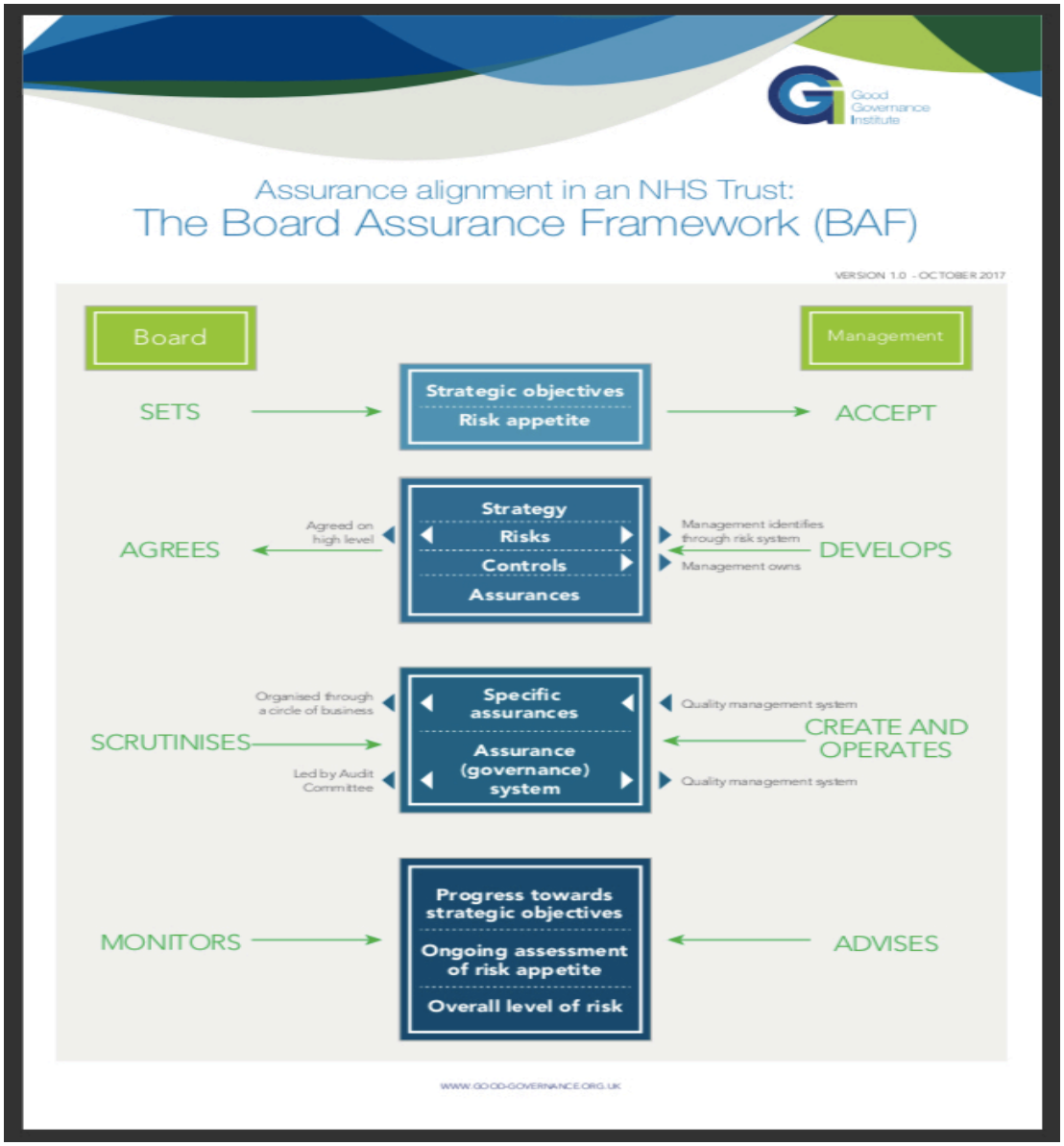
Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

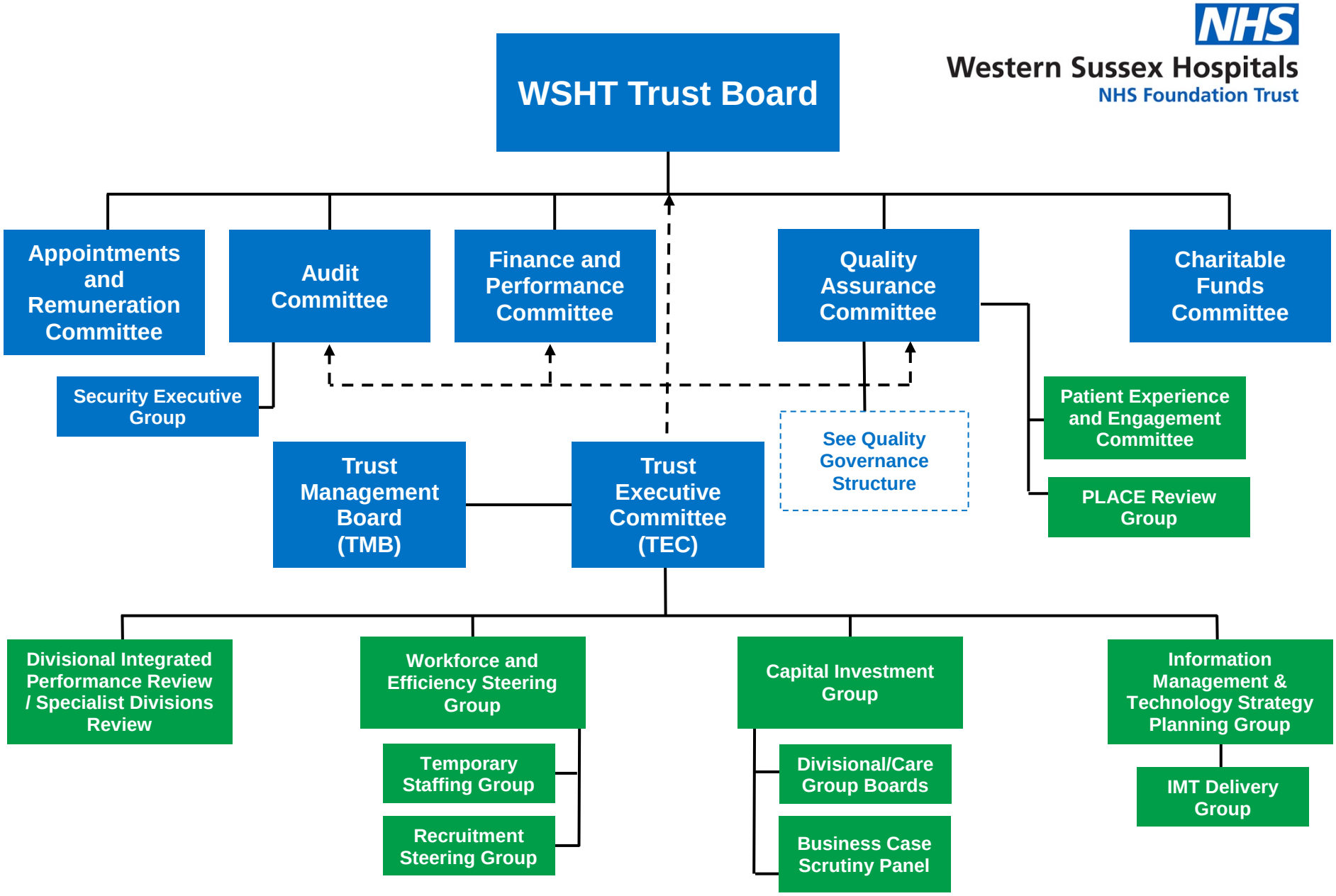
Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 2: Assurance Alignment in an NHS Trust – Board Assurance Framework

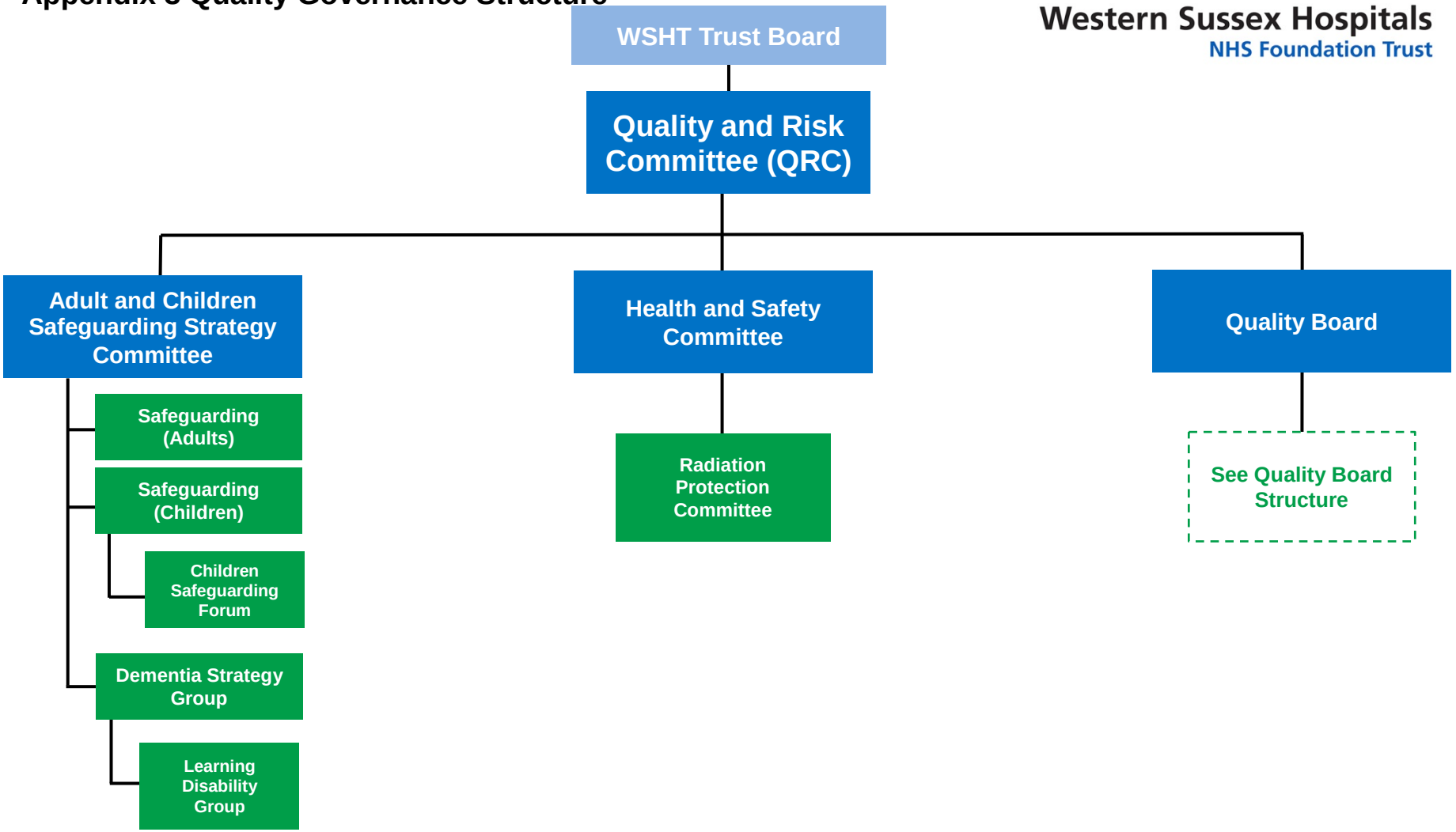


Appendix 3: Governance Structures



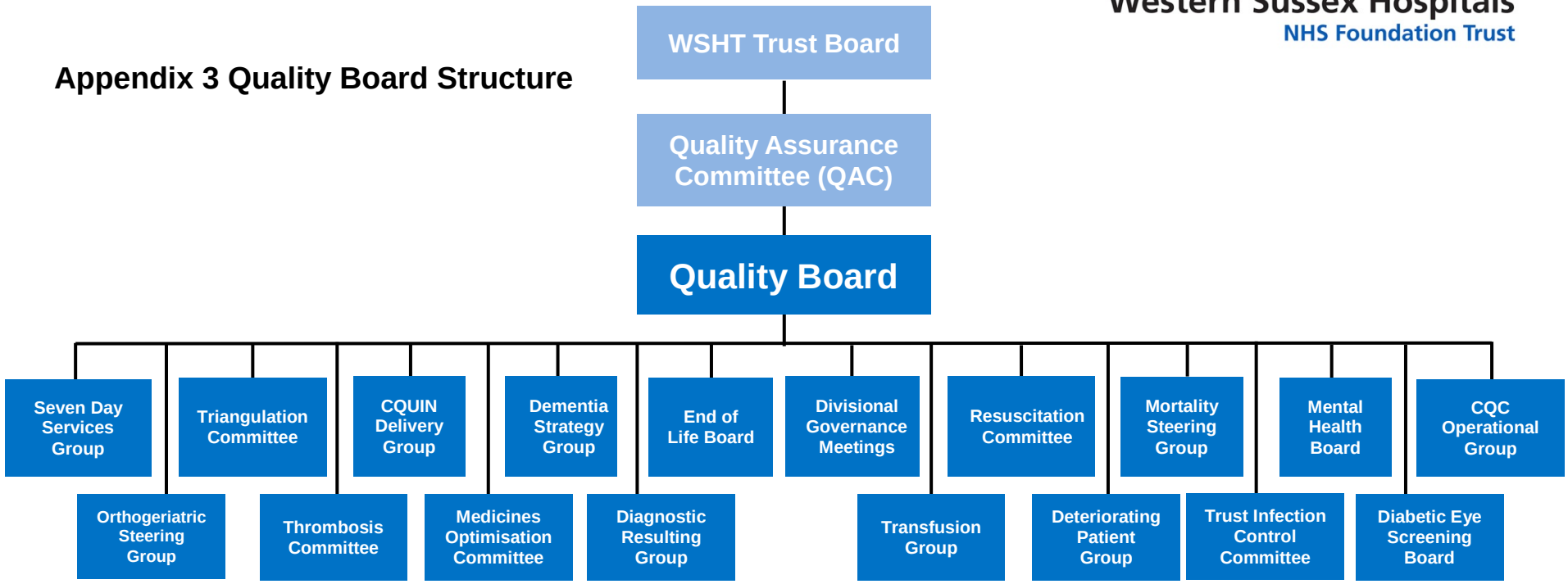
Appendix 3 Quality Governance Structure

Western Sussex Hospitals NHS Foundation Trust



Western Sussex Hospitals NHS Foundation Trust

Appendix 3 Quality Board Structure



Brighton and Sussex University Hospitals NHS Trust

Agenda Item:	3.2	**Meeting:**	Board	**Meeting Date:**	24 April 2019
Report Title:	**BSUH Risk Management Strategy**				
Sponsoring Executive Director:	George Findlay, Chief Medical Officer				
Author(s):	Glen Palethorpe, Group Company Secretary				
Report previously considered by and date:					
Purpose of the report:					
Information	☐		Assurance	☐	
Review and Discussion	☐		Approval / Agreement	✓	
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	☐		Staff confidentiality	☐	
Patient confidentiality	☐		Other exceptional circumstances	☐	
Link to Trust Strategic Themes:					
Patient Care	✓		Sustainability	✓	
Our People	✓		Quality	✓	
Systems and Partnerships	✓				
Any implications for:					
Quality					
Financial					
Workforce					
Link to CQC Domains:					
Safe	✓		Effective	✓	
Caring	✓		Responsive	✓	
Well-led	✓		Use of Resources	✓	
Communication and Consultation:					
Executive Summary:					

Introduction

An effective governance framework relies on a robust system for managing risk. In support of this the Trust has developed risk management structures, systems and processes that will ensure that the Trust meets its strategic and operational objectives and delivers safe, sustainable, high quality care.

The Trust has codified this within its Risk Management Strategy which sets out the Trust's approach to risk management which includes the identification assessment, reporting and management of risk. The Strategy also defines the contribution to be made by key parts of the Trust's governance structures. By managing risk effectively, the Trust aims to:

- ensure that risk management is an integral part of open culture
- identify risks to achieving the Trust's objectives requiring intervention, and
- drive a standardised, strategic, and accessible approach to risk management

It should be noted that the Strategy defines the Trust's risk appetite which will allow the Trust to maximising opportunities to achieve objectives, as well as reducing risks.

Risk Appetite

When the Risk Management Strategy includes the Board's stated risk appetite which was developed in September 2018 with a review date of March 2019. (this is reproduced for ease of review as an

appendix to this report).

The Board have used this appetite statement when determining target scores for the board Assurance Framework and in reviewing significant business developments. The Board over 2018/19 found this statement to be clear and relevant to the delivery of the Trust's objectives.

Update

At the end of March 2019 the Trust Board approved revisions to one of its Committee's terms of reference, this being that the Finance and Investment Committee would become the Finance and Performance Committee from April 2019.

The attached Risk Management Strategy has been updated to reflect these changes (within table 1 and appendix 3)

Key Recommendation(s):

The Board is recommended to consider and endorse there is no change to the Risk Appetite statement included within the Strategy that was developed in 2018

To Board is recommended to approve the Risk Management Strategy.

Appendix A

Risk Appetite Statement

The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Western Sussex Hospitals NHS Foundation Trust sets clear expectations for the Trust through strategic objectives.

The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

Patient Care: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

> We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

Safety: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

> We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

> We have a **low** appetite for risks that may jeopardise patient safety.

> We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

> We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

Sustainability: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

People: We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

Systems and Partnerships: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

Brighton and Sussex University Hospitals NHS Trust

Risk Management Strategy

Version:	Version 1.0
Approved by:	Trust Board
Date approved:	April 2019
Name of originator/author:	Amanda Harrison, Interim Head of Programmes / David Haycox, Interim Group Company Secretary
Name of accountable director:	Dr George Findlay, Chief Medical Officer
Review date:	March 2022

With our partner:

brighton and sussex medical school

Table of Contents

1 Introduction

1.1 The Board of Brighton and Sussex University Hospitals NHS Trust (BSUH) is committed to ensuring that risks to the quality, safety, effectiveness and sustainability of it services are identified and managed so that they are reduced to an acceptable level or eliminated as far as reasonably practicable. This Risk Management Strategy sets out the Trust's intentions and approach to risk management. It should be read in conjunction with the Trust's Risk Management Policy which sets out the methods and responsibilities for delivering this strategy.

1.2 The successful management of risk in all aspects of the Trust's business and by all those working within the Trust is fundamental to delivering the Trust's strategic and operational objectives. It also ensures the Trust is resilient and able to deal with unanticipated exposure to risks that could threaten our success. Therefore, the Trust will ensure that effective risk management is an integral part of everyday working practice in all aspects of the Trust's business as part of its overarching strategy and approach to delivering its strategic objectives.

1.3 The Trust is committed to an integrated risk management system, which incorporates all aspects of risk including strategic, clinical, financial, workforce, infrastructure, health and safety, operational, compliance and reputational risk.

1.4 The Trust's governance framework relies on a robust system for managing risk. This strategy describes how the Trust's risk management structures, systems and processes will ensure that the Trust meets its strategic and operational objectives and delivers safe, sustainable, high quality care. This will involve maximising opportunities to achieve objectives, as well as reducing risks.

1.5 The strategy sets out the Trust's approach to risk management which will include the identification assessment, reporting and management of risk. It defines the contribution to be made by key parts of the Trust's governance structures. By managing risk effectively, the Trust aims to:

- ensure that risk management is an integral part of open culture
- identify risks to achieving the Trust's objectives requiring intervention, and
- drive a standardised, strategic, and accessible approach to risk management

1.6 In addition to this Risk Management Strategy there are a range of policies that support the identification and management of risk within the Trust. These include the following policies:

- Risk Management Policy
- Incident Management Policy
- Complaints Policy

2 Scope

2.1 The risk management approach described in this strategy applies to all areas and activities of the Trust and to all individuals working within the Trust. The Trust will work in partnership with its staff, service users and stakeholders to ensure it takes a comprehensive approach to risk management and that all opportunities for the identification and management of risk are fully exploited including risk management approaches that can only be delivered in partnership with others.

3 Risk Management approach

3.1 Risk is inherent in all the Trust's activities: for example, treating patients, determining service priorities, project management, record-keeping, communication, staffing, service design, and setting strategy. Equally, there is also risk associated with not taking any action at all.

3.2 The Trust supports a dynamic and proactive approach to risk management, with the aim of identifying and managing potential threats and hazards before adverse events occur. The identification and assessment of risk should be seen as opportunities to improve care quality.

3.3 The Trust's strategy for the management of risk is to integrate the identification, assessment, and control of risk into all areas of the Trust's business so that risk is routinely identified by all staff and appropriate action is taken to reduce risks to acceptable levels. The Trust will support all staff to take an active role in the identification and management of risk and to take responsibility for the health, safety, and wellbeing of patients, visitors, staff and others accessing and using the Trust's facilities and services. This approach will also enable staff to make an active contribution to the management of risks associated with the delivery of services in line with the NHS Constitution, and with the delivery of the Trust's objectives.

3.4 While the Trust Board carries overall responsibility for risk management, the key to success is local leadership. The Trust's divisional structure is fundamental to the risk management system, and divisional leaders and their teams will work with colleagues holding specialist Trust-wide governance remits, and the Trust's Executive directors to ensure it is successfully implemented.

3.5 It is the responsibility of all staff to identify risk and report concerns that may affect the quality, safety and effectiveness of service provision. The Trust aims to work in partnership with staff and support them with their responsibilities by creating a culture of openness and willingness to admit mistakes. The Trust is committed to learning from mistakes, incidents, near misses, complaints and claims and using this learning to improve systems. The Trust is committed to a just culture where the reporting of incidents and concerns is encouraged and staff are supported in delivering their responsibilities for safe care.

3.6 This strategy sets the objectives for risk management within the Trust as follows:

- to take all reasonable and appropriate steps in the management of risk in order to protect patients, staff, the public, its assets and reputation
- to meet statutory, regulatory and legal obligations
- to develop and maintain an effective system to identify, assess, manage and review risks across the Trust
- to offer staff appropriate training and support in the principles and practice of risk assessment and management
- to provide assurance to the Board via the Audit Committee) regarding the effectiveness and robust implementation of the Risk Management Policy and its associated systems and processes
- to manage risk within the risk appetite that has been agreed by the Trust Board

4 Risk Management System

4.1 The risk management system will be an integral part of the Trust's framework for assuring and delivering good governance. It will enable the Trust to identify and monitor risks to its strategic objectives, supports the appropriate management and escalation of these risks and informs the Board whether the systems and process in place are providing effective controls and assurances.

4.2 The key components of the Trust's risk management system will be the risk appetite statement, the Board Assurance Framework, the Corporate Risk Register and local risk registers. The production of these components is supported by the Trust's risk management processes

Risk Appetite Statement

4.3 Risk appetite can be defined as the amount of risk or the level of potential impact that an organisation is willing to accept in pursuit of the achievement of its strategic aims and objectives. Risk appetite therefore is at the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

4.4 The amount of risk an organisation is willing to accept can vary from one organisation to another and between one type of risk and another depending upon the specific organisational and risk circumstances. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

4.5 In order to transfer, treat, terminate, or tolerate risks those staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the Trust's Board

4.6 The risk appetite of the Trust will be defined by the Board. The Board will make a decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, the Trust's risk appetite will address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

4.7 Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and should be used to determine the target risk rating throughout the risk management process.

Risk Appetite

4.8 The following risk appetite levels, adapted from those developed by the Good Governance Institute (see Appendix 1), form the background to the Board's discussion and decision when defining the Trust's risk appetite. Using this model as guidance the Trust Board will agree an appetite statement that aligns to the Trust's strategic aims. The statement should be then be considered when assessing risk target and tolerances in the Board Assurance Framework, Corporate and Local (Divisional) Risk Registers.

Appetite Level	Description:
None	Avoid: There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low	Minimal: There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	Cautious: There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.
High	Open: There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.
Significant	Seek: There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is Mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

Risk Appetite Statement

4.9 The Boards of NHS Trusts are accountable for ensuring the quality, safety and sustainability of the services they provide to patients. Brighton and Sussex University Hospitals NHS Trust sets clear expectations for the Trust through strategic objectives.

4.10 The Trust operates in a high risk environment and the day to day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a **moderate** appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

4.11 Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients. We have defined our appetite for risk in relation to our strategic objectives as follows:

4.12 **Patient Care**: We make delivering an excellent care experience for our patients our highest priority. However, we will accept **moderate** risks to patient experience if this is required to achieve patient safety and quality improvements.

4.13 We have a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality, safety and sustainability, may affect the reputation of the Trust or of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Board.

4.14 **Safety**: We will deliver safe, high quality clinical services and demonstrate they achieve optimal clinical outcomes and deliver best practice for our patients whilst ensuring we meet regulatory standards. Overall, our risk appetite for safety is **low**. Specifically:

4.15 We have a **low** appetite for risks that could result in poor quality care or unacceptable clinical risk, non-compliance with standards or poor clinical or professional practice.

4.16 We have a **low** appetite for risks that may jeopardise patient safety.

4.17 We recognise that it can be in the best interests of patients to have a **moderate** appetite for some individual patient care and treatment risks in order to achieve the best outcomes. Therefore we support our staff to work in collaboration with the people who use our services to develop appropriate and safe care and treatment plans based on assessment of need and clinical risk.

4.18 We will apply strict safety protocols for all of clinical and non-clinical activity, when and wherever possible. We will report, record and investigate our incidents and ensure that we continue to learn lessons to improve the safety and quality of our services.

4.19 **Sustainability**: We strive to use our resources efficiently and effectively for the benefit of our patients and their care and ensure our services are clinically, operationally, and financially sustainable. We will always aim to achieve this objective; however, overall we have a **moderate** appetite for risk in this area. Specifically:

4.20 We have a **moderate** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.

4.21 We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a **moderate** appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance

4.22 We will increase our appetite for financial risk to **significant** in some instances and consider all potential delivery options to ensure the delivery of our objectives. Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards. A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require sign off by the Board.

4.23 We are prepared to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level. Value and benefits will be considered and resources allocated in order to capitalise on opportunities.

4.24 **People:** We value and respect all our staff equitably, involve them in decisions about the services they provide and offer the training and development they need to fulfil their roles. We will rarely accept risks that would limit our ability to achieve this objective and the Trust's overall risk appetite for workforce related risks is **low**. Specifically:

4.25 We have a **low** appetite for risks related to the recruitment, retention and training of staff to deliver safe, high quality services and good patient experience.

4.26 We have **no** appetite for risks associated with unprofessional conduct, bullying, or an individual's competence to perform roles or tasks safely nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values.

4.27 We have a **moderate** appetite for risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing, and staff development models where these enhance or improve patient safety, care quality, service delivery or financial sustainability.

4.28 We have **no** appetite for any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.

4.29 We have **no** appetite for any risk that could result in us being in breach of our contractual or statutory responsibilities in relation to our staff or in a breach of our staff's employment rights.

4.30 **Systems and Partnerships**: We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards. Overall we have a **moderate** appetite for risks to the achievement of this objective. Specifically:

4.31 We have a **moderate** appetite for risk where this results in improvements in the design or delivery of healthcare services for our patients or the population we serve. Our appetite for risk in this area recognises that the Trust operates in a complex environment and is subject to very challenging economic conditions and changing demographics with intense scrutiny. We consider the risks associated with innovation, creativity and clinical research to be an essential part of the Trust's risk profile. We increase our appetite for risk in this area to **significant** in order to maximise the opportunities to improve patient outcomes and the Trust's sustainability. . A decision to take this level of risk would be based on a rigorous risk assessment and a review of the robustness of the controls and would require support of the Board.

4.32 We will collaborate with commissioners, local authorities, our other partners and other care providers to prevent ill health, plan and deliver services that meet the needs of our local population and deliver operational and NHS constitutional standards.

Risk Tolerance

4.33 Risk 'tolerance' is the minimum and maximum risk the Trust is willing to accept as reflected in the risk appetite themes above. All risks with a total risk score of 12 and above and those with a consequence/impact score of 5 will be considered as Corporate Risks and as such require executive oversight by the Trust Executive Committee (TEC). TEC will be responsible for ensuring that Corporate Risks are managed and controlled in accordance with the risk appetite defined by the Board and with the Risk Management Policy.

Board Assurance Framework

4.34 The Board Assurance Framework (BAF) will set out the strategic risks which may threaten the achievement of the Trust's strategic objectives. It will enable the Board to monitor progress in achieving the strategic objectives, attend to key accountability issues, ensure the right issues are debated and that remedial actions are taken to reduce risk, strengthen controls and assurances. All NHS bodies are required to sign a full Annual Governance Statement, and must have the evidence to support this. The BAF brings together a significant part of this evidence

4.35 The BAF will be designed to assess the strength of the internal control measures that are intended prevent these risks occurring and to identify and evaluate sources of assurance. It supports the identification of gaps in control and

assurance and enables the Board to monitor progress on the actions being taken to address these gaps.

4.36 The BAF will also describe the assurances and sources of assurance the Board has agreed are necessary to assess the achievement of the Trust's strategic objectives, and will thus drive the cycle of Board and Board Committee work and reporting to the Board.

4.37 The BAF also describes the controls that the Trust's Executive must ensure are effective in order to manage strategic and operational risks and to assess that the adequacy and strength of these controls are aligned to the Board's risk appetite for individual strategic risks.

4.38 The BAF will be regularly review by the Board, Board Committees and TEC as determined by their roles and responsibilities set out in Section 7 and defined in the Risk Management Policy.

4.39 The assurance alignment within the Trust is shown diagrammatically by Good Governance Institute, see Appendix 2.

Corporate Risk Register

4.40 The corporate risk register (CRR) will be comprised of all risks with a score of 12 or above or that has an impact score of 5, and will be compiled from divisional and corporate directorate risk registers. It will be the key tool for the management of risk and will be informed by the Trust's risk escalation process.

4.41 The CRR will be routinely reviewed by TEC and the Trusts Management Groups as determined by their roles and responsibilities as set out in their Terms of Reference. This will ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk
- these actions have been effective in reducing the risk level
- risks to strategic objectives are identified
- gaps in control are identified and included in the BAF
- the ongoing integrity of the risk management system

4.42 In addition the CRR will be routinely reviewed by the Audit Committee in order to assess the adequacy and effectiveness of the Trust's risk management systems and processes so that the Committee can provide the relevant assurance to the Board.

4.43 The Audit Committee will also assess whether the linkages between the CRR and the BAF are robust and enable the Board to effectively identify gaps in control and assurance. Risks on the CRR may indicate a gap in control or identify that the Board is receiving inadequate, insufficient or incomplete assurances.

Local Risk Registers

4.44 The local Risk Registers (RR) will be held at divisional and corporate directorate level and are the mechanism and management tool through which identified risks, controls and actions to mitigate or manage risks are recorded, monitored and managed. RR will follow the same format as the CRR.

4.45 Divisional RR will be routinely reviewed and monitored through the divisional governance structure. Corporate directorate RR will be routinely reviewed and monitored by Executive Directors and their teams.

4.46 In addition the CRR and RR will be reviewed as required by TEC and Trust Management Groups to ensure consistency between all RR in the identification, assessment and rating of risks and to ensure effective management action is being taken to mitigate and control risks.

5 Risk management processes

5.1 The Trust's risk management processes will be described in the Risk Management Policy and will be determined in line with NHS and regulatory requirements and best practice. They will govern how risk is contextualised, identified, analysed for likelihood and impact, prioritised and managed and how risks will be communicated, reported, recorded, monitored and reviewed.

5.2 The Trust's risk management processes will ensure that risk is identified from a wide range of sources both proactively (for example through audit or assessment of provision against clinical guidelines) and reactively (for example through complaints, incidents and claims).

5.3 The Trust will manage identified risk through one of the following approaches:

- **Treat**: control or reduce by taking action
- **Terminate**: remove altogether by stopping practices, or
- **Tolerate**: accept where appropriate and in line with risk appetite
- **Transfer**: move to another organisation or service

6 Governance Structure

6.1 The Trust's governance structures will support the ward to Board management of risk throughout the organisation. The Trust's Governance structure is set out in Appendix 3.

6.2 The Board's is responsible for setting the objectives and strategy for risk management, setting the Trust's risk appetite and assessing the outputs and outcomes of the Trust's Risk Management Systems to ensure that they deliver appropriate levels of assurance and demonstrate that the risks to the Trust's strategic objectives are being effectively managed and controlled The Board

delegates some of its responsibilities to its Committees as described below. The BAF is the key tool used by the Board in fulfilling its responsibilities.

6.3 The Trust's management structures will have the responsibility to ensure risk is managed and controlled in line with the Trust's Risk Management Strategy and Policy. Gaps in control will be identified through the management structures, and actions to strengthen controls or address gaps in control will be defined and monitored.

6.4 TEC will be the principal governance forum for the management of risk and will delegate some of its responsibilities to other management groups in order to ensure appropriate levels of scrutiny and action to manage risk. The Risk Management Policy CRR and RR will be the key tools used by the Executive and Trust managers in fulfilling their responsibilities.

6.5 Assurances on the effectiveness of the Trust's risk management system will be developed through the Trust's management systems and will be assessed and scrutinised by the Board and its Committees. The Board and TEC will agree the format and content of management and Board reporting that supports the provision of robust assurance.

Risk escalation

6.6 In order to successfully monitor and manage operational and strategic risk it is essential that high risks, areas of escalating risk, gaps in control and delays in implementing actions to strengthen controls or address control gaps are escalated through the risk management governance structure. The risk escalation process will be described in the Risk Management Policy. In addition to regular reporting to provide assurance it is expected that all component parts of the Trust's risk management governance structure will identify and escalate risks in a timely manner, reporting concerns to ensure awareness and the implementation of strengthened actions.

Learning from the management of risk

6.7 The Trust is committed to continuously developing as a learning organisation and ensuring that it can learn from the outcomes and processes of its risk management system. Learning will include the identification of improvement actions that will enable incremental improvement in the effectiveness of the risk management system, the implementation of effective controls and risk mitigations and the development and delivery of assurance. Learning opportunities will be identified throughout the Trust's risk management process and highlighted to the Board. Plan for risk management improvement will be incorporated into the Risk Management Strategy, Policy and practice.

7 Organisational responsibilities

7.1 In line with the governance structure illustrated in Section 6, Table 1 below describes the key responsibilities of the Board and its Committees. Table 2 describes the roles and responsibilities of the Trust's key management groups for the delivery of the Trust's risk management systems and processes and the development of assurances in relation to the management.

7.2 The Terms of Reference for the Board Committees and Trust Management Groups are available on the Trust's intranet.

8 Strategy Implementation and monitoring

8.1 The Trust's Risk Management Strategy will be implemented through the mechanisms described in Section 7 and through the Risk Management Policy. The Board will review the Risk Management Strategy at least annually making any changes required to reflect national and regulatory standards, best practice and learning and improvement opportunities identified by the Trust including through internal or external reviews the of risk management systems.

Table 1: Responsibilities of the Board and Board committees

Group and responsibilities
The **Trust Board** is accountable for • Agreeing the Trust's Risk Management Strategy • Agreeing the key risks to the achievement of the Trust's strategic objectives • Agreeing the Trust's risk appetite in relation to the strategic objectives and the types of risk1the trust is managing • Agreeing the BAF; defining the controls, assurances and gaps in control and assurance for each of the key risks that will be the focus of the Board's assurance assessment activity • Ensuring the BAF informs the business of the Board and drives the Board agenda • Scrutinising and testing the assurances received on the effectiveness of controls and actions to address gaps in control through the annual cycle of business • Challenging the risk controls and sources of assurance described within the BAF to ensure they are effective and robust • Considering the wider strategic implications of the risks identified, and making recommendations to improve management of risk by taking a strategic corporate approach
The Board delegates responsibility to the **Audit Committee** for**:** • Assessing the quality and strength of the assurances received on the Trust's risk management, quality and financial governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) and that this supports the achievement of the Trust's objectives • Testing the integrity and completeness of the risk management system through reviewing the strength of operational and strategic risk management and internal control. • Assessing the accuracy, adequacy of the assurances provided on the effectiveness of controls and the actions being taken to address gaps in control processes that indicate the effectiveness of the management of principle corporate and clinical risks. • Identifying gaps in assurance, assessing the adequacy and robustness of the actions being taken to address these gaps and the progress being made to close them • Regularly reviewing and testing the contents of the BAF, CRR,and local RRs in pursuit of the above responsibilities • Regularly reviewing and testing the contents of the Trust's Risk Management Strategy, Risk Management Policy and associated policies in pursuit of the above responsibilities. • Ensuring there is independent scrutiny of the Trust's risk management and governance systems and processes and of the strength and adequacy of related assurances through internal and external audit work programmes • Making recommendations to the Trust Board on the development and implementation of the Risk Management Strategy and Policy • Reviewing and testing all risk and control-related disclosure statements (e.g. the Annual Governance Statement) to provide assurance to the Board that they are accurate and adequate. • Reviewing the Trust's Risk Management Annual Report, and agree recommendations on actions for improving the Trust's risk management systems and processes

The Board delegates responsibility to the **Quality Assurance Committee** for

- Assessing the quality and strength of the assurances received on the Trust's quality and clinical governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of quality and clinical governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives
- Testing the integrity and completeness of the quality governance system through reviewing the strength of operational and strategic management and internal control of quality and clinical risks.
- Assessing the accuracy and adequacy of quality reporting and the assurances developed through the Trust's quality management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic;
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Assessing the effectiveness of the controls implemented through the Trust's quality management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic
- Escalating concerns about areas of inadequate control to the Board
- Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for quality improvement
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Reviewing and testing all clinical and quality related statements (e.g. the Quality Account) to provide assurance to the Board that they are accurate and adequate.
- Making recommendations to the Trust Board on the development and implementation of the Quality Strategy
- Regularly reviewing and testing the contents of the Quality Improvement Plan, Clinical Governance Annual Report and associated policies in pursuit of the above responsibilities.

The Board delegates responsibility to the **Finance and Performance Committee** for**:**

- Assessing the quality and strength of the assurances received on the Trust's financial and operational performance governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of financial and operational performance governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives
- Assessing the accuracy and adequacy of financial reporting and the assurances developed through the Trust's financial management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic objectives
- Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board
- Assessing the effectiveness of the controls implemented through the Trust's financial management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic
- Escalating concerns about areas of inadequate control to the Board
- Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for financial improvement
- Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities
- Reviewing and testing all financial statements (e.g. the Financial Accounts) to provide assurance to the Board that they are accurate and adequate.
- Reviewing and testing the reported performance of the Trust to provide assurance that the information reported is accurate and adequate.
- Making recommendations to the Trust Board on the development and implementation of the Trust's Financial Strategy

Table 2: Responsibilities of the Trust's management groups and divisions

The **Trust Executive Committee** is responsible for**:**

- Ensuring the effective identification, evaluation and management of operational and strategic risk in all aspects of the Trust's business and providing effective and proactive leadership of risk management within the Trust by implementing the Trust's Risk Management Strategy and Policy and the associated framework of processes, procedures and controls that enable risks to be managed directly and through delegated powers and ensure the Trust meets its strategic objectives
- Ensuring the Trust's Risk Management Strategy and Policy and the annual risk management improvement plan are developed, regularly reviewed and updated taking into account recommendations for improvement arising from internal and external scrutiny and recommending these to the Board for approval.
- Developing and providing assurance to the Board and its Committees on the effectiveness of the Trust's risk management systems
- Reviewing the local RR, CRR and Board Assurance Framework routinely to ensure risks and controls are described clearly and accurately, rated consistently, and managed appropriately to reduce risks to the agreed target level. Recommending the BAF to the Board for approval.
- Identifying gaps in assurance or control and ensuring actions to address these gaps are agreed and delivered in a timely fashion to make the necessary improvements, taking action as required to address delays and enable and support successful delivery
- Escalating risks, gaps in control or gaps in assurance to the Board
- Promoting continuous quality improvement with regard to the management of clinical and non-clinical risk and the control environment throughout the Trust by examining and challenging action plans developed to control risks, and assessing their wider impact.
- Assessing the quality and strengths of the assurances developed through the Trust's quality management system and its sub-groups to provide evidence of the effectiveness of quality risk management within the Trust, taking action to strengthen assurances as required
- Assessing the quality and strengths of the assurances developed through the Trust's performance management system to provide evidence of performance risk management within the Trust, taking action to strengthen assurances as required
- Assessing the quality and strengths of the assurances developed through the Trust's financial management system to provide evidence of financial risk management within the Trust, taking action to strengthen assurances as required
- Considering the wider strategic implications of risks and themes arising, and opportunities to improve management of risk by taking a corporate approach
- Delegating powers for the management of risk to the appropriate management groups as set out in their approved Terms of Reference.

Appendix 1: Risk Appetite for NHS Organisations

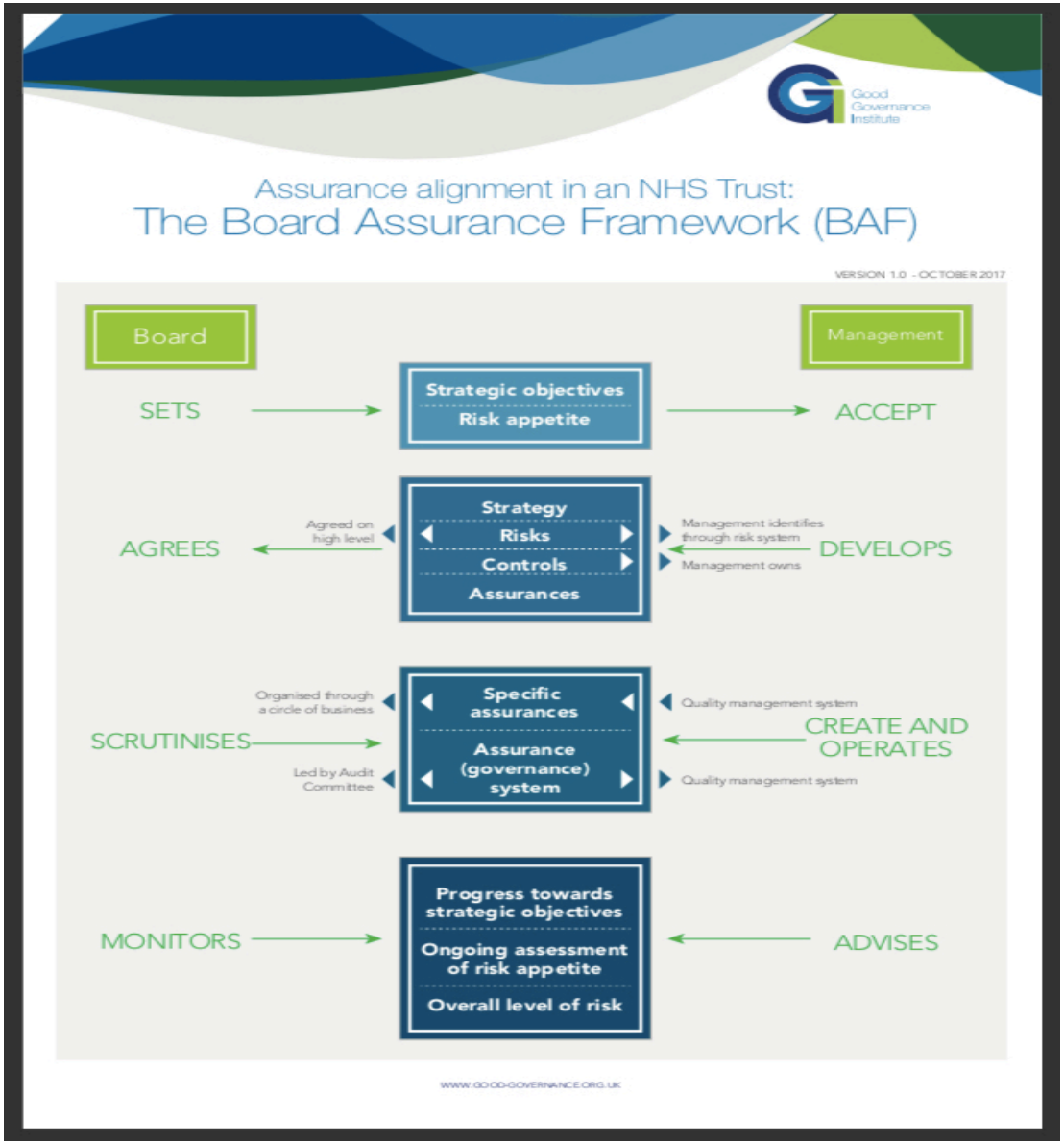
Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

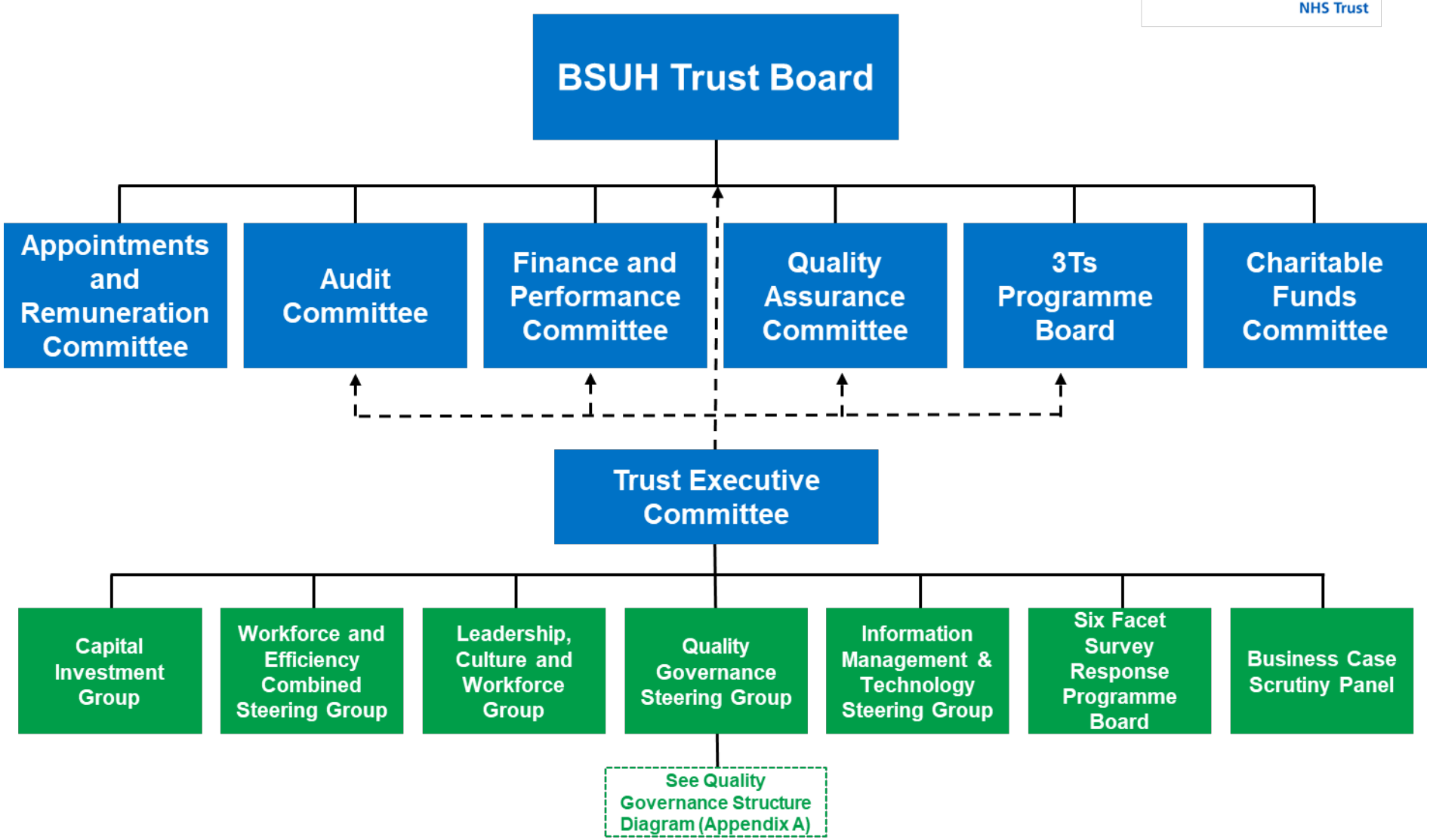
Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 2: Assurance Alignment in an NHS Trust – Board Assurance Framework



Appendix 3: Governance Structures



Quality Governance Structure