Board of Directors Meeting in Public
Friday 5th July 2024, 08:30-11:30
Town Hall, LG3, Greenwood Offices, Ascot

A G E N D A

Item		Lead	Action	Paper	Time
1.	Welcome and Introduction	Chair	-	Oral	08:30
2.	Apologies and Declarations of Interest	Chair	Declare	Oral	08:32
3.	VIP Awards	Chief Executive	Note	Oral	08:35
4.	Minutes of the previous meeting	Chair	Approve	Attached	08:45
5.	Action Log from the previous meeting	Chair	Note	Attached	08:47
6.	Patient Story	Chief Nurse	Note	Video Presentation	08:50
7.	Ward to Board: Therapies	Chief Nurse	Note	Slide Presentation	09:00
Strategy					
8.	Chief Executive's Report	Chief Executive	Note	Attached	09:20
Board Oversight and Assurance					
9.	Operating Plan Delivery Report a) COO Report b) Committee Chair Report Quality and Safety Report a) CNO/CMO Report b) Committee Chair Report People Report a) CPO Report b) Committee Chair Report Finance Report a) CFO Report b) Committee Chairs Report (Finance and Audit)	Chief Executive and Executive Leads	Assurance	Attached	09:30
Short Break (10:20-10:30)					
People Reports					
10.	Sexual Safety Charter Report	Chief People Officer	Assurance	Attached	10:30
Quality and Safety Reports					
11.	Nursing and Midwifery Staffing	Chief of Nursing & Midwifery	Assurance	Attached	10:45

12.	Director of Infection and Prevention Annual Report 2023/24	Chief of Nursing & Midwifery	Assurance	Attached	10:55
Governance and Compliance					
13.	Risk Review a) Board Assurance Framework b) Corporate Risk Register	Chair	Approve/ Note	Attached	11:05
14.	Standing Financial Instructions	Chief Finance Officer	Approve	Attached	11:20
15.	Committee Terms of Reference	Chair	Approve	Attached	11:25
Other Business and Public Questions					
16.	Any Other Business	Chair	-	Oral	11:30
17.	Public Questions	Chair	-	Oral	11:30
	Date of Next Meeting: Friday 6th September 2024, 08:30 – 11:30, Board Room, Administration Block, Frimley Park Hospital				

Report Title	Minutes of the previous meeting
Meeting and Date	Public Board of Directors, Friday 5th July 2024
Agenda Item	4.
Author and Executive Lead	Hannah Farmhouse, Assistant Company Secretary & Victoria Cooper, Acting Company Secretary Caroline Hutton, Interim Chief Executive
Executive Summary	The attached minutes records the items discussed at the Board of Directors meeting held in public on Friday 3rd May 2024
Action	The Board is asked to **APPROVE** the minutes as a correct record of the meeting.
Compliance	NHS Provider Licence; Standing Order 14.1

Frimley Health NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC

Friday 3rd May 2024, 08:30-11:30

Boardroom, Frimley Park Hospital

MINUTES OF MEETING

Members Present:

Bryan Ingleby	Trust Chair
Na'eem Ahmed	Associate Non-Executive Director
Michael Baxter	Deputy Chair, Non-Executive Director
John Lisle	Non-Executive Director
Gary McRae	Non-Executive Director
John Weaver	Non-Executive Director
Jackie Westaway	Non-Executive Director
James Clarke	Chief Strategy Officer
Tim Ho	Chief Medical Officer
Caroline Hutton	Interim Chief Executive
Matt Joint	Chief People Officer
Ellis Pullinger	Interim Chief Operating Officer
Kishamer Sidhu	Chief Financial Officer
Melanie van Limborgh	Chief of Nursing and Midwifery

In Attendance:

Simon Coxon	ViP Award Winner: Desktop Support Engineer
Sofia Torre	On behalf of ViP Award Winner: Yogesh Kaushik
Carol Deans	Director of Communications and Engagement
James Taylor	Assistant Director of Communications *(for item 3)*
Deirdre Race	Ward to Board: Head of Nursing for Safeguarding & Vulnerable Patients
Knowledge Nyamaradzo	Ward to Board: Mental Health Co-ordinator
Michelle Golds	Ward to Board: Service Manager Psychiatric Liaison Team (Surrey and Borders Partnership NHS Trust)
Mark Lepine-Williams	Ward to Board: Assistant Hotel Services Manager
Ben Thornton	Operational Security Officer
Suk Taman	Ward to Board: Senior Sister
Steven Roots	Freedom to Speak Up Guardian *(for item 14)*
Victoria Cooper	Acting Company Secretary (Minutes)
Hannah Farmhouse	Assistant Company Secretary (Minutes)
Michael Ellis	Staff Governor: Heatherwood and Community Hospitals
John Lindsay	Public Governor: Bracknell Forest and Wokingham
Udesh Naidoo	Staff Governor: Frimley Park Hospital
Sarah Peacey	Public Governor: Bracknell Forest and Wokingham (Lead Governor)
Andy Gray	Facere Melius
Jerry Andrews	Member of the Public
Jan Burnett	Member of the Public
Simon Strachan	Member of the Public
Ross Wade	Member of the Public
Jill Wakefield	Member of the Public

Apologies:

Janet Rubin	Non-Executive Director

1. Welcome and Introduction

1.1 The Trust Chair opened the meeting and welcomed Caroline Hutton to her first meeting as Interim Chief Executive, Ellis Pullinger as Interim Chief Operating Officer and John Lisle, one of the new Non-Executive Directors. The Chair noted that Janet Rubin was an apology for the meeting as she had a prior commitment. The governors, Values in Practice (ViP) award winners and members of the public were welcomed to the meeting. The Chair advised that the substantive Chief Executive, Lance McCarthy would be joining the Trust on 20 August.

1.2 The Chair explained that the key themes for the meeting were the Trust's mental health services, plans for the year ahead, people, culture, and leadership.

2. Apologies and Declarations of Interest

2.1 Apologies were noted as above.

2.2 There were no declarations of interest.

3. VIP Awards

3.1 Caroline Hutton introduced the Values in Practice awards which recognised the work of Frimley Health staff. There were around 70-80 nominations received each month from staff, patients and members of the public. There were 3 winners selected for the May Board meeting, however one of the winners, Dr Wilewardane, was unable to attend.

3.2 The first award was presented to MRI radiographer Yogesh Kaushik, who had been nominated by a colleague for his helpfulness and professionalism, even working very late into the evening on several occasions to reduce delays to patients caused by a scanner failure. A colleague collected the award on Mr Kaushik's behalf.

3.3 The second award was presented to desktop support engineer Simon Coxon, who had also been nominated by colleagues who had described him as cheerful and polite and always quick to respond to help with IT issues. He always went above and beyond the call of duty to support colleagues.

4. Minutes of the previous meeting

4.1 Subject to adding wording to reflect comments made by Jackie Westaway regarding the Research and Development team working with Pharmacy, the Board **APPROVED** the minutes of the meeting held on Friday 1st March 2024.

5. Action Log from the previous meeting

5.1 The Board noted the completed action, and the following was noted with regards the actions in progress.

5.2 ***7th July 2023 – 5.6 Patient Story***

Matt Joint reported that the number of apprenticeships was increasing year on year and across all levels. Increasing apprenticeship opportunities was a priority in order to support the domestic pipeline.

5.3 ***7th July 2023 – 9.4 Nursing and Midwifery Report***

The Trust recognised that a significant proportion of nurses within the Trust were internationally educated nurses from red listed countries and the Trust wanted to find the right balance. A targeted recruitment campaign had been developed to address the balance. The People Committee maintained oversight of international workforce recruitment.

6. Patient Story

6.1 Deirdre Race introduced the Patient Story which had been told by a member of staff to respect the confidentiality and anonymity of the patient who was being referred to by pseudo name Stephanie. It was noted that the safeguarding team had contacted Stephanie's mother and consent was provided to share her story. The story explained that Stephanie had attended local hospitals Emergency Departments (ED) on a frequent basis and was well known to the community mental health team. Stephanie had been brought to ED by ambulance during 2023 and following completion of a mental health (MH) triage, the ED team had identified Stephanie as high risk. The Patient Story continued on with a summary of the events that took place.

6.2 Deirdre explained that the Patient Story highlighted that mental health was a very important and complex subject, and that often, as was the case in the story, involved multiple departments and services including ED, inpatient clinical teams, allied health professionals, security, chaplaincy, adult safeguarding and Trust partner Surrey and Borders Partnership Psychiatric Liaison Service, Adult Social Care and the Community Mental Health Service.

6.3 It was reported that upon discharge Stephanie shared with the ward team her gratitude and thanks for the care she received. She stated that for the first time she felt that she had been treated like a human being.

6.4 Deidre highlighted the areas of good practice and areas of challenge including the challenge in accessing registered mental health nurses (RMNs) to support patients and the need for additional mental health training to increase staff knowledge and skills. She noted that actions being taken included the submission of a business case for 2 RMNs, substantive lead for Mental Health and a review of the recommendations included in the commissioned review that had been published in April.

6.5 The patient journey from the Emergency Department to Discharge and Teams involved, highlighted that multiple teams and individuals across the Trust contributed to a patient's journey. Deirdre advised that they continued to make further improvements. Members of the security team and Suk Taman, Senior sister were invited to share their experiences of supporting the mental health services within the Trust. Their experiences emphasised the pressures on the Trust when dealing with patients with mental health difficulties; often the security officers would have to support the teams for the entirety of their shift and therefore limit the security presence on other parts of the hospital estate. Suk explained how Stephanie had been cared for during her inpatient stay on the ward and the impact on staff. She highlighted that throughout Stephanie's stay, the team had been well supported by Knowledge Nyamaradzo, the Psychiatrics team and others and the team had learnt a lot through the experience. They had been pleased to hear the positive feedback from Stephanie on discharge.

6.6 The Board **NOTED** the Patient Story.

7. Ward to Board: FHFT Mental Health Services

7.1 Following on from the patient story, Deirdre Race and Knowledge Nyamaradzo presented the Ward to Board on FHFT Mental Health Services.

7.2 Deirdre reported that commissioned Mental Health Services at the Trust included the Surrey and Borders Partnerships (SABP) Psychiatric Liaison Services at Frimley Park Hospital and Berkshire Health Foundation Trust at Wexham Park Hospital. The Board received an overview of the support provided by the SABP Psychiatric Liaison Service. It was highlighted that there was a close working relationship between the service and the Trust team and that it was evident that the knowledge around mental health had significantly improved across many of the wards. The challenge however was the limited

supply of mental health beds, limited resources to support more ward based liaison and increasing demand. The challenges aligned with the issues nationally regarding mental health services. SABP commended the Trust for the mental health support provided to patients in their care.

7.3 Caroline Hutton thanked the team and its partners for all their work in mental health services across the Trust, recognising the significant pressure the teams and wards were under. She noted that dealing with patients with mental health difficulties could be a daunting and stressful experience for those staff that were not trained. She asked whether there were staff that were dual trained, and Deirdre Race advised that there was only one dual trained individual working in the Trust. Deirdre reported however that the first cohort of 20 people had completed the Mental Health course at the Buckinghamshire New University, and were now Mental Health Ambassadors in the Trust.

7.4 Tim Ho reported on the parallel work going on in the Paediatrics team, noting that child and adolescent mental health services (CAMHS) were also under significant pressure.

7.5 Jackie Westaway referred to the resource challenges and that currently the requirements of the CORE24, a standard for adult mental health services, were not being met and asked what could be done to address the challenges. Deirdre Race explained that there were complexities around mental health patients, at one moment the individual could be calm but then suddenly change and at that point more resource was required to support the individual. Often it was difficult to access an RMN at the point of need as agency nurses were required and whilst the situation was being managed in the Emergency Department, the Emergency Department was still dealing with many other pressures. It was noted that the team would endeavour to admit high risk individuals to a ward to provide the support they needed. Deirdre explained that it was not possible to eliminate all risk.

7.6 Deirdre Race advised that high risk care plan practitioners were in place to recognise high risk patients and identify when more intervention was needed.

7.7 Referring to the difficulties that the Security team experienced, Na'eem Ahmed asked if further support was required. Mark Lepine Williams explained that he provided wellbeing support to the team, including debriefs, and a business case was being submitted to re-band the roles within the team to reflect the work undertaken by those individuals. He emphasised the risk with dealing with a patient and diverting security from other parts of the hospital estate.

7.8 Gary McRae commented that support for staff dealing with mental health patients was vital. Deirdre Race advised that a lot of conversations and support was provided to staff by the mental health team but more resources and funding to provide greater support would be beneficial.

7.9 The Chair thanked the team for their significant work in mental health service provision across the Trust, recognising that more support was required. He noted that system working was making a difference to mental health service provision in the area.

7.10 The Board **NOTED** the Ward to Board Presentation.

8. Chief Executive's Report

8.1 Caroline Hutton presented the Chief Executive's Report, first thanking people, particularly the executive team for their support as she transitioned into the Interim Chief Executive role. Caroline highlighted the following key points:

- At the end of March performance against the national standard of at least 76% of patients attending emergency departments being treated and discharged or admitted within four

hours was achieved with the final position at 76.2%. She thanked all staff for the concerted effort to achieve the performance target.

- The Trust had nearly finalised its 2024/25 Operational Plan including adjusting elements of the plan to align with the NHS England Operational Planning and Guidance which had been received just before Easter. Priorities continued to focus on recovering core services, supporting the workforce, and a strong focus on improving productivity. More recent messaging also emphasised the importance of digital transformation, driving productivity and efficiency.
- To increase the Trust's focus and drive on transformation and improvement – Dr Gareth Roberts and Liz Howells had been appointed as Chief of Service for Transformation and Continuous Improvement and Director of Transformation and Continuous Improvement respectively. Gareth and Liz would be leading on the delivery of improved quality of clinical services throughout the organisation, underpinned by the capabilities of digital transformation and support clinical and operational teams to deliver rapid improvement.
- The Trust was continuing to develop the FHFT Strategy to 2030 and a first draft was expected to be ready in Q1, 2024/25 and would involve the incoming Chief Executive. The strategy would then be launched and published later in the year.
- Following the national staff survey at the end of the 2023/24, the Trust achieved some excellent results, with some of the greatest improvements and feedback putting the Trust in the top third of trusts for staff being recognised and rewarded, feeling they have a voice that counts, team moral and working flexibly.
- The Trust launched a new Care Quality Programme and ward accreditation programme to support the focus on quality and continuous improvement and Trust preparations for any CQC assessment or on-site inspection. The two initiatives had been well received and staff were engaged with the work.

8.2 John Lisle commended the positive report and asked whether the year-end performance was sustainable. Caroline Hutton reported that the 76% performance in the emergency department had required significant effort but assured the Board that an urgent and emergency improvement plan was in place to support continued good performance. Trajectories had also been established, particularly around elective targets and the drive for continuous improvement would support all this work.

8.3 In response to Linda Burke's question on the priorities around health inequalities, Caroline Hutton advised that the Frimley ICS lead for health inequalities would be leading a discussion on health inequalities at the upcoming Board of Directors/Council of Governors workshop. Tim Ho advised that certain pathways such as maternity, diagnostics for cancer and access for children were key priorities for health inequalities and the Trust was working closely with ICB colleagues to target those areas.

8.4 The Board **NOTED** the Chief Executive's Report.

9. FHFT Operating Plan 2024/25

9.1 Ellis Pullinger presented the Frimley Health Operating Plan for 2024/25 which provided an overview of the Trust's plans and priorities for the year ahead. Ellis highlighted that the plan aligned with the Trust's ambitions 2020-25 'Our Future FHFT' Strategy which established a framework for the organisation and included 6 Strategic Objectives that would be supported over the 5 years, linking longer term plans and priorities to the shorter timeframe of 2024/25. The plan also provided a summary of the Trust's response to the 2024/25 priorities and operational planning guidance issued by NHS England on 27 March 2024, delivering and/or exceeding those wherever realistic and safe to do so. The plan had been presented to both the Trust Management Board and Finance and Investment Committee in the previous week. The following key points were highlighted:

- The Finance and Investment Committee had reviewed the costs and finance associated with the plan.
- The key headlines for the plan, as set out in the paper were highlighted, in particular the bed base. The aim for an annual average bed base (general acute) of up to 1,400 through the year was not without challenge, particularly the challenges across the estate e.g., impact of RAAC but the executive team was determined to deliver the target. Transformation and continuous improvement would support this work, for example addressing the challenges with length of stay.
- A key performance indicator dashboard was being developed to measure progress against the plan and the plan would also be published on the Trust website.
- The performance report was being redesigned and reassessed to align with the operational plan. The performance report would now also include metrics on people -Equality, diversity and inclusion, freedom to speak up etc. to ensure Board oversight of the people agenda.

9.2 The Board raised questions and had discussions on length of stay and bed base plans, targets, outpatients, theatre utilisation, system support and the following was noted:

- Ellis Pullinger was chairing a group which was reviewing long stay patients. Currently there was 230-280 medically fit for discharge patients across the sites, and to support flow the target was 150-180 patients. Addressing the challenges with length of stay required both internal efforts and Frimley ICS support. A focus on flow through the emergency department, particularly utilisation of same day emergency care units was vital for supporting the challenges with length of stay. Addressing length of stay at Wexham was a key priority for the Trust.
- Trajectories to meet targets had been incorporated into activity plans and the redesigned performance report would provide performance against targets.
- Theatre capacity to treat more outpatients was being considered in outpatient transformation work. Digital transformation would support that work.
- Demand and capacity figures were part of activity planning by speciality. Changes in the way people work was being discussed i.e., weekend working to increase capacity.
- System support was positive with joint working to open the new urgent care centres and utilisation of Heathlands. There was however a challenge with long length of stay patients which needed resolution and Ellis Pullinger was currently in the process of addressing. It was noted that the FHFT Operational Plan was a subset of the Frimley ICB Operational Plan with shared objectives and therefore continued close working with the system was important.

9.3 The Board commended the work undertaken to produce the operational plan.

9.4 The Board **APPROVED** the Frimley Health Operating Plan 2024/25.

10. Finance Report

10.1 **Finance Report – Month 12**

Kish Sidhu presented the month 12 Finance Report and highlighted the following key points:

- The full year position was a deficit of £10.8m but had benefited from £3.7m of additional Industrial Action funding in March.
- The full year position had been underpinned by significant non-recurring support including CNST and balance sheet movements.
- Key drivers of the adverse variance included unfunded RMN, unfunded escalation costs and pay inflation. In the first half of the year outsourced WLI had been a key driver but had reduced in the second half.

- The cost improvement program (CIPs) had been achieved, with the Trust reaching £33.4m, £0.1m ahead of the full year plan. 59% of the CIP had been delivered recurrently.
- The capital programme had been reached at £67.77m which was £0.1m ahead of the revised plan.
- Cash closed at £99.8m.

10.2 John Weaver commented that historically within the Frimley ICS, the deficit had been split 50/50 and he asked whether this was the same for 2023/24. Kish Sidhu confirmed that when the accounts had closed the split was 50/50 however in the last 24 hours the ICB had experienced an adverse movement.

10.3 The Board **NOTED** the Finance Report for Month 12.

10.4 **Financial Plan 2024/25**

Kish Sidhu presented a summary of the 2024/25 financial plan which had been submitted on 2 May. The income expenditure position was currently showing a deficit of £27.2m after £45m of savings. Whilst there were unfunded items impacting the position, the majority of the deficit was being driven by the 2023/24 recurring run rate. Kish reported that the current plan did not include non-recurrent income as it was not yet known He further noted that the income statement aligned with the commissioners.

10.5 Kish Sidhu explained that internally the resolution of the deficit required recurring plans to deliver productivity improvements sustainably, benefits of previous cases being realised and new developments such as M Block. Externally the Trust was scheduled to meet with NHS England to discuss the controls the Trust had in place. The Trust was also required to provide details of the RAAC calculations to NHS England to better their understanding of the RAAC impact.

10.6 Kish Sidhu advised that realising the benefits of recent investments was important and currently the benefits had not been incorporated into the plan.

10.7 John Weaver commented that there was a good set of metrics in the plan and there was an understanding of the actions required to support the plan which included the closure of escalation wards. He highlighted that 140 beds were due to be closed by the end of June. Ellis Pullinger confirmed that a plan was in place to achieve the closures and that it would be evidenced in the reduction of bank and agency spend.

10.8 Gary McRae highlighted the importance of productivity improvements within the Trust. Kish Sidhu confirmed that productivity metrics were being developed. The Chair advised that NHS England was also developing standardised metrics which trusts would be mandated to monitor.

10.9 Caroline Hutton advised that controls on workforce numbers was a priority for 2024/25 and a workforce plan was being developed for the Frimley ICS.

10.10 In response to John Lisle's question on the longer-term financial plan to return to financial sustainability, Kish Sidhu explained that whilst the plan was for 2024/25, he anticipated that the Trust might be asked to prepare longer term plans.

10.11 The Board noted that the cost improvement plan for 2024/25 was ambitious but that the operational plan was fully costed. It was recognised that there would be pressure to deliver the plans and the Trust would have to make some difficult decisions.

10.12 The Board **NOTED** the Financial Plan 2024/25 submission, based on delegated authority. The Board further **NOTED** that the financial plan could not be finalised until the system control total had been agreed with NHS England, a process that was iterative and ongoing.

11. Performance Report

11.1 The Board received the Performance Report which provided a summary of the Trust's performance against the national quality indicators. Caroline Hutton advised that the performance report would be presented in a different format at the next meeting to support the operating plan. The performance report would also include the People metrics and Caroline Hutton welcomed suggestions of other key metrics that would shape the report.

11.2 John Lisle suggested evaluated activity/service line cost and length of stay/total bed days lost be included in the report. It was noted that the performance report contained a lot of data but lacked supporting narrative.

11.3 The Board discussed the forum for discussing performance metrics; as the Trust did not have a separate performance committee, the Board took a unitary approach to performance. It was suggested that the Board review and discuss productivity metrics at a Board Seminar.

11.4 Ellis Pullinger was pleased to report that the Trust delivered the 76% performance standard in March. There were challenges in recent weeks surrounding ambulance handovers, although the Trust's performance was relative in comparison to surrounding Trusts, the pressure comprised the level of care. The Trust was working under the highest level of escalation available. Bryan Ingleby acknowledged that although the Trust reached the nationally mandated standard in March, it came at a cost to the workforce and there was significant pressure on all sites.

11.5 The Trust was introducing PURPOSE T, which risk assessed patients for pressure ulcers.

11.6 Ellis Pullinger advised that a review was commissioned so that areas could be risk assessed accordingly. ENT and surgery were identified as areas of focus. The Board would receive the full plan at a future meeting. **Action: EP**

11.7 The Board of Directors **NOTED** the Performance Report.

12. National Staff Survey Results

12.1 The Board was presented with the National Staff Survey (NSS) Results and the following key points were highlighted:

- The response rate had substantially improved, with 6,169 responses received.
- The Trust achieved the 5th best improved response rate compared with other nationally benchmarked organisations.
- The highest ranking scores were:
  - the people you work with are understanding and kind to one another (74.5%).
  - the people you work with treat each other with respect (75.7%).
  - individual differences are respected (74.8%).
  - where the people you work with show appreciation to one another (71.6%).

- you know what your work responsibilities are (88.7%).
- you feel trusted to do your job (92.4%).
- you enjoy working with colleagues in your team (83.6%).
- and your immediate manager encourages you at work (74.0%).

12.2 Considering that staff were operating under Opel escalation during the response period, the results the Trust received were very positive. It was noted that neighbouring Trusts were amongst those most engaged nationally, and therefore when benchmarking regionally the Trust was around average.

12.3 Areas of focus included:

- unwanted behaviour of a sexual nature from patients/service users, their relatives, or members of the public (7.5%).
- Can approach immediate manager to talk openly about flexible working (70.6%).

12.4 Action plans were developed for each of the responses and the HR team were heavily focussed on communicating the Trust's zero tolerance approach to harassment and discrimination. Overall, there would be focus on protecting staff, compassionate leadership and flexible working to improve work life balance.

12.5 John Lisle queried whether the results could be disaggregated to identify pockets of staff. Matt Joint acknowledged that that clinical response rate was typically lower and advised that the pay disputes were ongoing during the NSS.

12.6 John Lisle asked how the team intended to communicate actions taken as a result of the survey, so staff felt their voice had been heard and felt valued. Matt Joint explained that Chiefs communicated with their directorates and messages were filtered down through people managers.

12.7 Na'eem Ahmed commented that it would be interesting to review the results by protected characteristic to determine whether there was a variation in experience. Matt Joint said that at a high level there was little difference. He acknowledged that staff of a global majority background were more likely to be subjected to bullying and harassment.

12.8 MB advised that the People Committee had also discussed the National Staff Survey at depth and found some of the responses unsettling and had requested sight of the raw data for better granularity. The Committee had also discussed bullying and harassment, freedom to speak up and flexible working.

12.9 Caroline Hutton assured the Board that areas of concern were identified, and action plans were in place and campaigns would be implemented rapidly.

12.10 It was agreed that the Board would receive an update on the actions and results of the quarterly Pulse surveys. **Action: MJ**

12.11 The Board of Directors **NOTED** the National Staff Survey Results.

13. Equality, Diversity and Inclusion – High Impact Actions

13.1 The Board received the Equality, Diversity and Inclusion High Impact Actions report and were told that NHS England had set out 6 actions with a range of deadlines from 2023-2026. The Trust was quick to adopt the actions and progress was detailed in the report.

13.2 A key action was the incorporation of an EDI Committee chaired by Geeta Menon. The Board would receive an update from the Committee at a future meeting. **Action: MJ**

13.3 Linda Burke praised the work of the team and suggested they be linked to the Workforce Race Equality Standard data. Linda asked how the Trust ensured diverse interview panels. Matt Joint advised that the team were actively implementing new recruitment practices and the actions were moving at pace.

13.4 The Board of Directors **NOTED** the Equality, Diversity and Inclusion High Impact Actions report.

14. Freedom to Speak Up Report

14.1 Steve Roots, Freedom to Speak Up Guardian presented the Board with the Freedom to Speak Up (FTSU) report. He explained that his role was continuously developing, and large portion of his time included finding local resolutions for bullying and harassment. He also worked closely with the EDI team and recently published a LGBTQ+ blog focussing on unconscious bias.

14.2 Matt Joint commented that the Executive Performance Oversight Delivery Group had recently approved a business case for additional resource equating to 3 part time guardians. The team were also looking into reporting software which would encourage staff to report anonymously.

14.3 John Weaver commented that the way the team dealt with concerns was exemplary however the number of staff who did not feel safe to speak up was not decreasing and queried the team's plans and ambition to tackle the figure. Steve Roots assured the Board that the team's ambition was to bring the number down and to move away from using the FTSU Guardian as a safety net, but to actively encourage and promote reporting. The Board challenged the team to adopt a new approach to reduce the number of staff. The Board would receive an update at a future meeting. **Action: MJ/SR**

14.3 The Trust Chair thanked Linda Burke for her time as the Freedom to Speak Up Champion and noted that the role would pass to Janet Rubin.

14.4 The Board of Directors **NOTED** the Freedom to Speak Up report.

15. SIRO Annual Report

15.1 Kishamer Sidhu presented the Senior Information Risk Owner (SIRO) Report which summarised the key activities of the Information Governance (IG) department during 2023/2024.

15.2 The report highlighted that the Access to Health Records Team struggled to respond to requests for copies of records within the legal timescale, due to volume of work and vacancies in the department, though significant improvement was made in the last in the 3 months of 2023 and in 2024 Q1.

15.3 The ICO was taking an individual perspective on queries, rather than evaluating the general case it would concentrate on the specific issue.

15.4 The Board of Directors **NOTED** the SIRO Annual Report.

16. Committee Terms of Reference

16.1 The Board received the Terms of Reference for the Charitable Funds Committee, Finance Investment Committee and People Committee. It was noted that the Finance Investment Committee Terms of Reference may require further revision in coming months to incorporate performance.

16.2 The Board of Directors **APPROVED** the revised Terms of Reference for the Charitable Funds Committee, Finance Investment Committee and People Committee.

17.	**Committee Reports**
	Charitable Funds – 11 March
17.1	The Committee Chair had nothing further to add.
	Finance and Investment – 29 February and 11 April
17.2	The Committee Chair had nothing further to add.
	People – 18 April
17.3	The Committee Chair had nothing further to add.
	Quality Assurance – 15 March
17.4	Linda Burke was now the Committee Chair and Melanie van Limborgh the Executive Lead. The Committee would receive updates on the Care Quality Programme and ward accreditation. The Committee would also begin to consider Equality and Diversity from a patient experience perspective.
18.	**Board Registers of Interest**
18.1	Victoria Cooper presented the 2023/2024 Board Registers of Interest and Register of Gifts and Hospitality.
18.2	The Board of Directors **NOTED** the Board Registers of Interest.
19.	**Annual Board Cycle of Business**
19.1	The Board received the Annual Cycle of Business for 2024/2025. Bryan Ingleby asked that comments be submitted to the Company Secretariat.
19.2	The Board of Directors **NOTED** the Annual Cycle of Business.
20.	**Any Other Business**
20.1	There was no other business to discuss.
21.	**Public Questions**
21.1	Sarah Peacey, Lead Governor asked for more information on the Trust's mental health services. TH said that the Trust's mental health provisions were good however flow remained a challenge. Work with the ICB and NHS 111 was ongoing.
21.2	In relation to early cancer diagnosis, Sarah Peacey had received feedback from her constituents that they were experiencing difficulties accessing GPs and were often referred to Urgent Care Centres. TH replied that the majority of early cancer diagnosis was linked to national level screening programmes and investment at a national level would educate patients on assessing symptoms and accessing healthcare earlier, rather than waiting until they present at A&E.
21.3	Jan Burnett, member of the public, acknowledged the discussion around the Trust's financial position and queried the impact on the New Frimley Park Hospital. The Trust Chair explained that the hospital would be funded separately as part of a national programme and that the funding had been allocated.
22.	**Date of Next Meeting**
22.1	Friday 5th July 2024, 08:30-11:30, Town Hall, Greenwood Offices, Heatherwood Hospital

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

Name:	Bryan Ingleby
Signature:	
Date:	

BOARD OF DIRECTORS MEETING IN PUBLIC ACTION LOG

Friday 5th July 2024

AGREED ACTION	LEAD	END DATE
CLOSED ACTIONS		
3rd May 2024 – 12.10 National Staff Survey Results The Board will receive an update on the actions and results of the quarterly Pulse surveys. ***Update: These have been added to the Board Annual Cycle of Business.***	Matt Joint	5 July 2024
ACTIONS IN PROGRESS		
5th May 2023 – 11.5 EPR Programme Update Board to receive outcomes from the EPR optimisation/managing change learning event. ***Update: A report following a two-year post 'go live' event is currently under review with the Transformation Board. Once the report has been approved by the Transformation Board it will be uploaded to the reading room.***	Caroline Hutton	5 July 2024
1st March 2024 – 11.7 People Update The Board will receive a detailed update on actions the Trust is taking on staff wellbeing at a future Seminar.	Matt Joint	December 2024
3rd May 2024 – 11.6 Performance Report The Board would receive an update on paediatric performance at the next meeting. ***Update: A verbal update will be provided at the meeting.***	Ellis Pullinger	5 July 2024
3rd May 2024 – 13.2 Equality, Diversity and Inclusion – High Impact Actions The Board will receive an update on the progress being made on the Equality, Diversity, and Inclusion (EDI) High Impact Actions and the work of the EDI Committee at a future meeting.	Matt Joint	1 November 2024
3rd May 2024 – 14. Freedom to Speak Up Matt Joint and Steve Roots were challenged by the Board to adopt a new approach to target the 35% of staff who did not feel safe to speak up, and to set an ambition to improve the metric.	Matt Joint	6 September 2024

Report Title	**Chief Executive's Report**
Meeting and Date	Public Board of Directors, 5th July 2024.
Agenda Item	8.
Author and Executive Lead	Caroline Hutton, Interim Chief Executive
Executive Summary	The Chief Executive's Report provides a bi-monthly update on key activities and events in the Trust. The report highlights the national context, the Trust's developments and achievements, and strategic updates.
Action	The Board is asked to **NOTE** the Chief Executive's report.
Compliance	Board Assurance

Chief Executive Report July 2024

1.0 INTRODUCTION

This report highlights the main areas to bring to attention to the Board of Directors during this period. Please note the national context and recognise the developments and achievements of the Trust since we last met. To support the focus required on delivery of our plans for this year we have made a change to the format of our performance report which is included in the Board papers for this month, and I have removed any detailed performance updates from my report as they are now comprehensively covered in that document.

This will be my last public board meeting as Chief Executive (Interim) as we will welcome our new Chief Executive, Lance McCarthy, on 20 August. I will be working with the Chair and Lance to organise a thorough and balanced induction and smooth handover.

New Chief of Service for Medicine

I am pleased to report that Dr Chris Orchard, consultant cystic fibrosis and respiratory physician, has been appointed as our new Chief of Service for Medicine, succeeding Dr Gareth Roberts, who has taken on the new Chief of Service role for Transformation and Continuous Improvement.

2.0 NATIONAL AND SYSTEM UPDATE

National context and our plans

The backlog for non-urgent operations remains a significant challenge nationally, rising slightly in April to 7.57 million people from 7.54 million the previous month, having peaked in September 2023 at 7.77 million. This was despite staff in the NHS performing a record number of elective procedures, appointments and tests in April 2024. Suspected cancer referrals also hit a new record in April at 260,000. May 2024 saw 2.4 million people attending Emergency Departments across the country, which was the highest number on record and 5% higher than April. It was the second busiest month for emergency admissions (565,000, second only to March 2024).

These national trends were broadly reflected in our own performance. At Frimley Health the year-on-year increase in ED attendance was 7% for May. Although we are now in summer, we continue to see significant demand, with attendances in our emergency departments (EDs) frequently over 400 per day at each site and more than 500 people attending urgent care centres in Slough, Bracknell and Aldershot.

We have continued to reduce the number of long waiters and maintain focus on meeting the national directive of no more patients waiting over 65 weeks by September as well as a continued progress with reducing our 62-day backlog and 28-day diagnostic standard in cancer. But we are off plan with improving access to urgent and emergency care and with referral to treatment times. You can read more in the updated performance report included with this July's Board papers.

Regionally, virtual wards across South East England, including at Frimley Health, are set to be increased having been recognised as a world leading initiative. The latest analysis, which was announced by NHS England in May, showed some 9,000 patients were treated in their own homes across the region last year instead of in hospital, overseen by hospital, community and primary care teams. Frimley Heath has been a significant contributor to this success, with over a thousand

patients seen by the Frimley frailty virtual ward alone in the past year. NHS England is now looking to incentivise best practice in virtual ward care nationally after NHS analysis calculated that 178,000 admissions could be avoided over the next two years.

Industrial action

Junior doctors were on strike nationally from 27 June to 2 July, just days before the General Election, in their ongoing dispute. Our teams planned well, using their experience of earlier actions to ensure we had enough staff in the right areas to continue providing urgent and emergency care and to retain as much elective care as possible. We have also started planning with ICB colleagues for the possibility of collective national action in primary care later this summer, pending the results of a ballot by the BMA of its GPs, which is due to close at the end of this month (29 July).

ICB Update

System visit by NHS Confederation

NHS Confederation Chief Executive Matthew Taylor visited Heatherwood Hospital and Frimley ICS recently to see how we are combining our electronic patient record with population health system data to improve and plan care for individuals and communities. In an online post about his visit, Mr Taylor described the proactive use of data as inspirational and innovative.

ICB oversight and assessment framework

During May and June, NHS England invited feedback on its updated Oversight and Assessment Framework for integrated care boards. This framework has been designed to foster a culture of continuous improvement to support ICB to achieve maturity. The framework's core purposes include aligning priorities for sharing ownership of improvements among organisations, sharing good practice, identifying where support and intervention might be needed and deciding when and how NHS England might intervene if necessary. The updated NHS Oversight and Assessment Framework is expected to be published and implemented later in 2024.

2024-25 Frimley ICS Operating Plan

Frimley ICS is aiming for its 1,439 bed capacity to be maintained, the delivery of 119% elective recovery (against 2019-20 levels) and an overall 0.1% reduction in workforce in 2024-25. It is also aiming to breakeven by the end of 2025-26 (within two years) and continues to identify improvements and mitigations to the Operating Plan position and risks submitted on 2 May 2024.

Discussions are ongoing regarding underlying risks to delivery and particularly in relation to RAAC which is a significant risk for our system until the new hospital is in place in 2030.

Primary Care Access Recovery Plan

The alignment between the Frimley Population Health Model, the Modern General Practice Access Model and other initiatives was discussed by Frimley ICB with progress reported in May 2024. The Modern General Practice Access Model aims to meet the needs of both patients and staff and make the best use of services and is a major change to how many practices have traditionally worked.

Frimley ICS has made some good progress including 99% of Frimley pharmacies are signed up to provide the pharmacy first service and 91% of Frimley practices actively participating in the service. The Committee in Common is leading on the work between primary and secondary care by bringing clinicians together to identify and resolve interface issues. This has resulted in the FHFT & Primary Care Collaborative Working Reference Guide.

ICB clinical policies update

Frimley ICB's clinical policy alignment project, which aims to achieve harmonisation of evidence based clinical commissioning policies across the ICB in order to reduce unwarranted variation in access to care and ensure that the commissioning of these services is consistent and applicable to all areas within NHS Frimley going forward, has appraised and agreed 56 clinical policies which have been recommended by the Buckinghamshire, Oxfordshire and Berkshire West (BOB) and Frimley Priorities Committee (BOBFPC, previously Thames Valley Priorities Committee). Twenty-six policies have been recommended for archiving following review. Each policy has undergone a robust process of evidence review and clinical input.

The new policies came into effect on 1 June 2024 for all new referrals. A transitional implementation arrangement is in place for patients who have been referred before the 1 June 2024.

There are still a small number of policy topics that are yet to be aligned across the Frimley localities. These policies have potentially high impact differences. This work is currently on hold, with a view to these being processed with the support of the new South East Regional Priorities Committee (SERPC), which was expected to start convening in June 2024.

3.0 STRATEGY

Operational plan

Our operational and financial plans for the year have been accepted by the NHS England national team, following a meeting in May between the NHS England national executive team, ICB representatives and me to review them and ensure they aligned with national and regional priorities and will be supported at all levels.

Strategic objectives

Our 2024-25 strategic objectives are aligned with the ambitions in Our Future FHFT strategy, which is now in its final year. These are in the process of being shared throughout the trust and teams are being encouraged to consider how they can contribute towards achieving them to enhance the experiences of our patients and our staff, this year. Our teams will be encouraged and supported to discuss and agree how they can contribute towards achieving the strategic objectives.

Performance indicators and metrics have now been finalised and included as part of our operational plan in order to track and demonstrate progress towards each of the ambitions.

Care Quality Programme

Our Care Quality Programme (CQP) has continued to make excellent progress, particularly with our ward accreditation work. More than 20 wards have completed accreditation, which is gaining real momentum and helping us ensure continuous improvement is at the core of everything we do.

We have developed a suite of resources to support teams and individuals to understand how they can contribute to our operational focus on quality and consistent best practice. This is also helping towards our aspiration of achieving an outstanding rating from the Care Quality Commission as we anticipate a potential inspection.

Earlier this month the Executive team met with our CQC engagement manager and the CQC regional lead as an introductory meeting which was followed by a walkaround visit to Heatherwood Hospital. The purpose of this meeting was to get to know our local CQC leads and provide an overview of the organisation. The visit went well and the Heatherwood visit was well received.

New Trust strategy

We are continuing to develop our longer-term strategy that will enable us to deliver the best possible care for our communities for the rest of the decade and this was discussed at the Board Seminar meeting in June. We expect to be revealing more on our strategy development for 2025-30 in the months ahead.

New Frimley Park Hospital Programme

Our Chief Finance Officer Kishamer Sidhu has taken on the senior responsible officer (SRO) role for the New Frimley Park Hospital Programme (NFPHP) after Nigel Foster left the Trust at the end of May. During Nigel's time as SRO we made significant progress, including establishing the Programme Management Office and advancing the search for the best site for the new hospital.

Our new hospital programme team is currently following a comprehensive site selection process to narrow down our search for a new site which began in summer 2023 when we first asked a specialist land agency to identify a range of potential sites. Since then, we have used various criteria (such as a site's overall ability to deliver for 2030, access and distance from the current site being less than a five-mile radius) and considered feedback from our recent engagement period. This has helped rule out unsuitable sites from a long list and find our preferred locations.

We are now undertaking a continued level of due diligence on our preferred sites before further decisions can be made to enable us to take the necessary steps to secure our preferred site.

We used the public and staff feedback, comments, and opinions to shape our site evaluation criteria and have published a report that explains how the feedback was considered in our site selection process so far. This is available to download on our website, alongside independent analysis of the feedback we received during the engagement period.

We remain on track to redevelop Frimley Park Hospital for 2030 and are working closely with all partners to optimise our programme plans to achieve this challenging deadline.

Transformation and Continuous Improvement Board

Dr Gareth Roberts (Chief of Service for Transformation and Continuous Improvement) and Liz Howells (Director of Transformation and Continuous Improvement) are now leading our newly established transformation and continuous improvement board, which is helping to coordinate and prioritise work and ensure that we are prioritising resources around our key priorities and objectives for this year including building on recent successes, such as the new Heatherwood Hospital and our electronic patient record (EPR). The transformation board will enable us to increase focus where it will have the greatest impact. By aligning the digital and EPR opportunities with Frimley Excellence continuous improvement and large transformation work (such as urgent care improvement, outpatient transformation and the cost and efficiency improvement work being led by the finance teams) as well as joining up other change initiatives and our major capital programmes such as the new Community Diagnostic Centre under construction in Slough, the Frimley Park diagnostic and inpatient extension due to be ready early next year, and of course the plans for our new Frimley Park Hospital, we will be able to drive transformation and improvement that maximises our investments and has the greatest positive impact for patients and staff.

We are in a fantastic position to utilise the skills and resources we have within our teams to optimise our EPR and make use of the extensive functionality it can provide to support more efficient and productive ways of working and improvements to patient care – something I know teams are very keen to progress.

One of these improvement projects is being rolled out for our electronic patient record (EPR). Epic Hyperdrive is our new web-based access that will make our EPR more secure and simpler to update and align with other systems, helping us to unlock the system's full potential over the coming years.

Feedback from the successful roll-out group of the initial pilot phase has been very positive, with users reporting that applications within Epic are faster and many of the new functions easy to use. This comes as one of our objectives for the year ahead is to maximise the capabilities that Epic can offer us.

4.0 DEVELOPMENTS AND ACHIEVEMENTS

MBE for former Chair

Our congratulations to Pradip Patel, the former Trust Chair, who was awarded an MBE in the King's Birthday Honours last month in recognition of his service to healthcare. Pradip served as our Chair for seven years before stepping down last year and we are delighted for him that his efforts and commitment have been acknowledged in this way.

Artificial cornea story hits national news

Our Trust received widespread coverage in the national media after being the first in the country to perform a transplant using an artificial cornea. Consultant ophthalmologist Tom Poole carried out the first procedure in February at Frimley Park Hospital, and the sight of his 91-year-old patient has since been improving week on week. It was covered in several national newspapers, including the front page of The Guardian, a multitude of online articles and broadcast coverage on Sky News, BBC London, ITV Meridian and many independent radio stations, and included a positive quote from NHS England medical director Stephen Powys.

Diabetes specialist nurses shortlisted for national award

Our diabetes specialist nurses were shortlisted for the Secondary Care Nurse of the Year category of the Diabetes Nursing Awards, which honour nurses who have demonstrated exceptional dedication to the care and support of people living with diabetes in secondary care settings. This recognises the team's achievements in developing our diabetes service in recent years.

Estates and Facilities Day

National Healthcare Estates and Facilities Day on June 19 was an opportunity for us to say thank you to our amazing EFM (estates and facilities management) colleagues for the amazing work they do to keep our hospital and services running. James Clarke, Chief of Strategy and executive director for EFM, recorded a special message for teams who also welcomed visits from our Chair and members of the executive team and worked with our communications team to highlight some of the different areas of their work for staff and the public to read about.

AI project highly commended at awards

The ophthalmology department's use of its innovative AI clinical assistant 'Dora' was highly commended at this year's HSJ Digital Awards held at Manchester Arena last month. The awards recognise excellence in digitising, connecting, and transforming health and care and the Frimley eye team received a high commendation in the Driving Change Through AI and Automation category - out of a total of 393 entries. The team's successful entry was entitled 'Optimising a high-volume cataract pathway with an artificial intelligence autonomous clinical assistant'.

Report Title	Performance Report
Meeting and Date	Public Board of Directors, Friday 5 July 2024
Agenda Item	9.
Author and Executive Lead	Health Information Services Caroline Hutton, Interim Chief Executive Officer
Executive Summary	The Performance Report provides a summary of the Trust's performance against the national quality indicators. The report highlights: • Updates from relevant Executive team members in the following areas: Quality, Performance, People, Money • Enhanced performance reporting using SPC methodology linkedto a number of metrics across a range of domains • Benchmarking reports • Use of resources, activity and CQC Insights reports
Action	The Board is asked to **NOTE** the Performance Report and receive assurance on the Trust's performance against the national quality standards.
Compliance	CQC quality standards and NHS performance standards

Our future FHFT

Committed to excellence | Working together | Facing the future

NHS
Frimley Health
NHS Foundation Trust

Version 3.1

Performance report

July 2024




Contents

This report includes data over time to allow comparison with historic performance.
The targets, actuals and exception reports relate to the reporting month May 2024 for the financial year 2024/2025
Please note that metrics where data is not currently of sufficient quality for external reporting have been excluded from the report. They are being monitored internally and will be added into the report as soon as they are available.

Cover sheet – Quality – Melanie van Limborgh

Incident reporting system

Inphase, our new incident reporting system, has been successfully launched, with no significant changes to our reporting profile. This transition marks a significant milestone in our ongoing efforts to enhance our data management and reporting capabilities and is fully compliant with new national reporting requirements.

Trust quality priorities 2024-25

We have finalised our quality priorities for the year, which include pressure injury prevention and sepsis recognition. These two areas were included in last year's priorities, but we have decided to keep our focus on these very important areas for the year ahead. We have introduced a task and finish group in relation to pressure injury prevention in line with national requirements. The group will focus on implementing Purpose T, a new framework for recognising, diagnosing, and managing the risk of pressure injuries.
Other quality priorities will focus on malnutrition, patient, family and carer experience of end-of-life care and healthcare-associated E-coli bacteraemia related to urinary tract infections associated with a urinary catheter.
In response to an increase in patient falls in the past year, we have identified a new Trust falls lead who will be spearheading initiatives to address this issue and reduce the incidence of falls within our facilities.

Inpatient Falls

In response to an increase in patient falls in the past year, we have identified a new Trust falls lead who will be spearheading initiatives to address this issue and reduce the incidence of falls within our facilities.

Ward accreditation programme

As part of our drive for continuous improvement across the trust and our CQP initiative, we have 20 wards and patient facing areas that have completed our ward accreditation programme, which provides assurance for patients and their friends and family regarding the care a ward or department provides. We are continuing to roll the programme out across the Trust.

Martha's Rule pilot site

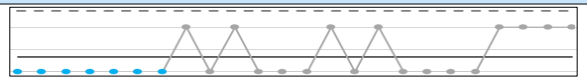
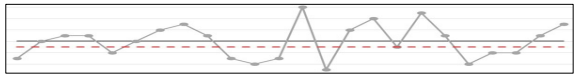
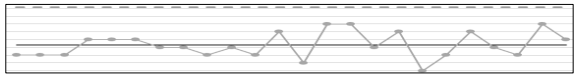
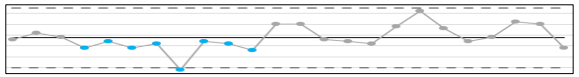
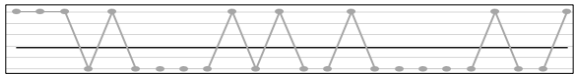
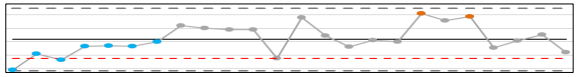
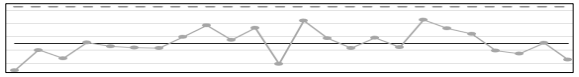
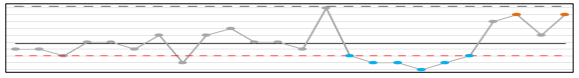
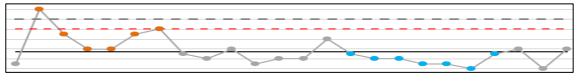
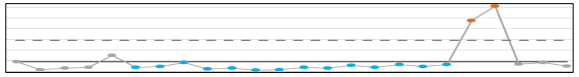
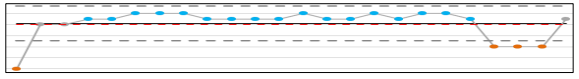
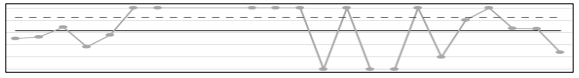
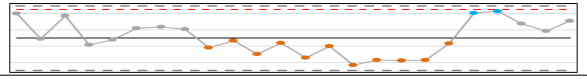
Frimley Park and Wexham Park hospitals have both been chosen as two of 143 sites nationally to pilot the introduction of Martha's Rule. The scheme is named after Martha Mills, who died from sepsis aged 13, having been treated at King's College Hospital, London in 2021, , due to a failure to escalate her to intensive care and after her family's concerns about her deteriorating condition were not responded to. The purpose of Martha's Rule is to provide a consistent and understandable way for patients and families to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to. We are now developing plans to introduce the rule, building on our existing Call 4 Concern initiative and shared decision- making work.

Cover sheet – Quality – Committee assurance statement

Key Highlights and Discussion Points Including Assurance Points for Board	• Patient experience annual report – good progress but still work to do to further improve complaints performance and follow up from PALs issues re behaviour of some staff at WPH • IPC – again some positive progress but still some concerns re specific areas of care, eg catheter care not as good as we would like. Removing sinks project showing some early positive outcomes • Mortality data shows positive outcomes
Key risks to Escalate	• First care quality programme report indicates that there is good engagement from staff in the programme. The Trust is continuing to progress the work in this area.
Recommendations/ Decisions Made	• It was agreed that the quarterly maternity report should include the maternity dashboard. • The care quality programme report will, in future, show where areas are performing well or where we have concerns.

Quality Scorecard – key indicators at-a-glance

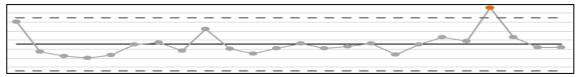
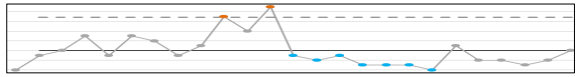
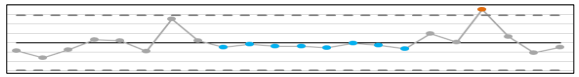
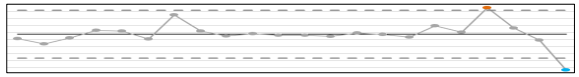
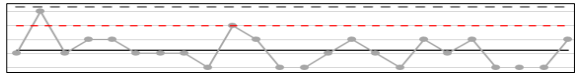
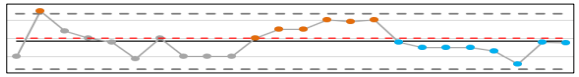
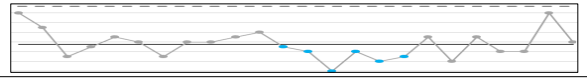
Improving Quality for Patients

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
MRSA~	1	2	0	-		
C-Diff~	9	16	≤5	-		
MSSA~	4	10	0	-		
E.Coli	14	39	TBC	-		
Never Events~	1	1	0	-		
Number of Falls	209	444	≤200	-	?	
Number of Falls (per 1,000 bed days)	4.63	4.95	TBC	-		
Number of Falls resulting in serious injury (April 2024)*~	8	8	≤2	H		
Number of Serious Incidents	6	8	≤10	-	?	
Mixed Sex Accommodation Breaches	23	64	0	-	?	
Patient FFT	96%	N/A	≥95%	-	?	
Complaint response time (40 day) – March 2024*	27.3%	59.5%	≥85%	-	?	
Complaint response time (60 day) – February 2024*	70.7%	50.2%	≥85%	-	?	

* - data is in arrears; ~ - numbers are too low for valid SPC assurance

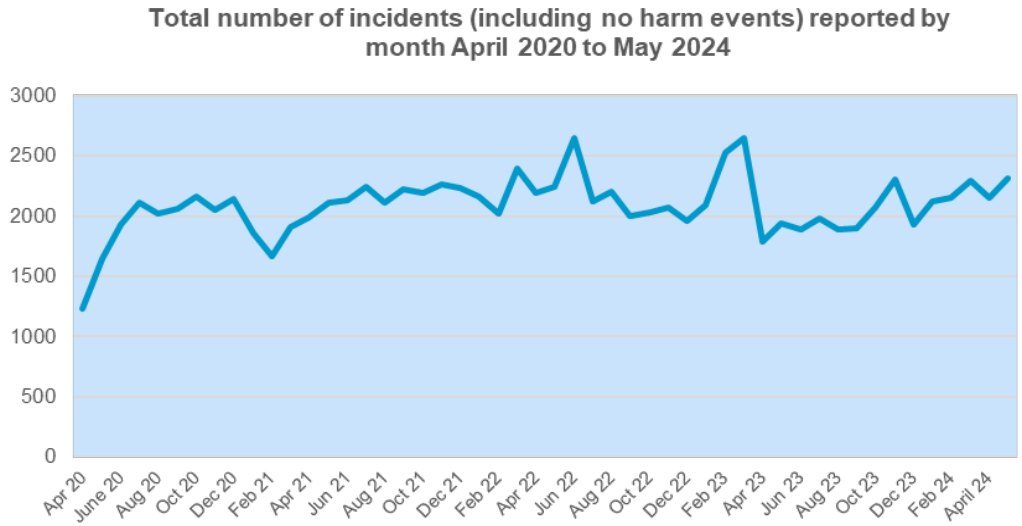
Quality scorecard – key indicators at-a-glance

Improving Quality for Patients

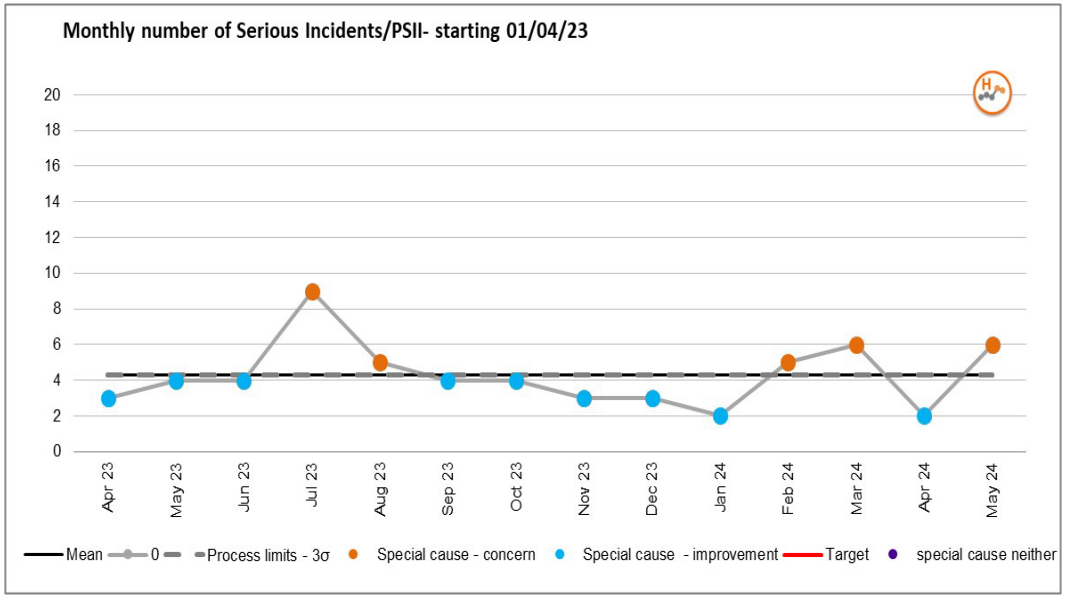
Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Pressure ulcers – hospital acquired (category 2) – April 2024	62	62	TBC	-		
Pressure ulcers – hospital acquired (category 3) – April 2024*	4	4	TBC	-		
Pressure ulcers – hospital acquired (category 4) – April 2024*	1	1	TBC			
Pressure ulcer rate – (per 1,000 bed days; category 2,3 and 4) – April 2024	1.50	1.50	TBC	-		
Maternity – Number of Serious Incidents*	2	2	TBC	-		
Maternity – Midwife to birth ratio	1.25	1.25	≤1.25	L	?	
Maternity – Number of complaints received	6	18	TBC	-		

* - numbers too small for valid SPC assurance

Serious Incidents – as at end May 2024



Month	Total Incidents Reported	Number of PSII's
April 2024	2149	2
May 2024	2315	6



Patient Safety Incident Investigation Categories for April 2024 (2)

- 1 Diagnostic Incident
- 1 Surgical Invasive Procedure

Patient Safety Incident Investigation Categories for May 2024 (6)

- 1 Diagnostic Incident
- 1 Maternity/Obstetric (Baby only)
- 1 Maternity/Obstetric (mother only – maternal death)
- 1 Surgical/Invasive incident meeting Never Event Criteria
- 1 Fall
- 1 Treatment delay

- Inphase – Incident Reporting Module went Live on 22nd April 2024
- Patient Safety Incident Response Framework approved by the ICB with implementation from 1st April 2024.

Maternity Services – Key Information (as of May 2024)

	May-24	YTD
Maternity SI	1	2
MNSI	1 (also reported as SI)	1
RCA	1	2
Training compliance	94.41% (overall)	94.41%
Midwifery 1:1 care in Labour	98%	99%
Obstetric Weekly cover	132 (at each site)	132 (at each site)
Formal complaints (May 24)	5	9
HSIB/NHSR/CQC concern or Board request for action	CQC action plan	
Coroner Reg 28 made to trust	Nil	Nil

CQC Must-Do Actions:

- We have completed 3 out of 4 mandatory actions required by the Care Quality Commission (CQC).
- The remaining action, ensuring all medical staff complete mandatory training, is at 79% completion (target: 85%). Midwifery & nursing staff exceed trust target of 85%.
- The Chief of Service is addressing this with medical staff and completion dates are planned.
- Monthly attendance reviews are ongoing.

CNST Safety Actions:

- The Trust has met all 10 CNST standards in year 5, and already awarded with £ 3.1 M
- Year 6 Safety Actions are published and already distributed to all designated "Safety Action Leads."

Serious Incidents Summary Report

FPH

Serious Incident: Baby born in Poor Conditions (18th April 2024) **–** Currently being investigated

- Mother admitted to the birth centre in early labour, transferred to labour ward for augmentation. Delay in going to theatre due to high activity in the unit. At time of completing (72 hr) report, no neurological concerns.

MNSI referral: Maternal Death (13th May 2024) **–** Currently being investigated

- Mother found unresponsive in bathtub at home, 36+3. RIP.

WPH

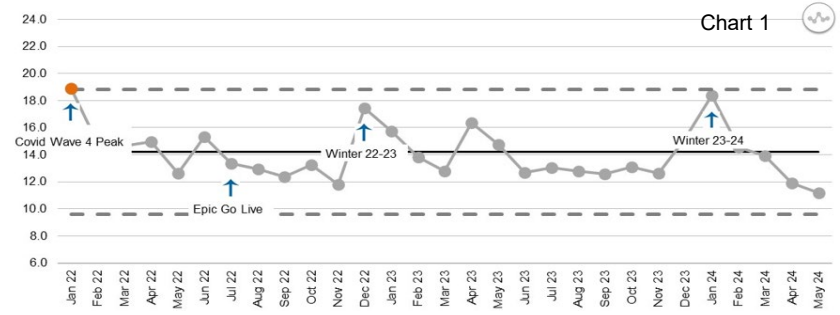
- There were no Serious Incidents reported or MNSI referrals made from Wexham Park Hospital during April and May 2024.

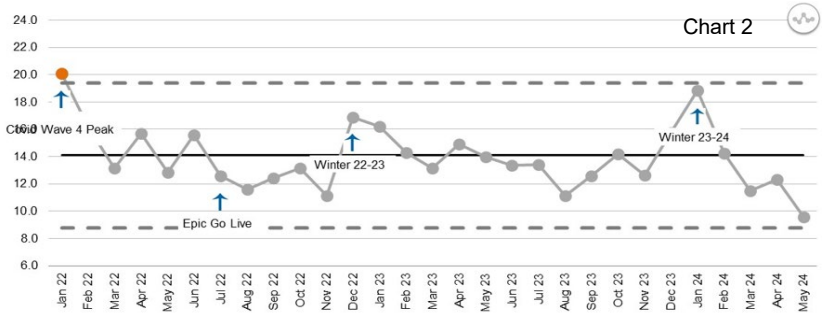
Mortality report

	20/21	21/22	May-23	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May-24	YTD
Number of inpatient deaths	3172	2714	235	203	201	203	209	225	221	216	305	238	246	196	194	390
Total deaths screened (including < 30 days post-discharge)	4105	3489	360	299	301	315	317	329	338	350	441	356	394	334	367	701
Cases sent for review	316	303	22	21	44	33	38	47	44	40	40	41	55	19	26	45
Total number of deaths judged > 50% likely to be due to problems with care	9	4	0	1	0	0	1	0	1	0	1	0	0	0	0	0
Number of deaths of patients with a Learning Disability	27	18	3	1	1	2	5	5	3	3	5	4	4	3	0	3
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

+The number of completed reviews updates monthly and may increase as there is a 12-week review time

In Hospital Monthly Mortality





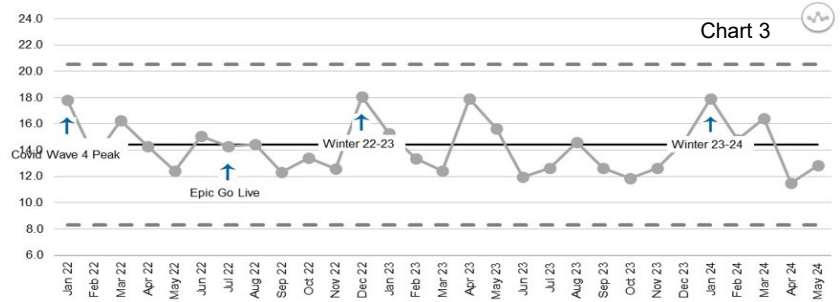


Chart 1 – Frimley Health In Hospital Mortality rate

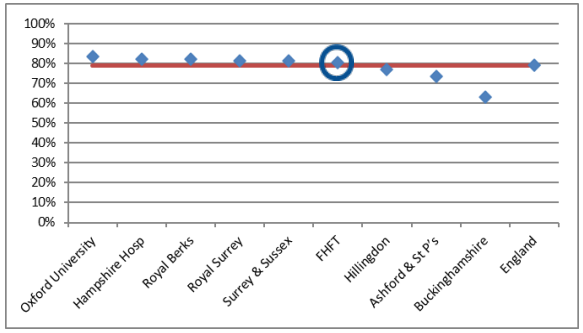
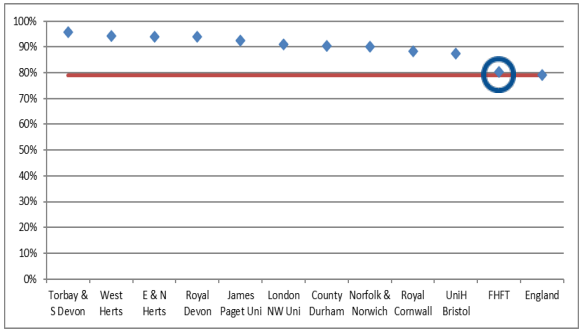
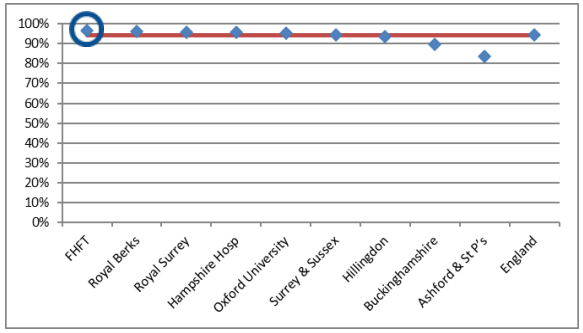
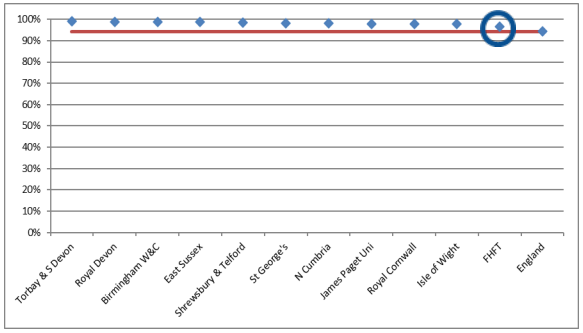
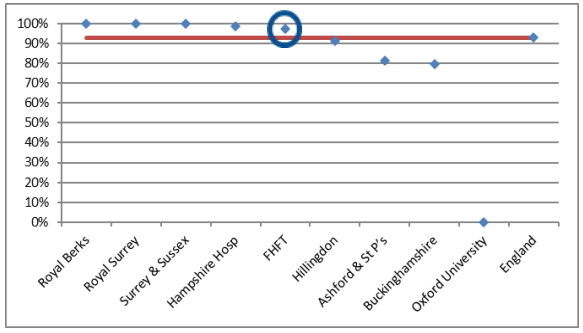
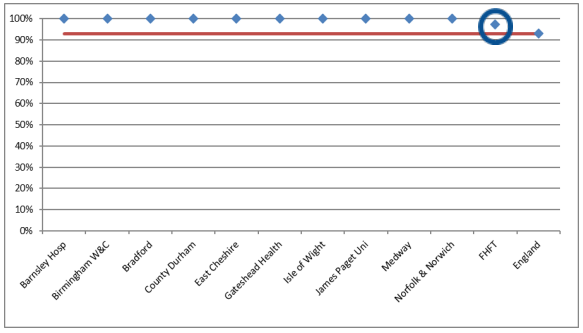
Chart 2 – Frimley Park In Hospital Mortality rate

Chart 3 – Heatherwood and Wexham Park In Hospital Mortality rate

Note: These figures do not include deaths < 30 days after discharge

Mean | Rate per 1000 discharges | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

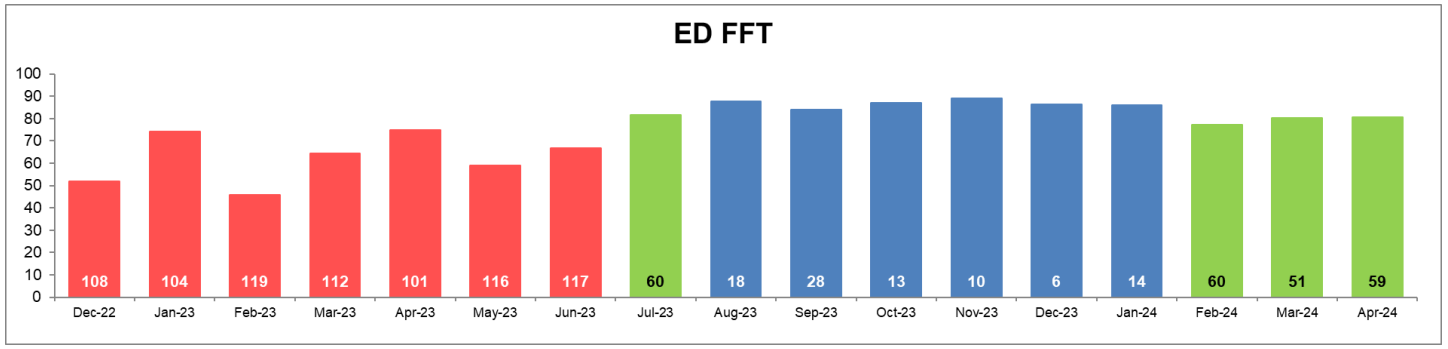
Benchmarking – selected measures

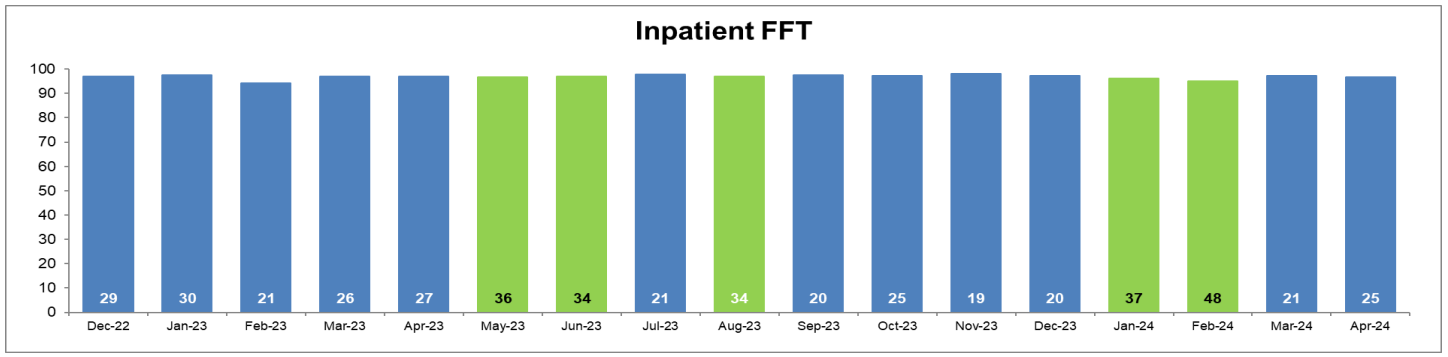
	Local trusts	Best in class	Rank	Quartile
ED FFT			59/122	2nd
Inpatient FFT			25/122	1st
Maternity FFT			36/118	2nd

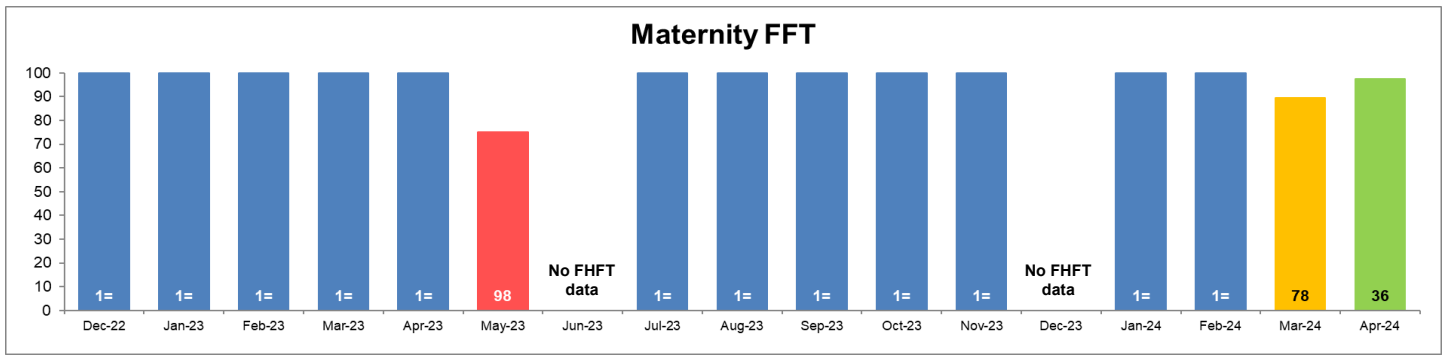
NOTE *– for each graph, the position furthest to the left is the best performing trust.* ***Data periods:*** *ED FFT, Inpatient FFT, Maternity FFT = April 2024. Maternity Best in Class is truncated alphabetically as there are more than ten trusts who are performing at 100%. Best in class peer group has been expanded to include both Acute and Acute & Community trusts*

Benchmarking – FHFT historic monthly performance (selected measures)

- Quartile 1
- Quartile 2
- Quartile 3
- Quartile 4







***NOTE** – for each chart, FHFT's rank compared to other acute trusts is shown in the relevant column.*
From March 2022 the cohort was expanded to include both acute and acute and community trusts, so the cohort now includes up to 125 trusts.

Cover sheet – Performance – Ellis Pullinger

In terms of FHFT's relative performance against key performance indicators agreed within the Trust's Operating Plan, the current closing position for May 2024 and forecast for June 2024 performance is outlined as follows:

Performance Standard	May Performance	FHFT Operating Plan Target	June Performance forecast	FHFT Operating Plan Target	National Target
ED (All Types) 4 hour standard	72.19%	77%	72.47%	77%	77%
RTT 65-week waits	527	248	620	168	0 (by Sept 2024)
RTT 52-week waits	4881	1773	5020	1663	N/A
RTT waiting list size	84,597	78,315	88,540	79,098	N/A
28-day FDS	80.1%	78.01%	82.1%	80%	75%
62-day Cancer	69.2%	72.16%	70.1%	72.96%	70%
DM01	12,383 (waiting list size)	12,761	12,365	12,634	N/A

Underlying productivity measures that we are tracking aligned to what is contained within the Board Performance Report (see below).

Productivity metrics			
Metric	Current month	YTD	Target / concern threshold
Day case rate	88.9%	89.3%	≥85%
Theatre Utilisation	77.9%	79.5%	≥85%
Elective Length of Stay (Acute)	2.96	2.86	TBC
Non-Elective Length of Stay (Acute NEL LoS)	6.3	6.31	6.6
Delayed discharges - No Criteria to Reside	252.2	250.4	TBC
Outpatient DNA rate	8.2	8.2	≤5%
New to Follow-up ratios (outpatient consultant led)	1.49	1.49	TBC

In summary of what is on plan (and the Trust will carry on against its operating plan) and what is not on plan (and so requires action) at this point in the 2024/25 year – the Trust has 4 indicators on plan, and 5 off plan.

On plan	Off Plan
Reduction in 65-week cohort by September 2024	ED performance
62-day cancer backlog reduction	62-day cancer performance
28-day Faster Diagnosis Standard performance	Current 65-week waits
DM01 waiting list	Current 52-week waits
	RTT waiting list size (see Slide 22 on Performance Report

Cover sheet – Performance

For areas which are off plan – there are a number of remedial actions against these which are being undertaken to bring these back to plan.

Indicator	Remedial Actions
ED performance	• Monthly Type 1 attendances was highest in May 2024 compared to previous 5 months. CFO and COO have commissioned analysis comparing forward trend against workforce model to assess sustainability. • UEC Programme focusing on two areas: The first is non-elective Length of Stay with particular focus at Wexham where LoS remains higher (9.77) than target plan compared to Frimley where LoS is under plan (6.89). Weekly meeting held with clinic teams involving CMO, COO and CNO. Secondly is to improve take for 'push and pull' appropriate patients through Same Day Emergency Care (SDEC) units on both sites – increasing from 6-10% to 15% in Quarter 2 this year. • External ICS UEC programme to agree location and purpose of existing Urgent Care Centre (UCC) in Aldershot, which though contributing to Type 3 activity, is not being adequately used in terms of attendance volumes. Active discussions underway whether UCC should be co-located next to main ED at FPH.
62-day cancer performance	• Active focus on reducing backlog of patients waiting 62-days plus for treatment aligned to national focus – which has reduced in April and May, but has impacted in-month performance – with expectation backlog should be reduced further through June and July to start shifting focus from August on 62-day compliance. • Given current 28-day FDS performance – main internal focus is on improving 31-day cancer target to treatment with specific focus on Urology and Skin to then improve 62-day performance.
Current 65-week waits	• Continue to focus on clearance of cohort of patients who will breach a 65-week wait for treatment by end of September 2024 as this will deal with current and potential tip-in patients. Good progress has been made on this – circa 9,400 of 15,000 patients in that cohort have already been treated and discharged since start of April. Ongoing focus on potential at risk specialties – notably ENT, Oral and Maxillofacial Surgery but plans are in place to sustain delivery.
Current 52-week waits	• Main focus is on reducing waiting times through improved productivity and focus on utilisation of Outpatient capacity – as waiting times are driving disproportionate proportion of patients waiting over 52-weeks in certain specialties. • Developing proposals with ICB to rollout enhanced referral pathways, including increase us of DXS to help support demand management. Proposals being developed in Dermatology and ENT to support with alternative means of managing demand on the Trust. • Outpatient Transformation and GIRFT Further Faster programme focused on improving access through Outpatients for patients – being led by Transformation team and tracked via Trust Transformation Board. ENT, Gastro, Gynae, Neurology and Ophthalmology identified as first specialties to focus on.
RTT waiting list size (see Slide 22 on Performance Report	• Developing proposals with ICB to rollout enhanced referral pathways, including increase us of DXS to help support demand management. Proposals being developed in Dermatology and ENT to support with alternative means of managing demand on the Trust. • Outpatient Transformation and GIRFT Further Faster programme focused on improving access through Outpatients for patients – being led by Transformation team and tracked via Trust Transformation Board. ENT, Gastro, Gynae, Neurology and Ophthalmology identified as first specialties to focus on. • Working with ICS on Evidence-Based Interventions Programme and identifying patients who could be appropriately discharged back to their GP as their treatments are not clinically necessary.

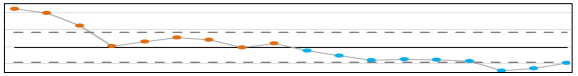
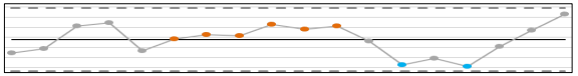
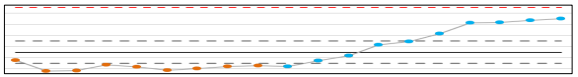
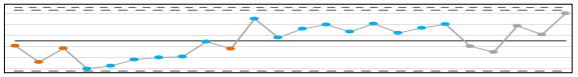
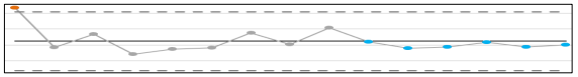
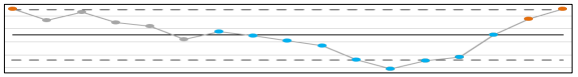
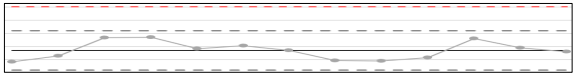
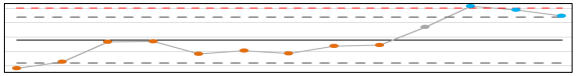
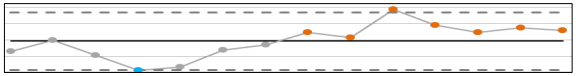
Cover sheet – Performance

In terms of Productivity Metrics – including those already referenced within the Board Performance Report – additional indicators are being tracked within the Trust to improve activity throughput.

Indicator	Trend	Commentary
Length of Stay		Overall LoS for non-elective care has been above plan for both April and May – largely driven by higher LoS (circa 9 days) at WPH.
ED Demand		Both ED departments have seen notable increases in activity over first two months of year with FPH running at 6% above previous year levels and WPH running at 9% above previous year levels.
Admissions		Overall admissions are running at below forecast levels but at roughly same as 2023 – mainly driven by WPH as FPH admissions are lower than 2023.
Discharges		Overall discharges are above 2023 levels and FPH is achieving target level but WPH remains some 20% short of target.
Non-Elective Overnight Activity		Non-Elective Overnight activity is running at circa 97% of plan currently – highlighting that non-elective activity remains generally static despite high ED demand.
Elective Overnight Activity		Elective overnight capacity remains circa 20% behind plan due to bed plan being behind schedule and failing to release capacity at Wexham Park and Frimley Park.
Day Case Activity		Overall Day Case activity remains above plan at circa 8% ahead of plan at M2.
Outpatient New Activity		Outpatient New Patient activity is running at circa 76% plan level. Ongoing focus on increasing new patients – as per action around RTT 52 week waits and RTT Waiting List size.
Outpatient Follow Up Activity		Overall Follow Up activity remains significantly higher than plan at 146% - exacerbating current new patient deficit against plan.
Outpatient Clinic Yield		Overall clinic yield (number of patients seen in a clinic session) is averaging circa 8 against a target of 9.

Performance scorecard – key indicators at-a-glance

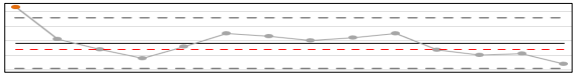
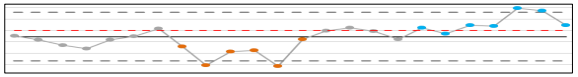
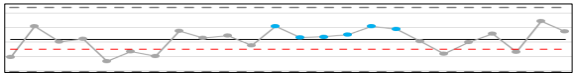
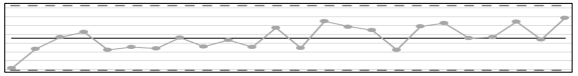
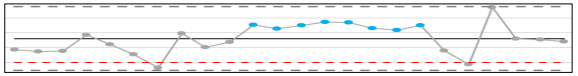
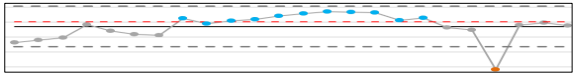
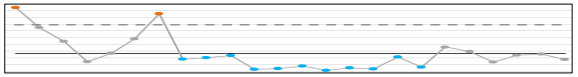
Transforming our Services

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Number of patients waiting 52 weeks or more for treatment	4,814	N/A	≤807	-	F	
Number of patients waiting 65 weeks or more for treatment	518	N/A	TBC	L	F	
RTT waiting list size (PTL)	85,306	N/A	N/A	-		
Diagnostics (% receiving diagnostic test within 6 weeks)	85%	N/A	≥95%	H	F	
Stroke – percentage admitted within 4 hours	75%	65.3%	≥80%	-	F	
Inpatient bed days used by children with mental health problems (where no acute paediatric care is provided)	100	N/A	TBC	L		
Number of children and young people on RTT waiting list	7,308	N/A	TBC	H		
A&E waiting times – Type 1 % seen within 4 hours	58.1%	58.7%	≥75%	-	F	
A&E waiting times – all types (system) % seen within 4 hours	72.3%	73.4%	≥75%	H	F	
A&E waiting times – 12-hour breaches (%)	9.2%	9.3%		H		

* - data relates to the performance of the ambulance trusts as a whole; it is not possible to disaggregate the performance for FHFT hospitals specifically

Performance scorecard – key indicators at-a-glance

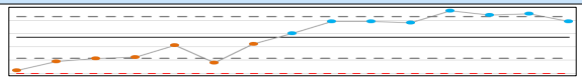
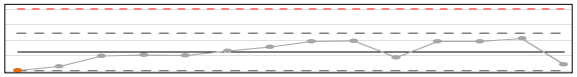
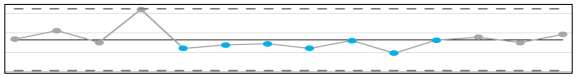
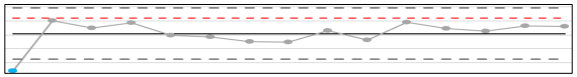
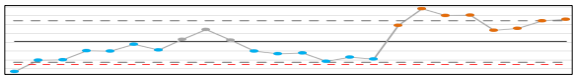
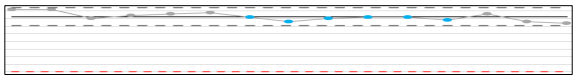
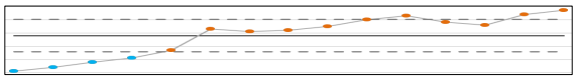
Collaborating with our Partners

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Cancer – performance against 62-day standard	5.4%	N/A	≤6.4%	-	?	
Cancer – performance against 28-day faster diagnosis standard (April 2024)	77.3%	N/A	≥75%	H	?	
Community services – 2-hour response	87.2%	90.7%	≥75%	-	?	
Community services – caseload discharges	1,485	2,725	TBC	-		
Community services – emergency readmissions within 30 days following discharge from a community ward (April 2024)	31	31	TBC	-		
Ambulance handovers – % within 15 minutes	72%	72.3%	≥65%	-	?	
Ambulance handovers – % within 30 minutes	93.8%	94.3%	≥95%	-	?	
Ambulance handovers – number over 60 minutes	35	86	0	-	?	

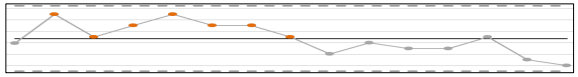
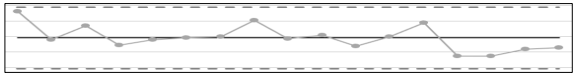
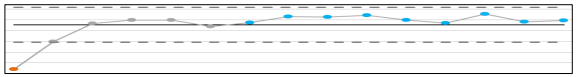
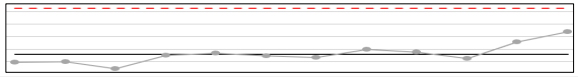
* **NOTE** – there is a stretch target for NTCR (No Criteria to Reside – previous Medically Fit For Discharge) to reach 100 by March 2024

Performance Scorecard – key indicators at-a-glance

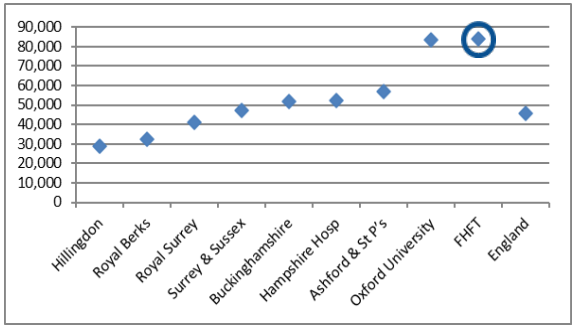
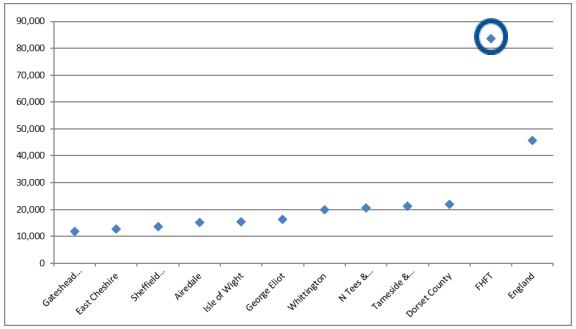
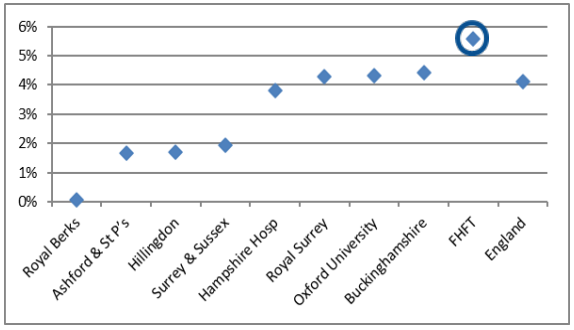
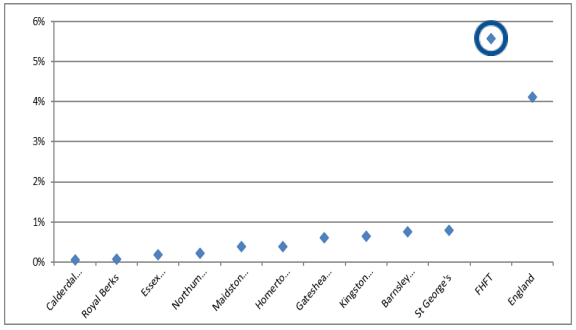
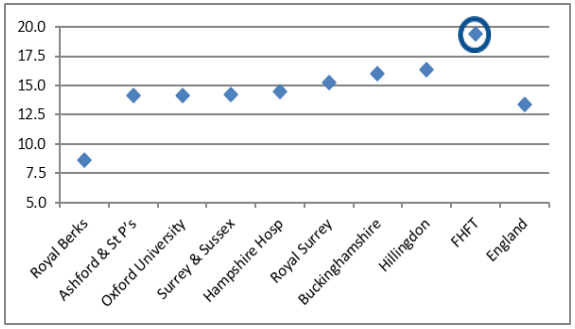
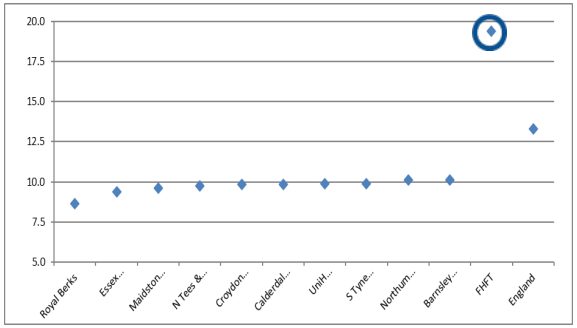
Productivity metrics

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Day case rate	88.9%	89.3%	≥85%	H	P	
Theatre Utilisation	77.9%	79.5%	≥85%	-	F	
Elective Length of Stay (Acute)	2.96	2.86	TBC	-		
Non-Elective Length of Stay (Acute NEL LoS)	6.3	6.31	6.6	-	?	
Delayed discharges - No Criteria to Reside	252.2	250.4	TBC	H	F	
Outpatient DNA rate	8.2	8.2	≤5%	-	F	
New to Follow-up ratios (outpatient consultant led)	1.49	1.49	TBC	H		

Performance Scorecard – key indicators at-a-glance

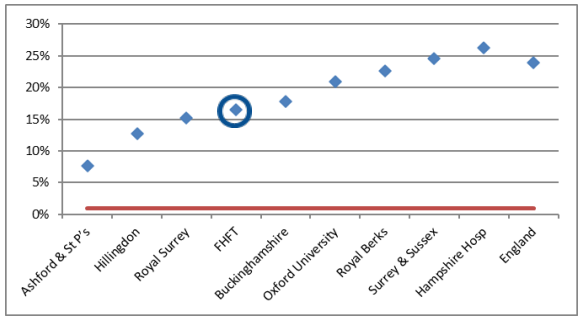
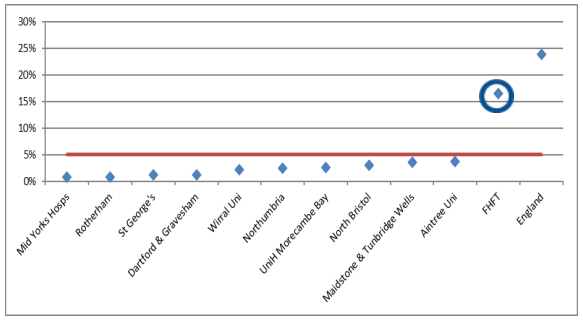
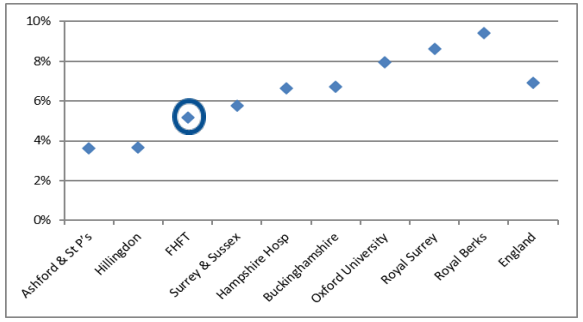
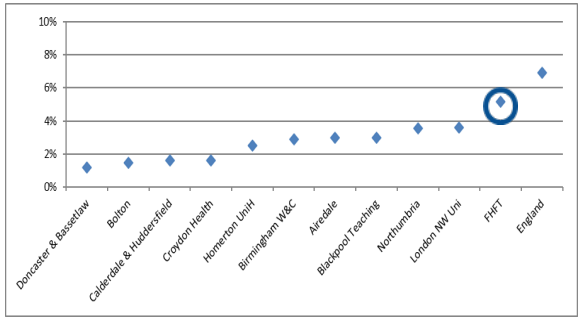
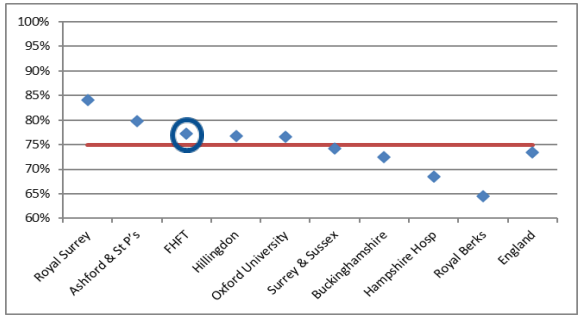
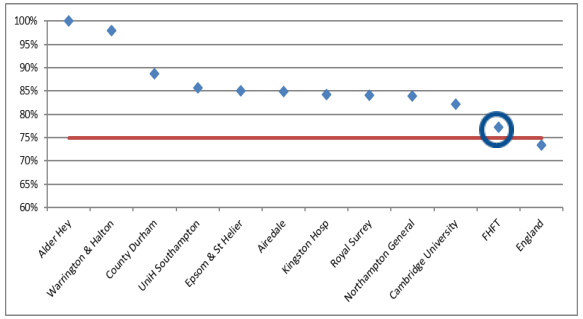
Efficiency metrics						
Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Outpatient hospital-initiated cancellation rate	1.7	1.7	TBC	-		
Clock stop ratio	1.03	1.03	TBC	-		
Outpatient attendances with no procedure seen virtually	27.1%	N/A	TBC	H		
Use of PIFU - proportion of patients who are put onto a PIFU pathway	5.7%	N/A	≥6.6%			

Benchmarking – selected measures

	Local trusts	Best in class	Rank	Quartile
RTT – Total incompletes			100/122	4th
RTT – 52 plus weeks (% of total incompletes)			107/123	4th
RTT – Median RTT waiting time			120/123	4th

***NOTE** – for each graph, the position furthest to the left is the best performing trust. **Data periods:** RTT = April 2024*
Best in class peer group has been expanded to include both Acute and Acute & Community trusts so the cohort now includes up to 125 trusts.

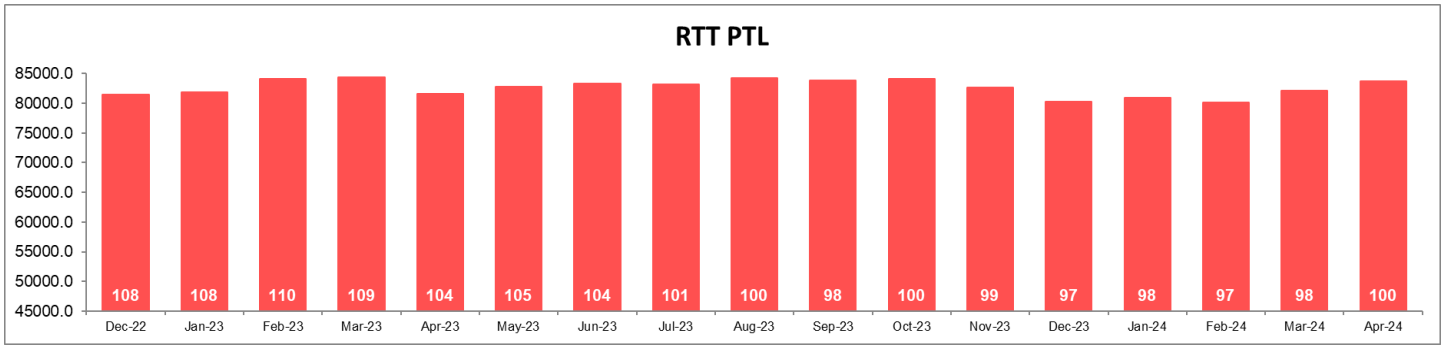
Benchmarking – selected measures

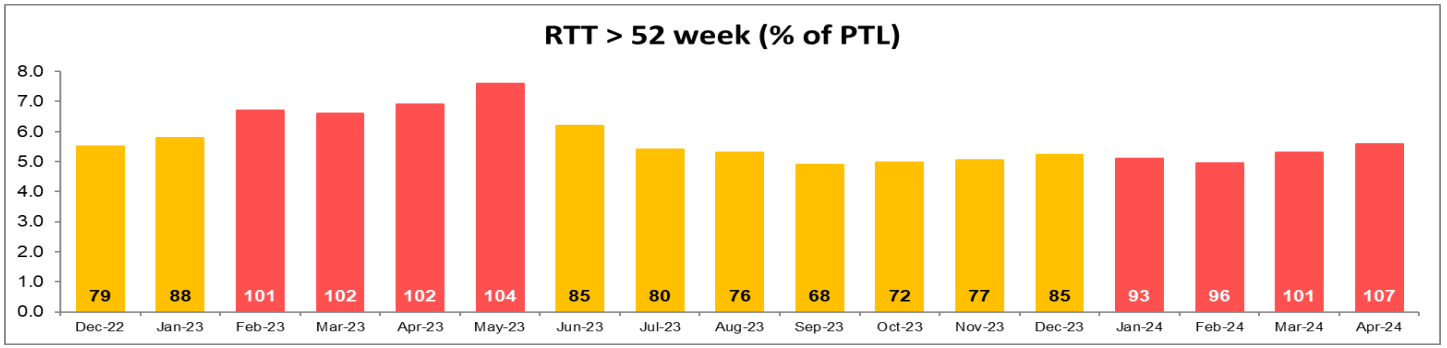
	Local trusts	Best in class	Rank	Quartile
Diagnostics			50/122	2nd
Cancer – Urgent PTL (proportion waiting over 62 days)			37/120	2nd
Cancer – 28-day faster diagnosis			41/121	2nd

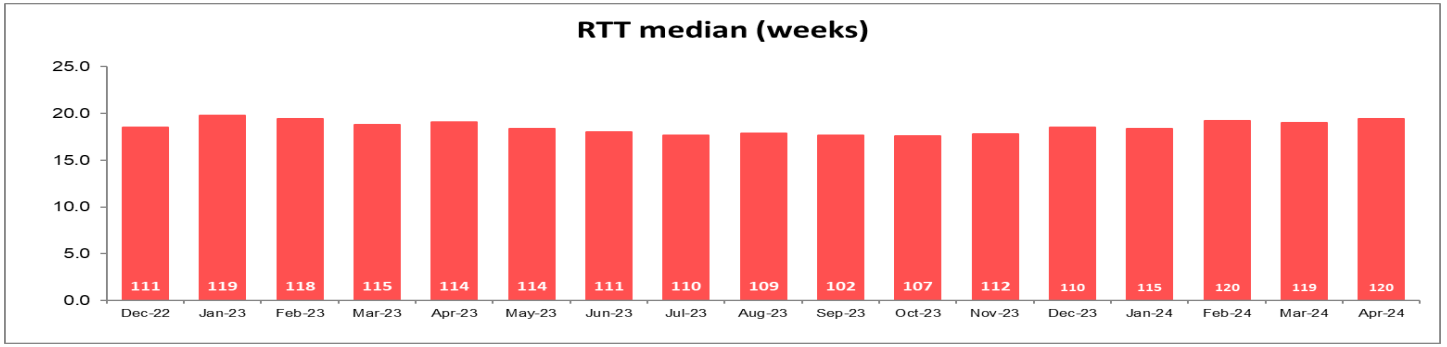
***NOTE** – for each graph, the position furthest to the left is the best performing trust. **Data periods: Data periods:** Diagnostics = April 2024; Cancer 28-day FDS = April 2024; Urgent Cancer PTL – proportion waiting over 62 days – position week ending 05 May 2024.*
Best in class peer group has been expanded to include both Acute and Acute & Community trusts so the cohort now includes up to 125 trusts.

Benchmarking – FHFT historic monthly performance (selected measures)

- Quartile 1
- Quartile 2
- Quartile 3
- Quartile 4



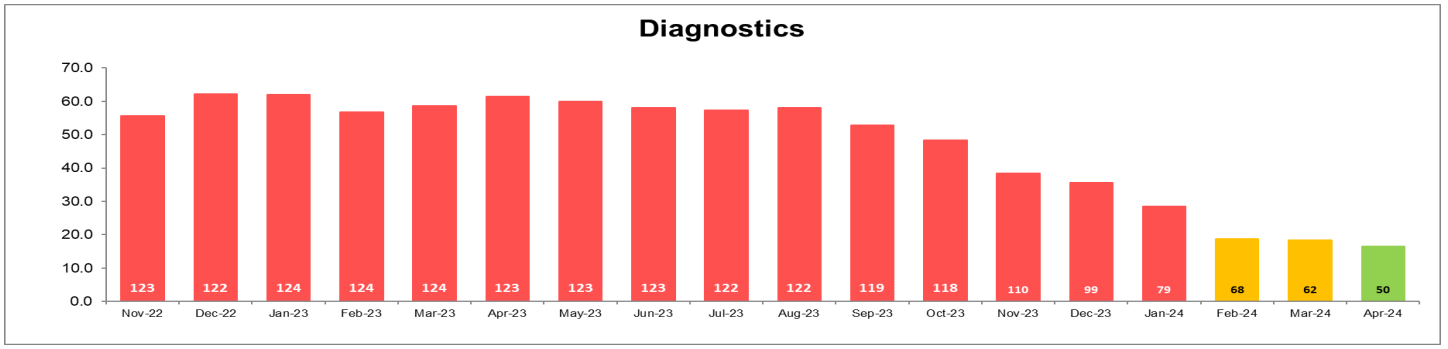


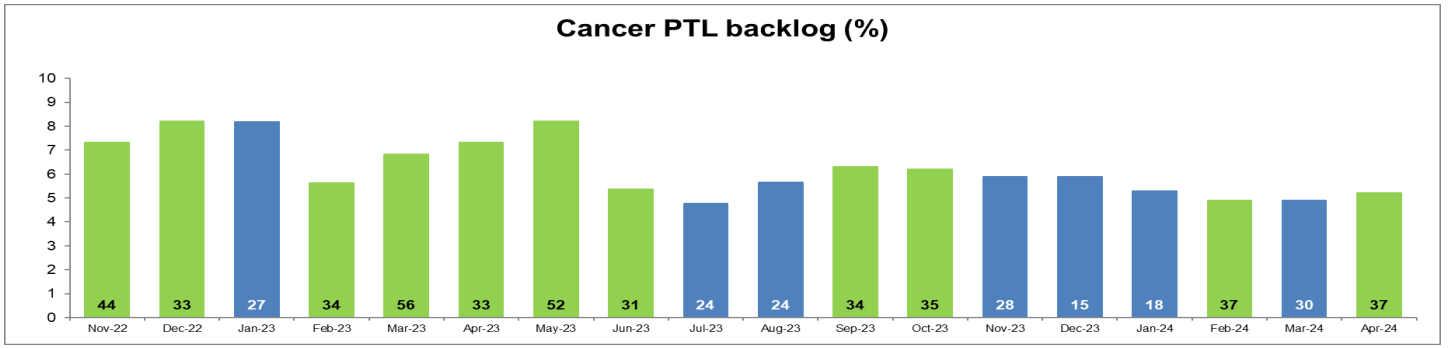


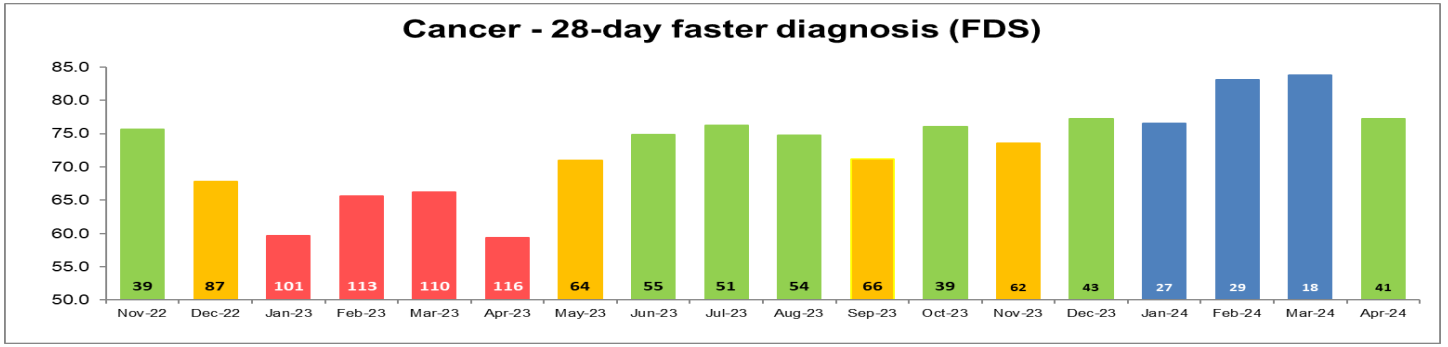
***NOTE** – for each chart, FHFT's rank compared to other acute trusts is shown in the relevant column.*
From March 2022 the cohort was expanded to include both acute and acute and community trusts, so the cohort now includes up to 125 trusts.

Benchmarking – FHFT historic monthly performance (selected measures)

- Quartile 1
- Quartile 2
- Quartile 3
- Quartile 4







***NOTE** – for each chart, FHFT's rank compared to other acute trusts is shown in the relevant column.*
From March 2022 the cohort was expanded to include both acute and acute and community trusts, so the cohort now includes up to 125 trusts.

Cover sheet – People – Matt Joint

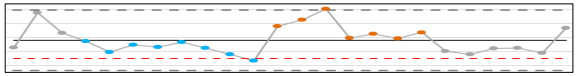
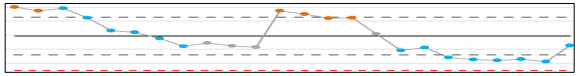
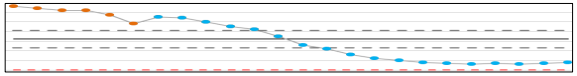
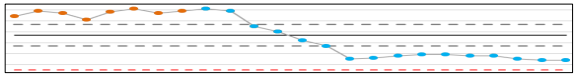
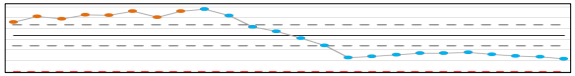
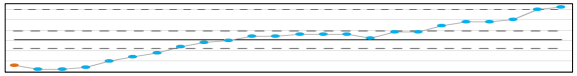
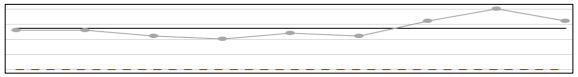
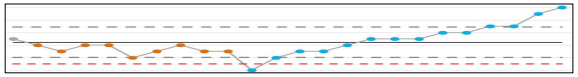
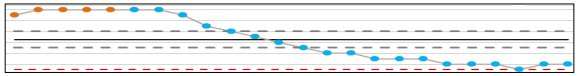
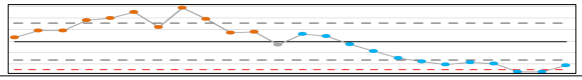
Executive Summary	**The core people metrics, including vacancies, turnover, time to hire and sickness remain stable and at or better than target. However, overall headcount has continued to increase. The use of temporary staffing is higher than planned, particularly the use of nursing and midwifery bank staff and medical agency. We are focusing on four key themes over the year to drive our culture and leadership initiatives, these are collaboration, compassion, equality, diversity, and inclusion (EDI), and learning.**
Background	This month there has been an increase in approximately 250FTE compared to last month. Turnover continues to remain below 11% and will be continuing to monitor this carefully. It is considerably lower than May 2023 and we do expect to see fluctuations. A programme of work is focus on driving down the temporary staff cost significantly over the coming months This includes the implementation of strict roster controls to ensure Directorates manage to budget. Collaboration: The Affina Team Journey programme, which provides tools for teams to help them improve engagement and performance, will launch this month with six cohort programmes planned for 2024-25. Compassion: A People Promise workshop was held in May and identified key recommendations to enhance compassion within our organisation. As a trust we will be working on implementing these changes and actioning the recommendations over the next nine months. EDI: In June we identified opportunities to enhance representation in alignment with our Workforce Race Equality and Disability Equality Standards (WRES/WDES) ambitions. Our aim is to grow representation of protected characteristics within our staff to better reflect our community and enhance inclusivity at FHFT. A cross departmental effort between the Clinical Education and the Organisational Development Teams invited colleagues from around the Trust to experience **wellbeing events**, including increasing awareness about 'Knowing Your Numbers' to stay fit and healthy. Three separate events were held at our main sites. We hosted our first quarterly **Women in Leadership Network.** Guest speakers included our consultant ophthalmic surgeon Professor Geeta Menon, Chief of Service for Clinical Education Pippa Skippage and Amrita Kumar, consultant radiologist and Trust AI lead.. We introduced resources to support the **Sexual Safety in Healthcare Charter** during May 2024 and ran events to provide greater awareness. We also created a central point of resources and guides for staff to access both externally and internally and will be developing further training and support sessions.
Issues and Options	The last 18 months saw a significant reduction in vacancies and turnover. However, there has not been a corresponding decrease in the use of nursing bank staff or medical agency. This is not a sustainable position and the actions outlined above are essential if we are to meet our financial targets.
Recommendation	The Directorates must continue to focus on improving roster controls and adhering to new guidance on budgetary approvals. It is also essential that there is continued focus on engaging our staff and responding to the recommendations arising from the National Staff Survey and quarterly Pulse surveys with each Directorate and Trust-wide.

Cover sheet – People – Committee assurance statement

Key Highlights and Discussion Points Including Assurance Points for Board	The People Committee has not met since the last Board meeting. The Committee Chair reported discussions from the April meeting to the May Board meeting. Discussions included the National Staff Survey, Equality, Diversity and Inclusion and the Freedom to Speak Up report. The next meeting will be held in July and the agenda includes: • Quarterly updates on Recruitment, Retention, Reward and Recognition • Actions from the National Staff Survey • Freedom to Speak Up Update • Leadership, Development, Talent Management and Succession Planning • Equality and Diversity Annual Report • Occupational Health and Safety Report • Apprenticeship Strategy
Key risks to Escalate	Not applicable
Recommendations/ Decisions Made	Not applicable

People Scorecard – key indicators at-a-glance

Supporting our People

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	SPC chart
Monthly vacancy rate – all staff	10.0%	9.0%	≤ 8.5%	L	F	
Monthly vacancy rate – medical	9.3%	7.6%	≤ 5.0%	-	?	
Monthly vacancy rate – nursing	9.5%	8.4%	≤ 6.0%	L	F	
Trust turnover rate	10.8%	10.7%	≤ 10.0%	L	F	
Agency spend as % of pay bill	3.9%	3.9%	≤3.0%	L	F	
Agency spend total (£)	£2.1m	N/A	£1.5m	L	F	
Appraisal rate (non-medical) %	86%	85.5%	85%	H	F	
Appraisal rate (medical) %	90%	92.5%	75%	Insufficient data for SPC analysis		
MAST training %	94%	93.5%	85%	H	P	
Sickness rate (rolling 12 month)	3.3%	3.3%	≤ 3.2%	L	F	
Time to hire (days)	48.7	45.9	≤45	L	F	

People Scorecard – key indicators at-a-glance

Supporting our People					
Metric	Annual metric	Target / concern threshold	Variation	Assurance	
% of staff say they experience discrimination from patients / service users, their relatives, or other members of the public	11.87%	TBC			Data taken from National Staff Survey – October 2023
% staff saying they experience incidents of bullying and harassment from line managers	9.57%	TBC			Data taken from National Staff Survey – October 2023
% staff saying they experience incidents of bullying and harassment from other colleagues	16.49%	TBC			Data taken from National Staff Survey – October 2023
% staff saying they experience incidents of discrimination from line managers or teams	9.36%	TBC			Data taken from National Staff Survey – October 2023

Cover sheet – Money – Kish Sidhu

Executive Summary	**The Trusts year to date (YTD) position at the end of month 2 was a deficit of £10.8m, which is £1.3m worse than budget** • The overspends seen in April to some extent reflect delays in disseminating and implementing planning. There remains issues with escalation areas being open which become more apparent as unconnected vacant posts are filled. • The impact of controls requires much more rigorous planning and management to avoid performance demands driving up costs latter in the year. • The modernisation of reporting and deployment of performance information is allowing more sophisticated conversations on underlying improvements. Time to implement change and breadth of conversation will be a challenge. • Looking forward the realisation of M-Block Elective income is a risk which needs assurances to be made more solid.
Background	The Trust has an agreed deficit plan for 2024/25 of £20.7m. Within this plan are £45.0m of efficiencies (CIPs) made up of £35.0m of Tier One (budget reducing) and £10.0m of Tier Two (cost pressure reducing). Tier One CIPs of £32.0m have been identified with work on-going to identify the remaining £3.0m target. The Trust has a full year capital plan of £88.5m made up of Estates (£61.3m), Digital Services (£5.5m), Medical Equipment (£5.5m) and New Hospital Programme (NHP) (£16.1m).
Issues and Options	The focus in the coming months both nationally and locally will focus on actions to stem run rates, while this can be achieved in the short terms through controls, sustainability requires a relentless focus on operational efficiency. Directorates need to ensure that the action to remove cost pressures which were not approved as part of the 2024/25 planning round is being taken. Deep-dives are being carried out into those areas with significant overspends at month 2 such as Medicine and ED.
Recommendation	Adherence to Standing Financial Instructions, enhanced roster controls and the No PO – No Pay policy are followed to avoid unbudgeted expenditure.

Cover sheet – Money – Key Points for M02 Financial Performance

- The Trust financial position shows a £10.6m adjusted deficit YTD, £1.3m worse than the submitted plan
- All budgets in this pack reflect the current Trust financial ledger position which has the same bottom line annual and monthly financial performance targets as the plan submitted to NHSE in June 2024 (£20.7m deficit 24/25) – There are I&E classification differences mostly due to reflecting the additional uplifts in income and expenditure for the consultant pay award which was mandated not to be included in the June submission. Income and expenditure budgets have also been uplifted to reflect specialised commissioned drug overperformance to date where appropriate. The external plan will be updated to reflect these classification changes as part of month 03 financial reporting in line with national guidance
- Agency costs for the month were £2.1m, which is the lowest since November 23; normally fluctuation is between £2.2m and £2.4m per month. Bank costs were high in April but did decrease May as escalation plans were implemented, however they remain much higher than planned to date in 24/25
- There has been a CNST rebate of £3.1m for 24/25 of which £0.5m is shown Ytd.
- Clinical supplies has seen some pressure within Cardiology and in Theatres. Both areas are being examined on their expenditure levels, a full conclusion has not been reached at the time of the report.
- The Trust delivered £4.2m of tier 1 efficiencies compared to a plan of £4.6m for the year. There is a £0.8m under delivery to date on recurrent schemes mitigated by £0.4m additional non-recurrent savings identified.
- Capital spend (£88.5m plan) showed overall expenditure of £9.2m in year, ahead of plan by £0.2m YTD, predominantly against the estates programme although anticipated this is due to the profile of spend vs plan and expected to remain on budget for the year
- Cash reduced from the £99.8m closing year-end balance to £77.5m at the end of May. This is £4.3m lower than planned. The I&E performance and working capital movement are the drivers.

Cover sheet – Money – Committee assurance statement

Key Highlights and Discussion Points Including Assurance Points for Board	The Finance Investment Committee met on the 26th June with the following points noted; 1. As at month 2, the year-to-date finance deficit was £10.6m which is £1.3m adverse to plan. Key drivers for this variance are being followed up 2. Through discussion, the importance of achieving greater productivity and efficiencies were emphasised and issues on non-pay controls were discussed 3. The significant benefits being derived from the Heathwood Hospital were noted, while recognising that new ways of delivering enablers will be required 4. An extract of the Corporate Risk Register, indicating risks assigned to the Finance and Investment Committee, was noted 5. A report was presented providing an update on the Trust's performance against the operational standards. The July meeting of the public Trust Board will receive a full report that covers the four domains of the Trust's operating plan, that is, quality, performance, people and finance.
Key risks to Escalate	Not applicable
Recommendations/ Decisions Made	1 The Committee agreed that issues of joint planning, flexibility of service delivery and benchmarking should be further developed in ensuring the provision of maximum potential at Heatherwood Hospital 2 The Committee agreed that further work in developing the Corporate Risk Register in advance of its presentation to the Board, should be undertaken.

Cover sheet – Audit – Committee assurance statement

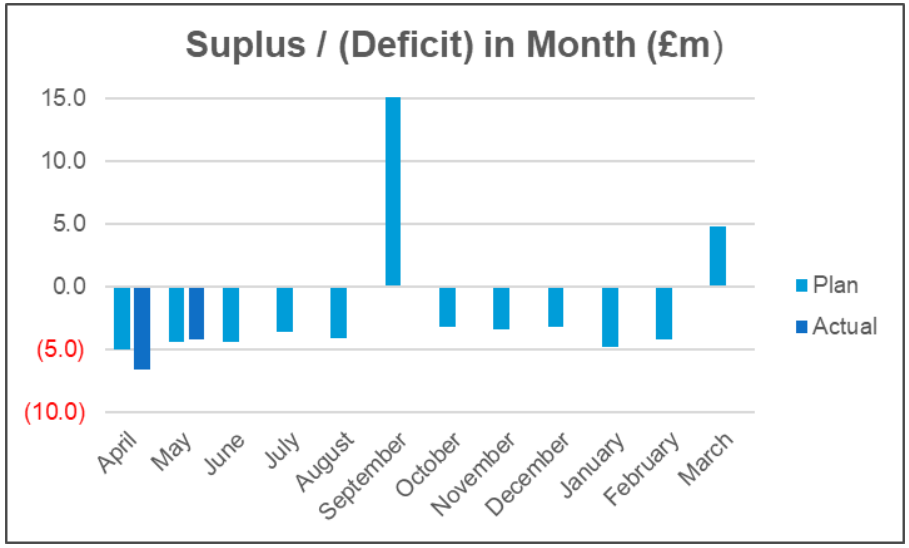
Key Highlights and Discussion Points Including Assurance Points for Board	The Audit Committee met on the 20th May and 14th June, with the following points noted; 1. The Internal Auditors presented their Internal Audit Progress Report, Internal Audit Reports for Data Quality (No Criteria to Reside) and the Data Security & Protection Toolkit, Follow Up Report and their internal audit plan for 2024/25. 2. The Counter Fraud Quality Assurance Annual Report 2023/24 and Local Counter Fraud Annual Work Programme were presented for review. 3. The Committee reviewed the Annual Waiver Report 2023/24. 4. The Committee reviewed the proposed changes to the Standing Financial Instructions. 5. The 2024 National Cost Collection – pre submission report was noted. 6. The Committee review the draft Annual Report and Accounts 2023/24, along with the draft KPMG report ahead of submission to the Board meeting on 27th June.
Key risks to Escalate	Not applicable
Recommendations/ Decisions Made	<u>20th May</u> 1. Approved the Counter Fraud Quality Assurance Annual Report 2023/24 for submission by the deadline of 31 May 2024. 2. Noted that16 losses at a total value of £6,292 had been identified and processed during Q4. Approved the total debts written off between 1st January and 31st March 2024 were £163,704,365 of which overseas debt totalled £123,470. 3. Recommend that the Board approves the amended Standing Financial Instructions. <u>14th June</u> 1. Recommend that the Board approve the Frimley Health NHS Foundation Trust Annual Report and Accounts 2023/24.

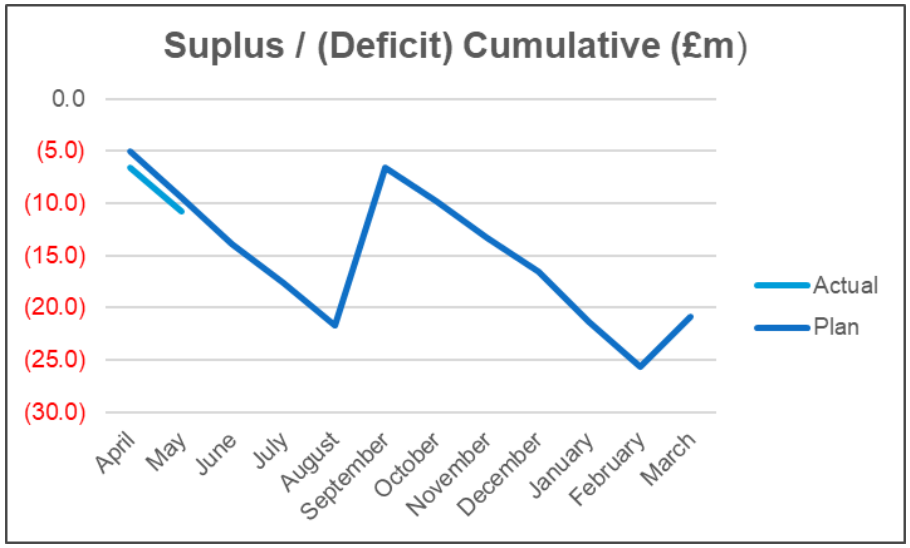
Money – Income and Expenditure Performance

Key messages in the month:

The Trusts year to date (YTD) position at the end of month 2 was a deficit of £10.8m, which is £1.3m worse than budget

- The overspends seen in April to some extend reflect delays in disseminating and implementing planning. There remains issues with escalation areas being open which become more apparent as unconnected vacant posts are filled.
- The impact of controls requires much more rigorous planning and management to avoid performance demands driving up costs latter in the year.
- The modernisation of reporting and deployment of performance information is allowing more sophisticated conversations on underlying improvements. Time to implement change and breadth of conversation will be a challenge.
- Looking forward the realisation of M-Block Elective income is a risk which needs assurances.





Money – Key Financial Indicators

Key Financial Indicators	Mth 2 Year to date 24/25			24/25 Full Year		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Income	169.1	168.3	(0.8)	1,007.5	1,007.5	0.0
Pay	(109.3)	(109.4)	(0.2)	(646.7)	(646.7)	0.0
Non-Pay	(59.6)	(60.1)	(0.5)	(346.8)	(346.8)	0.0
EBITDA	**0.2**	**(1.3)**	**(1.4)**	**14.0**	**14.0**	**0.0**
Financial items	(9.5)	(9.5)	0.1	(34.7)	(34.7)	0.0
Surplus / (Deficit)	**(9.4)**	**(10.7)**	**(1.3)**	**(20.7)**	**(20.7)**	**0.0**
CIPs	6.1	5.4	(0.7)	45.0	45.0	0.0
Substantive	93.6	93.4	0.2	560.7	560.7	0.0
Bank & Agency	15.7	16.1	(0.3)	90.3	90.3	0.0
Cash	**80.5**	**77.6**	**(3.0)**	**60.6**	**60.6**	**0.0**
Capex	**9.0**	**9.2**	**(0.2)**	**88.5**	**88.5**	**0.0**

Income : Lower than planed PP's, (£0.2m), Pathology tests (£0.4m) – offset by expenditure; with the remainder several smaller items

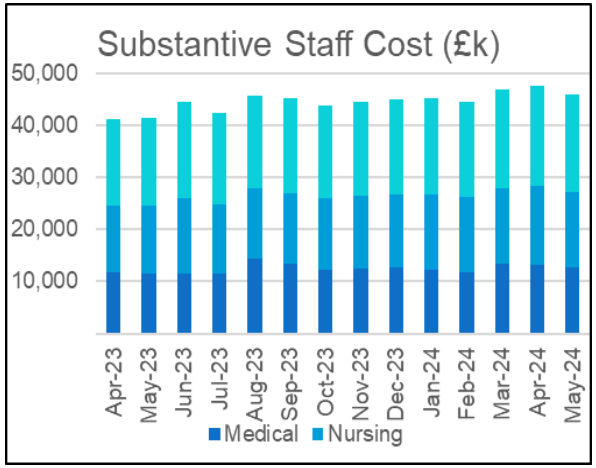
Pay: £0.2m worse than plan, driven by temporary staffing.

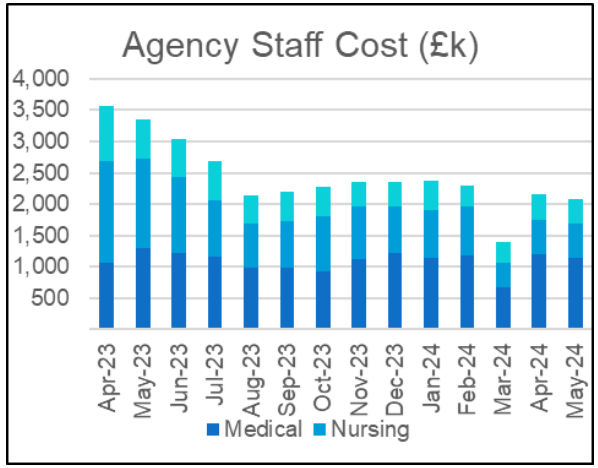
Non-Pay : is impact by consumables which are being investigated for stocking impact and causes of usage.

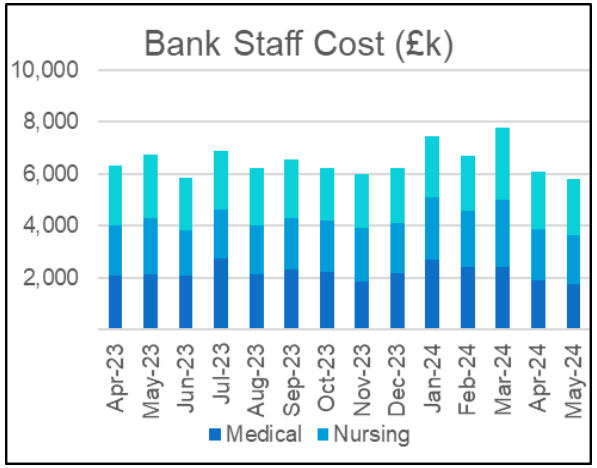
CIPs: Overall, the Trust has achieved **£5.4m** savings, against a plan of £6.1m. This is 89% of plan, efforts are expected to make up the shortfall.

Capex: Capital spend (£88.5m plan) showed overall expenditure of £9.2m in year, ahead of plan by £0.2m YTD, predominantly against the estates programme although anticipated this is due to the profile of spend vs plan and expected to remain on budget for the year

Cash: Is £3.0m lower than plan driven by I&E performance and working capital movements, including PDC to be drawn down.







Money – Efficiency Performance: 2024/25 overview

Overall performance:
The total efficiency target for 2024-25 is **£45m**; **£35m of Tier 1** savings and **£10m of Tier 2** savings.

The Trust has identified **£32.0m** of Tier 1 efficiency savings; 73% are planned to be delivered through recurrent measures. As at M2, **£4.2m** of Tier 1 savings have been delivered against a plan of £4.6m. Of the savings achieved, £2.7m (65%) are recurrent.

The Trust has achieved **£1.2m** of Tier 2 savings, against a plan of £1.5m. All Tier 2 CIPs are considered recurrent.

Overall, the Trust has achieved **£5.4m** savings, against a plan of £6.1m. This is 89% of plan.

Project Categorisation	Sum of 2425 total	Sum of 2425 YTD plan	Sum of 2425 YTD Actual	Sum of 2425 YTD Variance
Tier 1 Directorate	26,522	2,840	3,008	168
Tier 1 Trustwide	8,478	1,782	1,178	-604
Tier 2	10,061	1,518	1,224	-294
Grand Total	**45,061**	**6,139**	**5,410**	**-730**

Recurrent / Non Recurrent £'000	Sum of 2425	Sum of M2 Plan	Sum of M2 Act	Sum of M2 Var	Sum of 2425	Sum of 2425	Sum of 2425
recurrent	23,302	1,735	1,341	-394	3,599	2,738	-861
non recurrent	11,699	512	856	345	1,022	1,447	425
Grand Total	**35,000**	**2,246**	**2,197**	**-49**	**4,621**	**4,186**	**-436**
recurrent %	67%	77%	61%		78%	65%	
non recurrent %	33%	23%	39%		22%	35%	

*Note, recurrent / non-recurrent figures are only for Tier 1, as Tier 2 CIPs are all recurrent.

Money – Capital and Cash Month 2

Capital Expenditure (£m)	Annual Plan (£m)	Revised Annual Plan (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	FY (£m)	FY Variance (£m)		YTD Actual (£m)	Prior Month YTD Actual (£m)	Movement In Spend
Estates	61.3	61.3	6.2	6.6	- 0.4	61.3	-		6.6	3.1	3.5
Digital Services	5.5	5.5	0.8	0.8	0.1	5.5	-		0.8	0.4	0.3
Medical Equipment	5.5	5.5	0.8	0.7	0.1	5.5	-	*	0.7	0.3	0.5
NHP	16.1	16.1	1.2	1.2	- 0.0	16.1	-		1.2	0.6	0.6
Total Capital Expenditure	**88.5**	**88.5**	**9.0**	**9.2**	**(0.2)**	**88.5**	**0.0**		**9.2**	**4.3**	**4.9**

Capital Key messages:

- Capital plan for the FY 24/25 now totals £88.5m having recognised the further £1.0m allocation awarded through the 23/24 Q4 UEC performance and £16.1m for the New Frimley Park Hospital Programme (subject to approvals by the national new hospital programme team)
- Plan expenditure against estates programme (£61.3), digital services (£5.5m) and medical equipment (£5.5m) is funded through the Trust provider allocation of £34.3m and additional PDC funding awarded for the RAAC failsafe programme (£5.0m), ERF – M Block (£11.0m) and Slough CDC (£21.1m)
- Capital spend at M2 is £9.2m, £0.2m ahead of plan in ytd seen predominantly against the estates programme although anticipated this is due to the profile of spend vs plan and expected to remain on budget for the year

Cash	Mth 2 Year to date 24/25			24/25 Full Year		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
EBITDA	(0.5)	(2.1)	(1.6)	14.0	14.0	0.0
Working capital mov't	(3.0)	(3.8)	(0.8)	(12.0)	(12.0)	0.0
Capex	(9.0)	(9.2)	(0.2)	(88.5)	(88.5)	0.0
Capital donation	0.0	0.0	0.0	(0.4)	(0.4)	0.0
Disposals	0.0	0.0	0.0	18.6	18.6	0.0
PDC paid	(3.0)	(3.0)	0.0	(18.2)	(18.2)	0.0
PDC received	0.0	0.0	0.0	53.2	53.2	0.0
IFRS16 leases	(0.9)	(0.9)	0.0	(5.6)	(5.6)	0.0
Interest	0.6	0.8	0.2	3.8	3.8	0.0
Loans / other	(3.4)	(4.1)	(0.6)	(4.0)	(4.0)	0.0
Cashflow	**(19.3)**	**(22.3)**	**(3.0)**	**(39.2)**	**(39.2)**	**0.0**
Cash	**80.5**	**77.6**	**(3.0)**	**60.6**	**60.6**	**0.0**

Starting Cash	**99.844**

Cash Key messages:

- Cash balance as at the close of M2 finished at £77.6m, a movement of £22.2m from the opening balance of £99.8m at the start of the year albeit only £3.0m behind plan as a number of these movements had been expected
- The variance again plan is a result of; a net I&E deficit (incl interest) against plan of £1.4m as noted earlier in this report; an overspend against capital of £0.2m as described above; working capital movements of £1.0m against plan; and an increase in the inventories position of £0.6m
- Working capital and technical adjustments will continue to be monitored throughout the year but are anticipated to recover to plan as the cash balance of £60.6m has been retained in the forecast

Appendix

Activity (FHFT)

	21/22	23/24	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May-24	YTD
GP and general dental practitioner referrals to all outpatients																
NHS Buckinghamshire	12724	30588	2645	2976	2835	2523	2615	2920	3157	2277	3038	2047	1322	2354	2821	5175
NHS Frimley	156043	346339	32940	34086	31297	30701	28078	32793	33281	26762	33776	22090	13789	22282	26292	48574
Other CCGs	12287	25613	2126	2363	2426	2124	2245	2346	2593	1983	2649	1724	1085	1900	1926	3826
Sum:	181054	402540	37711	39425	36558	35348	32938	38059	39031	31022	39463	25861	16196	26536	31039	57575
Outpatient attendances																
New attendances	298963	393630	37343	37103	32883	30975	31479	33161	34424	26807	32707	30355	30669	31700	32799	64499
Follow-up attendances	613301	651042	51180	54405	51973	54647	54992	58258	61228	50898	62654	58395	55055	60813	62076	122889
Total	912264	1044672	88523	91508	84856	85622	86471	91419	95652	77705	95361	88750	85724	92513	94875	187388
Elective admissions																
Daycase	59472	69998	5741	5840	5612	5371	5930	6181	6882	5406	6064	5915	6051	6404	6644	13048
Overnight	11320	9765	926	934	828	886	868	843	857	672	760	673	714	726	831	1557
Regular day attenders	17393	15374	1606	1516	1369	1520	1366	1274	1096	948	1123	1093	1116	1124	1175	2299
Total	88185	95137	8273	8290	7809	7777	8164	8298	8835	7026	7947	7681	7881	8254	8650	16904
Emergency department (ED) attendances																
Total ED attendances	257335	264219	22165	22071	21976	21041	22000	22533	22490	22122	22521	21753	23455	21824	23873	45697
Non-elective admissions																
Non-elective – Zero LOS admissions	26776	11332	776	767	825	978	1093	1117	1040	1125	944	947	1024	939	849	1788
Emergency Admissions (excluding Zero LOS)	49269	48032	3930	3999	4080	3901	3975	4125	4049	4090	4193	3888	4050	3840	3980	7820
Other Non-elective admissions	17604	20614	1751	1641	1644	1803	1677	1718	1808	1713	1724	1675	1888	1761	1848	3609
Non-elective admissions (total)	93649	79978	6457	6407	6549	6682	6745	6960	6897	6928	6861	6510	6962	6540	6677	13217
Maternity																
Number of live births	9451	9251	795	757	734	835	777	787	761	753	771	729	827	786	813	1599

Glossary

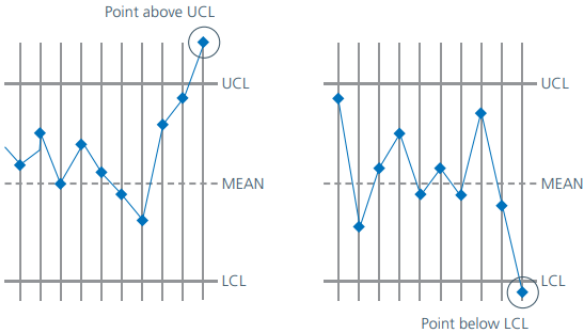
Term	Meaning
CIP	Cost Improvement Plan or Programme
FHFT	Frimley Health NHS Foundation Trust
YTD	Year-to-date

Statistical Process Control (SPC)

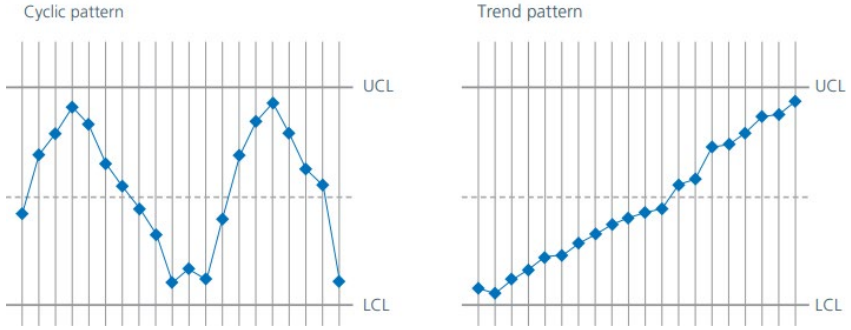
Statistical Process Control helps to understand what is the norm and what is different. Performance of a KPI is looked at over time and statistical analysis is used to calculate an "upper control limit" and a "lower control limit".

When interpreting SPC charts, there are 4 rules that help identify what the system is doing. If one of the rules has been broken, this means that "special cause" variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only "common cause" variation is present.

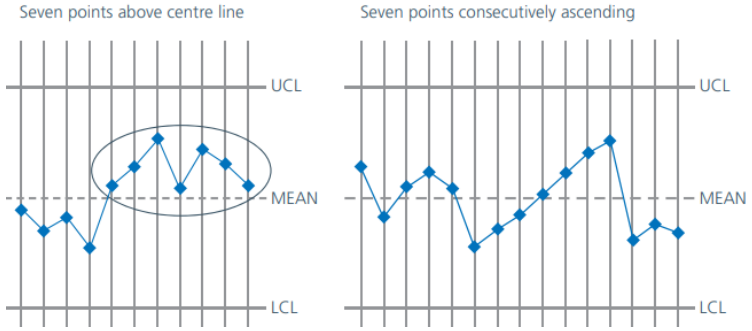
Rule 1 – any single point outside control limits



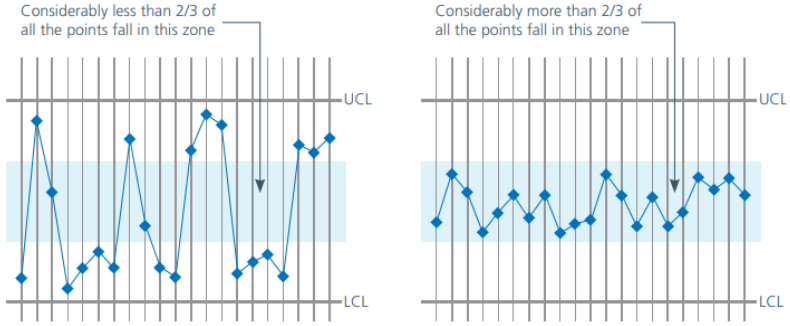
Rule 3 – any unusual pattern or trends within the control limits



Rule 2 – a run of seven points all above or all below the centre line, or all increasing or decreasing



Rule 4 – the number of points within the middle third of the region between the control limits differs markedly from two thirds of the total number of points



Produced with thanks to NHS England and NHS Improvement resources

Statistical Process Control (SPC)

This report uses icons to present the SPC analysis of each metric (where appropriate) and support interpretation of the analysis

Variation			Assurance		
-	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: Orange indicates concerning **special cause variation** requiring action; blue indicates where improvement appears to lie, and grey indicates no significant change (**common cause variation**)

Assurance icons: Blue indicates that the trust should consistently expect to achieve a target. Orange indicates that the trust should consistently expect to miss a target. A grey icon tells you that sometimes the target will be met and sometimes missed due to random variation

Produced with thanks to NHS England and NHS Improvement resources

Report Title	**Sexual Safety in Healthcare Charter**
Meeting and Date	Public Board of Directors, 5th July 2024
Agenda Item	10.
Author and Executive Lead	Victoria Blampied, Head of People Policy and Reward, People Directorate Matt Joint, Chief People Officer
Executive Summary	This paper looks at the Trust's response to the Sexual Safety Charter in Health care. It considers the background to the charter, the Trust's strategic objectives and the People Strategy. It goes on to look at interventions we are required to undertake and our progress against this. It also highlights challenges.
Recommendation	The Board is asked to **NOTE** and support the work being carried out to embed the Sexual Safety in Healthcare Charter at Frimley Health.
Compliance	Board Assurance

Background

In response to multiple independent investigations, including those by the BMJ and the Guardian, which highlighted serious concerns about sexual assault and harassment within the NHS, NHS England launched the Sexual Safety in Healthcare Charter in September 2023. This Charter mandates a zero-tolerance policy towards any unwanted, inappropriate, and harmful sexual behaviours within the workplace, outlining 10 key actions for signatories (see appendix 1). Over 270 organizations, including Frimley Health, have committed to upholding the Charter, demonstrating a collective effort to ensure a safer and more respectful environment for all healthcare staff.

The national NHS 2024/25 priorities and operating guidance states the importance of supporting our workforce, through improvements to staff experience and retention. It highlights the direct links between a positive staff experience and patient safety and outcomes. Sexual Safety of the workforce is highlighted as a key component within the plan and there is an explicit ask for organisations to commit to embedding the Charter.

Even before the launch of the charter and the operating guidance for 2024/25 one of the Trust's key corporate objectives was "*Supporting our People*" and our People Strategy highlighted developing a culture where our staff are able to "*Thrive*" as one of its core pillars. The Trust continues to embed the NHS People Promise work on the Sexual Safety Charter firmly supports the "*We are Safe and Healthy*" element of the Promise. Sexual Safety has been identified as a core activity for the delivery of our People Strategy in 2024/25.

In 2023, the National Staff Survey was amended to include a question related to Sexual Safety. On a national basis, 1 in 26 NHS staff reported unwarranted sexual approaches / harassment from work colleagues. At Frimley Health, our survey results indicate that 9% of our workforce have experienced unwanted sexual behaviour in the workforce over a 12-month period, which is over 600 of our colleagues.

This paper will look at the Trust's response.

The Frimley Health Response

The expectations of the Trust are that we:

	Trust Progress
Appoint Domestic Abuse and Sexual Violence leads	The Trust has appointed: Matt Joint, DASV Exec Lead Deirdre Race, DASV Operational Lead
Review policies and support- including data collection and analysis, dedicated sexual safety policies.	Currently awaiting new national policy frameworks. Support has been launched and will continue to be developed. While we are waiting for the new national policies, we will continue to manage issues using our existing policies, including: • Resolution policy, • Disciplinary policy, • Freedom to Speak Up policy, We have also created FHFT Principles of Sexual Safety and behaviours (appendix 2)
Sign up to DASV Future Collaboration Platform	Completed

Supporting our people

After the Trust committed to the Sexual Safety in Healthcare Charter a steering group was implemented to embed the Charter within the Trust. Chaired by Eleanor Shingleton-Smith, Deputy Chief People Office, this group brings together teams from across the Trust including Safeguarding, Staff Side, Freedom to Speak Up, Clinical Education, the People Directorate and Medical Education. The group has engaged with those leading the work across other Trust's to share knowledge and best practice, as well as using the resources available in forums, such as the NHS Futures Platform, and with national campaign groups who are leading work with NHS England such as Surviving in Scrubs.

The Steering group launched the Trust's sexual safety resources over the week of the 13th of May 2023. This week included two sessions from Surviving in Scrubs. The first of this raised awareness and the second talked about how to manage the disclosure of a sexual safety incident. The key event of the week however was our presentation on the Trust's commitment to the Charter. This was presented by Caroline Hutton, Interim Chief Executive, Matt Joint, Chief People Officer and Pippa Skippage, Director of Clinical Education. This event was attended by over 260 members of our staff and was well received by the Trust. Two members of staff were courageous enough to speak out about experiences they had had before joining the Trust that highlighted to those present just how important this topic is.

The launch was supported by a poster campaign to raise awareness (appendix 4). This poster also contains a QR code that takes those that scan it through to an externally facing resources platform. This platform was designed to be accessed while not on a Trust device. It was recognised by the steering group that our clinical staff often do not have quick access to a Trust device and often those in need of support may not be in a place where they can access a Trust device. This platform shares key internal and external contacts as well as reminding staff of the expected behaviour standards and the email address to contact if they need support. This email address is managed by our Employee Relations team. An internal hub has also been created on the Trust Intranet, Ourplace.

Our Future Plans

Following on from the initial launch the steering group is now looking how we can embed the Charter into the Trust. To successfully do this we will be launching a programme of training for current managers, focusing on raising awareness and the development of a culture where we embrace the zero-tolerance approach. We are aiming to launch this in the summer of 2024, with the first dates in the process of being confirmed and communicated. This training will also form part of the Management Essentials course.

Nationally, research has identified that surgical trainee doctors are potentially more vulnerable than others and the Thames Valley Deanery will be funding Surviving in Scrubs sessions for Surgical Consultants and trainees.

Work will be done to include Trust standards and expectations into corporate induction so all new starters to the Trust are aware and begin their FHFT journey understanding the expectations.

Once the new National Policy Framework is launched, we will develop a Trust policy that is in line with the national approach.

Other key areas of work within the People Directorate will also support the Sexual Safety programme. The recent funding to expand our Freedom to Speak Up team will help to facilitate

the further development of our speaking up culture which helps to create an environment where our people will feel psychologically safe to raise concerns of any nature, including sexual safety. The Culture and Leadership programme highlighted areas that need development, such as the skills of our managers, compassionate leadership and civility training. There is clear alignment with these programmes.

Challenges, risks and issues

There are several challenges related to the implementation of the Charter. Issues related to sexual safety can be ingrained and cultural. For example, they can stem from long held attitudes and beliefs, typical gender roles and stereo types and it can be difficult within the multi-generational and multi-cultural workplace such as the NHS to ensure that the needs of all staff are met. What is acceptable in one culture or by someone of a certain age may not be acceptable to another.

There is no "one size fits all" definition of what constitutes sexual harassment. The Equality Act 2010 defines it as *"unwanted verbal, non-verbal or physical conduct of a sexual nature which has the purpose or effect of violating the recipient's dignity or of creating an intimidating, hostile, degrading, humiliating or offensive environment for the recipient".* It very much depends on how the actions and conduct are viewed by the recipient, making the effect of the conduct as important as the intent. It could also be one act or several acts. There is no ceiling on compensation and, should events be reported to the police perpetrators could be prosecuted under criminal law.

A further challenge here is that we do not want to create a culture of fear for our staff. It is important that we deal with issues raised in an appropriate way. The zero-tolerance approach does not mean that every issue will result in the perpetrator being dismissed. We also need to maintain the confidentiality of the accused and strike a balance between this and the requirements of the charter to report and share feedback.

Another key issue is that there is known to be underreporting of issues, events, and crimes of this nature. In the workplace employees fear that there could be repercussions, for example that career opportunities may be withheld if you speak up. We do not know the full extend of these issues and whether this the Trust will see a significant increase in these issues being reported. Since the launch we have not yet seen an increase in the number of issues being reported at Frimley Health.

Conversations related to these issues are hard. They can be emotional and challenging for all involved. We need to ensure that there is support available for everyone who may be impacted. This includes anyone who is under investigation for matters relating to these events. We also know that the role of the bystander is key in addressing these issues, helping to resolve them informally before issues escalate. It takes courage for a bystander to speak up and intervene. It is crucial that they are also supported with this and that the example is set through proactive intervention and engagement from the Trust Board down.

Further challenges come from the ongoing operational pressures faced by our people. Our clinical areas remain extremely busy. The need to respond daily to these pressures limited the capacity our staff have available to engage in initiatives such as this. Again, making this a priority for the organisations needs to flow from the top down, with our senior leaders helping their teams to free up the time to support each other and engage with this programme.

Appendix 1

Sexual Safety in Healthcare – organisational charter

NHS England

Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.

Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.

We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

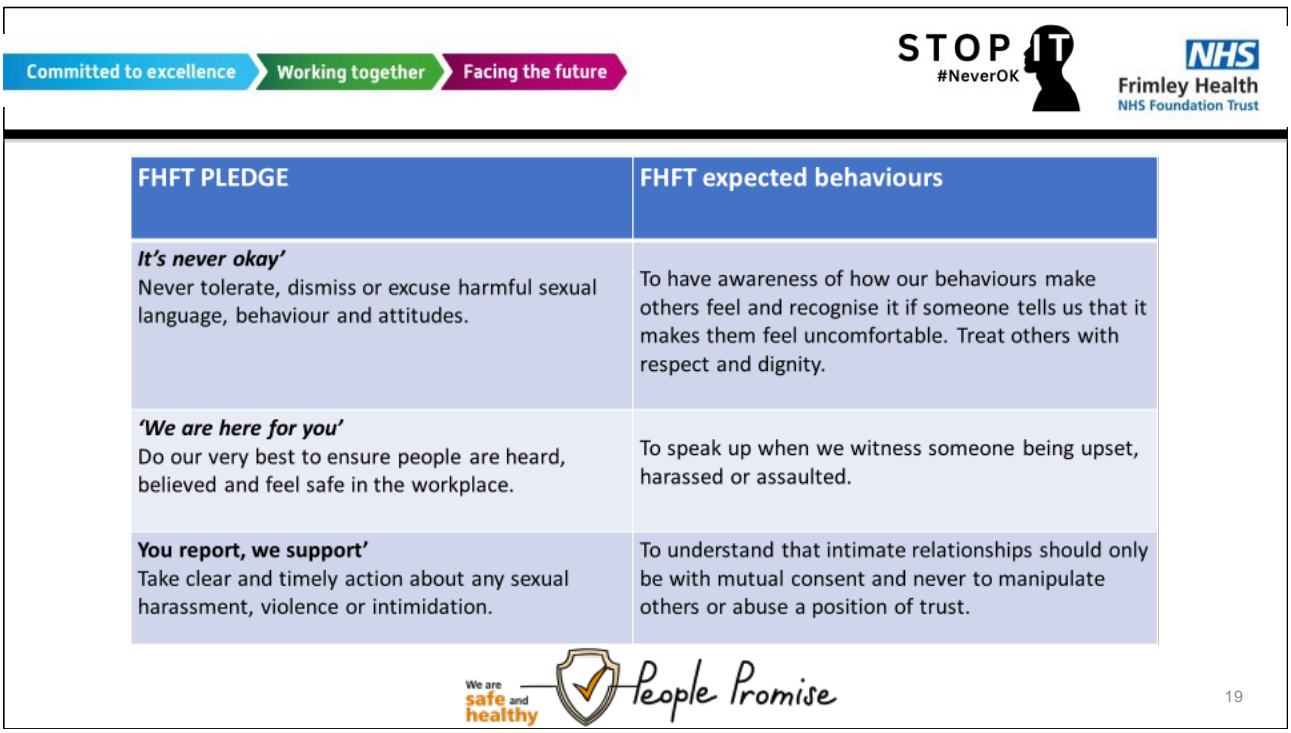
1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.
11.

These commitments will apply to everyone in our organisation equally.

Where any of the above is not currently in place, we commit to work towards ensuring it is in place by **July 2024.**

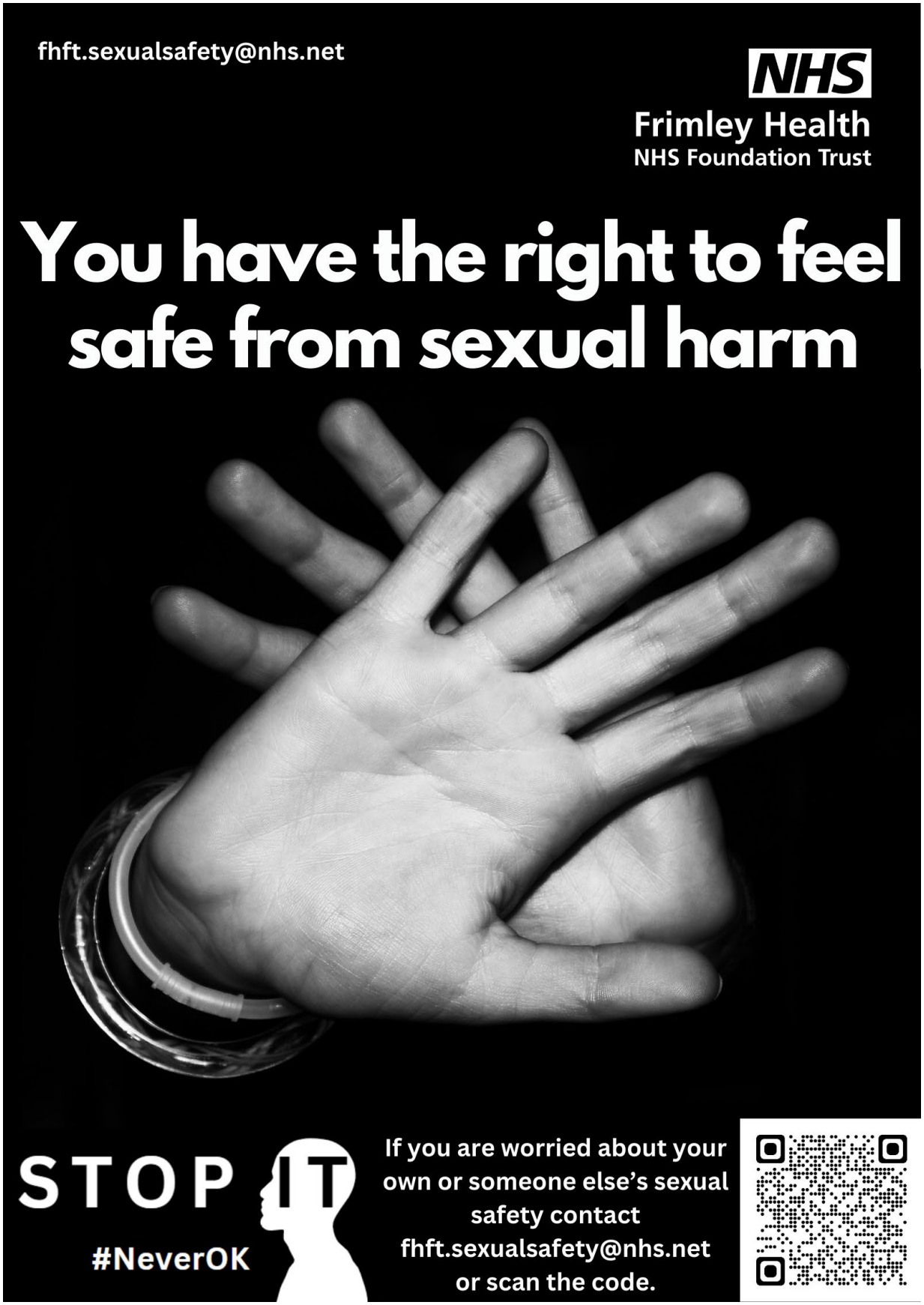
Appendix 2

FHFT Principles of Sexual Safety and Behaviours



Appendix 4

Sexual Safety Launch Posters



Report Title	**Six monthly Nurse and Midwifery Staffing update: July 2024**
Meeting and Date	Public Board of Directors, 5th July 2024
Agenda Item	11.
Author and Executive Lead	**Authors:** Neil Webb, Senior Lead Nurse Workforce (Lead author) Rob Shuttleworth, Head of Workforce Intelligence Emma Luhr, Director of Midwifery **Executive Leads:** Melanie Van Limborgh, Chief of Nursing and Midwifery Matt Joint, Director of People
Executive Summary	• This paper provides the Trust Board with an overview of nursing and midwifery staffing across Frimley Health NHS Foundation Trust, in line with National Quality Board expectations and the Developing Workforce Safeguards (NHSE). • Workforce reviews were held between September-December 2023 for budget setting for the financial year of 2024/25. These reviewed the nursing and midwifery staffing levels in our inpatient wards and emergency departments with the nursing leadership teams from these areas. At the time of this paper being produced we are currently awaiting the Trust Management Board (TMB) ratifying the executive team support for the budget uplifts. The paper provides assurance on activities within the Trust to ensure we deliver high quality care through a safe and sustainable nursing and midwifery workforce, benchmarks where available are also provided. **Nursing & Midwifery key items to note:** • Key success should also be noted within our Care Assistant recruitment. Over the last 12 months, month on month we have achieved a net gain (starters –leavers, a net gain of x**212** members of staff over 12 months).

	• Retention is stable within the **nursing registrant** *workforce*; remains sitting at around <10% which is still below the national % average and a FHFT trend of decreasing over the last 12 months. • Turnover within the **non-registrant** *N&M workforce* remains static around 15% within a known transient part of the nursing workforce. This is in comparison to the national median turnover of healthcare support workers of 15-20%. • The IEN pipeline for 24/25 had a projected requirement of 120 IEN (Internationally Educated Nurses) nurses over the 2024/25 FY. This was reviewed and reduced in May 2024 with a reduced number of x78 IEN's currently being our forecast requirement. IEN recruited nurses to work alongside an increased focus this FY on UK domestic pipelines. IEN required numbers for the rest of the financial year are currently under review as we review the workforce requirements for M block and the increase of x52 inpatient beds on the FPH site once M block opens and wards vacated that will be medically/CoE repurposed. • Enhanced care observation additional staffing requirements continue to be a challenge across the Trust as patient demand on requiring enhanced care additional staffing remains the same as that reported in January 2024 staffing update. • Our average overall CHPPD (Care Hours per Patient Day) is 8.6 for our inpatient wards/departments. This is line with peer and national Trusts. It is important that the Board notes that we are addressing our patients staffing requirements safely and in line with median CHPPD in other regional organisations. • The evidence collated within this document suggests that there are strong controls and oversight of nurse staffing in place. We have safe and sustainable funded staffing levels within our inpatient areas overall. Our retention work continues to be of prime importance building upon the success we are already having. This alongside a focus on domestic recruitment and complemented with overseas recruitment to reduce further our registrant vacancies. Nursing and Midwifery is fully committed in using our current workforce as cost effectively ensuring in this current financial climate we have effective rostering controls in place to demonstrate the safe and effective deployment of staff.

	• As stated in all N&M staffing assurance papers, that our Trust total % headroom uplift within each departmental cost centres is below the national recommendation of 22.5%. We have within the Trust a standard 20% headroom allowance. This immediately creates departmental cost pressures when balancing sickness, A/L and Study leave, especially where it is expected within a speciality that the clinical workforce will be required to attend a higher number of study leave hours >39 hours annually which is the current state. Clinical areas like critical care, emergency medicine, maternity and speciality medicine areas are often challenged working within this headroom %.
Recommendation	Set out in the report below, recommendations: The Board is asked to note: • The nursing, midwifery and care staffing information provided in this report is in line with the National Quality Board Safe Staffing Guidance, (July 2016) and NHSE Developing workforce safeguards (October 2018) document. • This paper assures the Board that the Chief of Nursing & Midwifery is satisfied that staffing is safe, effective, and sustainable considering the significant workforce challenges mentioned within this paper. • Where there are workforce challenges noted there are ongoing short, mid, and long-term plans to address these that the Chief of Nursing and Midwifery has oversight of.
Compliance	**Assurance (Nursing & Midwifery Workforce)**

1.0 Introduction: Safe Staffing:

1.1 The purpose of this report is to comply with the National Quality Board (NQB, 2016), 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (July 2016). This requires healthcare providers to ensure they have the right culture and leadership skills in place for safe, sustainable, and productive staffing. This Trust is compliant with NQB safe staffing expectations, which includes the mandated reporting metrics as outlined in this document.
The Trust works towards being compliant with the recommendations and requirements within the Developing Workforce Safeguards (NHSE, 2018).

1.2 Safe Staffing

Building upon the previous safe staffing paper in Jan 2024 we continue to focus on ensuring we have the 'right staff with the right skills in the right place'.
Our focus over the last quarter has been focussed on ensuring the considerable number of international educated nurses (IEN) recruited last year are suitably clinically supported. Focus on appropriate rostering practices and effective workforce financial use of budgets has also been a key focus Trust wide within directorates.

We have successfully implemented since April 2024, centralising IEN arrivals within one Cost Centre for the first 10 weeks of arrival in the Trust. This has allowed for local ward budgets to not be impacted with 'double running costs' covering both the IEN training costs and ward level shifts by use of temporary staffing.

At the time of this paper being written, focus continues to be on de-escalating cross site escalation beds over the next two months. This will create additional staff internally to relocate to wards where there are funded vacancies thus reducing external recruitment demands. De-escalation of beds has its operational challenges on beds being available for hospital flow from the front end of the hospital (i.e., ED flow). The Trust is monitoring this closely.

Through planned reviews of rosters daily in each department, reduction in vacancies and turnover we are at the time of this paper being written assured we have safe staffing for our patients. Where there are concerns raised by a nurse in charge, we continue to raise 'Red Flags' for safe staffing which are reviewed and addressed within the operational staffing daily reviews.

As reported in January 2024 staffing assurance paper, our financial challenge/risk continues around high levels of enhanced care observation patients and their associated numbers of shifts that require increased staffing levels. Section 1.3 outlines the current staffing demand.

With successful recruitment of student midwives alongside domestic UK midwifery recruitment, the risk highlighted within the previous staffing assurance paper within community WP midwifery teams has reduced. Pipeline recruited midwives should be in place over September and October 2024 as student midwives reach the end of their course over summer and receive their NMC registration.

It is also important to note (as within all previous staffing papers) that our Trust total % headroom uplift within each departmental cost centres is below the national recommendation of 22.5%. We have within the Trust a standard 20% headroom allowance. This immediately creates departmental cost pressures when balancing sickness, A/L and Study leave, especially where it is expected within a speciality that the clinical workforce will be required to attend a higher

number of study leave hours >39 hours annually which is the current state. Clinical areas like critical care, emergency medicine, maternity and speciality medicine areas are often challenged working within this headroom %.

1.3 Enhanced Care Observation: additional staffing requirements

As reported in the January 2024 staffing assurance paper, we continue to focus our attentions on reducing the additional temporary staffing requirements for enhanced care observation within nursing. This has not been without its challenges operationally as our workforce demands for safely nursing patient's with enhanced care is sustained.

Our focus on the governance of the required use of enhanced care additional staffing is a key focus over the next 12 months. We are utilising EPIC, Safecare and our effective rostering practices to ensure we are requesting appropriately any additional staffing requirements. Challenges also at local directorate level by Heads of Nursing with their clinical managers ensures that there is directorate ownership of this.

COE are currently setting up a pilot to safely cover their enhanced care staffing requirements through use of their allocated enhanced care budgeted £ that has been approved by the Trust.

The total spends on agency enhanced care needs 22/23 was £4.8M, last FY year we finished at £3.6M spend. The last 8 months of the year where we brought the average spend right down (£2.8M). We have further work to do on this area however this is very much tied closely with the patient acuity/dependency and demand in the Trust at any given time.

Our Nursing total business case for 24/25 was an ask of £2,760,000, of which £2,216,000 was already funded. There was within this business case an ask of an additional £120,00 to support the employment of x2 B7 RMN, and a £424,000 additional ask to top up directorates reflecting current usage and unidentified costs within concurrent bank mitigations.

Two Band 7 RMN's, one per main site FP and WP core role will be the daily review of our enhanced care patients and a check and challenge where appropriate where we are not following our Enhanced care Observation policy Rag rating's and the associated workforce additional staffing requests.

We continue to recruit into our Bank/temporary staffing Mental Health Care Assistants to increase the fulfilment at bank level rather than agency use. This with an aim of decreasing our Trust MHCA £ costs and increasing the patient quality of care.

We have successfully internally recruited on to a separate Band 3 bank contract several of our existing Band 2 Care assistants who have been trained up to deliver MHCA level care. This can be seen in figure 2 where we have taken over successfully the line of agency usage within our non reg workforce used.

- Recruited: x98, in training x42 and within ESR checks x20: Total of x160 recruited Bank MHCA (B3)

We are now focussing on the recruitment of bank Band 6 RMN's to reduce the Registered demand which is being currently fulfilled solely by agency.

Figure 1. Number of shifts requested from temporary staffing: Bank/Agency (Registered Staff, RMN):

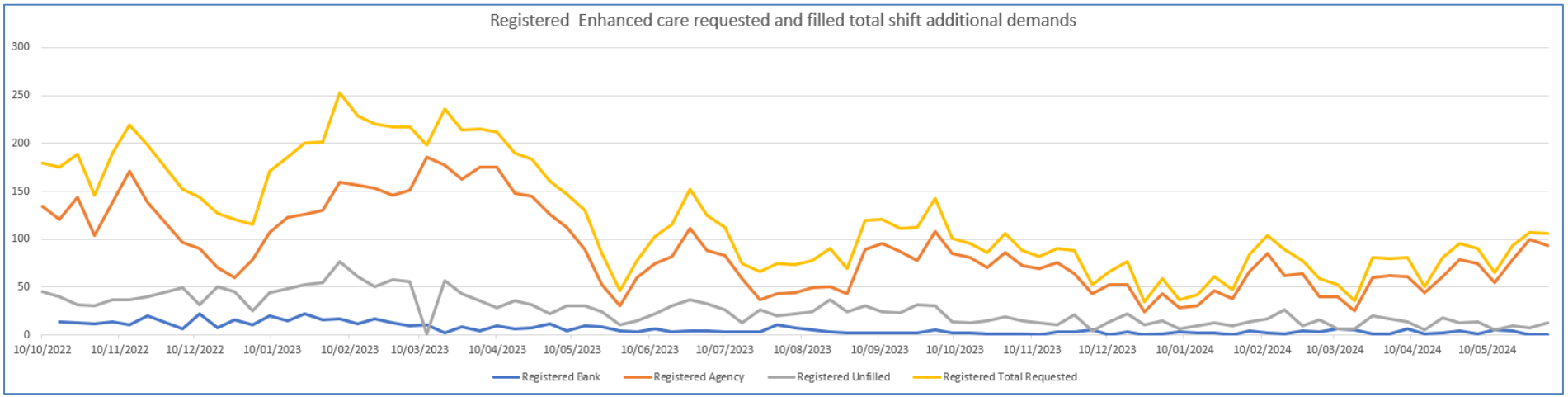
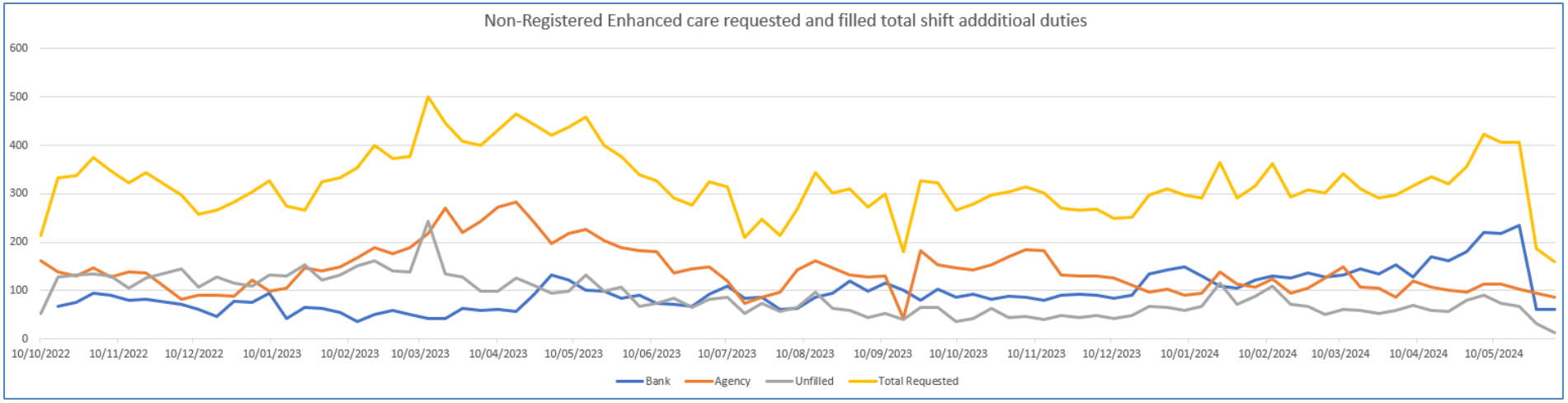


Figure 2. Number of shifts requested from temporary staffing: Bank/Agency (Non-Registered; Care Assistant, Mental Health Care Assistant):



2.0 Maternity services update ***(Narrative supplied by Emma Luhr, Director of Midwifery)***

The midwifery staffing is funded by the trust to achieve the recommended birth ratios from the last Birth Rate Plus review in 2020 of 1:24.5 at Frimley Park site and 1:23.3 at the Wexham Park site. (The ratio is one midwife: number of women that deliver). Which enables the trust to achieve compliance with Ockenden Recommendations (Dec 2019). This is a Key Performance Indicator (KPI) on the monthly maternity dashboard.

Birth Rate Plus is planned to be recommissioned in 2024 to undertake a further review to determine if these ratios are still applicable or require adjustment. Any increase required will be presented as a business case through the trust process.

Since the last update to the board the recruitment of midwives has remained the top priority for the department, throughout the past six months the vacancy rate was reduced still further and by the beginning of May (Quarter one) was at 12.6% (49 WTE vacant posts cross site) with 18.32 recruited and waiting to start. We currently have 19.61 WTE on maternity leave with 12.68 WTE being from the Frimley Park site.

Recruitment is active and currently the students that are due to qualify in the autumn of 2024 are being interviewed. We will be able to offer them positions if they are successful at interview which will further reduce the vacancy rate. This update will be shared with the board in the next report. Recruitment of Midwives remains on our risk register the last review from May 2024 scored sixteen.

During the past six months November 2023 to April 2024, both sites saw improvements in being able to achieve the funded midwife-to-birth ratios recommended by Birth Rate Plus, of 1:24 for the Frimley Park site and 1:23.5 at the Wexham Park site, this was achieved by improving the vacancy rate with the use of bank and agency staff. The trust however did not have to close the maternity service during this period. Both maternity units remained open and safely staffed during this period. This challenge is not unique to Frimley Health NHS Trust, as there is a national shortage of midwives. Our recruitment plan, shared regionally and nationally with NHS England, remains in place.

The Wexham park site, has most of its vacancies within the community midwifery service. Work has been progressed since the last report to improve this with dedicated advertisement to this area. The Head of Midwifery and Matron for community continue to keep The Royal College of Midwives regional representative updated who is supportive of our plan.

Our recruitment and retention lead midwife and lead midwife for international recruitment have been further funded for 2024/2025.

The recruitment lead continues to actively support the matrons with the recruitment plan and addressing feedback received from staff exit interviews and listening events. This dedicated post has enabled the turnover rate in the last six months to decrease to 10% which is a real improvement for the department.

International recruitment continued with a further four midwives joining the Frimley Heath team, they are currently progressing with their individually adapted preceptorship programme for working in England. Due to this pipeline being slower than anticipated, these will be the last four midwives we will support through this route. Our learning has been invaluable and the lead midwife for international recruitment continues to provide pastoral support to those relocating locally to enhance retention efforts. In total we have taken fifteen midwives from overseas, during the past 3 years, of which eleven of them are fully embedded as part of the midwifery teams and it is anticipated the remaining four will complete their individual preceptorship by the end of Quarter two of 2024/25.

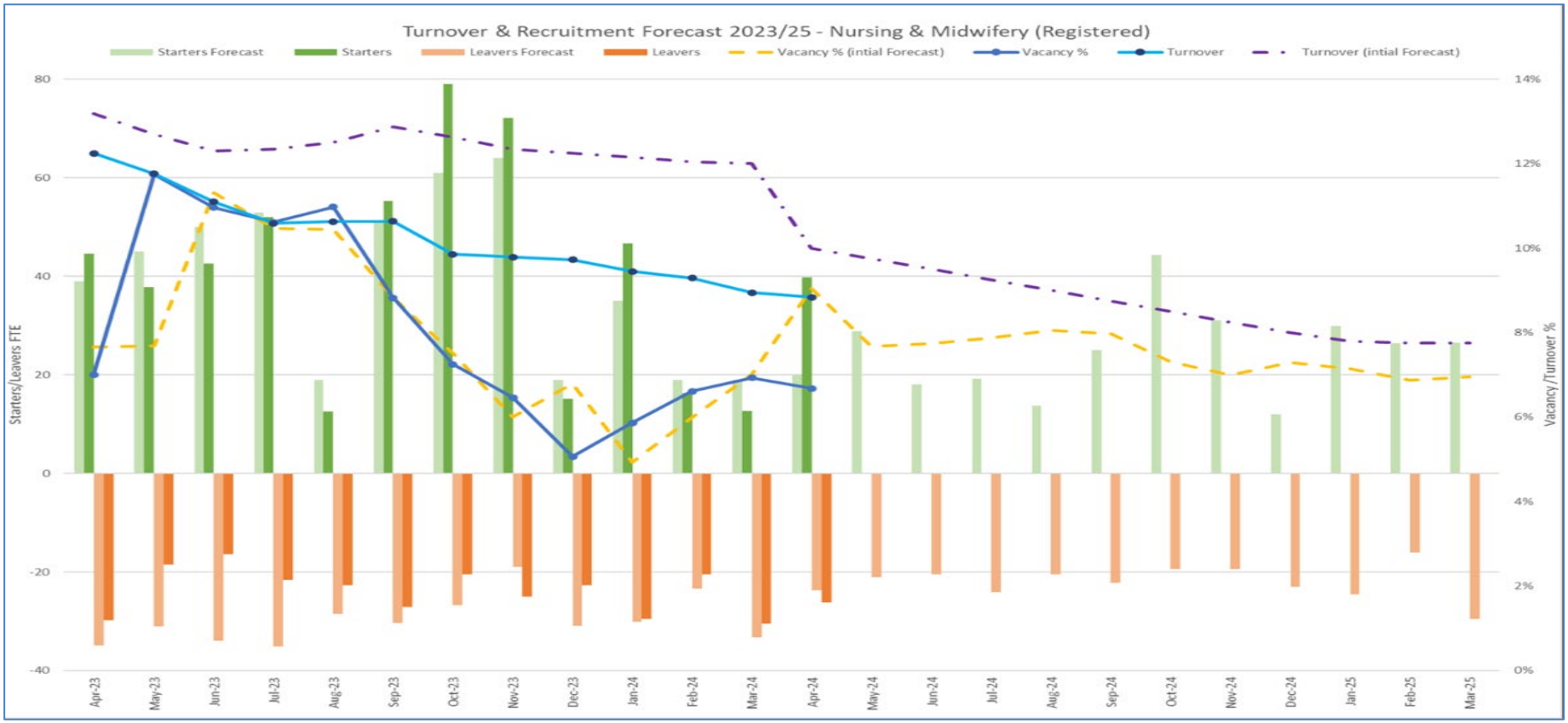
We continue to support midwives interested in returning to practice and offer programs for those seeking to maintain their midwifery registration. However, during the past six month we have received no applications.

The recruitment of Registered General Nurses has supported us in running our immunisation programmes for pregnant mothers and newborn babies.

The changes in the band three roles for maternity support worker (MSW) and hearing screening roles, is now completed across site. There is a dedicated team of hearing screeners who support the newborn screening programme.

3.0 Nursing and Midwifery (Registrant) Recruitment & Retention update: Trust current position and forecast trajectory:

FHFT Registered Nurse/Midwife (RN/M) 8.6 % 320 wte vacancies (May 2024 data published in June 2024) (includes IEN's on B3 until Passed OSCE exam) however this ***does not include*** the pipeline going through pre-employment process UK & IEN allocated to wards).



As noted within the graph above we have made considerable inroads into aspiring to get as close to around 5% vacancies within our registered budgeted workforce, this then allowing for 5% temporary staffing reliance.

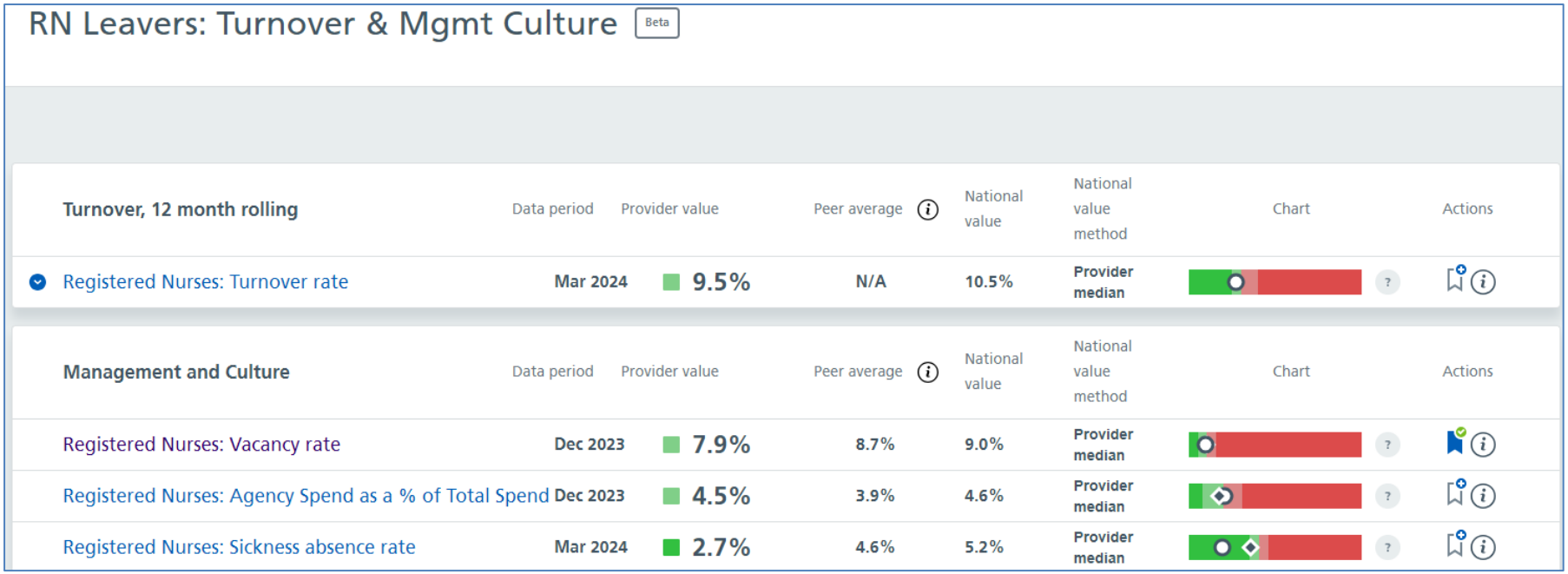
We await the starting of our 'domestic external recruitment' new starters (primarily student nurses/midwives) starting through September/October 2024. The ward level vacancies have significantly reduced within nursing and midwifery, with many inpatient areas as close to being fully recruited to at Band 5.

Through successful midwifery recruitment we anticipate (if all those recruited start), to be cross site fully recruited into midwifery budgeted positions at Band 6 level. These positions have remained vacant for several months. As reported in the Jan staffing assurance paper this was a significant risk within the WP community midwifery teams. Through the successful student midwifery recruitment this risk will be decreased/mitigated against if all that have been employed commence employment in September/October. This is an excellent position to be in if all start as anticipated.

4.0 Comparison of Trust leavers position with Model Hospital data extracted 19/06/2024 Registered Nurses Vacancies, Turnover, leaver rate %, FHFT vs Peer and National Median:

*Trust vs *Peer regional median vs National median % (For Regional Peer list, see appendix)*

- Improvements to be noted within our Trust level Turnover % latest Registrant rolling turnover of 9.5%
- Vacancy and turnover of registrant level roles are all within range Vs national averages.



5.0 FHFT International recruitment: International nurse update

The Trust continues with its focus on international recruitment however this FY numbers will be significantly lower. The anticipated IEN numbers to recruit will be circa of x78 over the FY. Initial IEN forecast numbers required was x120 required. In May 2024 we reduced this number of arrivals due to the stabilising B5 turnover %, de-escalation of cross site escalation beds (reducing the workforce requirements) and a greater focus on domestic/student recruitment.

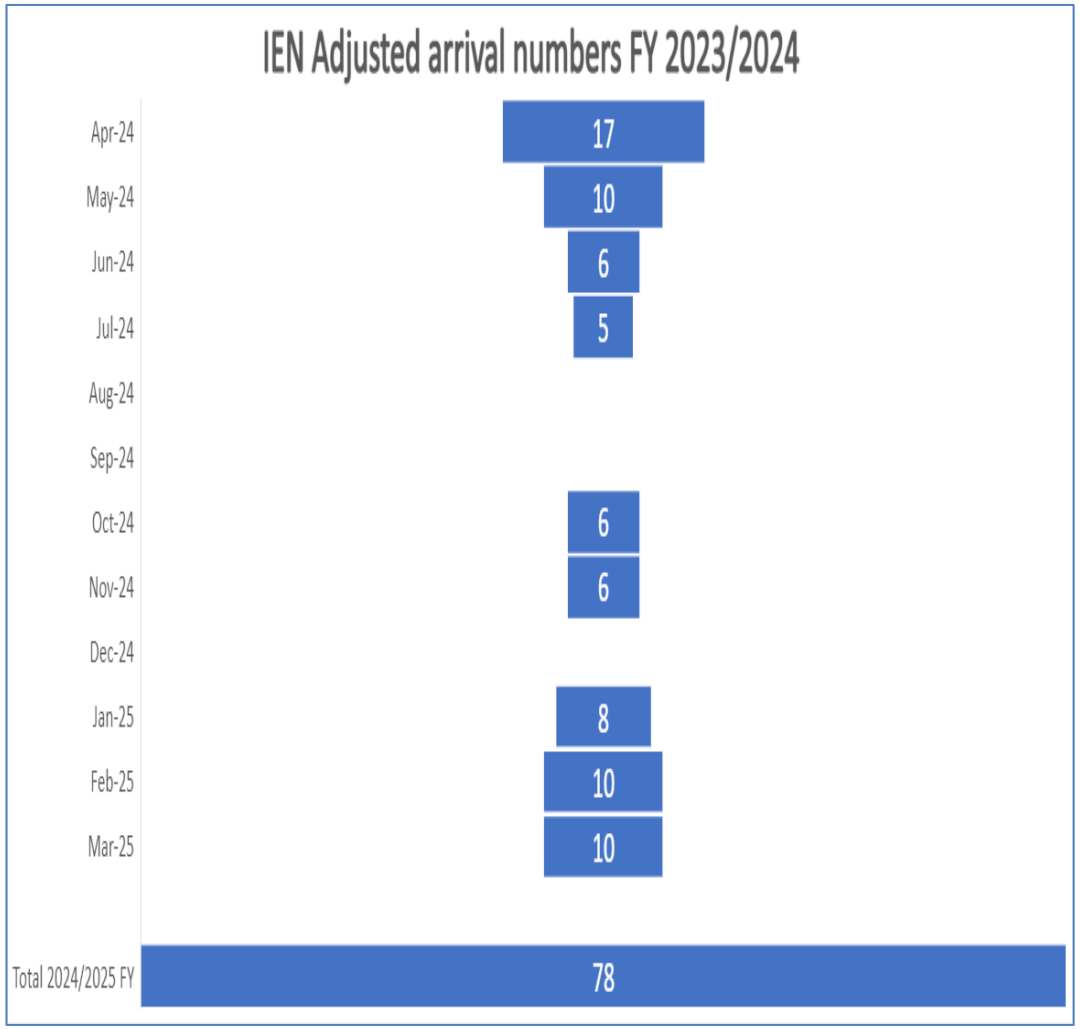
The IEN numbers required are under constant review as the changing workforce requirements unfold as we head towards next year of M block opening and an additional x52 beds on the FP site comes to fruition.

IEN resourcing is required to supplement of domestic recruitment which primarily comes each September when larger student numbers qualify.

The Trust this financial year target number of x78 (current forecast requirements) a significant reduction to the circa of x256 internationally educated nurses recruited last financial year (70 % reduction on IEN numbers employed last FY).

We continue to have an excellent overall pass rate of our OSCE test results, the exam all IEN/M's must sit and pass to successfully enter the Nursing and Midwifery Council (NMC) register to practice in the UK.

For governance and £ cost control since April 2024 all IEN's are managed on a central roster for their first 10 weeks in the Trust. This with an aspiration they are all OSCE passed and within Ward staffing numbers on the ward by the end of the 10 week point. This has this FY an added benefit of wards not having to 'double run' shifts with an IEN and then additional £ cost of paying for the temporary staffing whilst the IEN is going through OSCE preparation or local departmental supernumerary period within their local induction/orientation.



6.0 Health Care Assistant Recruitment

The below data shows the FHFT Healthcare Assistant (HCA) current recruitment activity over the last rolling 12 months alongside turnover %. This data is before we have this year's FY budgets uploaded (2024/25), and any additional CA's uplifts approved by TMB.

Totals: *leavers from the Trust over the last rolling 12 months May 2023- April 2024 inclusive:* x158 with x370 starters =
a net gain of x212 starters (Starters - Leavers). Every month (exception of March 2024) we have made a net gain.

We have slowed recruitment down over the last few months within CA's due to several Trust escalation beds/areas closing or planning to close over the coming 2 months. This has created several staff being planned to be re-deployed to existing internal Trust CA vacancies. With this continued CA recruitment monthly, stable turnover, we continue towards the trajectory of a 5% vacancy based on this year's non-registered budgets. Once TMB approve the additional CA's within (our separate staffing paper), this will require some further focussed CA recruitment campaigns.

Summary of FHFT: HCA Starters and Leaver's summary last rolling 12 months May 2023 – April 2024 (Actual):

Monthly HCA CAs Retention Data

Frimley Health	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Rolling 12 months total starters vs leavers
Starters	31	41	34	20	28	36	25	37	42	40	17	19	370
Leavers	13	8	17	7	15	17	14	10	16	13	19	9	158
Turnover %	16.96	16.58	16.55	15.48	14.37	14.83	15.13	14.29	14.47	14.11	14.23	14.16	15.10
Trust Turnover %	13.50	13.30	12.80	11.60	11.20	11.00	10.80	10.70	10.60	10.70	10.60	10.68	11.46
Rolling (Starters minus leavers)	18.00	33.00	17.00	13.00	13.00	19.00	11.00	27.00	26.00	27.00	-2.00	10.00	212.00

7.0 General other recruitment updates relating to nursing and midwifery:
General Recruitment *(Information supplied by Daniel Winchcombe, HR Resourcing*

The current recruitment volume within nursing and midwifery is currently managing x105 candidates in the checks/starting pre-employment process (Reg/Non Reg).
The average days in stage for Time to hire is 46.6. This is an increase on May 2024 due to team changes and some delays in occupational health referrals.
Talent Acquisition
Bespoke attraction campaigns:
Midwifery – is paused due to large recruitment and pipeline to cover all vacancies. This will be reviewed again in September.
ED Paediatrics.
Virtual Wards.
Booked Events in June

Student Nurse careers clinic (Part of the student nurse recruitment)

Accommodation

With the revised downward number of international nurses, less accommodation is required. Due to the clinical education "OSCE bootcamp" being based in Frimley now. FHFT has increased the accommodation/rooms in the Frimley location whilst decreasing accommodation at Heatherwood.

This change eliminates transportation cost for IEN's during the Bootcamp period from Wexham Park or Heatherwood, and easier commute for our international nurses.

8.0 Revalidation /Professional Registration lapses

- In the last rolling 12 months (July 1023 – June 2023 inclusive) there have been a total of x19 registrants who lapsed their professional registration with the NMC by error or whilst they have been on long term sickness.

- lapsed their registration due to not paying/processing their annual Nursing Midwifery Council (NMC) registration on time or not meeting their revalidation requirements. September date month will always have the highest risk associated for lapses as many UK domestic qualifying nurses

- September each year has the greatest number of lapses where registrants have an annual expiry due to being aligned with qualifying month of training.

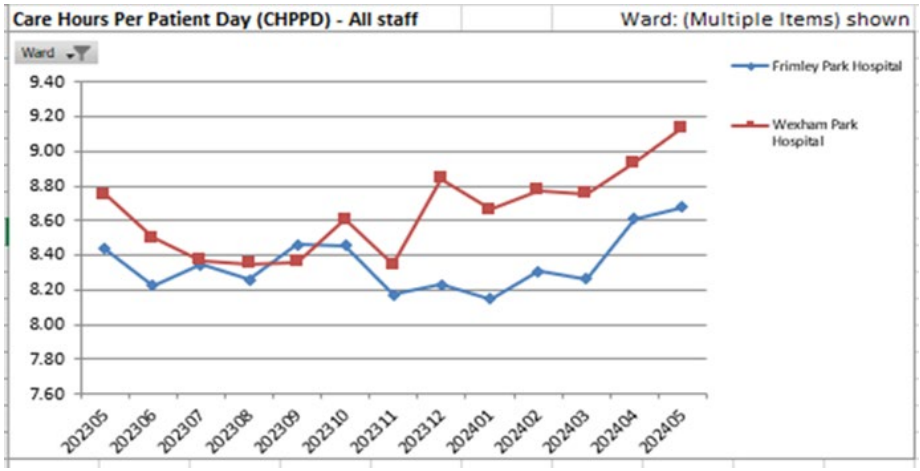
- All nurses returned to the register within 2 weeks maximum once their annual fee and their supporting return to the register documentation and renewal fee was paid to the NMC.
- All lapsed registrants did not work clinically during this period in the capacity recognised of a registered nurse. They were moved to a non-registrant banding (Band 3) and delivered non-registered nurse tasks whilst their NMC registration was lapsed.

9.0 Monthly Safe Staffing levels/CHPPD: Summary with Model Hospital data summary:

The Trust reports monthly national NHSd Staffing information of all inpatients planned and actual nursing hours. Planned nursing hours reported are based on the budgeted establishments. Below is a high-level summary of the Trust hours (Registered and Unregistered combined) for the Trust.
Nationally published nursing and midwifery data now solely focuses on **CHPPD** as a comparison metric between organisations; within the Trust we currently internally monitor both.

- The graphs below show the CHPPD averages up to and inclusive of **May 2024 with a 12 month look back date range.**
- **Please note due to HWD being x2 overnight inpatient bedded areas (TreeTops and HWD Parkside inpatient unit) the data within the charts are excluding these due to them not being accurately represented.*
- ***Appendix 2** has a full breakdown example from May 2024 data reported in June 2024 to NHS digital for our monthly Trust submission.*
  This being an example of our ward level submissions for the purposes of this assurance workforce paper, this does include the Heatherwood two areas.

Over the last 12 months the Trust CHPPD overall average (RN & Care Staff cross site, FP inc. community inpatient and WPH) Day and Night Shifts combined. **Date range: May 2023 to May 2024**



Methodology of CHPPD:

CHPPD are calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients in beds at midnight. As a monitoring tool this has some benefits; however, the methodology does not take into consideration any activity variances throughout the day or the acuity dependency levels of patients which all reflect in the workforce demands in a clinical area.

CHPPD monitoring is a mandated NQB requirement alongside NHSE.

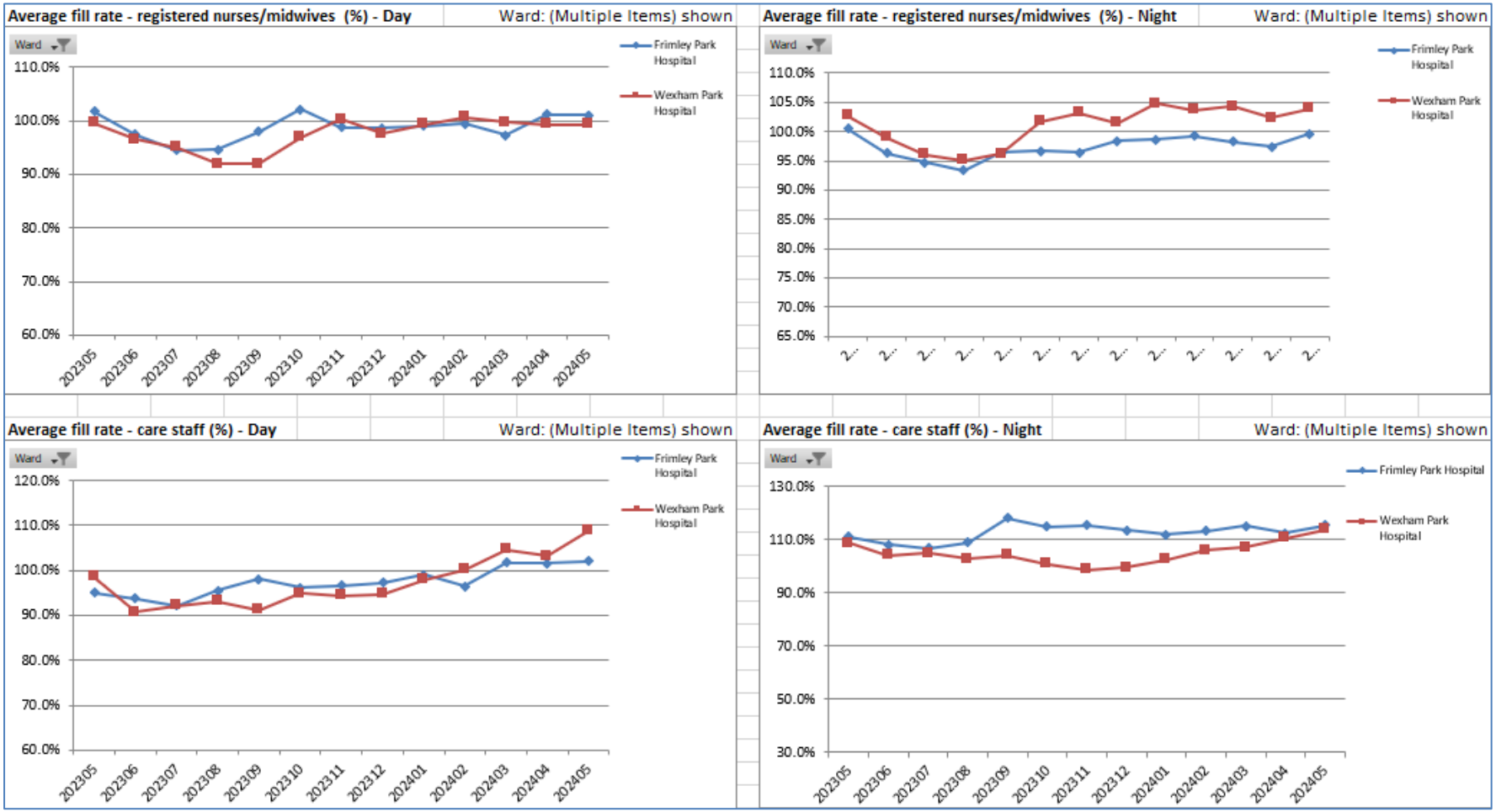
CHPPD staffing indicator is the key measure of staffing within a Trust to benchmark with other organisations nationally, moving away from fill rate %, (NHSi, 2018).

Model Hospital data on CHPPD median indicates we are in line with our regional peers and national median.

Over the last 12 months the Trust % overall fill rate is as follows (RN & Care Staff cross site, FP inc. community inpatient and WPH) Day and Night Shifts combined. Date range: May 2023 – May 2024

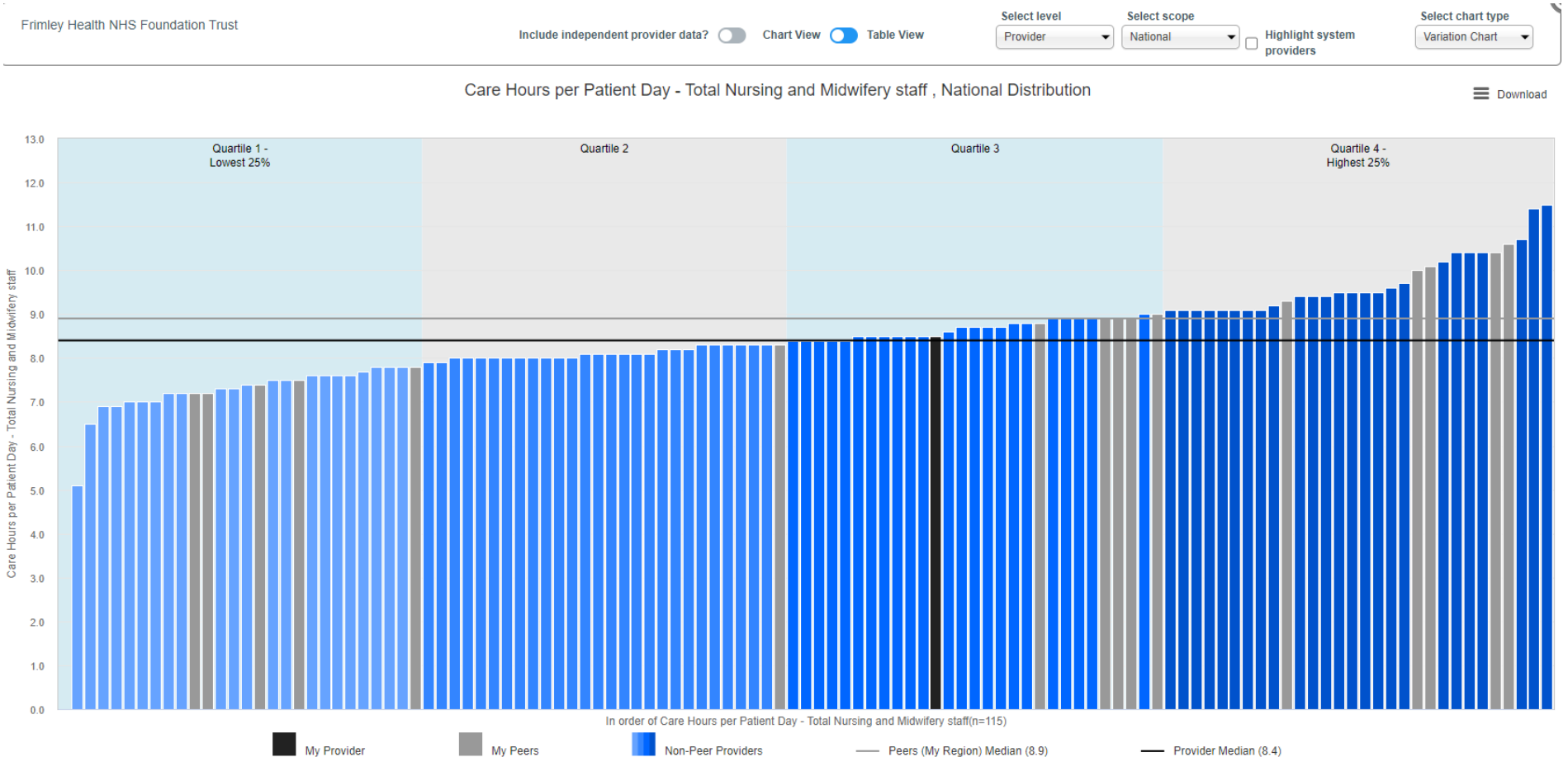
Note: Night duty shifts at over 100% fill rates related to enhanced care observation patients where this is a patient safety requirement to have in place due to the reduced numbers of staff around to be able to support Vs the day shifts.

*Please also note due to HWD being only x2 overnight inpatient bedded areas (TreeTops and HWD Parkside inpatient unit reported) the data within the charts excludes HWD inpatient beds as it is misrepresentative in comparison with the two main sites at FPH and WPH. The fluctuating average elective patient numbers at 23:59hrs used affects the data when only looking at fill rate %.



10.0 Model Hospital data comparison: CHPPD overview taken from Model Hospital, data period Feb 2024
(*Latest data available within the national system*)

- Average Trust CHPPD overall: **8.6** in line with our regional peer Trusts (Peer Median, region 8.9) and that of the national median, (Quartile 3, mid-high quartile). As reported within the January staffing assurance paper This may have a correlation to our increased rates of substantive staff now in post (and reduction in vacancies) and our increase in bank and agency shift fulfilment to safely staff our inpatient wards/departments. This has remained stable within our average overall Trust CHPPD (Last 12 months 8.4 – 8.6 CHPPD average Trust figure). It can be seen within the below graph we are in the middle quartile (Quartile 3) of levels of average CHPPD nationally form data taken from the Model Hospital data comparisons, (Data taken from Model Hospital, 19/06/2024).

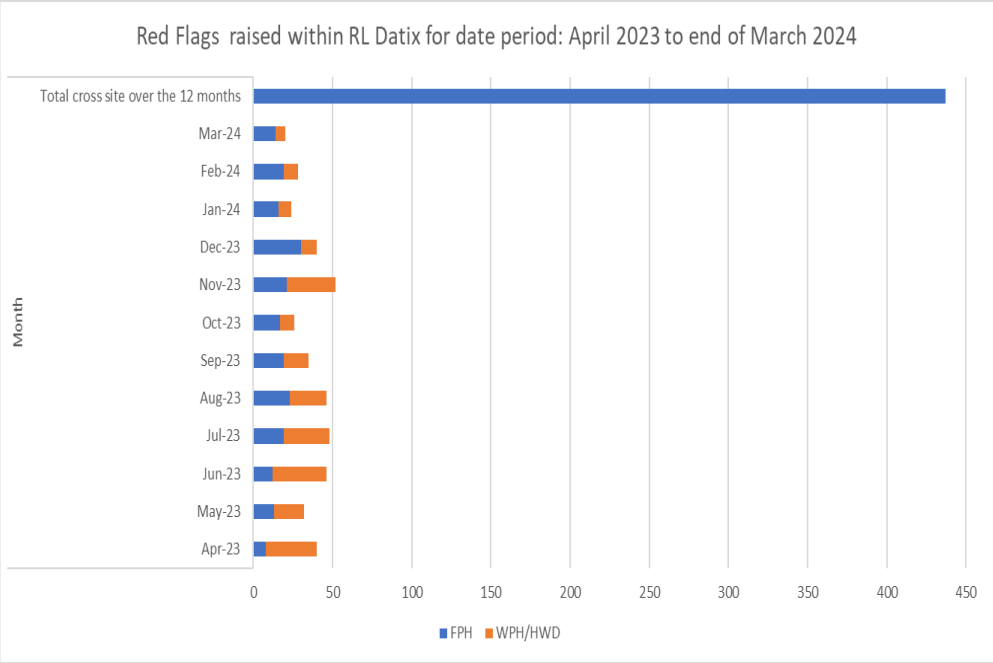


- ***CHPPD Model Hospital SE comparator with FHFT average CHPPD reported to NHSE: Reporting Date (latest data) February 2024*** ***See Appendix 2.***

11.0 Red Flags:

Raising a Red Flag is a professional judgement where a Nurse in Charge (NIC) escalates to a senior nurse where they feel that patient care could, or is, compromised due to either a lack of numbers of nurses or appropriately skilled nurses for the level of acuity /dependency of the patients. Reporting a Red Flag verbally (and within our Trust incident online reporting system) to a senior Nurse/Midwife is viewed as not being negative but one that protects both our patients and staff.

All Red Flags are reviewed by a senior nurse at the time it is raised, and any mitigating actions taken to protect the safety of our patients. All Red Flags raised on the Trusts incident reporting system are viewed by the Trust's Nursing & Midwifery senior lead nurse for workforce in addition to the location manager and other clinical leaders within the directorate the incident was raised within.
Reporting of a Red Flag via RL does not replace verbal escalation at the time of the staffing concern.



Red Flags notes to accompany diagram of Red Flags recorded trend (RL's) between April 2023 and March 2024.

- Between April 2023 and March 2024 there have been between x20 - x52 Red Flags for staffing raised.
- Across the last 12 months x437 RL professional judgement staffing concerns were raised. This has fallen in numbers on average over the last year to a new baseline number raised per month.
- Reg Flags being recorded on RL is actively encouraged to give a straightforward evidence base of staffing concerns. Numbers raised per month should not be seen as negative but used as data that is then compared to other workforce and quality and financial metrics to give a workforce risk picture of a unit.

Red Flags management:

- All staffing concerns raised operationally at the time had their risk assessed and any practical mitigating actions taken utilising the finite number of staff available. The Senior Nursing/Midwifery teams ensure that mitigating measures are taken to provide safe care to our patients through the daily site staffing meetings.
- Mitigations include Senior Sisters and Matrons being highly visible within the clinical areas or moving staff to support acuity and dependency needs of our patients. The resourcing department alongside the senior lead nurse for workforce are working closely with clinical directorates to ensure recruiting and retention strategies and action plans are in place to monitor progress.

12.0 Next Steps & Conclusion:

This paper has given an overview of the position of the Trust against the National Quality Board (NQB) expectations (including staff fill rates and CHPPD) alongside the Developing Workforce Safeguards NHSE document, *supporting providers to deliver high quality care through safe and effective staffing*.

There are further key actions which will be taken to strengthen compliance with this document to enhance the Trusts ability to monitor safe nursing & midwifery staffing over the coming 6 months. These actions include:

- Continued focus on effective use of roster and staff deployment controls to control temporary staffing spend, with key attention on enhanced care requirements. This includes new roster management access rights that will be launched at the end of June and part 2 at the beginning of July.
- Continued focus on appropriate use of additional staffing requirements for enhanced care and driving down agency use and replacing with bank use.
- The Board will be updated outside of the six-monthly cycle of these staffing assurance papers where there are any significant workforce risks identified.

13.0 Chief of Nursing and Midwifery assurance statement:

The evidence collated within this document suggests that there are strong controls and oversight of nurse staffing in place.

We have safe and sustainable funded staffing levels (once TMB ratifies the requested staffing uplifts outstanding) within our inpatient areas overall as evidenced by the KPIs in this paper.

Consistent gains in recruitment continue alongside the stable turnover and therefore lower vacancy rates. Overall CHPPD remains in line both regionally and nationally. All of this results in greater continuity of care for our patients.

The Board will be kept updated as to any new emerging workforce risk to Nursing or Midwifery.

Report Title	**Infection Prevention and Control Report Annual Report 2023/24**
Meeting	Public Board of Directors, 5th July 2024
Agenda No.	12.
Author and Executive Lead	Victoria Gentry (Infection Prevention Nurse Consultant FHFT) Melanie Van Limborgh (Chief of Nursing & Midwifery; Director of Infection Prevention & Control)
Executive Summary	This report seeks to provide the Board with assurance of compliance with the *Health & Social Care Act 2008: code of practice on the prevention and control of healthcare associated infections and related guidance (updated December 2022)*. The code sets out the ten criteria against which the CQC will assess the Trust on how it complies with infection prevention and control (including cleanliness and antimicrobial stewardship) requirements, and the IPC Board Assurance Framework provides a summary of the evidence and actions required for assurance. The purpose of the Infection Prevention and Control (IPC) report 2023/24, is to provide the Board with an annual summary of: • Infection Prevention & Control (IPC) activities • progress against national legislative assurance tools and related IPC guidance from other national bodies • healthcare-associated infection performance and benchmarking • progress on IPC ambitions, and the IPC Strategy • progress on agenda items presented at the Trust Healthcare Infection Control Committee (HICC) • IPC risks, and provide assurance that prevention and control of infection risks are being managed effectively in the Trust The report also provides an overview of the ambitions and focus for IPC in 2024/25. **Issues:** • Compared to 2022/23, FHFT achieved reductions in rates of healthcare-associated CDI (Clostridioides difficile Infection), MSSA (methicillin-sensitive Staph aureus) bacteraemia, and Klebsiella bacteraemia in 2023/24, despite exceeding NHS England thresholds set for the year. • FHFT had the 17th lowest rate of hospital-onset CDI nationally. • The Trust's work on water-safe care is helping guide national policy on the New Hospital Programme, and actions taken by the Trust to reduce hand wash basins has already reduced HCAI in Eden Ward. • The IPCT continues to increase the number of face-to-face education sessions, for more effective embedding of IPC standards in practice. • The operational impact of COVID-19 on the Trust, was significantly reduced in 2023/24, compared to the previous three years.

	Opportunities for future focus: • Performance on healthcare-associated Gram-negative bacteraemia and CDI requires further improvement, and the national objectives will be challenging to achieve again in 2024/25. Provision of antimicrobial prescribing data at the Antimicrobial Stewardship Group in 2024/25 will be critical in understanding the drivers for the increase in these infection categories and driving actions to reduce incidence, as well as providing assurance to Board of compliance with AMS within the Trust. • IPC Team (and other key stakeholder) involvement in Capital projects at an earlier stage of the project, is required to reduce impact on budget and programme, and will be vital for the New Frimley Park Hospital build. • The management of the Carbapemenase-producing Enterobacterales (CPE) outbreak at WPH, has highlighted the requirement for a risk assessed approach to the design and location of water outlets, including hand wash basins and showers, in clinical areas. • Increasing single room capacity for care of patients, increasing storage within clinical areas, and improvements to water and ventilation must be a priority for provision of healthcare environments that promote infection prevention and control. • Identifying a FFP3 resilience lead for the Trust in 2024/25 will be key in providing assurance in line with the national Emergency Preparedness, Resilience and Response core standard 12, requiring the organization to have in place arrangements to respond to an infectious disease outbreak, covering a range of diseases including High Consequence Infectious diseases.
Recommendation	The Board is asked to: • **NOTE** the Frimley Health IPC Annual Report 2023/24, and progress with actions to reduce healthcare-associated infections. • **APPROVE** the Frimley Health Infection Prevention and Control Annual Plan and Audit Programme for 2024/25 (Appendix 1 of this report).
Compliance	This paper is presented to Board to provide assurance of compliance with the *Health & Social Care Act 2008: code of practice on the prevention and control of healthcare associated infections and related guidance (updated December 2022)*.

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NHS
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NHS Foundation Trust

Infection Prevention and Control Annual Report 2023/24

Melanie Van Limborgh
Director of Infection Prevention and Control
Frimley Health NHS Foundation Trust

Infection Prevention and Control
Annual Report
2023/24

Infection Prevention and Control
Annual Report
2023/24

1. Introduction

This annual report from the Frimley Health NHS Foundation Trust Infection Prevention and Control (IPC) Team, provides the Board with an annual summary of assurance of healthcare-associated infection performance for 2023/24, in line with the requirements of the *Health & Social Care Act 2008: Code of practice for the NHS on the prevention & control of healthcare associated infections and related guidance* (updated December 2022).

The Trust IPC Team set the following vision and ambitions for 2023/24 which aligned with the priorities in the IPC Strategy 2021-2025 (Appendix 1):

'Our Vision is to prevent any patient from coming to harm from an avoidable Healthcare-Associated Infection, by supporting staff in facilitating best practice, and by ensuring the patient is at the heart of all interventions'

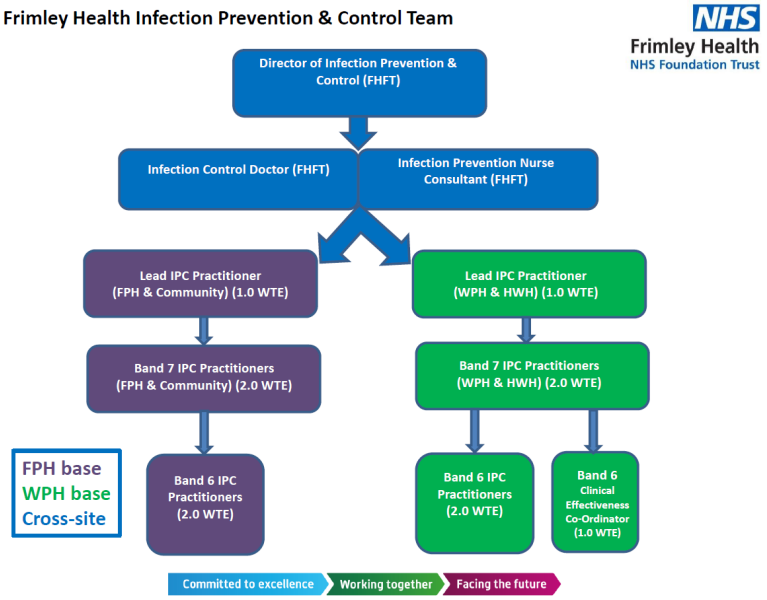
The IPC Ambitions for 2023/24 were also aligned with the Trust Strategic Ambitions:

Strategic Ambition	IPC Ambition(s) 2023/24
Improving Quality for Patients	Antimicrobial stewardship to be included in IPC Level 2 training packages – monitoring of effectiveness of training through PIR and AMS audits
Supporting our People	Continued implementation of Every Action Counts, supporting excellence in staff IPC behaviours: • Increasing clinical-based and face-2-face training sessions by 10% • Empowering staff to make IPC risk assessments (outcome measured by audits of Epic documentation)
Collaborating with our partners	IPC Team participation in Frimley ICB workstreams: • Improving quality of care of catheters • Improving hydration in domiciliary care
Transforming our services	*As per above: reducing impact of catheter-associated infections will reduce emergency admissions and length of stay – improving capacity for elective lists*
Making or Money Work	Education and embedding practice to reduce waste: • Non-sterile glove reduction by 5% (based on pre-pandemic usage) • Support Estates team in improving segregation of waste
Advancing our Digital Capability	Embedding use of Epic for: • Collection of data for mandatory HCAI data submission • Monitoring of IV device and urinary catheter-associated infections • Improving infection risk assessments • Improving patient information

2. Compliance with the Health and Social Care Act 2008

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Infection Prevention & Control Team Structure and Budget Allocation 2023/24



The above structure is supported by the following staff under the Infection Prevention & Control Department budget:

		Department	
FPH	Information Analyst	Pathology	0.6 WTE
WPH	Antimicrobial Pharmacist	Pharmacy	0.8 WTE

The following budget is allocated to the Infection Prevention & Control Department:

Overall budget	£891,389	
Contract income	£3577	
	Staff budget	**Non-staff budget**
FPH	£467,792	£2,307
WPH	£422,035	£2,832

The Infection Prevention & Control Department does not hold its own training budget and outbreak budgets are held by contingency.

Infection Prevention & Control Reporting Arrangements 2023/24

Healthcare Infection Control Committees (HICC) 2023/24

HICC was held quarterly in 2023/24, and the October 2023 meeting was postponed to November due to operational pressures. The terms of reference and membership are attached as Appendix 2. These are updated annually and were last ratified at the April 2023 committee meeting. Since April 2020, HICC has been held cross-site via Microsoft Teams.

Infection Prevention & Control Working Group 2023/24

The IPC Working Group is held in the months in between HICC, and reports into HICC. The June 2023 and March 2024 meetings were cancelled due to clashes with other Trust meetings being

subsequently booked at the same time, with the same attendance. The terms of reference and membership are attached as Appendix 3. These are updated annually and were last ratified at the April 2023 committee meeting.

HICC: Links to other committees

The following committees report into HICC:

- Decontamination Steering Group
- Antimicrobial Subgroup
- Built Environment Committee (including Ventilation Subgroup and Water Safety Subgroup)

The Director of Infection Prevention and Control (DIPC) is a member of the following Trust committees:

- Board of Directors
- Trust Management Board
- Senior Leadership Committee
- Executive Performance Oversight Delivery group
- Healthcare Infection Control Committee
- Quality Assurance Committee
- Care Governance Committee
- ICB Quality Board
- Frimley System DIPC meeting

The Infection Prevention and Control Doctor is a member of the following committees:

- Consultant Staff Committee
- Antimicrobial Subgroup
- Water Safety Subgroup
- Ventilation Subgroup
- Built Environment Committee

The Infection Prevention and Control Nurses are members of the following committees:

- Heads of Nursing, Midwifery & Therapies
- Patient Led Assessments of the Care Environment (PLACE)
- Medication Safety Committee
- Specialist Nurse Forum
- Decontamination Steering Group
- Sepsis Group
- CLIIPS
- Nursing, Midwifery & Therapies Board
- Capital Update meeting
- Patient Safety Committee
- Product Selection Group
- Health and Safety Committee
- Decontamination Steering Group
- Nutrition Steering Group
- MAST (Mandatory & Statutory Training) Group
- Water Safety Subgroup
- Ventilation Subgroup
- Built Environment Committee

And externally:

- NHSE SE Infection Prevention & Control Network
- Frimley Health & Care System Infection Prevention & Control Group
- Infection Prevention Society
- Infection Prevention Society Sustainability Special Interest Group
- Infection Prevention Society IV forum
- Healthcare Infection Society
- Surrey Heartlands Infection Prevention & Control Group (link to Frimley Park Hospital and Farnham Hospital)
- Links with ICB and external parties for healthcare-associated infection review and feedback:
  A monthly email with mandatory healthcare-associated infection data reported by the Trust, and risk factor data, is sent to the Director of Quality and Nursing, and Infection Prevention lead at Frimley ICB.
  A member of the ICB is invited to Post-Infection Review and outbreak meetings.

Infection Prevention and Control Governance Structure

Assurance is provided to the Trust Board by:

- The DIPC presents an Annual report to the Trust Board
- The HICC provides quarterly reports to the Care Governance Committee
- Quarterly report to Quality Assurance Committee

The FHFT IPC Nursing Team meet a minimum of twice a week (Monday clinical catch-up, and Thursday IPC Team huddle) via Microsoft Teams. An off-site IPC Team away day took place in March 2024, to enable face to face introduction of new team members and set priorities for 2024/25. The next meeting is planned for June 2024, when the new Lead IPCN at FPH starts in post.

Infection Prevention and Control Reporting Schedule

Date	Committee	Report type
April 2023	Care Governance Committee	Quarter 4 IPC Report & IPC COVID BAF (exception report)
June 2023	Care Governance Committee	DIPC Annual Report
June 2023	Quality Assurance Committee	Quarter 4 IPC Report & IPC COVID BAF (exception report)
June 2023	Care Governance Committee	DIPC Annual Report
July 2023	Board	DIPC Annual Report
August 2023	Care Governance Committee	Quarter 1 IPC Report & IPC COVID BAF (exception report)
September 2023	Quality Assurance Committee	Quarter 1 IPC Report & IPC COVID BAF (exception report)
November 2023	Care Governance Committee	Quarter 2 IPC Report & IPC COVID BAF (exception report)
December 2023	Quality Assurance Committee	Quarter 2 IPC Report & IPC COVID BAF (exception report)
February 2024	Care Governance Committee	Quarter 3 IPC Report & IPC COVID BAF (exception report)
March 2024	Quality Assurance Committee	Quarter 3 IPC Report & IPC COVID BAF (exception report)

Healthcare-Associated Infection (HCAI): Results of mandatory reporting

Terminology

Bacteraemia	Bloodstream infection: bacteria identified in a blood culture
Hospital-onset (HOHA)	These cases are apportioned to the Trust and count against objectives set. Bacteraemia and *Clostridioides difficile* Infection (CDI) cases are classed as hospital-onset if the positive sample is taken on or after the third day of admission (with the day of admission being Day 1).
Community-onset; Healthcare-associated (COHA)	These cases relate to patients that are recorded as receiving care within the Trust in the 28 days prior to the infection being diagnosed.
Community-onset (COCA and COIA)	These cases are apportioned to the ICB based on the location of the patient's GP and include cases where the sample is sent from the GP, Outpatients Dept, or within the first two days of admission to the acute Trust.

Healthcare-Associated Infection Summary 2023/24

A summary of the HCAI performance in 2023/24 is shown below. The rate data for the financial year has been obtained from the UK Health Security Agency (UKHSA) HCAI Data Capture System.

HCAI	Threshold set for 2023/24	Total healthcare-associated cases 2023/24 (hospital-onset rate/ 100k bed days)
MRSA bacteraemia	Zero preventable cases	**4 (0.87) (1 preventable case)***
MSSA bacteraemia	Internal threshold of 40	**39 (7.46)**
Clostridioides difficile Infection	52	**69 (10.78)***
Ecoli bacteraemia	183	**253 (35.86)***
Klebsiella species bacteraemia	60	**73 (12.19)***
Pseudomonas aeruginosa bacteraemia	33	**38 (6.33)***

* Threshold exceeded

Benchmarking of Healthcare-Associated Infections 2023/24 and Post-Infection Review

The IPC Team lead on the post-infection review (PIR) for all healthcare-associated; hospital-onset *Staphylococcus aureus* bacteraemia, Gram-Negative bacteraemia, and *Clostridioides difficile* Infection (for which community-onset; healthcare-associated infections are also reviewed).
PIR is carried out to:

- provide assurance of compliance with 'The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections' Criterion 1: systems in place to manage and monitor the prevention of infection
- identify risk factors, or parts of the patient's care pathway, that have contributed to the infection.
- To establish what went well with the care provided
- establish what could be improved
- identify learning that can be shared locally and Trust-wide, that can improve practice for the future, and potentially reduce the risk of further infections

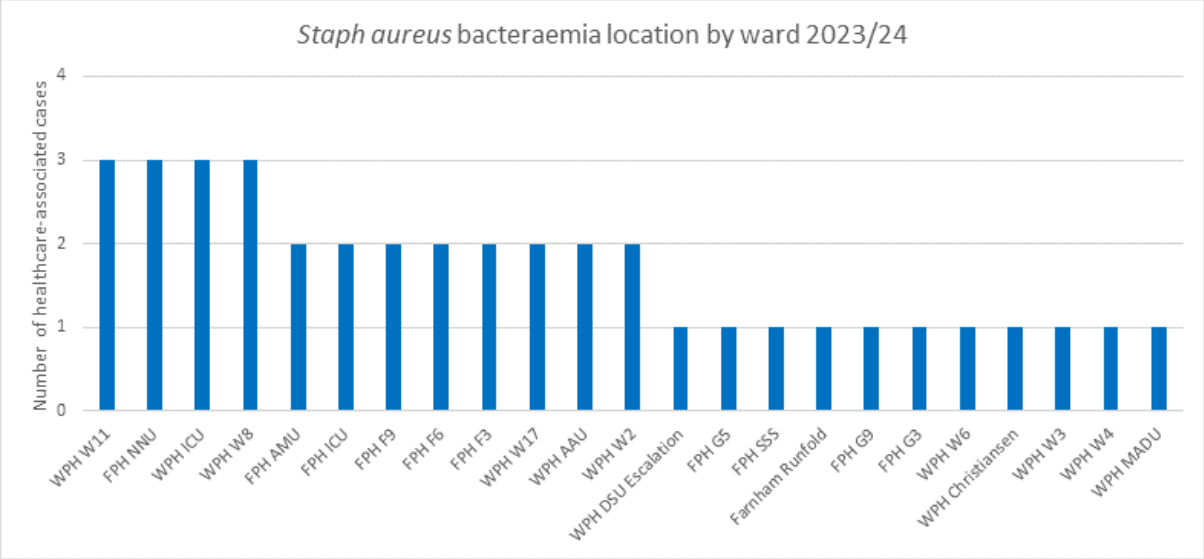
PIR involves a multi-disciplinary team including the IPC Team, the clinical team who had involved with the most recent (or relevant) episode of care, antimicrobial pharmacy, and a representative from Frimley ICB. Additional specialists, such IVAS, Dietetics, and Tissue Viability are included in reviews when their expertise are required.

Epic has assisted greatly with the PIR process, by enabling all patient care information to be accessed from one system. During 2023/24, the IPC Team started to bring post-infection review in line with the national Patient Safety Incident Review Framework (PSIRF), using Swarm huddles to gain meaningful learning and increase clinical engagement and ownership of actions to prevent healthcare-associated infections. A log of actions from PIR were shared with the IPC Working Group for clinical areas to feedback on progress. The matrix against which the IPC Team carry out PIR and incident reporting can be viewed in Appendix 8 of this report.

***Staphylococcus aureus* Bacteraemia**

Staphylococcus aureus is a bacterium that commonly colonises the skin of humans and can become an opportunistic pathogen if it enters the body via routes such as wounds or invasive devices. *Staph aureus* can be associated with a mortality rate of 30%, and if the strain of bacteria is meticillin-resistant, even higher.
It has been a mandatory national requirement to report all Meticillin-resistant *Staphylococcus aureus* (MRSA)-positive blood cultures, whether clinically significant or not, since 2004. The reporting of Meticillin-sensitive *Staphylococcus aureus* (MSSA)-positive blood cultures began in 2010.
Since 2019, reporting includes the organisms in the *Staph aureus* complex: *Staph aureus*, *Staph argenteus*, and *Staph schweitzeri*.

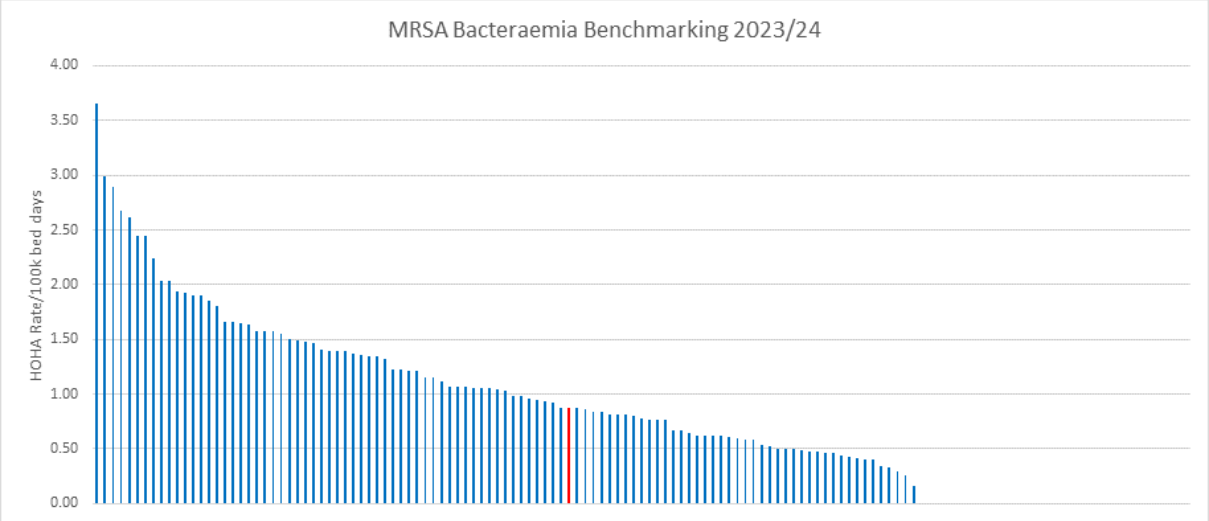
	Total Healthcare-Associated cases 2023/24	**Hospital-onset case rate/ 100k bed days**	**Case number comparison to 2022/23 (rate/ 100k bed days)**
MRSA bacteraemia	4	0.87	Increase from 2 cases (0.44)
MSSA bacteraemia	39	7.46	Decrease from 40 cases (8.81)



Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia

In 2023/24, MRSA bacteraemia cases apportioned to the Trust included both hospital-onset, and community-onset; healthcare-associated cases.

Four MRSA bacteraemia cases were apportioned to the Trust in 2023/24, with a hospital-onset rate of 0.87/100k bed days (highlighted in red on the graph below).



Summary of Hospital-Onset MRSA Bacteraemia Cases 2023/24:

Month	**Ward**	**Source**	**Risk Factors**
July 2023 (PIR meeting 10/8/2024)	WPH W2 Identified Day 36 of admission	Certain: Prostatic abscess	Continuing community-onset MRSA bacteraemia from June 2023. Past history of MRSA abscess in 2022 and had recent hospitalization and surgery for diabetic foot infection in Pakistan. **Learning:** • Clinicians need to review culture results on Epic to guide antimicrobial prophylaxis for cystoscopy, and UTI treatment. **Patient outcome:** Infection resolved and discharged home.
September 2023	FPH AMU	Certain: Skin/ soft tissue	Patient admitted with MRSA-infected pressure ulcers from home. Diabetes. All care in line with

(Formal PIR meeting not required)	Identified Day 8 of admission		Trust guidance. Diagnosis of metastatic colorectal cancer on admission, and patient was enabled to be discharged home for end of life care. **Learning:** • Possible earlier recognition of the patient approaching end of life - would have prevented blood culture collection, however the infection itself was an unavoidable community-onset infection. **Patient outcome:** Patient and family did not wish further treatment of the infection or cancer, and patient was supported to die at home.
February 2024 (PIR meeting 22/2/2024)	WPH DSU1 Escalation Identified Day 27 of admission	Highly likely: Peripheral cannula site Concluded to be preventable	Admitted with abdominal pain and a community-onset *Ecoli* bacteraemia. Diabetes. Prolonged duration of inpatient stay for social reasons. Patient was transferred to an escalation area, and was subsequently not reviewed by a registered Dr for over 7 days. **Learning:** • Documentation/ observation of care of invasive devices was not complete, and a previous cannula had been in place for 8 days (IVAS team provided educational updates as action) • Surgical Drs IPC Level 2 training was below 80% (set objective to be above 85% by 31/3/2024) • Ensure that patient referral pathways are completed. Infection resolved and remains an inpatient at the end of the reporting year.
March 2024	FPH ICU Identified Day 5 of admission	Probable: Femoral Haemodialysis Catheter Possible: Urinary catheter	Admitted to ICU with hyperkalaemia, after fracturing arm in which HD fistula was sited, and was unable to have haemodialysis in the community for over a week. MRSA colonised on admission. Traumatically self-removed catheter. All care in line with Trust guidance. **Learning:** • Current Trust practice of siting vascath for HD in ICU will be reviewed in April 2024. **Patient outcome:** Infection resolved and discharged home.

There were nine community-onset MRSA bacteraemia cases identified on admission to the Trust – an increase on five cases in 2022/23. The cases were not associated with recent care in the Trust, and were sourced to:

- Infected diabetic foot ulcers (three cases)
- Visceral abscess
- Prostatic abscess
- Pancreatitis

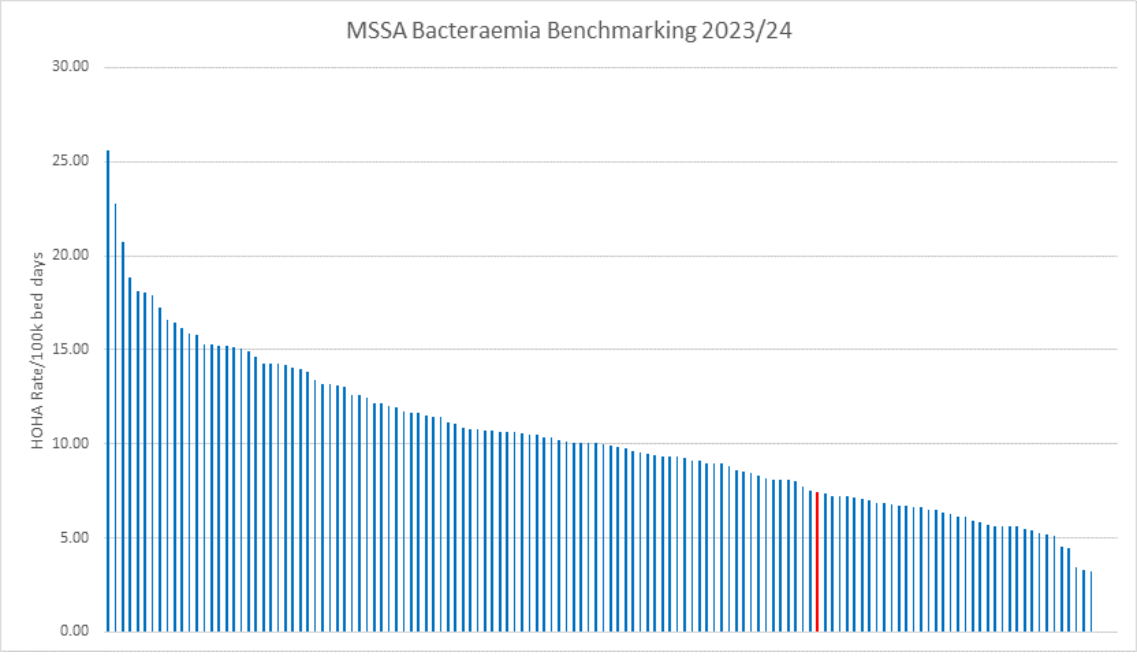
- Endocarditis
- Facial cellulitis
- Urinary/ genital infection

The most significant risk factors for MRSA bacteraemia were diabetes and previous MRSA colonisation/ infection (77% of cases).

Meticillin-Sensitive *Staphylococcus aureus* (MSSA) bacteraemia

There were 39 hospital-onset MSSA bacteraemia cases 2023/24 (19 at FPH, 19 at WPH and one at Farnham), meeting the internal objective that was set, to have no more cases than the previous reporting year (40 cases).

The Trust (highlighted in red) achieved a rate of 7.46/100k bed days, a reduction from 8.81 in 2022/23.



Source of MSSA bacteraemia at FHFT 2023/24:

Source	Number of cases
Skin/soft tissue	19
Pneumonia	10
Intra-abdominal	3
Septic arthritis	2
Intravascular access	2
UTI	1
Neonatal sepsis	1
Contaminant	1

The majority of skin/soft tissue infections were associated with diabetic and vascular foot and lower leg ulcers, with which the patients had been admitted from the community.

An increase in IV device-related MSSA bacteraemia was observed in 2023/24. Four of the 19 skin/ soft tissue infections were associated with infection of peripheral IV device sites, post-removal of cannulae (FPH G5 and F6; WPH Ward 8 and Ward 2), an increase from one case in 2022/23. Two MSSA bacteraemia cases were sourced directly to IV devices; A patient with an infected PICC transferred from WPH Ward 5 to FPH, and an infected peripheral IV device on WPH Ward 4.

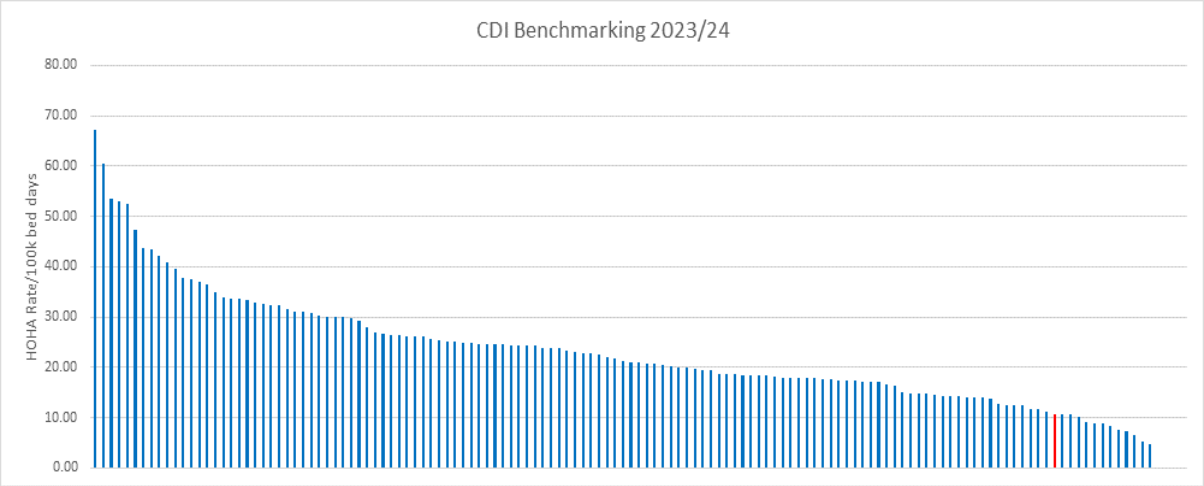
Just one contaminant (non-clinically significant MSSA blood cultures) was reported, for a baby on FPH Neonatal Unit. Although it was acknowledged that it is more complex to achieve aseptic non-touch technique when collecting blood cultures from this patient group, the IVAS team identify improvements that could be made with collection technique in the unit, and completed a programme of education for the unit staff.

***Clostridioides difficile* infection (CDI)**

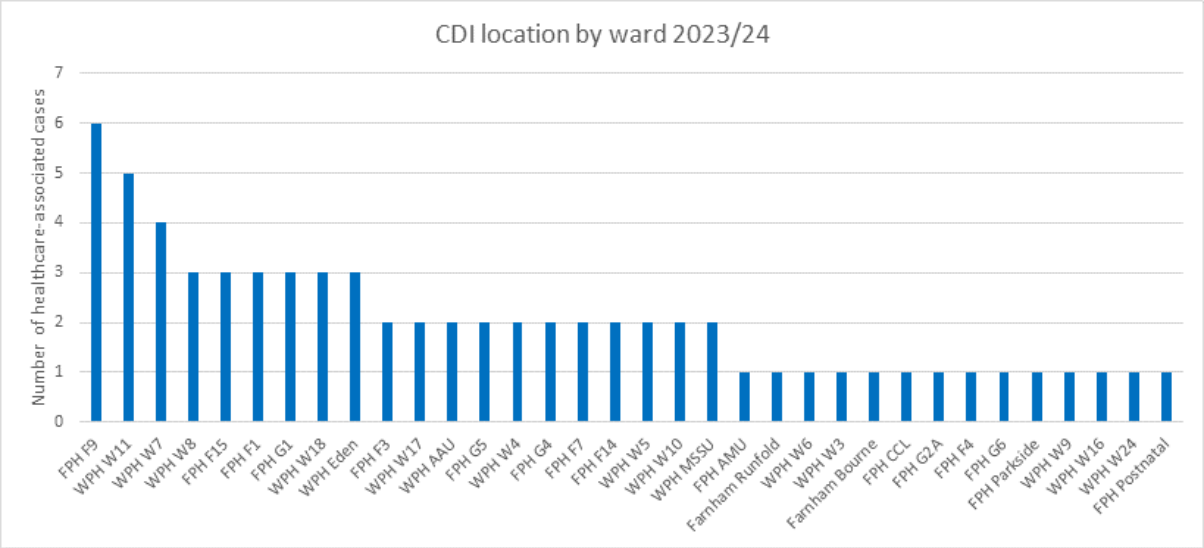
The threshold for *Clostridioides difficile* Infection in 2023/24 was 52 cases, which would have required a 28% decrease on 2022/23 case numbers to achieve. There continued to be increasing rates of CDI nationally, and the Trust unfortunately exceeded the annual threshold by the end of November 2023 (as had 45% of English Trusts), ending the reporting year with 69 Trust-apportioned cases, and a rate of 10.78/ 100k bed days.

Of the cases reported, 46 were hospital-onset, and 23 were 'community-onset; healthcare-associated' (COHA).

Despite exceeding the annual threshold, Frimley Health (highlighted in red) achieved the 17th lowest hospital-onset CDI rates nationally.



Wards with Trust-apportioned CDI cases 2023/24:



A continued theme from CDI PIRs, and investigation of PIIs, in 2023/24 was the delayed isolation and sending of stool samples for patients admitted with a suspected infectious cause of diarrhoea. This leads to a delay in diagnosis and treatment of infection and can increase the risk of environmental

contamination and transmission within inpatient settings. The root cause of delays was most often the high bed occupancy in the Trust.
Learning from PIR was fed back at the IPC Working Group, IPC Link Representatives meeting, and local clinical team meetings.

A review of Trust CDI risk factors identified:

- The root cause of the infection was antimicrobial use for 65 (94%) of the 69 Trust-apportioned CDI cases, who had two or more antimicrobials in the 6 months prior to infection. Four patients' infections had no association with antibiotics.
- 44% (24/ 65) of the CDI cases had at least one course of antibiotics that were not in line with Microguide/ valid indication.
- It was notable that 20% (14/ 69) of the Trust-apportioned cases were recurrent CDI. Action was taken by the Consultant Microbiologists to update the Trust Microguide, as Metronidazole was often not effective as first line treatment for CDI, and for an increasing number of cases, neither was vancomycin.
- The most common indication for antimicrobial treatment in the 6 months prior to CDI, was pneumonia, followed by UTI, then sepsis (unknown source).
- The most common antibiotics used in the 6 months prior to CDI were:
    - Co-amoxiclav (55% of cases). This was an increased association with CDI cases than in 2022/23 (50%)
    - Metronidazole (38%)
    - Amoxicillin (35%)
    - Gentamicin (35%)
    - Piptaz (26%)
- The highest antimicrobial use for a CDI case was for a WPH case on Ward 11, who had 20 courses in a two-month period for acute pancreatitis (nine different antibiotics, including 5 courses of co-amoxiclav).

As with the previous three reporting years, there was a close correlation with CDI and Gram-negative bacteraemia (especially *Ecoli*) associated with urinary tract infections and highlights the work around preventing UTI and improving urinary catheter care is likely to have a benefit to both CDI and Gram-negative bacteraemia reduction. Data on antimicrobial stewardship is required to gain a greater understanding of any link between prescribing practices and CDI both within the Trust and the System as a whole. With the re-commencement of the Trust Antimicrobial Stewardship Group in January 2024, local audit data for wards/ specialities with the highest prevalence of CDI (FPH Gastroenterology, WPH General Surgery and Frailty) was requested.

CDI multi-disciplinary team ward rounds include input from the IPC Team/ Consultant Microbiologist, a Gastroenterology Consultant, Antimicrobial Pharmacist, and Dietician. The CDI ward rounds are valuable for review of medication, providing patient advice, and have resulted in patients' symptoms resolving in a shorter space of time than prior to the rounds. Members of the MDT have reviewed the cases in 2023/24 on an individual basis and communicated advice and changes to care via Epic, email and telephone conversation.

A UKHSA notification on 29/11/2023, alerted organisations to a newly evolving *C. difficile* ribotype (955) which has emerged in England over the last two years (48 cases in total). This new ribotype has caused two large hospital clusters, with sporadic cases identified elsewhere in England with no apparent links to the two hospital clusters. It appears to transmit readily, may present with severe disease or as a recurrence and has caused significant mortality (10 patients died in the 30 days following the detection of the infection (all-cause mortality)).

To monitor trends in ribotyping, samples were sent regularly sent from FHFT for typing, and this reference laboratory service was free until the end of February 2024.

Clostridium difficile Periods of Increased Incidence (PIIs)

There were two Periods of Increased Incidence (PII) triggered for CDI investigation and management in 2023/24:

Ward	Month of PII	Number of cases	
FPH F15	June 2023	2	Different ribotypes, outbreak ruled out
WPH Ward 7	September 2023	2	Different ribotypes, outbreak ruled out

The two patients reviewed in the FPH PII had been admitted with intra-abdominal conditions (diverticulitis and GI bleed), and only one had received antimicrobial treatment. There was not significant learning highlighted by the review.

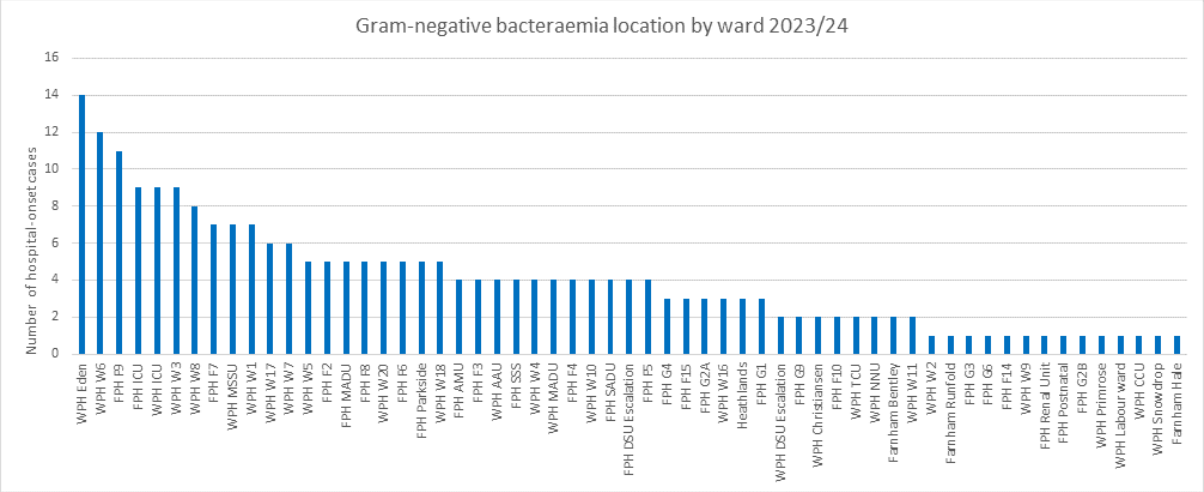
The PII on WPH Ward 7 was associated with repeated broad-spectrum antimicrobial use for healthcare-associated UTI. The review of the ward highlighted low adherence to the Hand Hygiene policy (compliance with the '5 Moments for Hand Hygiene' was at 57%), over-use of non-sterile clinical gloves, and processes for decontamination of re-usable patient equipment were not robust. Support and education were provided by the IPC Team to resolve the issues identified.

Gram Negative Bacteraemia (GNB)

The national objective for the reduction of healthcare-associated Gram-negative bacteraemia cases (in the HM Government *'Tackling Antimicrobial Resistance 2019-2024. The UK's 5-year national action plan'*) is 50% by 2024. Healthcare-associated in this incidence, is described as Gram-negative bacteraemia cases that have received healthcare in the 28 days prior to infection. For national objective setting, this is when the healthcare is provided during an inpatient stay in the reporting Trust.

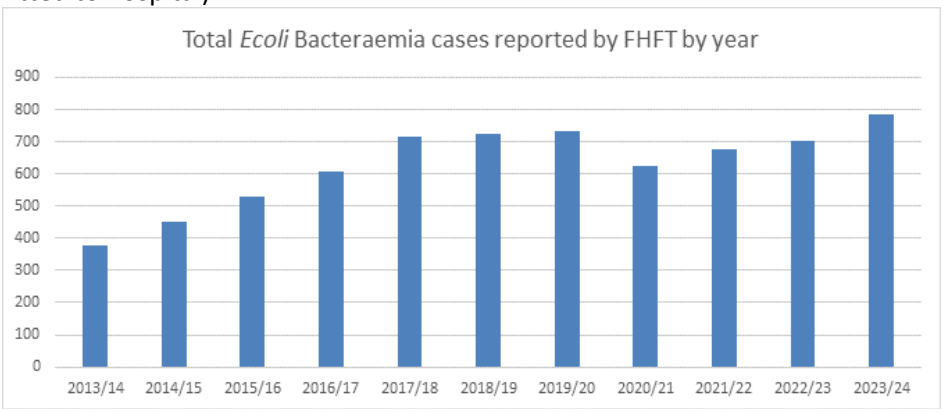
	Total Healthcare-Associated cases 2023/24	Hospital-onset case rate/ 100k bed days	Case number comparison to 2022/23 (rate/ 100k bed days)
***Ecoli* bacteraemia**	253	36.10	Increase from 190 cases (28.20)
***Klebsiella* spp. bacteraemia**	73	12.19	Decrease from 77 cases (13.40)
***Pseudomonas aeruginosa* bacteraemia**	38	6.33	Increase from 32 cases (5.17)

The wards with higher prevalence of Gram-negative bacteraemia were notably augmented care areas (WPH Eden Ward, WPH ICU and FPH ICU)

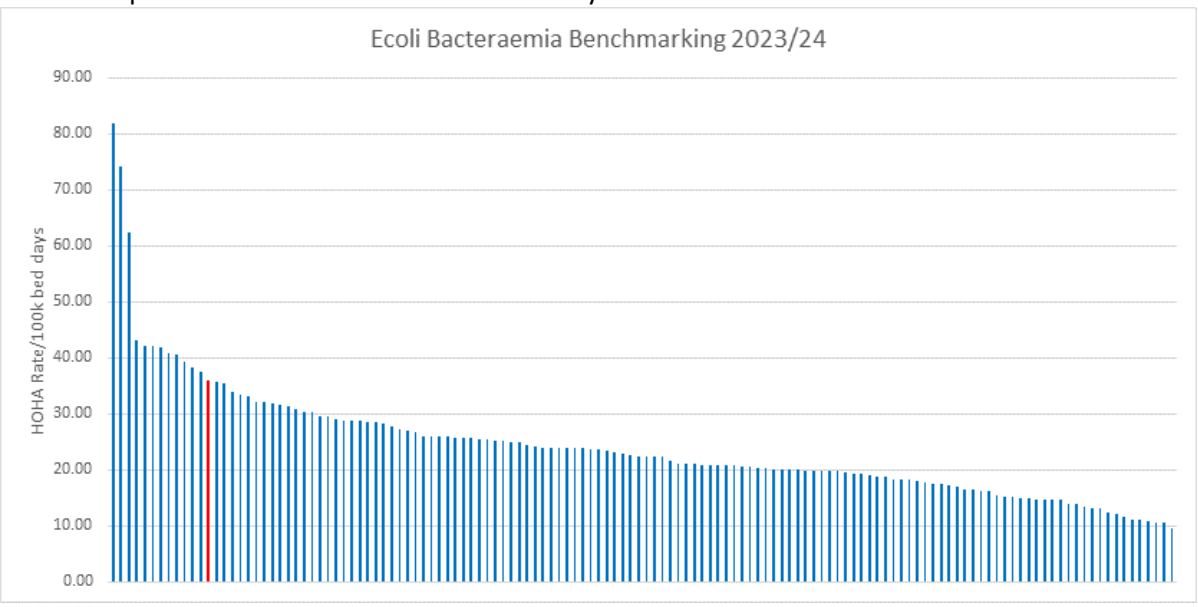


<u>*Escherichia coli* bacteraemia</u>

There were 782 *Ecoli* bacteraemia cases reported by the Trust in 2023/24, with a hospital-onset rate of 36.10/100k bed days. Far from decreasing *Ecoli* bacteraemia, there continues to be an increase (excluding the lower case numbers in the peak of the COVID-19 pandemic due to differences in patient groups admitted to hospital).



253 of the cases were healthcare-associated (both community- and hospital-onset; healthcare-associated), far exceeding the annual threshold set, and resulting in the Trust having the 13th highest rate of hospital-onset *Ecoli* bacteraemia nationally.



The main source of these *Ecoli* bacteraemia continue to be urinary tract infections, followed by a hepatobiliary source. The hospital-onset cases most commonly occurred in the frail, elderly, over 21-days stay patient group.

Klebsiella spp bacteraemia

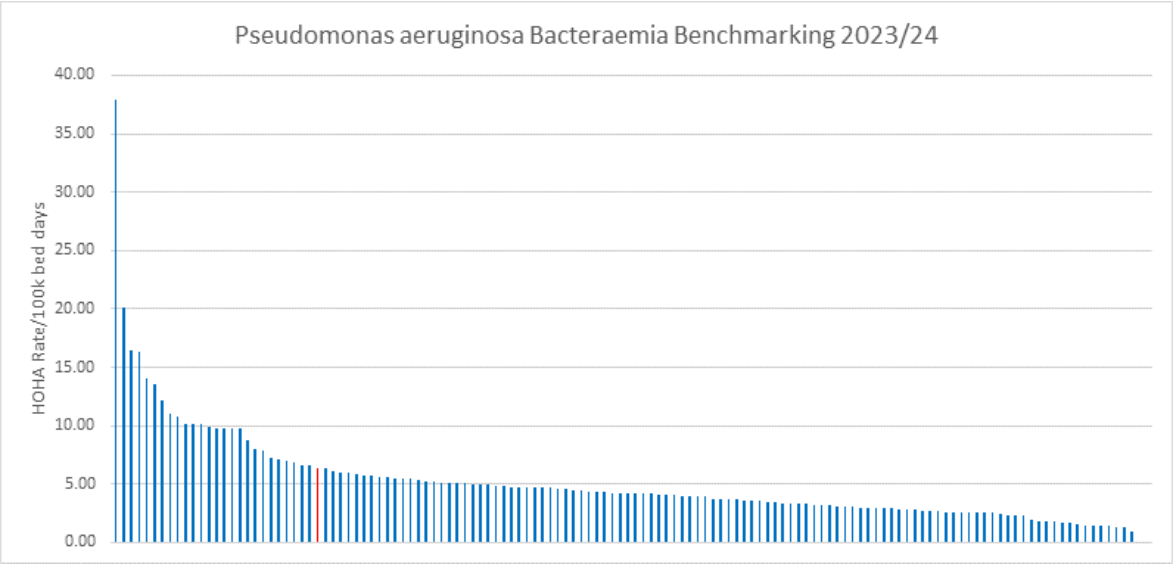
There were 193 *Klebsiella* spp bacteraemia cases reported by the Trust in 2023/24 – only a 4% decrease in cases compared to 2022/23. 73 of these cases were categorized as healthcare-associated, which exceeded the annual threshold of 60 cases.

Lower urinary and lower respiratory tract infections were the most common source of *Klebsiella* bacteraemia.

The Trust (highlighted in red) hospital-onset *Klebsiella* bacteraemia rate benchmarked 48th highest in 2023/24:

Pseudomonas aeruginosa bacteraemia

There were 69 *Pseudomonas aeruginosa* bacteraemia cases reported by the Trust in 2023/24. 38 of the cases were healthcare-associated (27 hospital-onset, and 11 community-onset), exceeding the threshold of 33 cases set by NHSE.



Actions to Reduce Gram Negative Bacteraemia

The increase in healthcare-associated *Ecoli* and *Ps aeruginosa* bacteraemia in the Trust has been raised as a significant concern – for patient outcome, and the financial impact of these infections.

PIR in 2023/24 continued to highlight the following key areas for further action, and for which the IPC Team continue to set ambitions for 2024/25:

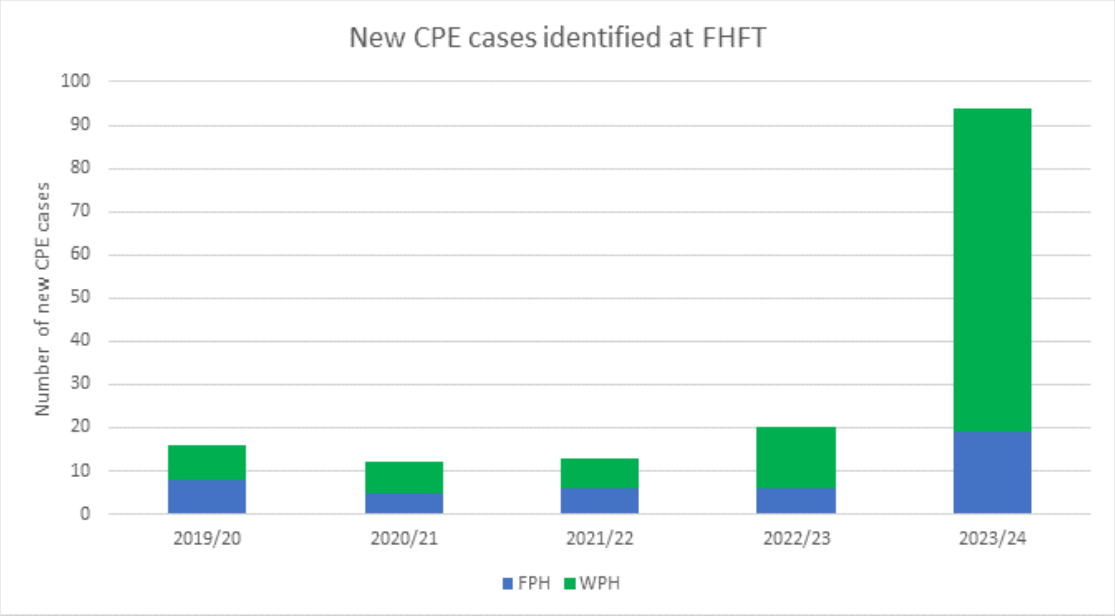
- 45% of all Trust-apportioned *Ecoli* bacteraemia cases sourced to urinary tract infections; 33% of these UTIs were associated with urinary catheters.
- 40% of patients with an *Ecoli* bacteraemia sourced to a UTI had received antimicrobial treatment for a UTI prior to the bacteraemia.
- The average length of stay prior to diagnosis of hospital-onset *Ecoli* bacteraemia, is 17 days (higher than nationally).
- Trust catheter guideline expired in 2020 and is in the process of being updated by the Urology teams (planned for completion in Quarter 1 2024/25), to include up-to-date, evidence-based practice.
- Delays in TWOC pathways for both inpatients and patients discharged with catheters. FHFT is working (monthly working group) with the Frimley ICB on improving quality of care of urinary catheters, with a large focus on improving the TWOC pathways.
- The standards of catheter care are largely unknown, due to incomplete documentation of catheter observations, continence, hydration, and personal hygiene on Epic. Standards being monitored retrospectively via CAUTI surveillance by the IPC Team using Epic, which has highlighted as outliers for CAUTI in Orthopaedics (F4, F5, & F6) at FPH. CAUTI surveillance data being used to target education on urinary catheter care.
- Association with antimicrobial stewardship is currently unknown, as data has not been available to analyse. There is likely to be a part played in recurrent and under-treated urinary tract infections, as data from the IPC Team quarterly catheter audits, National Point Prevalence Survey, and on-going monitoring of CAUTIs has identified prescribing outside of Microguide or culture sensitivities. This will be an action for the AMS Subgroup.
- There has been lack of engagement from clinical teams in the review of healthcare-associated infections, identification of learning, and completion of actions, which has attempted to be resolved by the use of PSIRF huddles. A timetable was set for wards to feedback on HCAI and IPC audit performance the IPC Working Group, which commenced in February 2024.

Carbapenemase-Producing Enterobacterales (CPE)

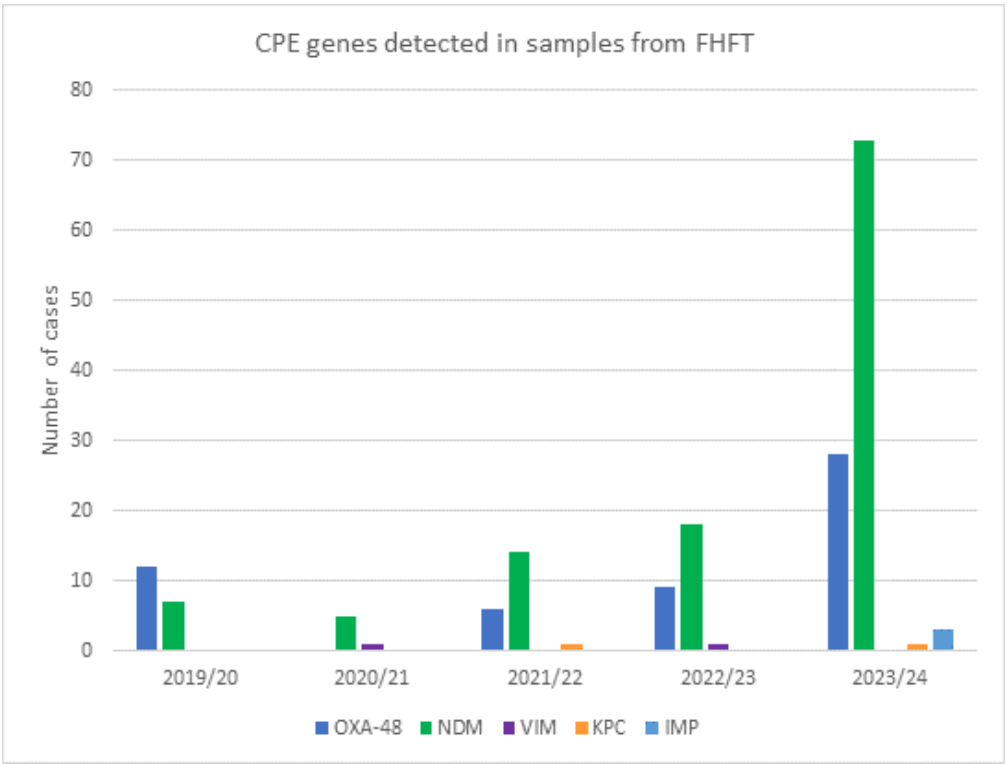
Carbapenemase-Producing Enterobacterales (CPE) refers to Gram-negative bacteria that are extensively multi-drug-resistant, including resistance to carbapenems, which are currently the broadest spectrum of antibiotics used to treat serious infections caused by Gram-negative bacteria.

CPE screening numbers are reported quarterly to the UKHSA via the HCAI Data Capture System, as part of the quarterly mandatory laboratory reporting (QMLR). Positive cases are reported directly to UKHSA via laboratory reporting, and in 2021, CPE was added as a notifiable organism.

94 new CPE cases were identified during 2023/24 (75 at WPH; 19 at FPH).



The CPE genes detected from CPE-positive samples is shown below. New Delhi metallo-beta-lactamase (NDM) was the most common CPE type identified, and 11 of the positive cases had two types of CPE detected (most often NDM + OXA-48).



There was a three-fold increase in CPE cases detected at FPH compared to 2022/23. Almost all of the 19 cases were admission screens on transfer from other healthcare providers, either in the UK or abroad, and is likely associated with increased CPE prevalence and outbreaks at those other organisations. There were two incidents of cross-infection of CPE at FPH during 2023/24; the first resulted from delayed screening of a transfer from WPH to a bay in Vascular Surgery (ward F2), resulting in another case acquisition of a NDM-producing *Ecoli* case (this was reported as an outbreak to the UKHSA); the second resulted from admission of a patient with a known CPE infection from WPH,

to a bay on F7. The same NDM-producing *Proteus* was transmitted to a patient in the adjacent bed, and this was incident-reported as a failure to isolate.

The significant increase in CPE cases on the WPH site was associated with a large CPE outbreak and the subsequent change in screening protocol put in place for its management. This is described in the outbreak section of this report.

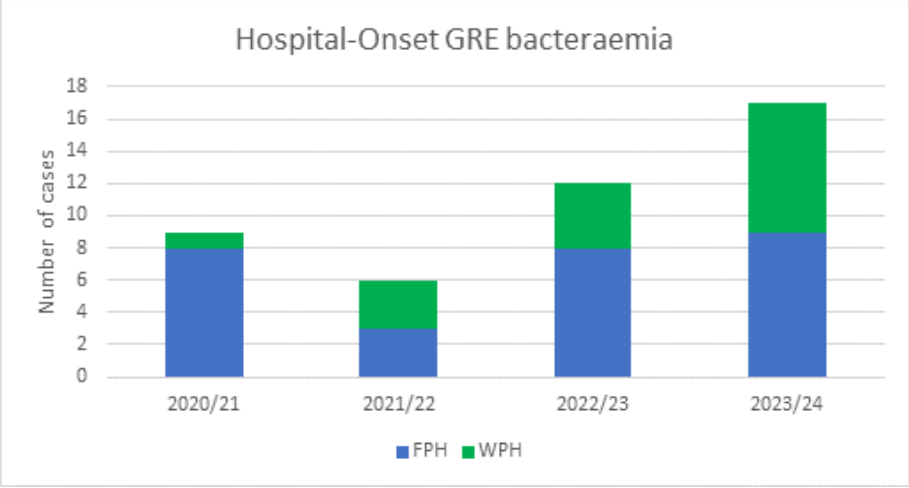
Glycopeptide-Resistant Enterococci (GRE)

The UKHSA does not apportion GRE bacteraemia cases to Trust or community, and no objective has been set for this infection to date. Within 6-weeks of the end of each quarter, the IPC Team must complete the quarterly laboratory return which includes the total number of GRE bacteraemia cases, but not patient-level data.

There were 21 GRE bacteraemia cases reported in 2023/24, 17 of which were hospital-onset (nine at FPH, eight at WPH). Although the total number of cases was not significantly different to 2022/23, an increase in hospital-onset GRE bacteraemia was observed at WPH.

As a resistant bowel coloniser, the patient groups in which higher prevalence was identified, were in GI Surgery, Gastroenterology, and Haematology/ Oncology.

Delayed receipt of typing results of cases at WPH in April 2024, highlighted two GRE bacteraemia cases on Ward 3 (Gastroenterology), which were genetically linked on whole genome sequencing (WEXH01EC-54). The links identified between the patients, were occupation of the same room (side-room 22) on Ward 3 during their admissions in which they had acquired their bacteraemia (although their stays were almost two months apart), and they had both had two OGDs during their admissions. There was a high likelihood that the infections were associated with the standard of decontamination of patient environment or equipment during their stays. A review of decontamination practices took place, and no significant areas of concern were raised. At the time of writing this report, there had been no further cases for over 28 days.



Candida auris

Candida auris is a yeast that has attracted increasing attention due to its multi-drug-resistance, and after the first European outbreak with the organism at Royal Brompton Hospital in 2016.

There were no *Candida auris* cases identified in the Trust during 2023/24.

Mandatory Orthopaedic Surgical Site Infection Surveillance

Orthopaedic Surgical Site Infection (SSI) surveillance became mandatory in April 2004, and Trusts must submit a minimum of three months data from an orthopaedic category each year. FPH, WPH and Heatherwood report on the categories of hip and knee replacements every quarter of each year, to enable continual monitoring of trends.

The following guidance is applied to SSI reporting:

- In implant surgery, infections that are identified within **one year** of the surgery are reportable to SSISS.
- In line with the UKHSA guidance, infections that develop after 30 days post-surgery cannot be classed as 'superficial'.
- No infection case is submitted without confirmation of infection from the relevant Consultant Orthopaedic Surgeon.

Data is submitted separately by site; the data is published nationally by Trust. FHFT SSI rates by hospital site January-December 2023 are shown below:

Jan-Dec 2023	FPH	WPH	Heatherwood	Trust SSI rate (inpatient & re-admissions)	National average (inpatient & re-admissions)
Hip replacement Total operations	227	81	622	**0.3%**	0.7%
Hip replacement All SSI rate	0.4% (1 SSI)	1.2% (1 SSI)	0.2% (1 SSI)		
Knee replacement Total operations	89	55	1029	**0.9%**	1.0%
Knee replacement All SSI rate	1.1% (1 SSI)	0%	1.0% (10 SSIs)		

A 'high outlier' letter was received from the UKHSA for WPH, for the January-March 2023 quarter, to which the IPC Team responded. There was one hip replacement SSI reported in that quarter, and due to the low number of surgical procedures, the SSI rate was skewed. The patient had a history of depression, anxiety and anorexia, known to community psychiatric service, and was admitted with a fall and hip fracture. The patient was un-cooperative with surgical wound care and had a prolonged stay due to acquiring COVID-19. They developed a surgical wound collection and returned to theatres for wash-out and subsequently a Girdlestone procedure. There were no significant areas of learning identified on post-infection review.

The IPC Team also responded to a 'low outlier' letter from UKHSA for Heatherwood, for the April-June 2023 quarter. The IPC Team confirmed that surveillance of SSIs was robust and followed the guidance set by UKHSA.

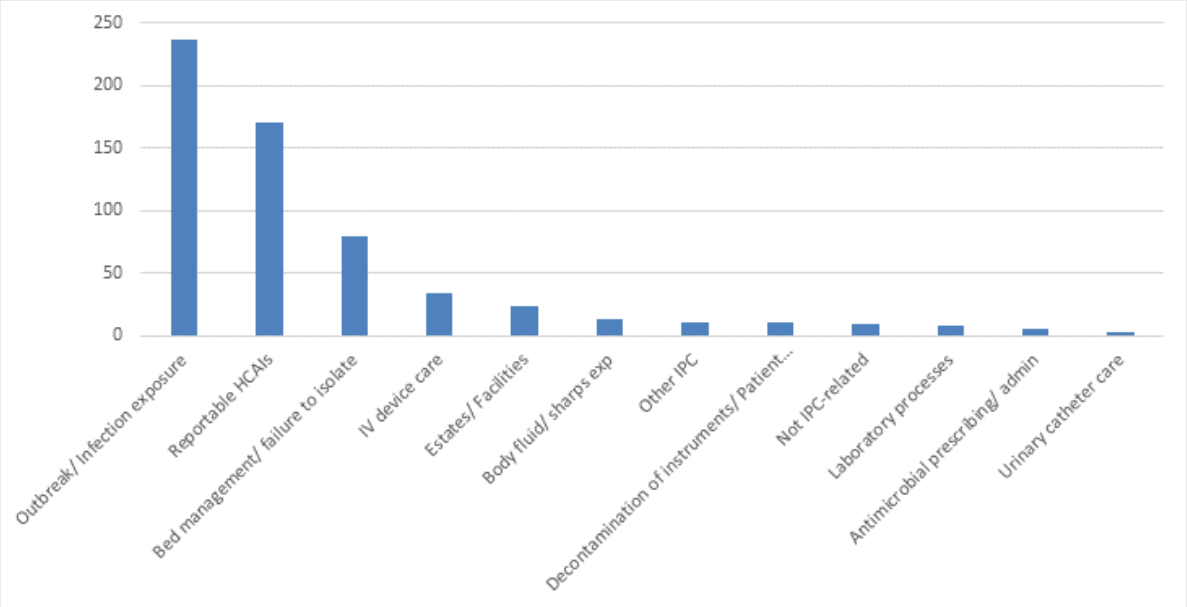
Although the Trust has remained below the national average SSI rates for hip and knee replacements in 2023, there was a significant increase in the number of suspected surgical site infections in the knee replacement category at Heatherwood in Q3 (Oct-Dec 2023), with three confirmed infections of primary TKRs reported. Investigation of pre-, peri-, and post-operative care was carried out by the IPC Team in Q4, with recommendations made for practices and environmental management in Heatherwood theatres. A report has been prepared for response to the 'high outlier' letter that is likely to be received from the UKHSA in June 2024, as the rate for that period was above that of the national average.

The IPC Team have continued to work with the Epic analysts, to ensure that mandatory reportable SSI data can be collected by the system. A dashboard has been created to collect data and monitor for infections, however, reports produced are not yet in a format that can be automatically uploaded to the UKHSA SSI Surveillance Data Capture System.

Untoward incidents including outbreaks

The IPC Team received alerts of IPC-related incidents, via the RL system in 2023/24. All incidents are investigated by the appropriate manager and some cases are discussed at Patient Safety Committee meetings and the IPC Working Group.

601 incident reports raised infection prevention and control concerns in 2023/24 (a 26% decrease on 2022/23), and the graph below shows the most common themes.



The greatest number of RL6s flagged for 'Infection Control', continued to be associated with COVID-19 outbreaks or patient exposure to COVID-19, as clinical teams were encouraged to complete a RL6 for any incident of nosocomial COVID-19 exposure and nosocomial infection. Although this made up the highest proportion of incidents, the number in this category more than halved that in 2022/23, which correlated with a reduction in numbers of outbreaks.

The category with the biggest increase in incidents was 'failure to isolate' (58% increase) and related frequently to delays in isolation of infectious diarrhoea (including CDI) cases, respiratory infectious diseases, and CPE.

Infection Prevention & Control-Related Complaints

There were 11 complaints with an element of infection prevention and control that required formal response from the IPCT in 2023/24.

Themes from the complaints:

Theme	Comments
Nosocomial COVID	Five complaints related to acquisition of COVID-19 while under the care of the Trust. Two of these cases were confirmed nosocomial, however two of the patients were admitted with COVID-19, and the fifth case had no evidence of COVID-19 (no positive test or symptoms).
MRSA bacteraemia	Complaint regarding a hospital-onset MRSA bacteraemia at WPH in 2022/23.
Ecoli bacteraemia	Two complaints related to hospital-acquired *Ecoli* bacteraemia, with the complainants requesting details on the IPC post-infection reviews completed for these cases.
Non-isolation of clinically vulnerable patient	A complaint was received regarding non-isolation of a clinically extremely vulnerable patient admitted to FPH escalation area (where there is no single room accommodation).

Hospital-cleanliness	The family of a patient admitted to a WPH ward raised concerns regarding the standard of environmental cleanliness and condition of the single room to which they were admitted.
CPE screening	A complaint was received from a patient who had been screened for CPE on admission to WPH, with insufficient information provided on why the screen was requested, and was not informed of their result.
Hospital-onset food poisoning	A patient's family wanted further details of how their mother had tested positive for Campylobacter two weeks into their admission. Investigation of the case had been reported to UKHSA, and symptoms of infection had been experienced prior to admission.
Visitor D&V	A complaint was received from a visitor to FPH, who believed they had acquired diarrhoea and vomiting from their visit. It was confirmed that there had been no cases of infectious diarrhoea on the ward in question, and no cases of norovirus since a year prior.

Outbreaks

Norovirus

On 3/1/2024, a norovirus outbreak was declared on WPH Ward 6, after three patients developed symptoms, and tested positive for the infection. The ward was closed to admissions for 4 days to manage the outbreak, which occurred alongside a COVID-19 outbreak, during a period where there was insufficient single room capacity to isolate all symptomatic patients. The outbreak closed on 15/1/2024, after there had been no new patients with symptoms for 48 hours. A total of five patients tested positive for norovirus in the outbreak, and it is acknowledged that diarrhoeal symptoms experienced by two other patients may have been associated with COVID-19 rather than norovirus.

CPE Outbreak: FPH F2

A CPE outbreak was declared in F2 Vascular Surgery on 26/6/2023, after two patients in a bay were identified as colonised with an NDM-producing *Ecoli* on screening. Both patients had transferred from other hospitals: one from Wexham Park, and one from Royal Surrey. In line with the Trust CPE screening guidance, the patient from Royal Surrey should have been screening on admission to FPH, however this screening opportunity was missed. It was therefore difficult to ascertain the index case for the outbreak, and there was also a possibility that the index case could have been the patient who transferred from WPH, linked to the reported outbreak on that site. A third case of colonisation was identified on 5/7/2023.

Environmental screening did not isolate CPE from drain samples on the ward, and it was considered likely to have been a limited transmission event, associated with missed screening of patients transferred from other hospitals with CPE outbreak, and missed hand hygiene and decontamination opportunities on the ward.

The outbreak was closed on 2/8/2023, after no new cases had been identified for 28 days. Vascular Surgery continues to screen all admissions for CPE, as this patient group are at high risk of colonisation due to contact with other healthcare organisations.

CPE Outbreak: WPH Site

An outbreak of Carbapenemase-Producing Enterobacterales (CPE) was declared on the Wexham Park Hospital site on 16/6/2023, after an observed increase in prevalence of colonisation and infection. The highest prevalence of cases had been associated with wards in the south of the site, namely Eden Ward (Haematology/ Oncology), Ward 5 (Endocrinology), Ward 6 (Rheumatology), Ward 7 (Frailty), and Ward 8 (Frailty).

Identification of the outbreak coincided with issues detected in the water and drainage systems in the undercroft of the Radiology Department, and through environmental testing (drain fluid and sink swabs), the working hypothesis for the outbreak was association with site drains, which global

evidence shows are the biggest reservoir for these organisms in healthcare. Environmental testing at Frimley Park and Heatherwood Hospitals as controls (and where CPE prevalence had not increased), did not identify CPE in drain samples/ sinks.

The first meeting of the Outbreak Control Team was held on 21/6/2023, which included engagement with the UKHSA, NHS England, Frimley ICB, and external experts (including Dr Mike Weinbren from the New Hospital Programme, and Dr Joost Hopman from the Dutch National Institute for Public Health and the Environment). An action plan was formed, and the subsequent meetings involved feedback on actions from the specific workstreams, focussing on:

- Patient screening
- Environmental screening
- Clinical practices
- Drain remedial works
- Sink rationalisation
- Antimicrobial stewardship
- Communication
- Incident reporting

On 21/8/2023, a three-month period of enhanced CPE screening began in ITU, Eden Ward, and Wards 5-8, screening patients on admission and weekly thereafter. In the first four weeks of screening on these wards, one in five patients in those wards were identified to be colonised with CPE.
To gain an understanding of the prevalence of CPE across the whole WPH site, a further business case was approved for a three-month period of enhanced CPE screening (admission and discharge screening in adult inpatients) across the whole WPH site, beginning 18/12/2023. Due to result errors with the EntericBio analyser in the WPH laboratory, this period was extended until 19/4/2024.
A serious incident report was submitted for the outbreak, and as part of this, a morbidity and mortality review completed.

Key learning from the outbreak focused around the increasing global evidence that healthcare water and drainage systems act as 'superhighways' for gram-negative bacteria, including CPE. Organisms colonising pipework in biofilms are able to travel through the drainage system (even upwards), leading to colonisation of other water outlets. Inappropriate use of hand wash basins for disposal of fluids such as drinks and washbowl water, and antimicrobials excreted in wastewater into drains, increases the likelihood of biofilm development and selective pressure in favour of resistant bacteria.
Once these risks were identified, the learning associated with the outbreak has been focussed on actions to reduce the risk of drains within the healthcare setting being a source of infection to patients – through environmental controls and changes to clinical practice.

The outbreak is not planned to close until a period of 28 days has passed since the last CPE case associated with the outbreak. However, the conclusion from the investigation to date, is that this outbreak has been linked to the drainage system at WPH. Environmental actions arising from the recommendations will have a long timescale due to the significant structural changes required to be funded and timed to reduce operational impact.

Recommendations from management of the outbreak are:

- A recommendation to the UKHSA has been made, to consider a change in national CPE screening criteria. Increasing CPE prevalence and outbreaks have been observed in numerous UK healthcare organisations in the past 12 months, however national screening guidance has not changed (and remains more selective than MRSA screening).
- The recommendations for the patient environment and clinical practice, are those recommended by national and international experts, in line with the Hierarchy of Controls:
    - Eliminating the hazard - Sink rationalisation

- Removal of sinks from high-risk areas such as Clean Utility rooms, and clinical areas with the highest risk patients (such as ITU and Haematology/Oncology).
- Reducing the number of hand wash basins in all new builds and refurbishments.
- Ensuring sinks are not located within 2m of patients and equipment/ medication storage.

- Engineering solutions - Redesigning sanitaryware
  - Ensuring soap and paper towel dispensers are located such that they are not at risk of contamination from the sink, dripping onto outlets, or causing blockage of sinks.
  - If sinks are unable to be removed/ are required in areas too small to segregate from people and equipment, splashguards should be installed.
  - Avoiding flow straighteners in faucets, that are difficult to clean and easily form biofilms.
  - Re-design of showers/ wet rooms, that reduce the risk of patient' feet making contact with drain outlets.
- Administrative controls – policies/ guidelines and education

  All of these recommendations have been actioned through IPC education and support to clinical areas cross-site, and practices monitored through the Annual IPC Audit Programme.
  - Hand hygiene - The Trust Hand Hygiene policy (IPC05) was updated to include recommendations for sink design and location, and the recommendation that use of alcohol-based hand sanitiser after washing hands, will mitigate the risk of any re-contamination from drain splashes.
  - Reinforcing the guidance that hand wash basins are for hand washing only (basins are labelled for this).
  - Medication preparation and clinical procedures must take place more than 2m away from sinks.
  - Inpatients with open wounds, including diabetic foot ulcers, wash these with sterile water rather than in showers where splashing from drains can contaminate wounds. Trust guidance was amended in collaboration with the Tissue Viability Team.
  - Staff are not to don personal protective equipment prior to hand washing, as this will become contaminated from splashing from the drain.
  - Patient items must not be placed in sinks where they will have contact with drain outlets (for example, patient washbowls and water jugs during filling).

CPE Outbreak: WPH Ward 1

During the review of the WPH site CPE outbreak, a local outbreak of an NDM- and OXA-48-producing *Klebsiella pneumoniae* was declared on Ward 1 (Orthopaedics). Three cases (including two urinary tract infections) were identified within a week period in July 2023. The outbreak was investigated and managed alongside that of the WPH site outbreak.

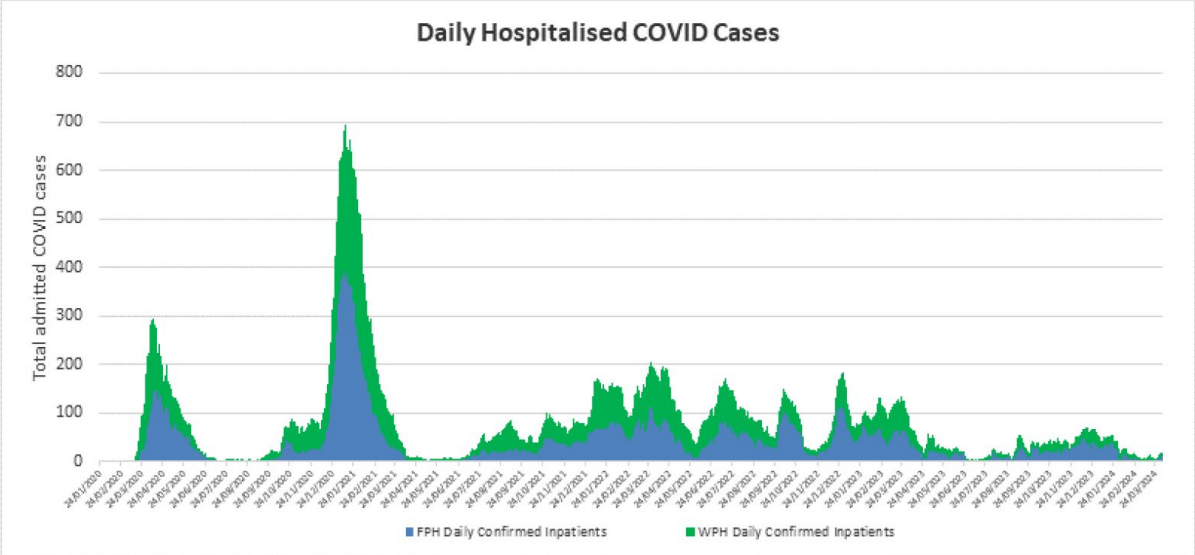
PVL-MRSA Colonisation Outbreak WPH Neonatal Unit (NNU) February 2022 to July 2023

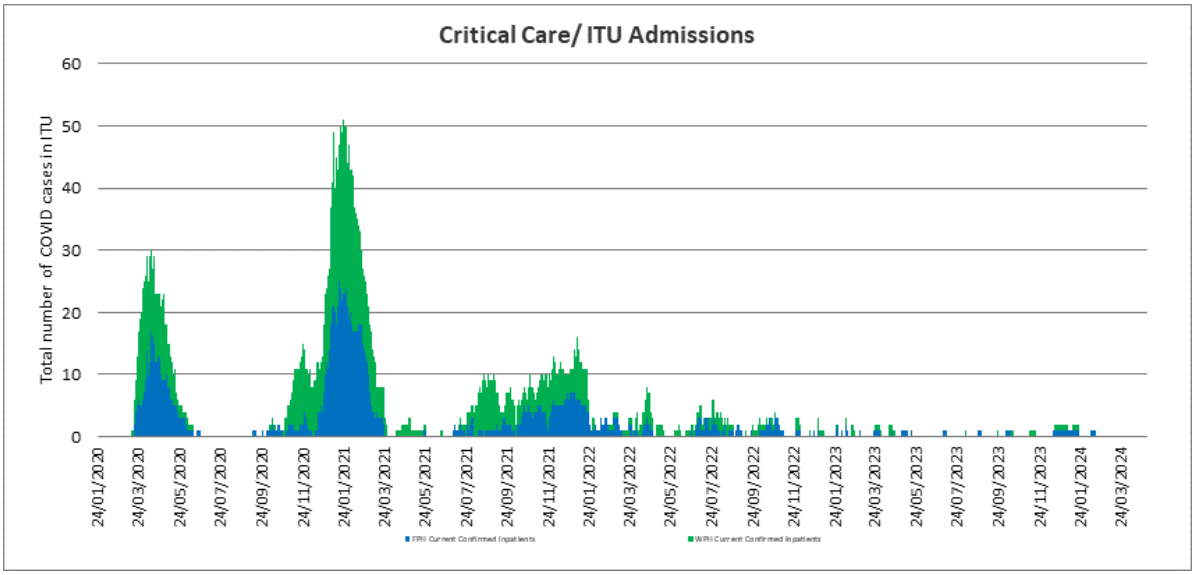
On 13/2/2022, three babies located in the WPH NNU (two of which were siblings) had routine MRSA screens (colonisation, meaning MRSA was cultured from their intact skin surface) that were reported as positive. This cluster of MRSA colonisation (above that of the Trust baseline) initiated samples to be sent for typing on 17/2/2022. Typing results were received 3/3/2022 which identified the three cases had the same cluster ID (MLST 22: C22-2012:3029:3381:4407), and an outbreak was declared. The three babies were discharged home by 1/3/2022 and none of them acquired an infection with MRSA.

The IPC Team were informed by the UKHSA of an adult who had received treatment at Stoke Mandeville for recurrent skin abscesses caused by the same cluster ID MRSA from a test taken 2/2/2022 (11 days before the first WPH case), however no epidemiological link was identified.
There were no further MRSA cases identified in NNU for a 6-months period, and then in August 2022, a further cluster of four babies (two sets of twins) were identified with MRSA colonisation on routine MRSA screening. The samples were sent for typing and three were confirmed to have the same outbreak/ cluster ID as the cases in February 2022, and one baby had a MLST 672 identified. A new outbreak was declared, linked to the February 2022 outbreak.
There were no further MRSA cases identified in NNU for a 2-months period, and then between 30/10/2022-27/2/2023, 14 more babies had MRSA colonisation identified on routine screening. Typing of samples identified three cases of MLST672 (confirming a new outbreak with this strain), and seven more cases of the original outbreak strain (MLST22) – indicating this outbreak was still on-going (in three waves, involving babies that had not had exposure to each other).
Outbreak Control meetings were held on 16/2/2023 and 30/3/2023, involving local Health Protection Teams as well as representation from the *Staph aureus* reference laboratory at Colindale.
By the end of March 2023, extensive environmental/ equipment screening of the unit had taken place (no MRSA was cultured), IPC practice audits had been repeated (scores providing high assurance with standard of practice), and enhanced environmental decontamination had taken place with hydrogen peroxide vapour.
The final action of the outbreak investigation was to carry out a programme of staff self-screening for MRSA, which commenced on 24/4/2023. Screening identified three staff members who had colonisation with MRSA, one of which was confirmed to carry the outbreak strain. The staff member was supported in completion of colonisation treatment, and a re-screening regime put in place that enabled return to patient-facing care once negative screens had been received. Although a staff member was confirmed to have the outbreak strain, it was important to clarify that this was not confirmation of the root cause/ source of the outbreak, as is it not possible to state the direction of transmission (staff to patient, or patient to staff).
The outbreak was closed on 20/7/2023, after no further patient cases were linked to the outbreak strain since May 2023.

<u>Coronavirus Disease 2019 (COVID-19) Pandemic Outbreaks</u>
On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause in Wuhan City, Hubei Province, China. On 12 January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus was later referred to as SARS-CoV-2, and disease caused by the virus, COVID-19.

During 2023/24, the IPC Team continued to monitor daily the number of tests, positive results, admissions, symptoms, and management of COVID-19 cases, providing a daily report to the Trust Information Team.
The graphs below demonstrate the trend in daily number of patients hospitalised with COVID-19, since the start of the pandemic, and those requiring ITU admission:





The overall severity of COVID-19 infections during 2023/24 continued to be much lower than that in the first two years of the pandemic, and admissions to ICU with COVID-19 have remained low since January 2022, demontrating the impact of COVID-19 vaccination in reduction of severe infection.

COVID-19 outbreaks were defined by NHS England (required to be reported via the NHSE Outbreak Reporting System during 2023/24) as:
'Two or more cases in a single setting (eg. bay, ward) that have become symptomatic or detected on screening on or after day eight of hospital admission'.
There were 85 COVID-19 outbreaks at Frimley Health in 2023/24 reported to NHSE and UKHSA – significantly lower than 146 in 2022/23. The outbreaks ranged in size from 2 cases to 28 cases. Nine of the outbreaks involved co-infection/ outbreak with influenza during the winter months.
A protocol for COVID-19-specific outbreak management and investigation was first put in place from June 2020, and from March 2021, this process included a set of actions in checklists for completion on identification of the outbreak, for reviewing processes twice-daily, and on closure of the outbreak – to ensure standardization of actions across the Trust. Additional actions specific to the needs of individual outbreaks were added as required.

Investigation and management of COVID-19 outbreaks involved the IPC Team working alongside, and supporting the ward staff, in identifying risks and making recommendations to mitigate them, and ensuring the hierarchy of controls was in place.
Formal outbreak control meetings were held for complex outbreaks only, including those at Farnham hospital. In addition to this outbreak investigation and management process, the IPC Team attended TOC and site management meetings daily, and nosocomial COVID-19 death reviews took place with Patient Safety, a Medical Examiner and medical clinician regularly until July 2023 (when deaths associated with COVID-19 had significantly reduced).

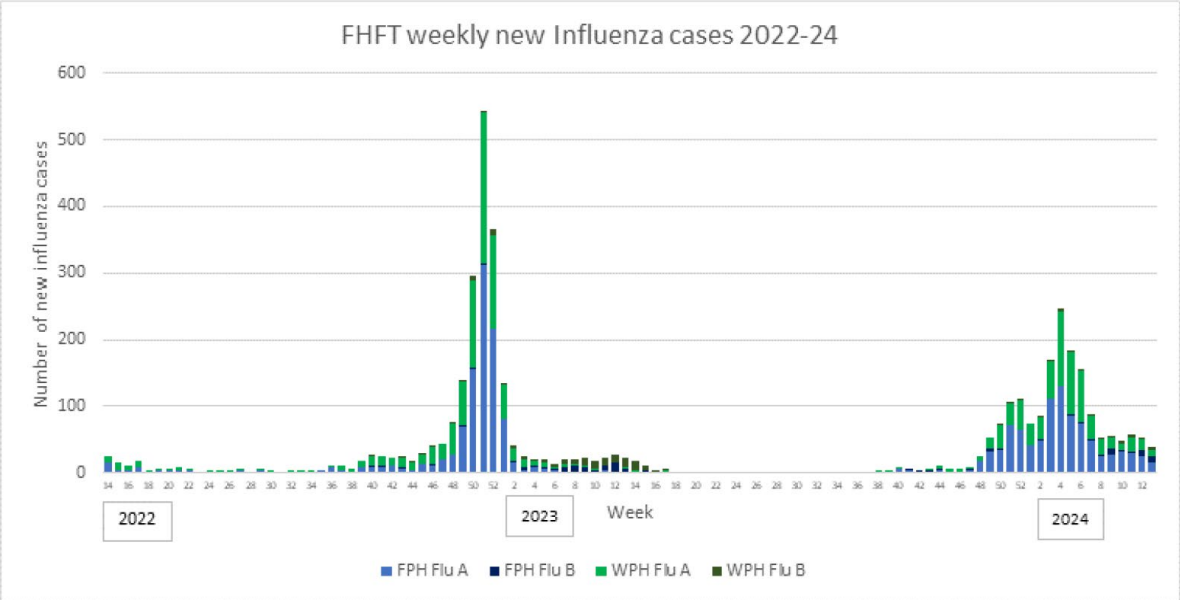
FPH F3 continued to be the ward with the most frequent and largest (including two COVID outbreaks of 28 cases) outbreaks. Themes from these large outbreaks were:

- the patient group (frailty and dementia) unable to follow the precautions required to prevent transmission (ie. wear surgical facemasks, or remain in isolation rooms)
- delays in testing and isolation of patients who were either admitted with, or developed new, COVID-19 symptoms, due to lack of recognition of the broad range of symptoms associated with COVID-19
- delays in isolation of patient who had confirmed SARS-CoV-2-positive test results
- staff reluctance to follow the IPC guidance of wearing respiratory protective equipment (FFP3 respirators and eye protection) for care of patients with COVID-19, despite continued education provided on the rationale for this advice.

Changes in national COVID-19 IPC guidance during 2023/24, were associated with bringing the testing and management of COVID-19 in line with that for other seasonal respiratory viruses (such as influenza):

Date	**Change in guidance**
1/4/2023	Screening to de-isolate patients the COVID-19 ceased. Testing of symptomatic staff was not longer required, unless working with primarily immunocompromised patients.
18/5/2023	The NHS response to COVID stepped down from NHS Level 3 incident.
30/6/2023	Reporting of patient deaths with COVID-19 via the CPNS system was stepped down.
25/3/2024	Notification that from 1/4/2024, COVID lateral flow device screening is no longer required for patients being discharged to care homes and hospices.

Influenza
The local influenza season 2023/24 started in October 2023, and FHFT had the first influenza outbreak in the South-East, on 3/10/2023 (six cases of influenza A on FPH F10).
The peak of the influenza season was in the last week of January 2024, was significantly lower than that in the 2022/23 winter, however the season was approximately eight weeks longer.
There were 23 outbreaks of influenza reported during 2023/24, nine of which were co-outbreaks with COVID-19.



Occupational Exposures to Infection

Tuberculosis

A TB lookback exercise took place in August 2023, after a strain of TB from a Trust staff member was linked to a patient TB case they had provided care for in December 2022. The staff member had been wearing appropriate personal protective equipment and was not immunosuppressed, however, from the data shared by the UKHSA, they believed the infection had been acquired from the patient. There was no exposure identified from the staff member's infection, however on advice from UKHSA, 'Inform & Advise' letters were sent to other staff that had provided care for the child in December, as the TB may have been highly transmissible.

Another TB lookback exercise took place in October 2023, after an open pulmonary TB case was admitted to WPH ITU. All staff contacts wore correct personal protective equipment and were not immunosuppressed, however, the UKHSA considered the case to be 'highly infectious' and requested staff follow-up. Epic was used to trace staff contacts, and Occupational Health followed-up with 'inform and advise' letters.

National Measles Surge

In preparation for a measles resurgence in England (due to reduction in uptake of the MMR vaccine), clinical areas were reminded that suspected measles cases must be isolated immediately to protect other patients, and that all healthcare workers (including receptionists) should have satisfactory evidence of protection against measles (two or more doses of a measles-containing vaccine and/ or a positive measles IgG antibody test). A change in national guidance meant that staff are now required to wear respiratory protective equipment (FFP3 respirator and eye protection) for care of suspected and confirmed measles cases, even when fully vaccinated, although at the time of writing this report, the exclusion of staff contacts is based on vaccination status only.

National Pertussis Surge

The resurgence of pertussis (whooping cough) in Q4 2023/24 (particularly in Paediatrics), has resulted in several incidents of contact tracing by the IPC Team, however staff have been protected by vaccination and PPE in each instance, resulting in no exclusions from work.

Death Certificates and Healthcare-Associated infections

Death Certificates which record MRSA or CDI as a primary or secondary cause are monitored by the IPC Team and reported to HICC.

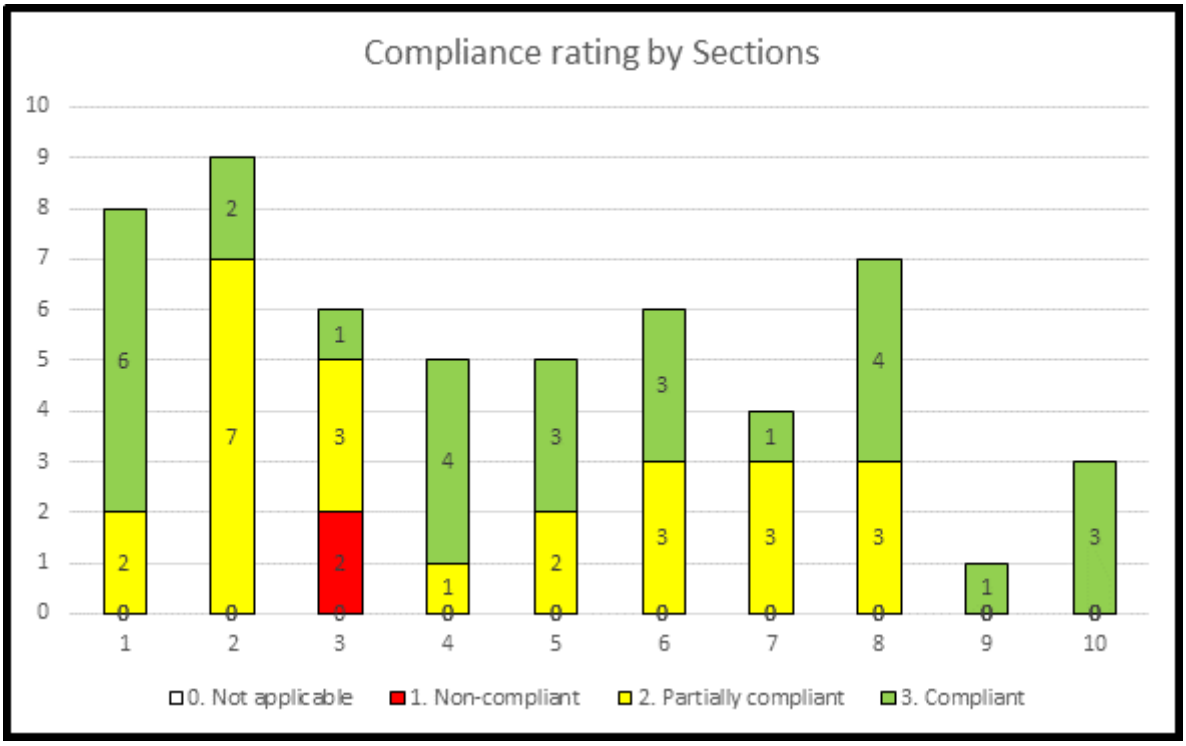
The appropriateness of the death certification is discussed at PIR meetings. The number of death certificates that record MRSA or CDI as Primary or Secondary cause of death in 2023/24 are recorded below (months not shown had no recorded cases).
Two community-onset; community-associated CDI cases had CDI documented on their death certificate:

Month	Ward & Dept	Date of death	Dr Discussed Case with Cons & micro prior to Completion of Death Cert	C: Diff Secondary Cause of Death
Aug 2023	WPH MSSU (died at post-discharge)	6/9/2023	No	Yes - Part 2
Sept 2023	WPH AAU	24/9/2023	No	Yes - Part 2 C-diff colitis (patient was Cdiff toxin-negative, however treated for a community-onset CDI during admission)

The formal review of deaths of patients who had acquired nosocomial COVID-19 continued until July 2023. During April-July 2024, the cases of 22 patients that died with COVID-19 were reviewed by the IPC Team, Patient Safety Team, and a Medical Examiner. COVID-19 was recorded as part 1a for two patients, part 1b for four patients, and part 2 for three patients. From July 2023, it was agreed that cases would be referred for review where concerns were raised by the ME, patients' families, or IPC, rather than a formal weekly meeting.

IPC Board Assurance Framework

NHSE published a completely reviewed National Infection Prevention & Control Board Assurance Framework (IPC BAF) in March 2023 (v1.0), to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections', and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).
The IPC BAF, which was published in Excel format (Appendix 4), provides an overview of compliance against the Code of Practice criteria, with the focus now moved away from COVID-19. The Excel format provides a RAG system for compliance with the key lines of enquiry (KLOE), summary plots for visual representation of compliance, and also charts summarising overall compliance with the BAF (as shown below for the 10 criteria, as at 31/3/2024).



The IPC Team updates the BAF quarterly for HICC, highlighting risks for inclusion in the local Risk Assurance Framework. Key line of enquiry (KLOE) with 'Partial Compliance' all have mitigating actions in place as a plan to achieve compliance.
The two KLOE that continued to flag as non-compliant and high proportion of partial compliance at the end of March 2024 were associated with insufficient oversight of key performance indicators for antimicrobial stewardship (AMS). Although there has been no formal report on AMS audits at HICC since 2021, it is an expectation that this KPI data will become available via the re-started AMS Subgroup.
Criterion 2 had a high proportion of 'partially compliant' KLOE, pending roll-out of the National Cleanliness Standards, standardising waste segregation cross-site, and water safety plans/ issues.
An increase in 'partially compliant' KLOE for Criterion 6, was associated with insufficient assurance of resilience in FFP3 respirator fit-testing.
A higher proportion of 'partially compliant' KLOE for Criterion 7, was due to delays in isolation of patients with infectious diseases as a result of single room capacity and operational pressures.

National Point Prevalence Survey of Healthcare-Associated Infection and Antimicrobial Use

The IPCT participated in the National PPS of HCAI and AMU in September 2023, completing entry of the data by the end of November 2023.
Ward-level data was submitted for every inpatient ward/ unit on the FPH, WPH, Heatherwood, and Farnham Hospital sites (excluding day wards/units, and Renal), and patient-level data submitted for 1344 inpatients on those wards.
A link to the UKHSA summary of the Trust's survey results is provided in Appendix 9, and at the time of writing this report, the final national report was pending publication.

The overall prevalence of healthcare-associated infections in the Trust, was 8.9% (8.4% if HCAIs acquired in other organisations are excluded), compared to the average prevalence of 7.5% in 'acute general NHS' hospitals. The prevalence of HCAIs differed between the Trust sites, with a higher prevalence (10.7%) seen at WPH.
It is important to note that this was a survey of prevalence at one point in time, and does not necessarily represent on-going rates of HCAIs in the organisation.

Hospital/ Trust	Total patients (N)	Patients with HCAI (n)	HCAI prevalence (%)	Patients with AMU (n)	AMU prevalence (%)	Patients with CVC (n)	Patients with PVC (n)	Patients with Urinary catheter (n)	Patients with Intubation (n)
Frimley Health Nhs Foundation Trust (overall)	1,344	120	**8.9***	518	38.5	98	718	289	16
Frimley Park Hospital	616	48	**7.8****	268	43.5	44	377	133	8
Farnham Hospital	83	5	**6.0**	12	14.5	4	3	21	0
Wexham Park Hospital	628	67	**10.7**	236	37.6	50	321	132	8
Heatherwood Hospital	17	0	**0.0**	2	11.8	0	17	3	0

***8.4% Trust-related HCAIs (excluding the 6 SSIs transferred to FPH for treatment)**
**** 6.8% Trust-related HCAIs (excluding the 6 SSIs transferred to FPH for treatment)**

The last National PPS was carried out in 2016 (participation by the Trust was not cross-site, nor for all specialities in that year), when the prevalence of HCAI was 6.4%. There were several differences in the categorisation of HCAIs between the 2016 and 2023 surveys, and also inclusion of nosocomial COVID-19 impacted on reported HCAI prevalence.

Some key points to note from the Trust report are:

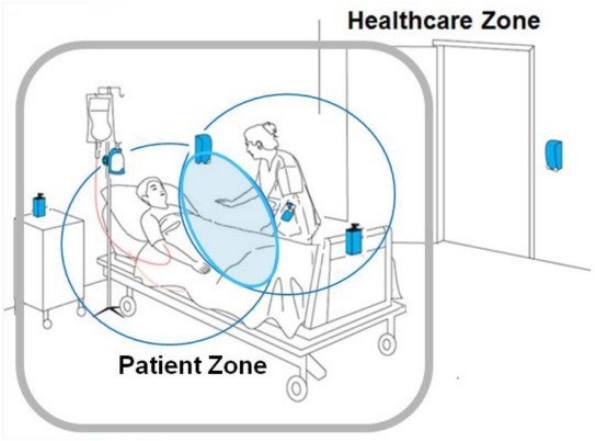
- The proportion of healthcare-associated infections that were UTI was almost twice that of the national average for acute general organisations (29.2% compared to 16.7%). The overall prevalence of healthcare-associated UTI was 2.6%. *This is likely to be a driver for the high number of Ecoli bacteraemia cases at FHFT (13th highest rate nationally in 2023/24).*
- A significantly higher prevalence of HCAI was observed in Frailty/ Geriatric Medicine than the national average (and also the Trust was caring for a higher proportion of inpatients aged over 80 years (42% of inpatients, compared to 32% nationally)).
- Although the prevalence of urinary catheters was not significantly different to the national average, the proportion of patients that had a urinary catheter in place in the 7 days prior to healthcare-associated UTI diagnosis (ie. was likely to be a CAUTI) was much higher (24%) than the national average (8%). *This infers that an improvement in quality of care of urinary catheters is required at FHFT to prevent CAUTI.*
- The organisms causing HCAIs were largely Enterobacterales (41%), compared to 33% nationally. *Infections with the organisms were primarily UTIs and skin/ soft tissue infections, and may be associated with contamination from hospital drainage systems.*
- The highest proportion of HCAIs (36%) occurred in patients with a length of stay of more than 3 weeks (compared to 24% nationally). *Reducing length of patient stay will be paramount in reducing HCAIs.*

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

The 'environment' means the totality of the Trust built environment, including the fabric of the building, related fixtures and fittings, and services such as ventilation and water supplies.
A member of the IPCT attends Capital Projects updates, Built Environment Committee, Patient Led Assessment of the Care Environment (PLACE), and meetings/ groups associated with the planning, design and management of building works. Summaries of the quarterly Environmental reports to HICC can be found in Appendix 7 of this report.

Provision of hand hygiene facilities (hand wash basins and alcohol-based hand sanitiser)
It is a global recommendation (as per the World Health Organization's '5 Moments for Hand Hygiene') that alcohol-based hand sanitiser (ABHS) is made available at every 'point of patient care', to enable effective hand hygiene by healthcare staff. It also promotes hand hygiene to visitors and patients.

Compliance with ABHS availability is also one of the standards required by the Patient Led Assessment of the Care Environment. Spot-check audits are carried out by the IPCNs to ensure ABHS is available at the point of patient care – ie. attached to a patient bed/ trolley, on a wall in the patient care zone, or carried as a personal tottle in areas where it is assessed that it may be harmful if accessed by patients (eg. in Paediatrics).



Sanitiser spotcheck results 2023/24:

Date	Trust Compliance
April 2023	96%
July 2023	97%
October 2023	93%
January 2024	94%

Missing sanitiser at point of care in 2023/24 was associated with areas experiencing high numbers of bed moves, newly-opened escalation areas, corridor care, and boarding.

Water-safe Care

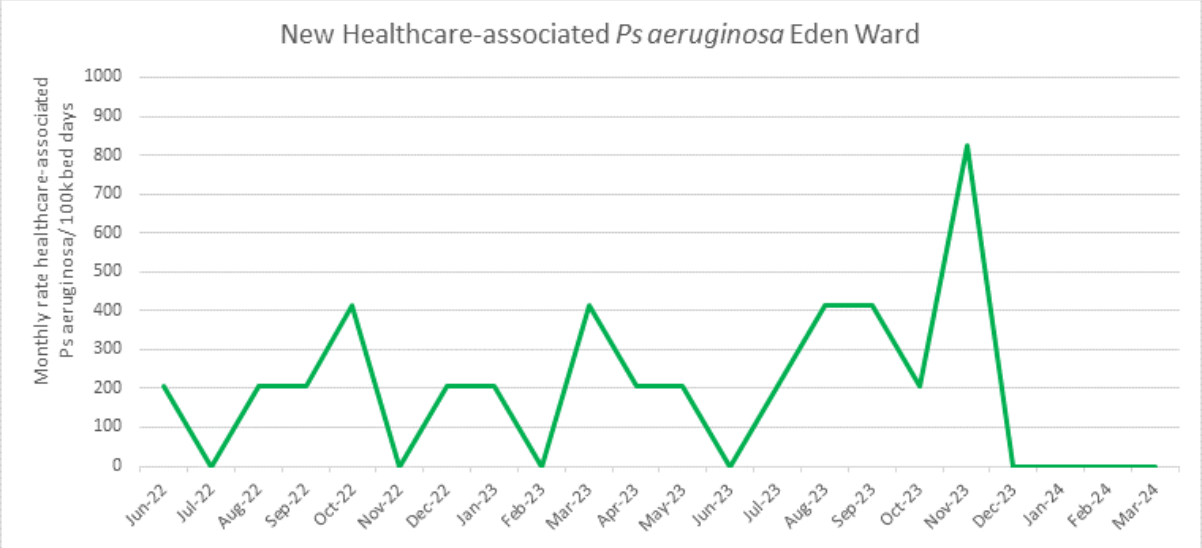
Nosocomial infections in Intensive Care Unit (ICU) result in patient morbidity and mortality. Environmental contamination in hospitals wards and ICUs is a recognised problem for infection prevention and control as the environment may facilitate transmission of several important health care-associated pathogens. As part of the traditional hospital hand hygiene strategy and patient care, sinks are present in virtually all hospital wards and patient rooms. While sinks in the proximity of patients are advocated as a best practice of ICU design, involvement of these sinks in hospital-associated infections have been reported as early as the 1970s. Recent publications have highlighted the role of sinks as a source of outbreaks and transmission of multidrug-resistant gram-negative bacilli (MDR-GNB) in intensive care units, including paediatric and neonatal ICUs.

The incidence of CPE infections in healthcare is increasing rapidly in the U.K and globally. Antimicrobial resistance (AMR) is named a current “silent pandemic” and without interventions the UN reports that the death toll due to AMR will exceed that of cancer and HIV by 2050.

Studies have shown that removal of sinks in ICUs was required to control outbreak of multi-drug resistant (MDR) pathogens including CPE. In 2017, Hopman *et al.* published the study the piloted water-free ICUs in a University Hospital in the Netherlands for the management of colonisation of patients with MDR pathogens and showed that this intervention alone resulted in the reduction of acquisition/ carriage of MDR pathogens in ICU patients.
The IPC Team have undertaken audits/ quality improvement projects and collaborative research into the potential adaptations that are required to the WPH ICU to adopt a water-less unit. Sampling sinks

for example for CPE has suggested that between 30 to 80% sinks may be colonised by CPE (based on testing method used) at WPH.
The IPC and ICU team at WPH have also been collaborating with colleagues in the Netherlands and with New Hospital Programme (NHP) advisors on best approach to manage the current outbreak of CPE at WPH site and in management particularly in the ICU. Currently the UK has not implemented this process. In Quarter 4 of 2023/24, a business case was submitted for approval, with options to enable WPH to be the first ITU in the UK to become waterless. Such an intervention will not only advise measures to be adopted at the new hospital build at Frimley, but also more widely to NHP 2.0.

On a smaller scale, the impact of this change has been shown with Eden Ward, where hand wash basins were removed from the patient side-rooms in Quarter 4, already resulting in a reduction in acquisition of *Ps aeruginosa* in this vulnerable patient group. This in conjunction with the changes in clinical practices, has also led to no new hospital-acquired CPE cases on the ward since September 2023.



Infection Prevention & Control Environmental Audits
The IPC Team carry out a continuing programme of audit of the healthcare environment to monitor its management in the prevention of healthcare-associated infections. The audits monitor water and ventilation safety, cleanliness, storage and management of patient equipment in clinical areas, as well as hand hygiene facilities, availability of personal protective clothing, safe management and disposal of waste, sharps and linen, and isolation facilities.
The following trends were noted from the audits in 2023/24 and were not significantly different from those in 2022/23:
Water Safety:

- Point of use filters on taps were often left in place long after water quality issues were resolved. Expired filters were reported to Estates by the IPC Team
- Slow water flow from taps/showers and slow drainage
- Older hand wash basins and taps not compliant with current Trust sanitaryware standards

Environment / building:

- Damage to the fabric of the building, such as damaged walls, ceiling tiles, floors, door frames, panels beneath clinical hand basins, broken cupboard doors, damaged door frames from beds and trolleys - all impacting on the ability to clean the environment effectively
- Insufficient storage for clinical equipment and consumables
- Inadequately sized dirty utility rooms which do not enable segregation of clean/ dirty pathways

Cleanliness:

- Terminal cleaning (including mattress checks) often not being completed in line with Trust guidance on discharge of patients, due to time constraints

Waste disposal:

- Lack of uniformity of bins for clinical or domestic waste (i.e. different coloured bins are labelled as either clinical or domestic waste bins)
- Domestic waste bins are not available at the hand wash basin leading to mis-segregation of waste

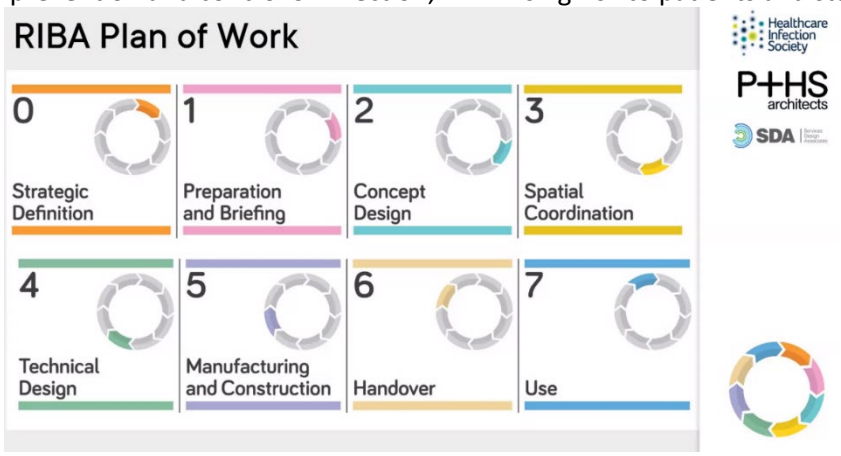
Practice issues:

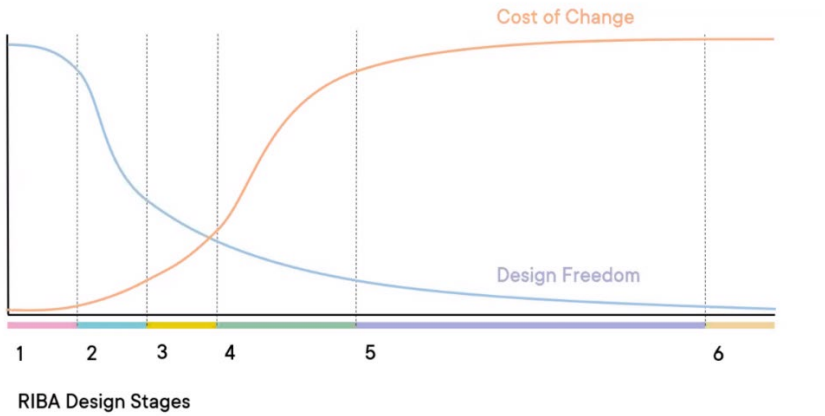
- Excessive storage of linen on dressing trolleys/ left exposed in bays and corridors of the ward
- Inconsistent assistance of patients with hand hygiene prior eating or after toileting
- Over-use of personal protective equipment for tasks that do not require PPE (eg. using computers, putting clean sheets on a bed)

Where action plans were required from the audits, these were requested to be returned within four weeks of the audit report date.

Capital Projects

National guidance (Royal Institute of British Architects) requires the IPCT involvement and consultation throughout every stage of capital projects (including new builds and refurbishments) and their views taken into account (HBN 00-09). Ensuring this involvement will reduce impact on budget and programme, which results from late changes required to ensure a healthcare environment suitable for the prevention and control of infection, minimising risk to patients and staff.





The number of capital projects continues to place a demand on the IPCT. There is IPCT representation at the meetings, and if derogations are made, the plans are signed off at Executive-level.

In Q4 the IPC Team requested Capital have in place a clear policy for the timing of involvement of the IPC Team and other key stakeholders (including the Authorised Engineers for Water, Ventilation and Decontamination) and what the 'sign-off' processes are. This will be vital in the project for the New Frimley Park Hospital.

The IPC Team have been involved in advice on the following projects in 2023/24

Site	**Project**	**Stage at which IPC included in project (RIBA Stage)**
FPH	ITU extension	0
FPH	Cardiac Cath Lab 1 & 2 refurbishment	4
FPH	G3 Stroke extension	2
FPH	M Block redevelopment	2
FPH	OPD1 extension into Physio & OT	3
FPH	MOD/ Discharge Lounge	2
FPH	RAAC work (multiple wards/ depts)	2
FPH	AECU/ SDEC	4
FPH	Fracture Clinic	2
FPH	Labour Ward, Rowan Suite	4
WPH	Radiology refurbishment	4
WPH	W1 refurbishment	3
WPH	Aseptic Suite (Pharmacy)	2
WPH	Lady Sobell/ Endoscopy upgrade	4
WPH	ITU additional side-rooms	1
Aldershot Centre for Health	Eye Treatment Centre	2
Farnham Hospital	Physio Outpatients	2
Upton Hospital	Slough CDC	3
Crowthorne Industrial Estate	Maternity Hubs	4
Bracknell Skimped Hill	Community midwives portacabins	5
Bracknell Skimped Hill	Bracknell Health Care Centre	4

Inadequate dust management by contractors was highlighted as a risk to the Capital Team, during building works at FPH in Quarter 2. A statement has been added to the contractors handbook on reducing the risk of aspergillus, and the updated Estates Aspergillus guideline is planned for publication early 2024/25.

The IPCT have advised derogation away from the HBN 00-09 'Infection Control in the Built Environment', in relation to placement of hand wash basins during new builds and refurbishments in 2023/24. This is due to the age of the HBN, most recent evidence about cross-infection risk in clean preparation rooms, and also that having one sink to 2-4 beds results in under-used outlets which increases the risk to water safety.

Facilities

The National Standards of Healthcare Cleanliness were updated and published in April 2021. The standards will be mandatory, and include changes to cleanliness auditing processes, ward/ dept star ratings, and changes to the cleaning method statements. During 2022/23, working groups were ran to organize the roll-out of the standards at Frimley Health, including a workgroup organised by the IPC Team to gain a consensus of cleaning frequencies and responsibilities, and the IPC Team confirmed the new functional risk ratings for each clinical area. The roll-out was delayed from May 2023, to May 2024, and the standards will involve star ratings for wards and departments, displaying compliance with the Trust cleanliness charter.

A programme of Cleanliness Audits takes place cross-site, with audit frequencies in line with the functional risk ratings of each ward/ department. It had been noted that there are differences in the audit process between sites, that requires aligning as part of the cleanliness standards work. The IPC Team have continued carrying out these audits on occasions alongside the Facilities team, and the Facilities team have joined the IPC Team on the annual IPC Environmental Audits, to enable oversight of processes. The IPC Team receives summary reports of the cleanliness scores every month, to observed for trends that may indicate areas that require more housekeeping or educational support.

The IPC Team raised as a risk that monthly auditing had not been completed in some inpatient areas where infection outbreaks or cohorting was taking place in Quarter 3 and advised that monitoring of cleanliness should be increased to weekly in those areas rather than reduced.

All housekeepers received refresher training by the Vermop (trolley and mopping system) on use of trolleys and correct dosing for cloths and mops, and a full audit of trolleys took place so that any replacement parts could be audited. Further education was provided by the IPCT and Housekeeping Supervisors in 2023/24 on the process for cleaning sinks and showers as part of the CPE outbreak actions.

Patient-Led Assessment of the Care Environment took place in November 2023, and the results are planned for feedback at a meeting on 7/6/2024.

Routine Programme of Deep Cleaning

FPH has a designated Deep Cleaning Team, and continued with the annual programme of cleans in 2023/24, including ad hoc requests for cleans post-outbreak closure and rooms on discharge of patients with CPE. The programme of deep cleaning at FPH was revised in Q4, due to the incorporation of increased Capital cleans required for the RAAC work.

The WPH Housekeeping team does not have a designated Deep Cleaning Team, however deep cleans are carried out on request. The Housekeeping team had a programme of deep cleaning all toilets and sluice areas on the inpatient wards, and the ventilation grills were cleaned in some areas. As part of an assurance plan regarding the outbreaks of MRSA in WPH NNU, there was a deep clean using UVC and hydrogen peroxide vapour of the ward and vents.

UVD robots (four of which were purchased during the first pandemic wave) have been routinely used by the Housekeeping teams at FPH and WPH, including as an adjunct to the deep clean programme of single rooms.

At Heatherwood, Theatres followed a six-monthly deep clean programme. There is currently no budgeted deep clean team for Heatherwood. This will form part of the cleaning standards review.

Estates

Theatres & Ventilation

A Ventilation Sub-Group was set up and began meeting in September 2022, to identify risks and actions in line with the national HTM 03-01 'Specialised Ventilation for Healthcare Premises' (updated in June 2021), and to assess all aspects of ventilation safety and resilience required for the safe development and operation of healthcare premises. The meeting includes the Authorised Engineer (Ventilation), and reports into HICC via the Built Environment Committee.

A focus in Quarter 1 and 2, was on ventilation for reduction of Entanox exposure (not IPC-related). Options for replacing the air handling unit in WPH Pathology were discussed, as well as possible options for improving ventilation in Heathlands (where although there are windows to patient bedrooms, lack of ventilation in corridors means air flow is not conducive for isolation of airborne infections).

In Quarter 2, the options for the air handling unit planned for the WPH Aseptic Suite were discussed.

In Quarter 4, the critical ventilation verification tender was in the evaluation stage, pending Procurement awarding the contract. ITU A & B at FPH passed all ventilation verification tests post-completion of their extension. Interventional Radiology room 1 had an air change rate lower than recommendations, and investigation is taking place into the cause. Also at FPH, annual verification of Theatres 3 and 4 in February 2024 made recommendations to replace the UCV canopy HEPA filters. Options to increase the air change rate in the Labour ward, to comply with COSHH requirements for nitrous oxide usage.
The annual verification of all six operating theatres at Heatherwood is scheduled for June 2024. Re-balancing of the ventilation systems in the Endoscopy scope rooms, and Procedure rooms 1 and 2 has been recommended, due to pressure regimes not meeting that of HTM 03-01.

Water Safety

A Water Safety Sub-Group was set up and began meeting two-monthly from June 2022, with attendance from the Authorised Engineer (Water). Additional water safety meetings have continued two-weekly to work through the specific actions for areas with high legionella counts (including at FPH wards fed by the A4 water tank).
The IPC Team receive water sample exception reports, and follow-up whether action has been completed by Estates (including installation of point of use filters if required). There have been issues identified with in terms of timeliness of installation and changing of these which requires further focus.

In Quarter 1, the focus of water safety was:

- Legionella risk assessments: A tracker was started to alert when risk assessments are due, for future planning.
- Undercroft of Radiology: A review of the water pipework in the undercroft of the WPH Radiology department took place, after high legionella counts were detected on testing during the on-going capital project. A large number of dead legs and some leakage from pipework was identified. A survey of the undercroft had been commissioned at the time of writing this report (to guide remedial work required to address the water safety risk), and an update to the water schematics for WPH had been requested.
- WPH CPE outbreak: A number of actions were being worked through as part of the CPE outbreak investigation and management, including a drain survey and removal of sinks identified at high risk for CPE contamination (such as those located in clean utility rooms).
- Water safety at non-Trust properties: The water safety plans for Heathlands are being followed up with Bracknell Forest Council, and Kier are being invited to future Water Safety Sub-Group meetings to provide assurance on water safety at Farnham Hospital.
- Sanitaryware specifications: It was agreed for thermostatic mixer valves (TMVs) to be used on sinks, only when a risk assessment indicates for their use (for example, when high risk of scolding to patients). The Armitage Shanks Markwik tap was agreed as the current Trust standard, which has feature that reduce risk (such as absence of flow straighteners and the ability to dismantle the tap for decontamination).
- FPH Dialysis points: Dialysis points that had been installed in the FPH ITU extension, did not have a flushing regime in place prior to the planned date of use, resulting in additional water testing being required prior to connection of the points for use.

In Quarter 2, the focus of water safety was:

- Water safety plan for WPH: This had been worked on by Watermans over the past nine months and was still not been completed. The Estates team set a deadline for completion.
- Heathlands: Water testing of the building's cold water tank in August 2023 identified coliforms (drinking water regulations require the count to be zero), which led to the requirement to use bottled water for a period of time, whilst tank cleaning and re-testing took place. The incident has

highlighted gaps in assurance of water safety in the building, and regular meetings were commenced by Bracknell Forest Council with an action plan for Windsar Care to provide assurance. Repeat testing was clear and indicated likely contamination during the contractors' sampling process.

- Sink Rationalisation: In line with the most up to date evidence base which has not yet been included in national HBNs and HTMs, the IPC Team are advising for fewer hand wash basins to be installed in new builds (including FPH M Block) and refurbishments.
- WPH CPE outbreak: A number of actions were being worked through as part of the CPE outbreak investigation and management, including a drain survey and removal of sinks identified at high risk for CPE contamination (such as those located in clean utility rooms). The IPC Team have shared a list with Estates which has sinks in order of priority for removal.
- FPH Dialysis points: These points were agreed for use once water testing requirements have been completed.

In Quarter 3, the focus was:

- Temperature monitoring results throughout FPH continue to remain good, with the majority of outlets within specification.
- Contractors had been tasked to install an auto-flushing device in FPH Neonatal Unit's relative's rooms shower, to increase the water turn over and prevent stagnation.
- Heatherwood Hospital water risk assessment and water safety plan are now completed and being implemented.
- A monthly water results review between Estates and the IPCT began, to provide assurance of actions taken to address aby high counts identified on the routine testing programme.

In Quarter 4, the focus was:

- Monitoring of chlorine dioxide levels at FPH continued, with initial audit results indicating sufficient levels to supply the outlets at 0.5ppm total oxidants. The haemodialysis ports in FPH ITU were approved for use in January 2024, after satisfactory water testing results were received. The final design of the softened/ potable B7 water tank arrangement is required prior to the replacement of this final tank in 2024/25.
- The Authorised Engineer (Water) carried out an audit of the water systems at WPH, and the report will be available by the end of April 2024. A business case for removal of hand wash basins from point of patient care in the WPH ITU, was pending review and approval from the Executive team. A long-term plan for a borehole at WPH was pending the development and agreement of a water quality testing and maintenance specification before approval.
- A flushing regime continued to be in place in Heatherwood Treetops, to reduce the water risks from the frequently unoccupied areas (planned for re-development into Day Case procedure rooms).

A new course ran by the Healthcare Infection Society (HIS) begins in April 2024, and is being advised to be completed by IPC practitioners, Estates, Capital Projects, and contractors, to raise awareness of the water safety requirements in healthcare.

Decontamination

Infection Control Doctor and Infection Prevention Nurse Consultant are members of the Decontamination Steering Group and provides specialist advice on decontamination queries, including advice regarding endoscope decontamination and action required on test results for rinse water. Quarterly assurance is provided to the HICC by the Decontamination Lead.

The FPH Sterile Services Department required transfer to WPH, during RAAC works in Quarter 4.

An unannounced MHRA audit in Sterile Services in February 2024, highlighted issued with the steam quality in the FPH site. The auditor has marked this for review at the re-certification audit planned in

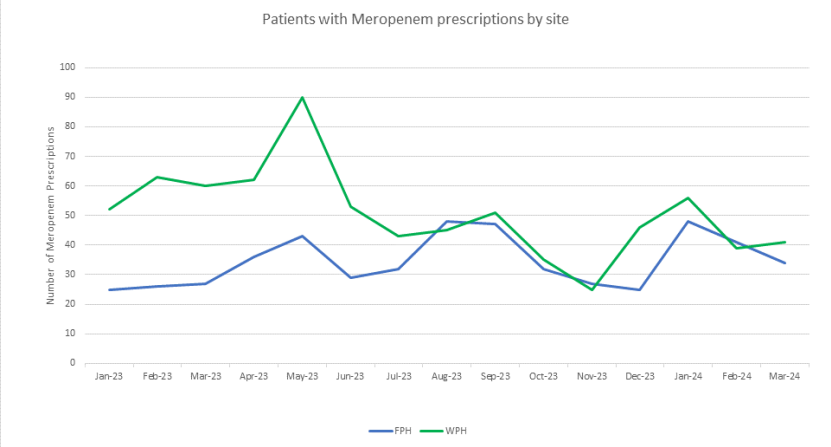
July 2024, with the expectation of compliance (or plans for gaining compliance) by this time. An action for the April 2024, was for the Decontamination Lead to prepare a paper for Trust Management Board on the options/ actions required for resolution.
Both the FPH and WPH SSDs have been noted to have non-compliant ventilation in the wash areas, and the insufficient temperature control has made it difficult for staff to work in the required PPE. RL6 was completed for this issue.

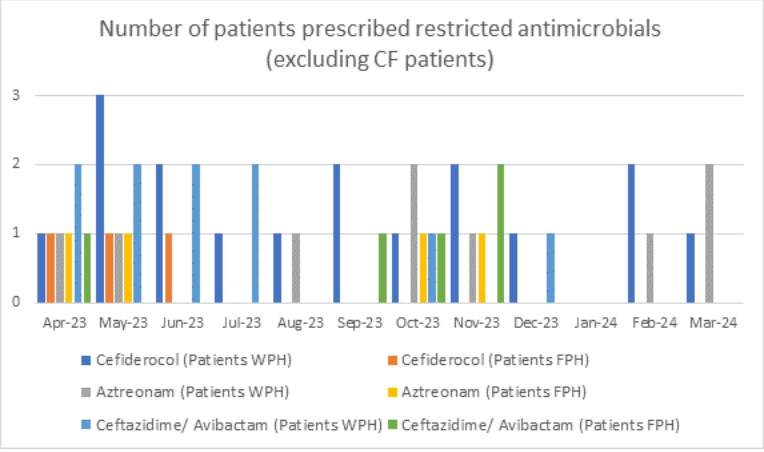
Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial Stewardship
Gaps in antimicrobial stewardship assurance are described under Criterion 1 of this report. The Trust and System AMS groups in 2023/24 will be key in providing assurance moving forward.

A cross-organisational Antimicrobial Stewardship group set up by the Frimley ICB, has representation by the IPC Team.
The Trust Antimicrobial Stewardship (AMS) subgroup, chaired by the Medical Director, had its first meeting 21/1/2024, and focussed on the Terms of Reference, and data planned. Regular reporting on key performance indicators for antimicrobial prescribing will be key in learning whether there is an association with CDI and Gram-negative bacteraemia rates.

The IPC Team carried out monthly surveillance using Epic on meropenem prescriptions, and use of antimicrobials used to treat CPE infections, as part of the WPH CPE outbreak management.
The use of meropenem cross-site has remained aligned since the formation of the cross-site Infection Service.





The IPC Team updated the IPC Level 2 e-learning package to include further education on antimicrobial stewardship for antimicrobial prescribers and administrators, in line with the NHSE 'Infection prevention and control education framework' published in March 2023.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

Patient hand hygiene
The IPC Team carried out a project on promotion of patient hand hygiene from October 2023, with the aim of actively encouraging patients to clean their hands at mealtimes and after using the toilet. The project included discussions with a patient focus group in December 2023 with assistance from the Patient Experience team.

CPE Screening
The CPE screening information leaflet for patients was updated in July 2023 as an action from the management of the WPH CPE outbreak.

Water-safe care
A patient information leaflet was developed in October 2023 in response to environmental changes being made to reduce risk from water/ drain-borne pathogens. The leaflet explained the rational for reducing the number of hand wash basins, and how to use sinks safely, and was amended in line with feedback from patients within WPH Eden Ward.

Communication of HCAIs
A 'Communication of HCAIs' audit is carried out by the IPCNs, to demonstrate compliance with Trust guidelines and national statutory requirements in the communication of healthcare-associated infection information, to:

- Patients
- Relevant staff providing care in the acute hospital setting
- Other relevant healthcare providers.

The audit in 2023/24 (June 2023) concluded:

- The communication regarding CDI continuous to be outstanding. Good documentation of diagnosis and treatment, and CDI treatment was promptly initiated.
- The Epic system flagged positive MRSA results for all reviewed cases, however, not all GPs were notified of an MRSA diagnosis on discharge letter. There were also instances where MRSA suppression therapy has been either delayed, not completed, or had been prescribed on TTO unnecessarily.
- All patients with a multi-drug-resistant Gram-negative bacteria (MRGNB) result were flagged on Epic, however not all patient's MRGNB diagnoses were recorded in the electronic notes. Additionally, the MRGNB diagnosis for some patients was not communicated in the discharge letter to their GPs.
- The discharge/transfer letters sent for patients being discharged or transferred to other healthcare facilities included the necessary details regarding their alert organism information.

<u>Recommendations</u>
Effective communication of HCAIs is important for the appropriate treatment of patients. Accurately providing information about patient's HCAI diagnoses can greatly assist in ensuring they receive the correct medical treatment and appropriate antimicrobial prescribing and prevent CDI and MRGNB occurrence.

The evidence of communication must be found in patients' electronic record. The multidisciplinary team must also ensure the following:

- GPs are notified about the MRSA and MRGNB diagnosis on discharge letter.
- MRSA suppression therapy are prescribed as per Trust Microguide and given promptly.
- Informing patients of their HCAI/colonisation positive result.
- Provide patient leaflets (available on intranet), where appropriate.
- Complete care pathways for CDI, MRSA and CPE on Epic.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

IT support

The IPC Team have continued two-weekly meetings with an Epic analyst during 2023/24, to enable the most effective use of the system. The system reports were key in the production of data for the National Point Prevalence Survey of HCAI and AMU in September 2023. The Bugsy dashboard provides and exceptional overview of suspected and confirmed infections for patients, that can be viewed and follow-up easily by the IPC Team. This has been especially useful for monitoring the increase in suspected measles and pertussis attendances to the Trust, and monitoring staff and patient exposures (contact tracing).

The Communicable Disease Screening tool on Epic was updated in December 2023, reducing the focus on COVID-19, and including several other risk factors that may increase risk of infection (including presence of invasive devices and wounds, and past history of multi-drug-resistant organisms).

In-house training on the Bugsy application was commenced in March 2024 for new starters in the team.

COVID-19 Screening

Routine asymptomatic screening for COVID-19 continued only for patients being discharged to care homes and hospices during 2023/24.

MRSA screening

The IPCNs carry out spot-checks on compliance with the Trust MRSA screening guidance, and provide education where patients have been missed from screening. The effectiveness of the support and education to improve screening of wounds and devices on admission, is being monitored by a programme of MRSA screening spotchecks.

74 MRSA screening audits took place in 2023/24, with an average compliance (proportion of patients that required screening that were actually screened) with the MRSA screening guidance of 77%. Missed screening of wounds and invasive devices accounting for this lower compliance.

In response the PVL-MRSA outbreak in WPH NNU, and the PVL-MRSA outbreak in FPH ITU in 2021, all new MRSA-positive isolates from inpatients (those likely to be healthcare-associated) continue to be tested for PVL and sent to the reference laboratory for typing.

Carbapenemase-Producing Enterobacterales (CPE) Screening

In the UK, over the last five years, there has been a rapid increase in the incidence of infection and colonisation by highly antibiotic-resistant group of bacteria, called Carbapenemase-Producing Enterobacterales (CPE), and a number of clusters and outbreaks have been reported in England. There is the very real risk of these organisms posing a threat to public health and modern medicine as we currently know it.

Patients requiring screening on admission to Frimley Health are:

- Patients with known history of CPE
- Patients with known contact with a case of CPE
- Patient transfers from other acute hospitals (including abroad)
- Patients who have had an inpatient admission to another acute hospital (including abroad) in the past 12 months
- Patients requiring the following:
    - Renal dialysis
    - Critical Care/ ITU admission
    - Haematology/ Oncology admission/ chemotherapy treatment

In addition to this in 2023/24, were the enhanced screening protocols in place on the WPH site.

66 CPE screening audits were completed in 2023/24, with an average compliance with screening of 75%.

Monitoring of Invasive Devices

A dashboard has been built into Epic for the real-time monitoring of Central Line-Associated Bloodstream Infections (CLABSI), however due to lack of completeness of documentation on insertion and care of IV devices, the data provided by this dashboard has been unreliable in 2023/24. Reports in Epic for identification of any suspected IV device-related infections are interrogated on a daily basis and have significantly improved the timeliness of identification and review.

Short-term Central Venous Catheter Infections

There were very few short-term CVCs cared for outside of the ICU environment, as a result of prompt actions by the IVAS team to site lower risk devices for continuing care.

There were also a low number of confirmed CVC-related infections: One MRSA bacteraemia was associated with a Haemodialysis line (as noted earlier in this report) at FPH, and a *Staph epidermidis* infection of a Hickman line was identified on FPH F8 in August 2023.

Peripherally Inserted Central Catheter (PICC) Infections

Surveillance of PICCs is carried out by the IPCT and the IVAS Team, who manage the insertion of the largest proportion of PICCs in the Trust.

A total of 13 infections associated with PICCs were diagnosed and treated (six at FPH and seven at WPH). Confirmation of these infections was difficult, as very few had the tip sent for culture (or swab of line site) when infection was suspected. Additional education was provided in these instances.

TPN-related PICC infections are reported quarterly to the Nutrition Steering Group, as TPN is known to significantly increase the risk of IV device infections. Two confirmed TPN-related PICC infections were identified in 2023/24; on FPH F8 and WPH MSSU (both in July 2023).

IV Device Audits

Spotchecks of IV device management were carried out quarterly on selected wards in 2023/24, with a cross-site in-depth audit of vascular access devices carried out in September 2023 in collaboration with the IVAS Team.

The common themes from the audits in 2023/24 were largely associated with documentation of care on Epic:

Insertion and continous care (care pathway) documentations of the intra vascular access devices are incomplete.
EPIC LDA (avatar) not updated. Intra vascular access device(s) of patients removed from previous admissions are still present on LDA and or patient's cannula present on current admmission is not reflected on the LDA.
Continous IV giving sets are not labelled.
Second intra vascular access devices are no longer required but remains in situ.

Insertion sites are either covered with a dressing, tapped or obscured by blood under the dressing and not visible for VIP score.
Patients verbalised excellent care received from medical and nursing staff.
Incomplete or no documentation of intra vascular devices inserted in ED and theatre.
Cannulas inserted by ambulance crew were not documented on EPIC.

In response, changes to the Epic Avatar were requested, including making completion of IV device care record three times a day mandatory.

Urinary Catheters

In response to the identification of urinary catheters being a common source of UTI and gram-negative bacteraemia within the Frimley Health & Care System, since April 2019, a point prevalence of urinary catheters has been carried out quarterly in the Trust, along with an audit of care of urinary catheters. The aims of the review for the Trust were:

- To ascertain the point prevalence of urinary catheters in the patients under the care of FHFT
- To review the care of patients with urinary catheters in place
- To identify any changes in practice that can be made to help reduce avoidable healthcare-related urinary tract infections.

The point prevalence of urinary catheters in inpatients at Frimley Health fluctuated during 2023/24, and was on average higher than the 18% prevalence seen 2021-2023.

Quarter	**Point Prevalence**	**Proportion of urinary catheters in place with no valid clinical indication**	**Proportion of catheters without 2x daily review**
Q1	19.3%	16%	43%
Q2	24%	15%	55%
Q3	18%	15%	56%
Q4	20%	16%	44%

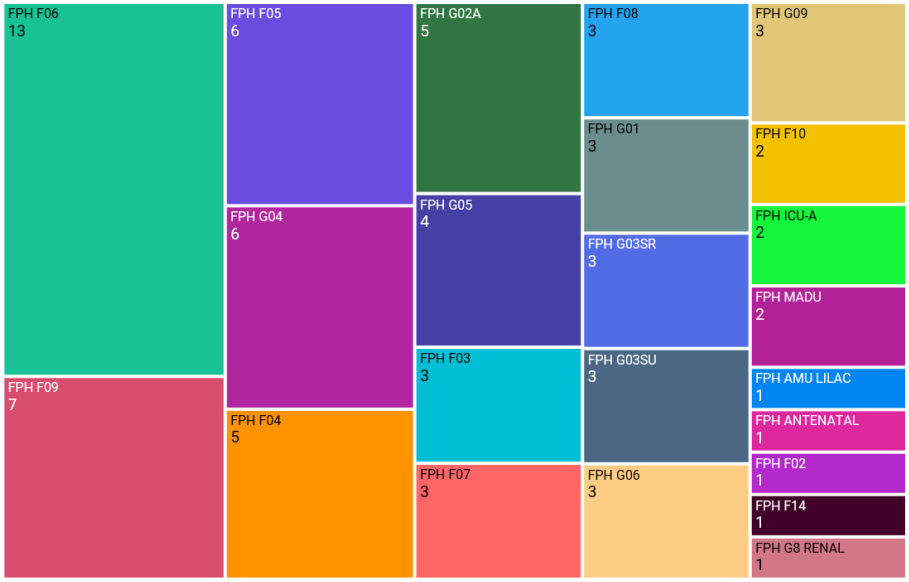
Summarising data from the quarterly audits 2023/24:

- There was consistent prevalence of urinary catheters that are in place without a valid clinical reason.
- The point prevalence will change according to patient groups in hospital, so it is not a reliable indicator of use (eg. prevalence was low in first year of pandemic when average age of patients was lower, and less surgical admissions).
- Consistently low levels of documentation of care of urinary catheters since use of Epic (lower care record completion than with paper charts).

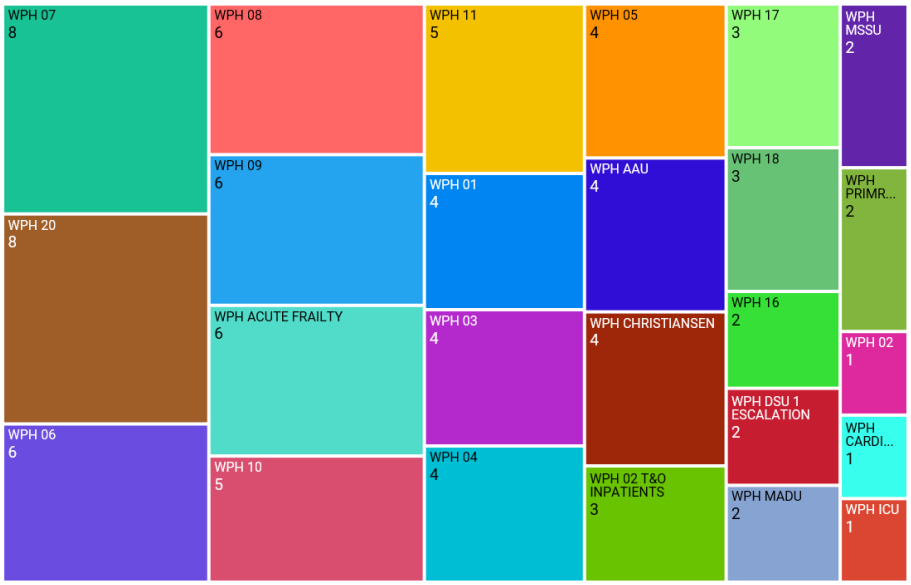
Lists are available in Epic for the IPC Team to see in real time, which patients have a urinary catheter in place, which enables proactive review of patients at higher risk of catheter-associated infections. A report of suspected catheter-associated UTIs is also run on a daily basis, to monitor for potential infections, and review treatment practices (for example antimicrobial prescribing and catheter changes).

181 catheter-associated UTIs (CAUTI) were identified through Epic surveillance in 2023/24, with the location of patients with these infections shown in the Epic infographics below:

FPH and Community Sites



WPH and Heatherwood



The quarterly audits and CAUTI prevalence in 2023/24, has highlighted the following areas for focus of monitoring and education in 2024/25:

FPH	**WPH**
F5 (Ortho)	W6 (Rheum)
F6 (Ortho)	W7/ W8/ AFU (Frailty)
F7 (Urology)	W20 (Frailty)
F9 (Gastro)	W9 (Resp)
F2 (Vascular – moved to F7 in 2024/25)	W10 (Gen Surg)

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Infection Prevention & Control training (including hand hygiene)

A key objective of the IPC education programme in the Trust, is to support improvements in IPC, antimicrobial stewardship, and antimicrobial resistance; align practice to the National IPC Manual for England (NIPCM) and Trust policies/ guidelines, align practice to evidence-based practice, and support IPC Practitioner professional development.

The Infection Prevention and Control Team carries out a programme of training, on induction and for mandatory updates, across the Trust for both clinical and non-clinical staff. The content of the IPC sessions is mirrored across all sites.

- All members of staff working within the Trust are required to complete IPC training on Induction to the Trust, including volunteers and contractors.
- Non-clinical staff with no patient contact, are required to complete the Infection Prevention & Control (Level 1) update every three years.
- Clinical- and patient-facing staff, are required to complete the Infection Prevention & Control (Level 2) training annually.

The publication of the NHSE IPC Educational Framework in March 2023, further segregated the IPC training into three Tiers rather than two levels, however at the time of writing this report, this had not yet been incorporated into the Skills for Health framework and national e-learning programme.

Since April 2020, the majority of formal face-to-face training sessions (including Corporate Induction and SaPS sessions) were replaced by staff completing the MAST e-learning packages for IPC Level 1 and Level 2 training. It was clearly observed during IPC clinical-based sessions and audits, that face-to-face training is far more valuable and effective in embedding high standards of IPC practice, than completion of an e-learning assessment. In response to this, the IPC Team requested an increasing presence on Trust education programmes during 2023/24, providing face-to-face training on the following:

- Junior Drs and FY1 Inductions
- Student Nurse & Midwife Inductions
- Preceptorship
- Care Certificate
- Bite Size update days
- Volunteer Induction & updates
- Midwifery annual updates
- Consultant training days
- Orthopaedic In-House Degree module – Surgical site infection prevention
- Respiratory In-House Degree module – Acute respiratory virus infections

The overall percentage of Frimley Health staff in date with their Infection Prevention & Control training rose above 90% in March 2024 for Level 2 patient-facing staff, for the first time in 2023/24.

	Trust compliance (as at 31/3/2024)
Level 1 (non-patient-facing staff)	94.12%
Level 2 (patient-facing staff)	90.26%

E-learning and classroom-based education is supplemented by a rolling programme of IPC clinical-based face-to-face sessions, through which the IPC nursing team provide training and support in

clinical areas. These sessions are also put in place as part of the response to outbreaks and infection incidents

The Level 2 IPC e-learning workbook was updated in December 2023, to include greater information on clinical staff roles and responsibilities in antimicrobial stewardship. The IPC Team have agreed to the change-over to use of the national e-Learning for Health IPC programme in 2024/25, while keeping the IPC Level 1 & 2 educational workbooks, to support Trust-specific information.

Additional education was provided during IPC awareness weeks, in May 2023 for World Hand Hygiene Day, and October 2023 for International Infection Prevention Week. International Infection Prevention Week (15-21/10/2023) was celebrated with IPC support and education in clinical areas, and providing IPC updates for over 600 clinical staff, focussing on:

- Hand hygiene
- Sustainability in IPC
- Vaccination
- Antimicrobial stewardship
- Decontamination

Infection Prevention & Control Link Representative Programme 2023/24

The Trust has 189 (92 WPH/HWH and 97 FPH/Community) Infection Prevention & Control Link Representatives, representing all clinical areas (including all inpatient wards, Community Care Teams, Outpatients depts. (including off-site OPDs), Theatres, Physiotherapy, Radiology and Occupational Therapy).

Meetings took place cross-site via Teams in April 2023, June 2023, October 2023, and January 2024, with an additional Q&A session with the Infection Prevention Nurse Consultant in August 2023. The meetings all had exceptional levels of attendance, with between 60-80 attendees at each meeting.

The meetings provide healthcare-associated infection updates and feedback from post-infection reviews, education from both internal and external representatives, and training focuses, which in 2023/24 included:

- The IPC Link roles and responsibilities
- Decontamination
- Epic use and documentation
- COVID guidance
- Patient hand hygiene
- IPC Ward Round Checklist/ preparedness
- Patient hydration
- CPE
- Macerator maintenance

Summaries of quarterly IPC Link Rep audit results were fed back at Link Rep meetings, IPC Working Group, and other relevant healthcare fora.

Criterion 7: Provide or secure adequate isolation facilities.

The IPC Nurse Consultant and Lead IPCNs attend monthly Capital planning meetings for FPH and WPH, and are invited to discuss any refurbishment or building project where this guidance is used to guide the planning team. Single rooms are required for patients in acute Trusts for a variety of reasons as well as for isolation of patients for infection prevention and control reasons. The number of single

rooms is monitored by the IPC Team and an update is provided regularly at HICC meetings and included in the local Risk Assurance Framework.
The estimated proportion beds needing to be in single rooms for infection prevention and control reasons (for both source and protective isolation) is 70%. The does not include single room capacity often required for end of life care, and privacy and dignity reasons.

In order to ensure the available single rooms are prioritised, during weekdays the IPC Nurses continue to carry out daily ward rounds, advise staff, liaise with bed management to ensure patients with infections (including COVID-19), are managed appropriately.
To ensure patients who require side-rooms for infection prevention and control reasons are prioritised, a scoring tool is used. This ensures all patients classified as high priority such as those with diarrhoea from a potentially infectious cause, are always isolated in a single room. Additional contingency plans are in place so that rooms are identified throughout the hospital which can be used in times of need – such as a respiratory virus infection pandemic.

Availability of single rooms for source and protective isolation of patients remains under pressure, as a result of the increasing number of inpatients with multi-resistant Gram-negative bacteria, and continued prevalence of COVID-19. The challenge has been significant especially on the FPH site, and requires a high standard of IPC practices in the wards, to prevent onward transmission. The IPCT ensures daily ward rounds include escalation areas and review of patients, and that the on-going IPC audit programme (including monitoring of hand hygiene), also takes place in these areas.

The redevelopment of M Block at FPH (due for completion early 2025) will increase single room capacity on that site.

Criterion 8: Secure adequate access to laboratory support as appropriate.

Both in-house laboratory PCR testing for SARS-CoV-2 and Point of Care PCR testing have been available throughout 2023/24. The IPC Team have kept close links with the Point of Care Team, to ensure respiratory virus testing capability within the Trust has met the national requirements.

Both the FPH and WPH microbiology laboratories had been thanked by the IPC Team, for their involvement in managing the WPH CPE outbreak, in processing environmental samples, and increasing resources to enable enhanced CPE screening for patients.

Quarterly meetings are held between BSPS and the IPCTs in the BSPS network, at which teams can raise any issues, and enable them to be resolved very quickly.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

The next full review of the IPC manual guidelines is due in July 2024, and will result in approximately one third of the Trust IPC guidelines being archived and replaced by the NIPCM (England). A proportion of the remaining guidelines with be replaced with shorter guidance describing any Trust-specific information to supplement the NIPCM. Extensions to the two IPC policies IPC02 (IPC roles and responsibilities) and IPC05 (Hand Hygiene) were granted until September 2023, and were approved and published by February 2024.

Monitoring of compliance with infection prevention & control guidelines and policies (including hand hygiene)

The Infection Prevention & Control Annual Plan for 2023/24 is attached as Appendix 5, and the audit summary for the year, as Appendix 6.

Hand Hygiene

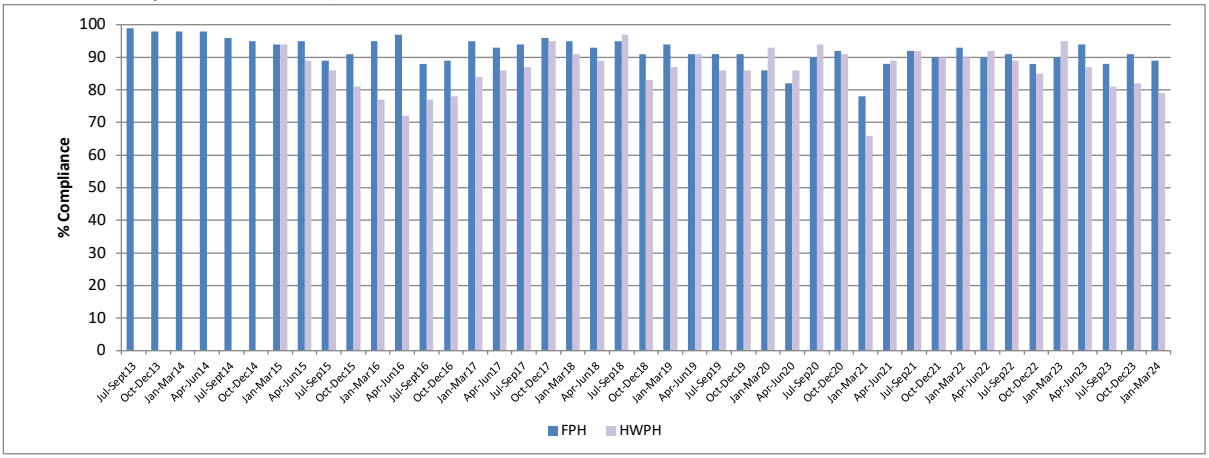
Hand Hygiene: Staff

Hand Hygiene audits are carried out by the IPC Team and Clinical Matrons. Dept. leads, to ensure Trust compliance with the World Health Organisation's (2009) '5 Moments for Hand Hygiene'. The Trust ambition for hand hygiene compliance is 100%, with the target of all staff groups obtaining 95% compliance or higher, as hand hygiene is fundamental in prevention and control of infection.

The Head of Nursing/ Midwifery/ Therapies, Clinical Matron and Senior Sister for every ward/ department is informed of the result for their ward on the day of audit and given advice on how to improve compliance based on which of the '5 Moments' where opportunities to clean hands have been observed to have been missed. Each individual is informed at the time of the audit how they can improve their hand cleaning compliance.

Any member of staff noted to be not adhering to the Trust uniform guidance during the session (e.g. by having long nails or wearing stoned rings) is educated at the time of audit. Anyone noted to have dry or irritated skin (dermatitis) is referred to the Occupational Health Department.

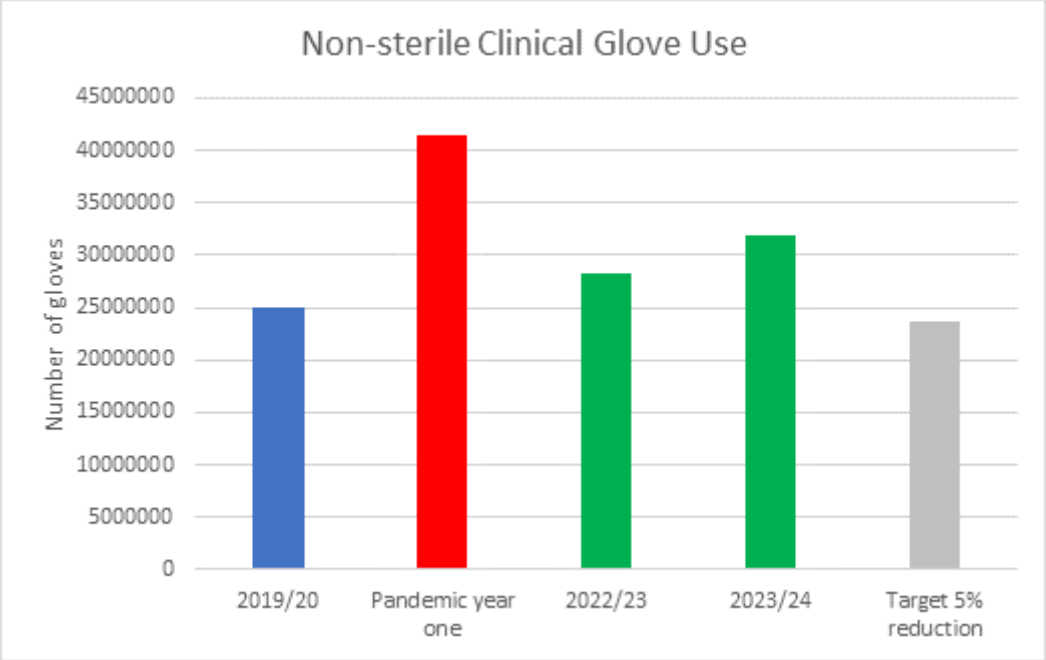
Trust compliance with the World Health Organisation's (2009) '5 moments for Hand Hygiene' (audits carried out by the IPC Team)



The hand hygiene performance audited by the IPC Team was 87% cross-site in Quarter 4 2023/24 (a slight improvement on 85% in Q3), with audit results consistently lower on the WPH and HWH sites compared to FPH and Farnham during 2023/24.

In 2022/23, IPC Team set the ambition of reducing non-sterile clinical glove use by 5%, based on the 2019/20 (pre-pandemic) baseline, as over-use of gloves had the biggest impact on hand hygiene adherence, as well as negatively impacting on staff skin health and waste volumes. As part of improving sustainability in IPC, this ambition continued in 2023/24 and will do so into 2024/25.

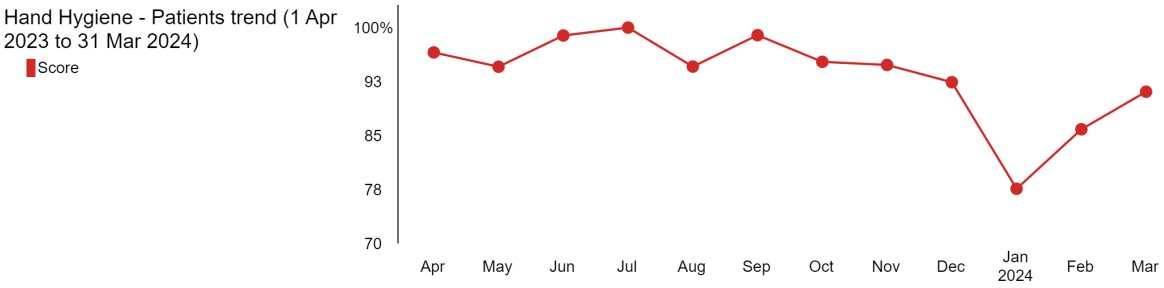
An increase in non-sterile clinical glove use was observed in 2023/24, however, as rate data was not available, it is not currently known if this was as a result of increased activity and bed capacity, or due to an increase in inappropriate use.

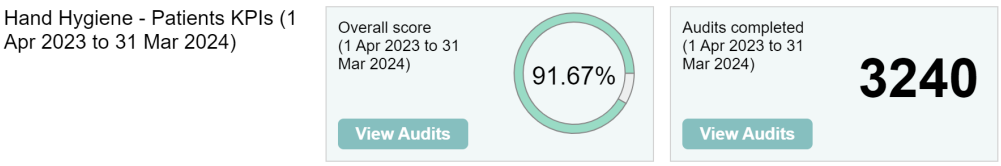


A change in Trust guidance for IV medication preparation and administration in 2023/24, encouraged the use of risk assessment for glove use, rather than always requiring their use.
Further promotional activities are planned for May 2024 (national Glove Awareness Week).

Hand hygiene: Patients

It is important that staff remind or assist patients to clean their hands to reduce healthcare-associated infection transmission, and is an opportunity to provide public health education for patients.
Audits of patient hand hygiene (based on observation of staff members prompting or assisting patients to clean their hands) prior to meals and after using the toilet, are carried out by Clinical Matrons and entered on IQVIA. Cross-site, the average compliance was 92% for 2023/24 for both of the hand hygiene opportunities. The IPC Team believe the dip in compliance from January 2024, was associated with the roll-out of the patient hand hygiene project, and the audits showing a more accurate reflection of the observations seen in practice.





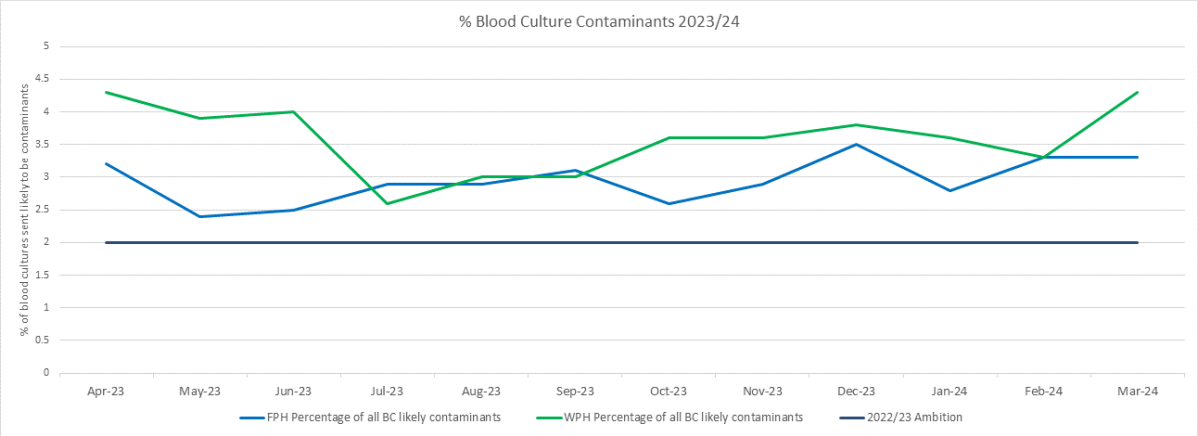
Hand Hygiene: Visitors

Visitor hand hygiene before and after contact with a patient (at the bedside) is audited as part of a regular rolling programme by the IPC Team in wards and clinical departments Trust wide. Cross-site in 2023/24, visitors were observed to clean their hands 83% of the time prior to visiting of the time prior

to visiting, and 77% after visiting. This was a marked decrease on visitor hand hygiene during the first three years of the pandemic, and may be as a result of relaxation of public health messaging.

Blood Culture Collection

The IPC Team set an ambition in 2022/23 for blood culture contamination rates to reduce to 2% - an ambition that will aide correct diagnosis and treatment of patients, prevent contaminants being reported as Trust-apportioned healthcare-associated infections, as well as reducing the time required for contaminated blood cultures to be investigated by the Consultant Microbiologists. The performance against this ambition continued into 2023/24.



Infection Prevention & Control Best Practice Assurance Audits

The IPC Best Practice Assurance Audits were completed quarterly in 2023/24. The audits were completed by senior nursing/ AHP staff (at Band 7 and above), to gain an overview of infection prevention and control practices in each clinical area, identify areas where more IPC support is needed, and also enabled areas to feedback on areas of innovation/ good practice.

The focus of the Quarter 1 audit was feedback from clinical areas on assurance against the criteria of the updated IPC BAF.

The most significant gaps in assurance, against recommendations were made, were:

- 13% of staff who prescribed or administered antimicrobials were not aware of how to access the Trust Microguide.
- 15% of clinical areas stated patients discharged with urinary catheters, were not provided with 'My Catheter Passport' – this was a much lower proportion of patients compared to that identified by the IPC Team audits.
- 43% of clinical staff that are required to wear respiratory protective equipment for their role, had not been fit-tested for a FFP3 respirator in the past 2 years.
- 21% of clinical areas stated that delays in isolation of patients with suspected or confirmed infectious diseases, were not reported on RL6.

Recommendations from the audit were:

- Awareness of the location of the Trust Microguide must be raised with prescribers and those administering antimicrobials, to enable their role and responsibilities in antimicrobial stewardship to be met.
- 'My Catheter Passport' must be provided to any patients discharged from Frimley Health with a urinary catheter in place. The information in the booklet is important for:
    - Patient education, and knowing what action to take/ who to contact in the event of catheter complications.
    - Continuity of catheter care between other health and social care organisations involved in the patient's care – including providing information on why the catheter

is needed (HOUDINI), is it planned for removal/ TWOC, what type of catheter is used, and who is responsible for catheter changes.

- Fit-testing for FFP3 respirators that are worn by staff for occupational health and safety, is a legal requirement, and is needed to ensure the device is providing an adequate level of protection for the staff member.
  Wards and departments were requested to:
  - identify department staff who will be fit testers for the department, and ensure they have received training required for the role
  - identify which of their staff require fit testing
  - ensure that fit testing is arranged for those identified staff
  - ensure staff fit test passes are recorded on HealthRoster as a 'Skill'
  - ensure that staff have access to masks for which they are fit tested
  - only assign fit tested individuals to provide care that requires the individual to be fit tested.
- Delays in isolation of patients with infectious diseases will increase the risk of cross-transmission and outbreaks. Clinical teams were asked to ensure delays are reported on RL6 to enable an understanding for the reason for the delay (for example, insufficient side-room capacity), and so that appropriate action can be taken.

The focus of the Quarter 2 audit was feedback from clinical areas on assurance of actions and practices for the prevention of CPE.
The most significant gaps in assurance, against recommendations were made, were:

- 26% of clinical areas reported that the hand wash basins present do not meet the standard described
- 74% of clinical areas had a sink present in the clean utility/ drug preparation room
- 12% of areas had sinks that were infrequently used
- 10% of areas were storing clean/ sterile equipment underneath u-bends of sinks
- 11% of areas reported shower rooms were being used for non-patient hygiene purposes (eg. as storage areas
- 13% of areas reported that rooms that had been occupied by a patient with CPE, were not deep-cleaned on the patient's discharge

Recommendations from the audit were:
The standards described to reduce the risk of Gram-negative bacteria contamination from sinks was described as below:

- Access to the hand wash basin is unobstructed*
- Hand washing instructions present (on poster or soap dispenser)
- Elbow-operated or non-touch taps are present
- Taps are wall-mounted and do not have a 'swan-neck'
- Soap dispenser is located to one side to avoid dripping onto outlet
- Gap between the back of the sink and the panel is correctly sealed
- No items are on the ledge of the basin*
- Stream of water from the tap does not flow directly into the plug hole
- No excessive splashing, due to high pressure flow, or too small a sink (which can increase the risk of organism dispersal, and wet floor)
- Water is draining quickly from the basin
- Patients and equipment are located more than 2 metres from the sink*
- Hand wash basins are used for hand washing only (ie. no other activities take place at the sink, such as cleaning equipment, disposing of drinks or IV fluids)*
- No clean/ sterile equipment is stored underneath sinks/ u-bends*

Within Trust older estate, there are a number of sinks that do not meet the standards above or are located in areas at high risk of contamination from sinks (eg. clean utility/ drug preparation rooms). There are plans for upgrades and potential rationalisation of hand wash basins in some clinical areas based on priority/ patient risk. The standards asterisked above, should however be put in place to mitigate risk.

The focus of the Q3 audit was winter planning, and assurance that clinical settings are prepared for the prevention and control of seasonal respiratory virus infections, and other seasonal infections (eg. Norovirus).
Highlighted areas for action and recommendations were:

- 41% of areas reported that staff providing care for patients with confirmed COVID-19 or influenza were not up to date with their seasonal vaccines. Vaccination is the most effective protection for staff from severe disease caused by COVID-19 and influenza and will also reduce the risk of transmission to vulnerable patients and colleagues. In addition to access in the Trust, COVID & flu vaccinations are provided at a number of Pharmacies for walk-in appointments during Autumn/ Winter.
- 34% of staff wearing FFP3 respirators had not passed a fit test with the mask type they were wearing. The performance of FFP3 respirators depends on achieving a good contact between the wearer's skin and the face seal of the respirator. Inadequate fit will significantly reduce the protection provided to the wearer and increase the risk of exposure to some infectious diseases. Fit testing is a legal requirement for checking that a tight fitting facepiece (a specific make, model, and size) matches an individual's facial features and can provide an adequate seal to the wearer's face.
- 61% of clinical areas did not have an accessible record of department staff that had been fit-tested for FFP3 respirators (such as on HealthRoster). Fit-tested staff should have this added as a 'skill' on HealthRoster (under Skill Group 'Medical Device'), to enable safe staffing for wards/ depts caring for patients with infectious respiratory diseases.
- 25% of clinical areas reported that recent international travel is not being documented in clinical details of pathology test requests
  It is critical to provide accurate clinical details on pathology test requests, to ensure:
  - samples are tested
  - the most appropriate processing of samples
  - correct assessment of the clinical relevance of results
  - adequate protection of laboratory staff from potentially hazardous organisms
  - safe handling of samples in the laboratory

The audit results and recommendations were an agenda item for the February 2024 IPC Working Group.

The focus of the Q4 audit was actions to reduce Gram-negative bacteraemia.
The most notable areas for action arising from the audit were:

- Only 36% of clinical areas reported that hand hygiene was consistently offered to patients prior to meals and after using the toilet. The IPC Team has worked on a quality improvement project in Q4, to improve staff awareness of the importance of offering and assisting patient hand hygiene.
- 25% of patients with urinary catheters, and 24% of patients with IV devices, did not have documentation of care completed in line with Trust guidance. This correlated with quarterly IV and catheter audits carried out by the IPC Team.
- The majority of clinical areas (59%) reported that staff would not have considered using an in-out catheter to resolve acute urinary retention, rather than an indwelling catheter. The updated of the urinary catheter guideline is planned to be completed early Q1 2024/25, which will provide more information to support in-out catheter usage.

- 14% of staff prescribing or administering antimicrobials were not aware of how to access the Trust Microguide. There was not a breakdown of staff groups available to pinpoint where education was required, so a further audit is planned for this through the AMS Subgroup.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The IPCNs include Occupational Health & Safety-related issues in Infection Prevention & Control training sessions, including prevention of sharps injuries, assurance of immune-status to vaccine-preventable infections, and promotion of the annual influenza vaccination programme.

Influenza & COVID-19 Vaccination

Planning for the 2023/24 influenza season began in July 2023, and the vaccination programme started in October alongside the COVID-19 booster vaccination programme for staff.
Nationally (data as at 24/1/2024), the COVID winter booster uptake in front-line healthcare workers dropped to 31.3%; FHFT was above this at 33.5%. For influenza vaccination, the national uptake reduced to 44.3%; 42.7% at FHFT. There had been a year-on-year reduction in both COVID and Flu vaccination uptake since the first year of the pandemic.

Measles Vaccination

All patient-facing staff require immunisation screening on commencement of employment to the Trust. Any staff requiring vaccination, are not cleared to commence work, until their first dose of MMR is received. The Occupational Health staff provided assurance of the processes and immunisation rates of patient-facing staff as part of preparation for the surge in measles cases in February 2024.

COVID-19 Testing

The routine requirement for symptomatic staff to carry out LFD testing ended on 1/4/2023. Staff who did choose to test, were still required to enter results into the Trust portal, for statutory reporting requirements to UKHSA.

FFP3 Respirator Fit Testing

There is not currently a designated 'FFP3 Resilience Lead' for the Trust due to the post-holder leaving, and it is likely that funding for a post to manage and provide assurance with the FFP3 resilience requirements will be needed. The IPC Team have raised as a significant risk that that the lack of robust respirator fit-testing programme for the Trust impacts future pandemic preparedness, as well as the assurance of protection of staff from routine airborne transmission risks (eg. COVID-19, pulmonary TB, and measles).

The national Emergency Preparedness, Resilience and Response core standard 12, requires assurance that the Trust is: 'In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organization or the community it serves, covering a range of diseases including High Consequence Infectious diseases'.

The free national FFP3 fit-testing service provided by Ashfield ended on 31/3/2023, and the IPC Team have continued to lead the Trust in FFP3 respirator fit-testing training in the absence of a FFP3 Resilience lead. The IPCT nursing staff receive training from 'Fit 2 Fit'-accredited trainers, and carry out fit-testing using the following equipment only, using the protocols provided by the manufacturers, and in line with the requirements of HSE guidance 'INDG479':

- 3M Qualitative Fit Test equipment
- Full Support Qualitative Fit Test equipment

- TSI Portacount Quantitative Fit Test equipment (the Trust has two 8048 models).

A workgroup was led by the IPC Team on 5/6/2023, with Occupational Health, EPRR, and the clinical education team, to formulate a plan for the FFP3 respirator fit-testing programme moving forward. Actions arising from the review were:

- A business case for a FFP3 Resilience Lead will be drafted by the IPC Team. There are a large number of staff trained to fit-test and continue the programme for new starters, however assistance with administration so an accurate record of staff fit tested is being kept.
- The five 'FFP3 Resilience Principles' will be included in more detail in the IPC local Risk Assurance Framework.
- It was agreed that the responsibility for identification of staff requiring fit testing on induction (and 2-yearly thereafter), and carrying out the fit testing, will sit with the clinical wards/ departments.
- The IPC Team arranged half-day sessions in 2023/24, to provide in-house refreshers for staff already trained to fit test, and train new staff in high use areas (eg. A&E, theatres, ITU, MADU), as the external training cost of £170+VAT for each individual trained would not be financed.
- Data on numbers of FFP3 masks in use cross-site, highlighted that 3M masks were still the highest used, despite the Ashfield national fit testing service not providing fit testing of these masks over the past two years.

3. Frimley Health NHS Foundation Trust Healthcare-Associated Infection Objectives for 2024/25

The 'NHS Standard Contract 2024/25: Minimising *Clostridioides difficile* and Gram-negative bloodstream infections' is pending publication at the time of writing this report, and will set out the quality requirements for NHS Trusts to minimise rates of both CDI and GNB to the thresholds set by NHS England. In April 2024, NHS Trusts were advised the thresholds for 2024/25 were planned to remain the same as 2023/24.

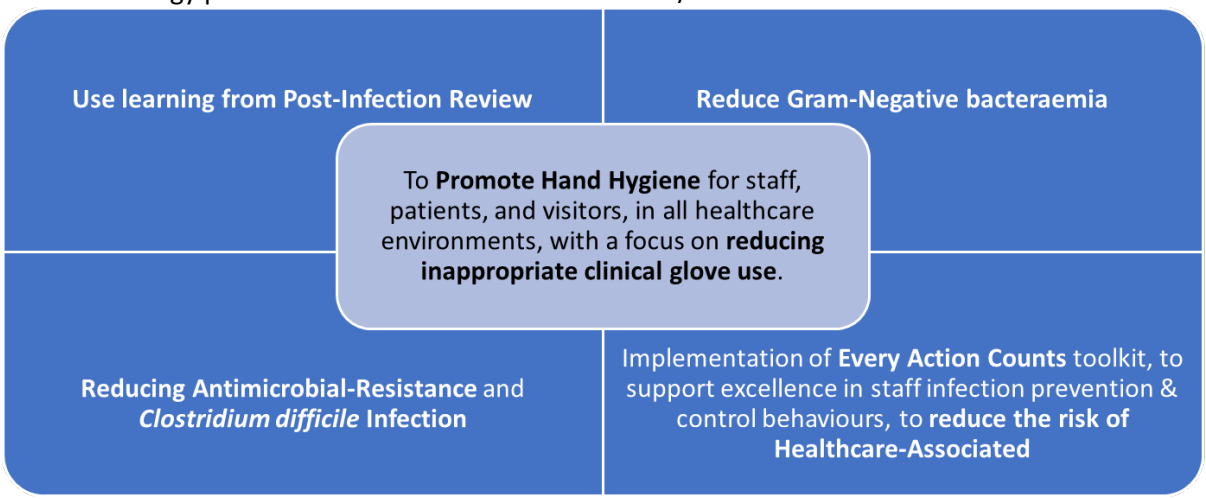
The national objectives set for 2024/25 are below:

	2024/25 objectives
Clostridioides difficile Infection	**52**
Ecoli bacteraemia	**183**
Pseudomonas aeruginosa bacteraemia	**33**
Klebsiella spp bacteraemia	**60**

The internal objective for MRSA bacteraemia, is to have no preventable healthcare associated cases, and for MSSA bacteraemia, to have no more than the number of cases in 2023/24 (ie. ≤39 cases).

The thresholds continue to be set as numbers of cases, rather than rates of infection (NHSE have explained the continual monitoring of bed days posed too great a challenge to provide rates this year), meaning the thresholds do not take into account the size or type of organisation.
The thresholds also do not take into account the changes to the apportionment of HCAI cases in 2024/25, which include cases admitted to Trust virtual wards being categorized as inpatients, and date of decision to admit being used rather than admission date.

The IPC Strategy priorities 2021-2025 continue into 2024/25:



The IPC Team have set ambitions against the priorities, in line with the Trust Strategic Ambitions, for 2024/25 (below), against which the IPCT have planned activities during the year. The ambitions were shared with the IPC Working Group in May 2024, with feedback on actions taken to achieve the ambitions requested to be brought to the August 2024 meeting. Updates on progress will be provided to Trust staff on a quarterly basis.

IPC Ambitions 2024/25:

Ambition	Reason for ambition	Link to IPC Priorities
To promote use of alcohol-based hand sanitiser as a safe and effective method for hand hygiene	There is increasing evidence for the link between water/drainage systems, and Gram-negative infections in healthcare. ABHS is the safest way to clean hands.	• Promoting and improving hand hygiene practices • Reducing Gram-Negative bacteraemia • Supporting excellence in staff IPC behaviours
To promote sustainability in IPC through education, and staff and patient engagement	Many unsustainable practices are driven by IPC risks – sometimes these risks are real, but sometimes the perceived risk of infection is disproportionate to IPC evidence or principles. The IPC Team is best placed to guide changes in practice.	• Promoting and improving hand hygiene practices • Supporting excellence in staff IPC behaviours • Reducing Gram-Negative bacteraemia • Reducing AMR and CDI
To promote feedback from clinical areas on actions taken in response to IPC audits and IPC/ HCAI incidents	Good practice in IPC should be shared Trust-wide, and feedback can also be used to identify where clinical areas require more support.	• Learning from post-infection review • Supporting excellence in staff IPC behaviours • Reducing AMR and CDI • Reducing Gram-Negative bacteraemia

Report Title	**Board Assurance Framework & Corporate Risk Register**
Meeting and Date	Public Board of Directors, 5th July 2024
Agenda Item	13.
Author and Executive Lead	Victoria Cooper, Acting Company Secretary Caroline Hutton, Interim Chief Executive Officer Melanie Van Limborgh, Chief of Nursing & Midwifery.
Executive Summary	Please find attached a refreshed Board Assurance Framework (BAF) together with the latest version of the Corporate Risk Register (CRR) which has been reviewed to ensure it reflects the organisation's current risks. Please note that some of the metrics within the BAF are still being finalised and the data for Q1 is not yet available for inclusion. Following an internal review of risk management processes, a decision has been made to establish a Risk Management Review Group which will meet monthly to review directorate risk registers, discuss any risks that require escalation to the CRR and review of the overall BAF and CRR.
Action	The Board is asked to **NOTE** the BAF and CRR and the plans regarding the Risk Management Review Group.
Compliance	NHS Board Risk Management

Frimley Health NHS Foundation Trust
Board Assurance Framework 2024/25

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Board Assurance Framework 2024/25

This BAF records the following principal risks to the Trust's strategic priorities:

PR1 Failure to protect patients from harm and deliver improvements for patients
PR2 Failure to support our workforce and deliver the best possible working experience for our people
PR3 Failure to collaborate with our system partners to reduce the need for hospital care
PR4 Failure to provide consistent excellent care as 'One Frimley' in the event that demand for services overwhelms capacity
PR5 Failure to deliver the Trust's financial plan and agreed trajectories
PR6 Failure to build on the investment in EPR and deliver the system benefits

The key elements of the BAF are:

- A description of each principal Risk and the associated risk appetite
- Risk scores informed by the Corporate Risk Register
- The strategic threats that are likely to impact on the principal risk
- Level of confidence that the annual strategic objectives will be delivered
- Level of confidence that the 2025 strategic ambitions will be achieved

Key to Strategic Objective/Ambition Ratings:

Confidence Level	Definition
1. Very likely	Almost certain achievement of strategic ambition
2. Likely	Well on track to achieve strategic ambition
3. Possible	Further action required to increase likelihood of achieving strategic ambition
4. Unlikely	Current trajectory indicates unlikely achievement of strategic ambition
5. Very unlikely	There is very little prospect of achieving the strategic ambition

Frimley Health NHS Foundation Trust
Risk Appetite Statement

- **Risk appetite** is the amount an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

- **Specifically:**

  - The aim of determining risk appetite is to provide an overarching framework for the conduct of the organisation
  - The risk appetite is defined by the Trust Board of Directors to provide guidance and principles in relation to risk management
  - The risk appetite provides a means of communicating the Trust's views and expectations on risk

- **Risk Appetite Statement for Frimley Health NHS Foundation Trust**

  - Frimley Health NHS Foundation Trust recognises that its long-term sustainability depends on the delivery of its strategic ambitions and its relationship with its patients, the public and its strategic partners within the ICS. The Trust endeavors to establish a positive risk culture within the organisation where unsafe practice, for example clinical or financial is not tolerated, and where every member of staff feels committed and empowered to identify, correct and escalate system weaknesses.

  - Accordingly, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks with regard to their impact on organisational issues. The Trust's greatest appetite is to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated within the constraints of the regulatory environment.

  - Risk appetite scores for each of the individual risks aligned to the Strategic Ambitions are recorded within the detail of the Board Assurance Framework, using the matrix attached at the end of the document, within a scoring range of 0 (no risk appetite) to 5 (acceptance of significant risk)

Strategic Ambition (SA1)	Improving Quality for Patients		
Strategic Objective 2025	FHFT to be in the top 10 trusts for safety and patient experience		
Principal Risk	Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm, poor clinical outcomes and poor patient experience		
Lead Executive	Chief of Nursing and Midwifery	**Risk Appetite: LOW**	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Industrial Action	**8**	**4x2**
Q2		Management of patients with mental health issues and learning disabilities	**16**	**4x4**
Q3		Water Drainage System	**16**	**4x4**
Q4		Ability to provide safe and effective maternity services	**12**	**4x3**
		Infection Control	**12**	**4x3**
		Aseptic Preparation Suite	**12**	**4x3**
		GP Referral and Advice and Guidance Management	**9**	**3x3**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve a CQC rating of 'Outstanding' overall alongside delivering improvements in Patient Experience (National Patient Experience Survey) and Safety (the Quality Priorities).

	Executive confidence level				
Measures	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
90% achievement of antibiotic screening within 1 hour. NICE Guidance NG51					
90% achievement IV antibiotics given in line with NICE Guideline. NICE Guidance NG51.					
Number of clinical accreditations (100) and out of hours quality visits (2 per site) completed by March 2025)					

Number of clinical accreditations (100) and out of hours quality visits (2 per site) completed by March 2025)					
FFT Percentage of Patients that feel overall they had a Good or Very Good Experience (Friends and Family Test)					
85% of complaints responded to within 60 or 40 days.					

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 Trusts in the country for patient safety and experience

Confidence Level	**Executive Confidence Level**				
1. Very likely **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
					The current challenges and level of risk exposure are impacting on our confidence level. However, achievement of the 2025 strategic objective is possible with further targeted action.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Shortfall in appropriately trained clinical staff or insufficient capacity in staffing establishment to meet rising NHS service demand may lead to increased incidence of avoidable harm and poor patient experience	• Workforce recruitment and retention projects with local, regional, and national funding streams. • Improved development of domestic supply • Defined safe medical & nurse staffing levels for all wards & departments • Daily staffing meetings to ensure transparency of staff resource and how risk is being managed • 'Teams in Distress' wraparound support including targeted recruitment and retention planning, OD and team development interventions as required • Ongoing discussions with NHS to influence national policy and backlogs • Ongoing review of IEN pipeline	• Workforce Governance Group (NWAG) in place with oversight of recruitment pipeline, domestic & IEN, retention, temporary staffing and rota controls • Monthly Performance Report to Board – including SPC analysis • Bi-annual Safe Staffing Reports to the Board • Establishment Reviews • Weekly reporting of key people metrics • Agreed trajectory for improvement on time to hire with weekly monitoring • Ongoing Managed Service Provider model for agency management. Demonstrating ongoing reduction in unit costs. • .Nursing staffing capacity risk score reviewed and reduced to 9 reflecting gains made in	Uncertainty of future IEN pipeline

	• Staffing hotspots identified and mitigation plan in place • Implemented a Managed Service Provider model to manage supply of agency staff • Completed establishment review and SLC approved right sizing nursing establishment across inpatient wards. Currently recruiting against establishment. Also SLC approval of ED and MADU establishments to reduce temporary workforce and recommendations on how long-term escalation use should be managed and staffed. • Funding secured to recruit to establishment • Recruitment team has sufficient capacity to recruit new staff	agency reduction (and average unit cost), turnover, retention and recruitment. Moderate risk remains reflecting reliance on IENs and resulting training needs and cultural adjustments, along with anticipated winter escalations.	
Demand: Sustained demand across the Trust sites leading to a loss of focus on patient safety and quality of care	• Winter planning and surge planning response • Formal SI review process with action planning and audit of changes in practice • CEO sits on ICB Board and chairs the Provider Collaborative Group • Chief Nurse attends ICB Quality Committee • Care Governance Committee and QAC triangulating safety, experience, effectiveness information • Patient Experience tracker and patient surveys • Insights from complaints and PALs • Weekly modelling of urgent care demand and IPC numbers to forecast and inform decisions through planning teams. • Multidisciplinary Urgent Care Board in place workstreams initiated to cover SDEC performance, Criteria Led discharge, and discharge planning pathways • Close working with ICB and system partners to plan, monitor and react to pressures through winter. • Every Day Matters programme in place to support reduction of Length of Stay and flow within FHFT hospitals.	• Monthly Performance Report to Board – including SPC analysis • National inpatient survey, PET, and Friends and Families test. • Quarterly reporting on the Quality Account and Patient Experience to QAC • Annual reports to the board including health and safety, patient safety, risk management strategy, maternity declaration, safeguarding, health & wellbeing, FTSU. • CQC insights report • National audit reports • Review of Safety FAB dashboards at Ward level • ICB oversight of patient demand and system response • Complaints Internal Audit (moderate assurance) • SE Regional Quality Dashboards	
An outbreak of infectious disease that forces ward closures or major re-configuration of patient pathways	• IPC Annual Plan in place, including IPC team structure, PICP and Board, Audit & Surveillance annual programme.	• QAC oversight of IPC reports, including nationally amended IPC BAF • Formal mortality reviews	

	• Programme of Post-Infection Review of mandatory reportable HCAIs (including nosocomial COVID) to identify actions and learning to be shared. • IPC online learning (both IPC Level 1 and Level 2) is supplemented by a programme of clinical-based education sessions, including hand hygiene and PPE use. • IPC Governance Structure headed up by HICC. The Built Environment Committee and Decontamination Steering Group. • The IPC Team work closely with the Frimley ICS and NHSE South East IPC Network, to ensure compliance with all national guidance	• SE Quality Dashboard with benchmarked information • ICB monitoring of community and prevalence of infectious diseases • Establishment of deputy DIPC role • Gram-negative bacteraemia reduction plan. • Responding to national guidance changes re: IPC measures for respiratory virus infections. • Water Safety and Ventilation Safety Subgroups in place and meeting monthly. Two-weekly meeting in place to complete action for the implementation of the NHS Standards for Healthcare Cleanliness. • The IPC Team has updated their IPC incident review matrix in line with PSIRF and is awaiting review with the Patient Safety Team.	
Human Behaviour: Supporting staff to maintain safety in a challenging environment of overwhelming demand for care, industrial unrest and workforce shortages	• Registration and re-validation of clinical staff • Formal SI Review Process with action planning and audit of changes in practice • Feedback from serious incidents & Never Events shared at cross site forums i.e. Patient Safety Committee, Medication Safety Committee • Collective review of all never events undertaken • Human Factors training programme in situ • Updating clinical guidelines and easy access for staff through use of Guideline App • EPIC optimisation around areas such as medication, administration and Ophthalmology • Additional initiatives to support morale and wellbeing through the periods of IA and IA recovery.	• Monthly Performance Report to Board – including SPC analysis • Ward assurance metrics • MaST training compliance • Board oversight of serious incidents • Clinical audit programme and monitoring • SLC and QAC oversight of SI workstream action plan • People Committee and Board oversight of wellbeing actions to support staff • Oversight dashboards of key safety and workflow metrics • Monthly Patient Safety learning TEAMs meetings for all clinical staff, nursing & medical • Continued implementation of mitigation measures during each strike round with review of effectiveness and any residual risk	

Strategic Ambition (SA2)	**Supporting our People**		
Strategic Objective 2025	To be in the top 10 best trusts to work for		
Principal Risk	Failure to realise our People Plan objectives and deliver the best possible working experience for our people		
Lead Executive	Chief People Officer	**Risk Appetite: LOW OR MODERATE**	

Cumulative Risk Score		**Informed by Current Corporate Risk Entries**	**Current Score (Q1)**	**Consequence and Likelihood**
Q1		Industrial Action	**8**	**2x4**
Q2		Completion of Annual Appraisal	**6**	**3x2**
Q3		Board Stability	**8**	**4x2**
Q4				

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Be a 'Great Place to Work' by delivering improvements in Employee Experience (National Staff Survey) and Retention (Turnover and Vacancies)

	Executive confidence level				
Measures	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Reduction in Trust vacancy rate (12.9% to 9%)					
Reduction in Time to Hire (79 days to 40)					
Agency spend capped at £1.8m per month					
Reduction in Trust Turnover (15.38% to 12%)					
5% improvement in staff recommending the Trust as a place to work					

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 best trusts to work for

Confidence Level	**Executive Confidence level**				
1. Very likely **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
					The current workforce challenges and external market factors, of which we have no control, suggest that we are unlikely to achieve the 2025 strategic objective. However, the delivery of the People Plan and further targeted actions are likely to improve the current trajectory. The NHS Long Term Workforce Plan will also support the strategic aim.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Inability to attract and retain staff due to external market factors resulting in critical workforce gaps in clinical and non-clinical services.	• Development of 3-year People Plan • HR monitoring reports on recruitment, retention & numbers of vacancies • Recruitment strategy/plans are in place, with active recruitment in place for hotspots • Processes to identify and escalate vacancy risks in place • Temporary staffing collaborative at system level • NHSE recruitment programme to reduce HCSW vacancies to zero. • Developing talent pool for prospective HCA roles • Focus on recruitment/retention of key staff groups critical to elective recovery • Expansion of HR Recruitment team • Implemented a Managed Service Provider model to manage supply of agency staff • Ongoing recruitment campaigns to fill vacant posts, at Heatherwood and Heathlands • Co design of ICS People Strategy and associated workplan with Partners across Frimley ICS	• The vacancy rate is 8.0% (May 2024) and lower for nurses & AHPs and doctors. • Sickness absence rate is 3.2% (May 2024). • People Committee and Board oversight of staffing levels • Reduction in Trust vacancy, rate, time to hire reduced from 76 (June 23) to 43.1 and turnover reduced to 10.6% (May 24). • Ongoing Managed Service Provider model for agency management. • Nursing Workforce Assurance Group continues to provide oversight and governance to working and operational groups. • Plan in place to address various retention, wellbeing, staff survey and other people actions.	External economic conditions and industrial unrest continue to impact on human behaviour with people choosing to retire or leave the service
A significant loss of workforce productivity due to reduction in staff availability, low morale and poor job satisfaction, which could adversely impact on patients and service users	• People at Work Plan in place to address various retention, wellbeing, staff survey and investors in people actions. • Retention strategy/plans are in place to help reduce unnecessary turnover • Leadership development programmes and leadership network in place • Access to coaching and mentoring • Management Essentials Programme in place • Management and Leadership Competency Framework developed • People Promise Exemplar site programme commenced • HR Business Partners developed action plans with areas of particular concern, monitored by senior HR and OD team	• Weekly reporting of turnover rates and monthly monitoring at corporate and directorate level • People Committee oversight of People Plan • EPOD oversight of People metrics • 100-day new starter and leavers surveys continue to be used to identify good practice and areas for improvement. • Retention target is 12%. Staff turnover in October was 11% • Plan in place around retention and part of People Strategy for 22/23 - implementing People Promise Exemplar programme - NHSE visit 30.08.23 - positive assessment on progress	

	• Cost of living measures - signposting staff to benevolent support		
Insufficient organisational focus on people or staff engagement which could lead to a lack of workforce cohesion and disengagement with the organisation (inconsistent values and behaviours in line with desired culture)	• Well-being activities and intervention • Action plan in place to address concerns raised in 2022 Staff Survey • Regular Executive Listening Events • Focus on more active consultation with different demographic groups • Implementation of refreshed EDI strategy and priorities incorporating six high impact actions, WRES and WDES • Management Essentials, Leadership Network and development programmes in place • Implementation of FHFT internal coaching network • Succession planning/talent management directorate planning for critical posts at tier 2/3 • Refresh of appraisal system to support talent management • Alignment of leadership and team effectiveness offering with Magnet4Europe and Continuous Improvement strategies • Measures to support and build talent from diverse and junior levels including reverse mentoring and stepping up programmes • Support for Teams in distress • People at Work Group to address a range of retention, engagement and wellbeing initiatives from staff surveys	• SLC oversight and directorate monitoring of staff survey action plan • Pulse survey results • Monitoring of WRES and WDES standards • People Committee oversight of People Plan • System leadership for six high impact actions on EDI • 100-day new starter and leavers surveys continue to be used to identify good practice and areas for improvement. • Launched the Culture & Leadership Programme	

Strategic Ambition (SA3)	Collaborating with Partners		
Strategic Objective 2025	To reduce the need for hospital-based care by working collaboratively with system partners		
Principal Risk	Working more closely with local health and care partners does not fully deliver the required benefits for patients		
Lead Executive	Chief Operating Officer	**Risk Appetite: HIGH**	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Industrial Action	**8**	**2x4**
Q2		Bed capacity and flow	**20**	**4x5**
Q3		ED Overcrowding and Performance	**20**	**4x5**
Q4		Winter pressures	**20**	**4x5**
		GP Referral and Advice and Guidance Management	**9**	**3x3**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve the 4hr A&E target (77% from April 2024) – ahead of National Targets and deliver improvements in our Non-Elective Length of Stay

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Reduce number of MFFD by 45 at peak to 180					
Reduce NEL LoS to 7.1 days					
Increase in % of patients that are discharged/admitted from ED within 4 hours from arrival					

Delivery of 2025 Strategic Objective by 31 March 2025: To reduce the need for hospital-based care by working collaboratively with system partners

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	Executive Confidence level				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
					Despite the high level of risk exposure and patient demand for hospital services, system partners are working collaboratively to reduce the need for hospital-based care. It is likely that the strategic ambition will be met.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Conflicting priorities of ICS partners, misalignment with financial plan and/or ineffective governance arrangements resulting in poor engagement, and limited ability to influence further service integration.	• Provider boards involved in developing ICS Strategy, Joint Forward Plan and UEC Strategy • Endorsement of ICB governance structure and shared workplan • CEO dialogue with system partners and other regional providers • Continued engagement with system partners to design new system operating framework • CEO chairs Provider Collaborative Group • FHFT Exec leadership allocated to the 5 ICS 'Places' • Work with ICB Board Partners and Non-Executive Members to ensure broad expertise and attention to constructing the ICB transformation delivery framework in the right way	• TMB oversight of strategic ambitions • Full Board engagement within Frimley ICS • Frimley ICS established and aligned with national guidance • Trust Board approval of Joint Forward Plan • System endorsement of revised 2023/24 Financial Plan	Significant system pressures impacting on delivery and recovery
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population which limits our ability to care for patients in the right place, at the right time	• Support Frimley ICS to deliver the Core 20 plus 5 approach - working jointly with place teams and partners to focus on 20 % of our most deprived population • Frimley ICB work with public health and other partners to improve uptake of immunisation and screening programmes • Frimley ICB take a population health management approach to target resources and programmes to areas of inequalities • Frimley ICB plan to embed an inclusive approach to engagement/co-production through the People and Communities Strategy • ICS Cardiovascular disease prevention group focused work to reduce the burden of CV disease morbidity and mortality • System Winter Plan in place	• Frimley ICB clarity of key delivery control information such as milestone planning, risks, issues, dependencies and benefits forecasting • Establishment of the ICB Transformation & Delivery Board to create a supportive forum, building on the success of the ICS Programme Delivery Board (2017 –2019) to ensure there is mutual accountability and visibility of risk to delivery	
A schism in relationships with professional groups arising from industrial action and NHS pressures at a national and regional level may negatively impact on collaborative partnerships and alliances within the ICS	• Regular dialogue with internal trade union representatives • Support from national and regional colleagues • System collaboration and agreement	• ICS People Board established with representation across partner organisations and Trade Unions. Programme of work underway with PMO oversight and assurance reporting • Continued implementation of mitigation measures during each strike round with review of effectiveness and any residual risk	

Strategic Ambition (SA4)	Transforming Our Services		
Strategic Objective 2025	To provide consistent excellent care as 'One Frimley Health'		
Principal Risk	Demand for services overwhelms capacity which adversely impacts on ability to deliver consistent excellent care as 'One Frimley'		
Lead Executive	Chief Medical Officer	**Risk Appetite: MODERATE**	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Waiting for diagnosis/treatment	**20**	**4x5**
Q2		Bed capacity and flow	**20**	**4x5**
Q3		ED Overcrowding and Performance	**20**	**4x5**
Q4		Winter pressures	**20**	**4x5**
		RAAC Roof Tiles at FPH	**20**	**5x4**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve the Cancer 62 day target (80% by March 2025) and Cancer 28 day Faster Diagnosis Standard (FDS) (85% by March 2025) ahead of National Targets, Achieve 113% in Elective Care – ahead of National Targets and, eliminate 65 Week Waits (by September 2024) – in line with National Targets, Deliver the Major Programmes that support Strategy Transformation including our CDCs, M Block and New Hospital Programme

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Reduce Waiting List – eliminate 65 week waits by September 24					
Deliver 85% theatre utilisation					
Deliver 85% day case rate					
Outpatient activity to be 46% new or follow up with procedure					

Delivery of 2025 Strategic Objective by 31 March 2025: To provide consistent excellent care as "One Frimley Health"

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	Executive Confidence level				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
					The current operational pressures are impacting on our confidence level to fully achieve the strategic objective. Targeted action continues to improve the performance trajectory.

Strategic Threats *What might cause this to happen?*	*Existing Controls* *How we are managing the risk*	Assurance on Controls *Evidence that the existing controls are effective*	*Assurance Gaps* *&* *Actions to address gaps*
Continued growth in demand for care arising from: **• An ageing population** **• Increased acuity leading to more admissions and longer length of stay** **• Flu epidemic or other infectious diseases** **• Insufficient primary care capacity to cope with patient demand**	• Integrated working with ICS partners on planning and delivery through winter • Planning for additional social care and care home capacity underway • GP escalation process in place • Improved volume to front door GP service, aiming for >15% • Working with system partners to reduce ED attendances and sign posting patients to alternative care pathways via NHS 111. • Development for replacement M Block beds for next winter – completion due December 2024 • Multidisciplinary Urgent Care Board in place workstreams initiated to cover SDEC performance, Criteria Led discharge, and discharge planning pathways • Establishment of 2 UCC in Slough and Aldershot to support patient demand • Continued working with ECIST with focus on discharge pathways to improve flow and reduce overcrowding in ED	• Site Assurance meetings twice daily on acute sites with multidisciplinary attendance. • Shared responsibility with Frimley ICS - close cooperation with system partners particularly around patients with extended length of stay and for those patients who are medically stable for discharge but require ongoing care. • UEC Strategy and Joint Forward Plan • System Winter Plan in place	
Reductions in availability of hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	• Creating capacity and improved access for SDEC services and ambulatory care services • Escalation capacity and clear escalation process utilised as required in order to manage peaks of demand. • Revised plans for Every Day Matters programme supported by QI approach, to drive improved discharge processes including board rounds, optimising TTO process and earlier discharge planning driven by EDDs • Planning for increased presence at weekends and bank holidays particularly through bank holidays to provide additional support to discharge Including MADE planned throughout the year	• Increase in % of patients that are discharged/admitted from ED within 4 hours from arrival remains a strategic objective. • Weekly ICS Gold level escalation calls. Each 'place' has onsite representation in order to support complex discharge. • Daily tracking of internal delays • New bed Escalation & De-escalation Policy completed • Every moment review of OPEL level for each acute site • Weekly LOS meetings and data review with COS • New bed Escalation & De-escalation Policy	

	• Work to drive compliance in use of Epic discharge functionality	completed with reference to ringfenced Parkside/elective beds	
Workforce: Shortage of clinical staff or fatigue leading to inconsistent service delivery	• Staffing hotspots identified and recruitment plans in place • GIRFT plan with clear priority areas drive for a "One FHFT pathway" across all sites and services. • Clinical prioritisation at each point of referral • Management of waiting lists through booking in priority order. • Harm reviews undertaken for any patients where potential harm may have occurred and any learning actioned	• Elective Recovery Reports to Board • Heatherwood Board chaired by DMD: oversight of elective waiting lists and Trust wide oversight through senior operational managers meeting and bi-weekly operational performance with ADs. • GIRFT Implementation Group monitors and reviews pathway implementation • Waiting list management and oversight through weekly operational managers meeting and bi-weekly operational performance with ADs. • Transformation Board	
Failure to meet the elective recovery trajectories which impacts adversely on funding and patients waiting for treatment.	• Elective recovery funding scheme and work programme in place for 2024/25 • Heatherwood Board established to maximise theatre activity and productivity through 'super week' activities • Established RAAC Planks Programme to manage the risks and minimise disruption on theatre usage at FPH from planned inspections and/or remedial works • Bed planning for NEL (SDEC) & EL ring-fenced beds to support national elective programme & return to 4hr standard • Winter plan to create cohorted areas for optimal management of urgent care pathways and LoS and protection of elective pathways by fully utilising the Heatherwood hospital capacity • Additional day case/OP activity to replace lost elective activity and WLI, opening of Heatherwood creates new 'green' space for activity. • Plan for Heatherwood to rollout additional treatment room capacity in Autumn '23.	• Elective Recovery Reports to FHFT Board • Senior ICB and regional engagement • Elective Care Steering Group oversight • Activity review meetings held between the Chief Operating Officer and Director of Finance, which includes an assessment of financial impacts, including the Elective Recovery Fund • Epic stabilisation work has improved elective activity reporting.	

Strategic Ambition (SA5)	Making Our Money Work		
Strategic Objective 2025	To be in the top 10 trusts in the country for efficiency		
Principal Risk	Failure to deliver the Trust's financial plan and agreed trajectories		
Lead Executive	Chief Finance Officer	Risk Appetite: MODERATE	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Operational Pressures adversely impacting financial performance	25	5x4
Q2		Medium term implications of financial environment	15	5x3
Q3		Reduction of Financial Freedoms	8	4x2
Q4		CIPs, Transformation Plans and Benefit Realisation	12	4x3

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve our Finance 'Income and Expenditure' Plan, Achieve our allocated Capital Plan

	Executive confidence level				
Strategic Objective	Q1	Q2	Q3	Q4	Rationale for confidence level that the objective will be achieved
Delivery of the 2024/25 Financial Plan					
Deliver of required efficiency target					

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 Trusts in the country for efficiency

Confidence Level	Executive Confidence level				
1. Very likely 2. Likely 3. Possible 4. Unlikely 5. Very unlikely	Q1	Q2	Q3	Q4	Rationale for confidence level that the strategic objective will be achieved
					The national financial constraints together with system accountability for break even suggest possible achievement of the strategic objective at this stage. The confidence level may increase as the year progresses with the delivery of the Finance Plan.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
A national reduction in funding, change in financial trajectory, or inflationary pressures resulting in a revised financial plan and requirement to reduce the financial deficit for the healthcare system	• Monthly financial monitoring processes and forecasts • Engagement at ICB and regional level, including pressing for additional funding for costs outside our control e.g. RAAC impairments and impact. • Keep abreast of changing financial regime requirement and influence regionally and nationally where possible • Development of 3-year finance plan with medium term financial modelling • Development of next FHFT 5-Year Strategy • Procurement support to all contracts to ensure optimal management of inflationary risks • Clearly articulate pressures not covered by funding envelope	• Board, Audit Committee and FIC oversight • ICB Finance and Performance Committee • Monthly Finance meetings with cost centre managers and directorates with increased focus forecast out turn and future years • Ensure alignment of planning assumptions with ICB	Uncertainty that transformation can be delivered at sustainable cost
The ICB system deficit results in a negative financial impact to the Trust.	• Financial plans developed in partnership with ICB colleagues for 23/24 • Collaboration with ICB on overall financial position • Investment Case Tracker in place to monitor business case spending • Capital plan in place with priorities identified • ICB dual focus on in year recovery alongside long-term financial sustainability. • Ensure alignment of planning assumptions with ICB	• FIC review of Trust and ICB's financial position • Capital Planning Committee • External Audit Unqualified Opinion on Trust's accounts for 2023/24 and with sufficient arrangements in place to achieve value for money • FHFT representation at ICB Board and other key decision-making forums. • ICB Director of Financial Sustainability appointed • System endorsement of revised 2023/24 Finance Plan	NHS Funding uncertain beyond next election
Failure to deliver the planned efficiency savings resulting in a higher deficit for the Trust and financial penalties	• Weekly CIP & Efficiency meetings are held with directorates chaired by COO or CFO with attendance of PMO and directorates. • Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board • PMO, Finance Business Partners and directorates meet on a weekly basis and prioritise directorates behind plan. • Additional CIP and efficiencies continuously being sought (including benchmarking and learning from ICBs in more formal turnaround)	• Benefits realisation reviews by FIC • Monthly finance report to FIC and TMB • Board oversight of Trust's financial position • Current forecast CIP delivery is in line with plan • Review of further opportunities with ICB System Sustainability group • ICS focus on strategic priorities including overseeing pan-ICS work streams to deliver financial balance and service changes and greater scale and pace than could be delivered by organisations individually	

Strategic Ambition (SA6)	Advancing Our Digital Capability		
Strategic Objective 2025	To be in the top 10 most digitally advanced Trusts in the country		
Principal Risk	Failure to build on the investment in EPR and deliver the system benefits		
Lead Executive	Chief Executive Officer	**Risk Appetite: MODERATE**	

Cumulative Risks to Advancing our Digital Capability		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Cyber Security	**16**	**4x4**
Q2				
Q3				
Q4				

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve the benefits of EPIC alongside the delivery of the Digital Projects Portfolio for this year

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
To be confirmed.					

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 most digitally advanced Trusts in the country

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	Executive Confidence level				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
					Despite the challenges encountered with the implementation of EPR, it is likely that the Trust will achieve advanced digital status by 2025.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
A large-scale cyber-attack that shuts down the IT network and causes major disruption to the availability of essential patient information for a prolonged period	• Regular review of Trust plans by NHS Digital • Regular Trust staff cyber risk awareness campaigns • Proactive alerts and response from Trust Cyber Team on NHS Digital CareCERT alerts specific to RDU • Trust Cyber Team hold Cyber accreditation and have CPD as part of Appraisal/PDP • Host based intrusion prevention systems • Anti-malware installed on all managed devices • SCCM Central Patch Management • Policies Standards & Procedures • Web filtering • Network Monitoring • Annual penetration testing • Vulnerability management • Web Application firewall • Large number of unsupported and Legacy systems are being managed as part of the Trust decommissioning programme of work with additional security controls implemented to lower risk of a security breach • Cyber Security training to be increased and form part of the refreshed IG mandatory training requirement for all staff. • Multi Factor Authentication (MFA) being rolled out to all staff to reduce the risk of compromised email accounts, this will be expanded to privileged network accounts to bring in line with NHS England policy change	• Data and Security Toolkit compliance with cyber security IG requirements • Oversight by IG and Audit Committee • Annual Internal Audit review of Toolkit evidence • Assurance dashboard in place to increase visibility of the network with a single, near real-time view to better manage vulnerabilities, remediation and compliance • Incident response plans finalised with EPRR – tabletop exercise complete • Due to the ongoing nature of the Cyber threat, and constantly changing threat landscape the cyber security risk remains on the corporate risk register – there is a continual programme of work with the Trust cyber security team to address new threats as they arise	
Insufficient capacity and capability in the digital team to advance the organisation's digital maturity	• Digital Services Oversight Group • Clear corporate plan of enabling digital projects • Ongoing support for EPR stabilisation/optimisation • Aspiration and focus areas for digital interventions and enablers are included in the Joint Forward Plan and are a shared priority for system partners	• ICB Digital Costed Plan for the Frimley system in place which provides a coherent focus on priority areas and risks to delivery • EPR Programme Board oversight of digital resource • Regular reports to FIC and Board	
Insufficient focus on Epic system optimisation leading to shortfall in financial benefits and clinical productivity	• EPR in optimisation phase with appropriate workstreams in place to realise system benefits • EPR Programme Board oversight of plans, risks and incorporating lessons learned from implementation • Workstream meetings created under new EPR Programme Director for Stabilisation	• EPR Programme Board oversight of all EPR matters • EPR External Assurance • Finance & Investment Committee review of EPR benefits realisation post implementation • Regular updates to Board and external stakeholders to provide assurance	

	• The EPR FBC equates to a series of cash releasing and non-cash releasing benefits which are tracked and monitored through EPR programme governance • A number of other programmes and BAU areas join up with EPR including Heatherwood, length of stay, elective recovery, and the people programme. • The lessons learned work continues with the NHSE Frontline Digitisation team. Focus has now moved to optimisation – plan for the future and lessons learned from other Trusts/what Frimley can add to lessons for those Trusts going live in future. • Ongoing escalation with Epic senior leaders regarding system issues • Regular liaison with NHSE	• TMB and IG oversight of all strategic initiatives and regular review by executive team • Stabilisation dashboard established and review incorporated into new and ongoing governance structure • Stabilisation and reporting plan agreed with PWC/NHSE • The stabilisation process is nearing completion Reporting has been a focus with a workstream focused on the statutory reports (DM01, CDS) which have now been submitted.	

Corporate Risk Register 2024-2025
May 24

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Frimley Health NHS Foundation Trust

Level of Risk	April	May	June	July	August	September	October	November	December	January	February	March
Extremely High	7	7	7									
High	6	6	6									
Moderate	8	8	5									
Low	2	2	2									
TOTAL	**23**	**23**	**20**									

New Risks / Risks Revised for 24/25

Descriptor	Grade
Capital and Resourcing to address built asset compliance	**16**

Risks Regraded or removed from the Risk Register

Descriptor	Previous Grade	New Grade
Epic Stabilisation - removed	**20**	0
Industrial Action	**12**	8
Board Stability	**16**	8

Likelihood	Consequence				
	Insignificant	Minor	Moderate	Major	Catastrophic
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

High Risk Tracker as at June 24

Chart Ref	Risk Name	Source	Current Score			Target Score	Score Trend			Date Risk Added
			C	L	R		Previous Month	3 months ago	6 months ago	
A	Bed Capacity & Flow	FH	4	5	20	8				Aug-21
B	ED Performance	FH	4	5	20	8				Apr-23
C	Winter Pressures	FH	4	5	20	8				Apr-23
D	Reduction in Financial Freedoms	FH	4	4	8	6				Nov-22
E	Waiting for diagnosis / treatment	FH	4	5	20	8				Oct-21
F	Medium Term implications of Financial Environment	FH	5	3	15	15				Jun-23
G	FPH RAAC Roof planks/tiles	FH	5	4	20	4				Aug-20
J	Cyber Security	FH	4	4	16	9				Oct-21
K	Operational Pressures Impacting Financial Performance	FH	5	5	25	6				Jun-23
L	Industrial Action	FH	3	4	12					May-23
M	Water & Drainage		4	4	16					Jun-23
N	Mental Health & Learning Disabilities	FH	4	4	16					Apr-23

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

	Risk Description				Initial Risk before controls are applied				Current Risk				Target Risk (appetite or agreed threshold if higher)					
Risk Number	Link to BAF	Risk Description	Source of Risk	Date Risk Added	Consequence	Likelihood	Total	Current Control Measures	Consequence	Likelihood	Total	If Current / Target risk, what Further Actions are being taken to close the gap	Consequence	Likelihood	Total	Actions owner	Review Date	Assurance Committee
1	SA 3&4	**Bed Capacity and Flow** We continue to experience high non elective demand together with high numbers of patients who are Non criteria to reside which in addition puts pressure on our elective capacity and plans. There is a risk that at times of peak or sustained demand, we will compromise patient care, specifically patient experience and patient safety.	Locally identified risk	Aug-21	4	5	20	* Comprehensive review of specialty ward layout and bed use completed on both acute sites. Hospital full policy in place utilising use of discharge lounge, fit to sit and boarding spaces in defined and risk assessed areas * Site Assurance meetings twice daily on acute sites with multidisciplinary attendance. * Close cooperation with system partners particularly around patients with extended length of stay and for those patients who are medically stable for discharge but require ongoing care. * Weekly LoS review meetings on both sites tracking patients with extended length of stay * 'Criteria to Reside' process in place to document reason for each patient required to remain in hospital. * Use of EPIC discharge functionality including EDD's * Weekly ICS Gold level escalation calls. Each 'place' has onsite representation in order to support complex discharge. * Daily tracking of internal delays * New bed Escalation & De-escalation Policy completed * Every moment review of OPEL level for each acute site	4	5	20	**Reviewed June 2024** * Continued live risk across both acute sites. Continued use of escalation beds and Opel status 3&4 in Q1 24/25 * COO continues to chair the monthly FHFT internal UEC board covering the four workstreams:- 1) Acute front door 2) 0 -72hr Workstream 3)Everyday matters 4) Pt flow - Clinical Site * COO Co-Chairs the monthly Frimley ICS UEC board which focuses on all system wide improvement programmes	4	3	12	Chief Operating Officer	Sep-24	Quality Assurance Committee
2	SA 4	**Waiting for diagnosis/treatment** Longer waits for diagnosis and treatment resulting in potential harm to patients	Locally identified risk	Aug-21	4	4	16	* Clinical prioritisation at each point of: referral, request for investigation, treatment agreed. * Management of waiting lists through booking in priority order. * Clinical validation programme contacting patients with no action undertaken in the previous 12 weeks or planned in the coming 12 weeks. * Waiting list management and oversight through weekly operational managers meeting and bi-weekly operational performance with ADs. * Non-clinical validation programme to review all waiting lists. * Harm reviews undertaken for any patients where potential harm may have occurred and any learning actioned * GP escalation process in place. * Oversight of clinical prioritisation by the Clinical Prioritisation Committee. * Weekly senior review of priority 2 patients over 4 weeks from DTA and cancer patients over 62 days.	4	5	20	**Reviewed June 2024** * Urgent and prioritised focus on EPIC data quality and reporting continues with Exec oversight and increased resource. Issues still being resolved and impacting on reporting and validation - work ongoing * Continued pressure on non elective demand requires daily management of capacity to ensure diagnostic activity is maintained with operational pressures requiring the use of Endoscopy for escalation beds * Additional day case/OP activity to replace lost elective activity and WLI, opening of Heatherwood creates new 'green' space for activity. * Further increasing 'grip and control' on management of list through winter to ensure focus is maintained. * Ring-fenced bed capacity to enable Endoscopy to function as a diagnostic space. * Templates review led by service with EPIC team to focus on correcting clinic templates designed to create more new patient capacity as well as support roll out of My Frimley Health app which will create capacity for operational teams. * Plan for Heatherwood to rollout additional treatment room capacity in Spring 2024 - now in place. * Further development of reports within EPIC to support oversight and grip of productivity metrics.	3	1	3	Chief Operating Officer	Sep-24	Quality Assurance Committee
3	SA 1	**Management of Patients in Mental Health crisis** Potential risk to safe management of both adults & children with mental health needs following exponential rise in presentations post pandemic, increase in complexity and acuity and length of stay. Risk of patients not receiving appropriate therapeutic intervention which could lead to further exacerbation & harm (for patients and staff). Risk of caring for patients in acute mental health crisis within acute hospital environment	Local Identified Risk/pandemic	Apr-23	4	4	16	* Band 8B MH Lead in post *Revised meeting and governance arrangements - MH/Acute/ED Interface group - MH working group, reporting to - Executive Safegaurding Committee * Violence Prevwntion Workng Group * RCRP bromze/silver tactical meetings * ED Frequent attenders/High intentsity user meeting * Mind and Body Programme reviewing - Enhanced Care Framework - Diversion from ED/Acute - Escalation pathway - Safe Harbour/Haven * Daily reporting and escalation through ops/COO/DepCNO regarding MH patients, detention status,length of stay, enhanced care needs * Epic risk assessment to support enhanced care needs * Audit and daily review of Epic risk assessmentsto inform deployment of available of resources * Development of bank MHCA role * Increase in CMAHS provision at FPH - funding, team composition, hours of service, and inclusion of NE Hampshire within service model * Direct engagement with agency RMN/MHCA workers to review handover, induction, supervision processes * Staff open sessions and updates * MH Clinical Education Lead on site 2/7 week supporting students *BDO audit Oct 2023 of MHA application and use. Resulting actions on track * Increased provison of de-escalation training (181 staff trained July-Dec 2023, plan for 270 Jan-July 2024) *Buckingham New University MH skills module, 21 completed Jan 24, further 30 due to start April 24 * MHA (Mental Health Act) training for site managers undertaken by SABP/BHFT (Berkshire Healthcare NHS Foundation Trust)	4	4	16	**Key actions as of April 2024** * Development of in house bank B3 MHCA role underway. x80 applications currently received to undergo 2 day training on enhanced care. * Enhanced care risk assessment developed within EPIC and in line with policy (expected Sept 23). launched 16/10/23 * Litigation and enviromental risk assessments being developed and embedded within EPIC (expected May 2024) * Security and clinical team interface meeting launched March 2024 reviewing incidents, interventions, restraint. * Business case written to support substantiove funding of MH B8b Lead (foxed term post due to end May 2024). Due to confirmed by end of April 2024 * Business case written to fund x2 B7 RMN site leads to support enhanced care assessments and delivery, training, supervision. * Working group established to review impact of Right care Right Place adoption by police * Receipt of SABP daily sit rep detailing current position, 136 capacity, bed state and outstanding referrals * Increase in training provision for ward staff * Liaison with HEI regarding accredited and non accredited MH courses and skills for non MH staff. Courses promoted and circulated * From Sept '23 commencement of 24/7 CAMHS provision at WPH * Core 13 CAMHS service at FPH in establishment. RC/Cons Psychiatrist and service lead in post. Ongoing recruitments to liaison teams. Service hours continue 08.00-17.00, to be extended upon further appointments * Sign off at Mind and Body Exec group April 2024 regarding SABP escalation policy, offering actions/responces at 4, 12 24 and 48 hour delay to admission * Commissioning Support Unit review of Adult MH services at FPH and WPH completed. Review of staff, partner, commissioner, service user feedback. Due for formal sign off 26 April 2024, and wider sharing, distribution and adoption of actions * Commissioning Support Unit review extended to incluide review of temporary staff supporting enhanced care needs (agency and bank) looking at indcution/orientation/appreciate and use of skills/supoervision. Due for formal sign off 26 April 2024, and for wider sharing, distribution and adoption of actions. * Engagement with South East Temporary Staffing Collaborative Mental Health project board * Review of site lockdown and ward access control provision acoprss all sites underway. Next meeet 07/05/24 **Updated 28th June 2024** *Business Case for teo additional B7 Registerd Mental Health Nurses, 1 for each acute site has been approved. *Recruitment underway and budger allocation for enhanced care has been distributed across clinical specialities	4	2	8	Chief of Nursing & Midwifery	Sep-24	Quality Assurance Committee

5	SA 1	**Maternity Services** Maternity services nationally are under intense scrutiny and required transformation. Failure to respond to national learning and direction could lead to loss in confidence and reputation locally	National Requirement / locally Identified Risk	Apr-23	4	4	16	* Birth-rate Plus completed 2020 recomoissioned for 24/25 * Detailed Staffing Plan in Place with robust escalation policies for times of peak demand. * Maternity recruitment improved significantly - Q3 plans to be fully recruited at Frimley Park site with minimal (<5WTE vacancies) at Wexhm Park site. * Maternity clinical outcomes are in line with national benchmarking * Maternity Governance Structures in place * Board Safety Champions, including monthly meetings established. * Oversight and challenge from an established LMNS (Local Maternity Network System) in place. * Maternity Improvement work commencing with CN and MD oversight * Ockenden Plan completed * Retention Midwife role established * Midwife to birth ratio reporting monthly	4	3	12	**June 2024 update** *Recruited // students who will qualify in October/November 24 and will enable full recruitment to be achieved at the Frimley Park site and minimal vacancies at the Wexham Park site. The service has not seen this midwifery establishment so complete in the past 7 years. * IEM pipeline to date we have employed 15 IEMs, this pipeline of recruitment has now been ceased in May 2024. *Build works to triage rooms at Frimley Park to enhance assessment process is being progressed alongside labour Ward Roof work to address RACC issues within trust. At the Wexham Park site reallocation of Day Assessment Unit to implement triage system more effectively in progress. * EPIC optimisation continues, and production of Obstetric Dashboard completed, data is much improved although there is additional manual collection of data to populate Dashboard which is shared through governance process by Heads of Midwifery. * National Maternity Dashbord reviewed monthly to determin if outliers in any of metrics reported * CQC report published for both sites maintained Good Rating Overall, action plan in progress with 2 outstanding actions that will be closed by end of quarter 2. *CNST year 5 compliance achieved, financial reimbursement confirmed. Progressing with year 6 to demonstrate compliance to trust board and ICB in January 2025. Submission of declaration to NHS Resolution due 3rd March 2025.	4	2	8	Chief of Nursing & Midwifery	Jun-24	Quality Assurance Committee
6	SA 3&4	**Emergency Department overcrowding and performance** Continued high volumes on emergency demand through both emergency departments with limited flow and tight bed capacity through the hospitals results in overcrowding and pressure in ED. Changes in primary care practice and the recovery of Covid backlogs has seen a significant increase in ED attendances on both acute sites, particularly for patients with minor illness and injury. There are no UTC/walk in centres supporting either Emergency Department currently. All of the above creates risk of increased ED occupancy, Ambulance queues and long waiting times leading to potential delay in patient treatment, ambulance delays to other calls, reduced quality of care, patient experience and patient safety and reputation risk. National requirements to improve waiting times for emergency care include reduction in waiting times for urgent ambulance attendances, over 76% of patients to be discharged from ED within 4 hours, reduction in patients waiting over 12 hours and reduction in LoS. From May 2023 FHFT returned to reporting the 4 hour access standard from previously working for several years to a pilot standard which encouraged patients to spend longer in the department while their treatment was delivered (CRS pilot). This is a significant change for the whole organisation which requires faster flow and behavioural change to deliver improved waiting times	National Requirement / locally Identified Risk	Apr-23	4	5	20	* 08.30 daily team brief monitoring activity and situation awareness in A&E for all Trust top leaders and assurance meetings throughout the day * Hospital at night handover meetings include monitoring and management of waiting times and overcrowding issues into the night * Implemented NHS 111 First criteria and planned appointments for 111 patients 24/7 across all age groups. * Brants Bridge Minor Injuries Unit reopened post COVID in order to provide an alternative pathway from ED for patients with minor injury. * Plans progressing to maximise use of SDEC and Ambulatory pathways to move activity away from ED help to reduce overcrowding * Multidisciplinary Urgent Care Board in place to manage Urgent Care Program including ED performance, SDEC, 111 First, and discharge planning pathways. * UEC improvement plan in place and active management includes: 1) Acute front door - with key focus on return to 4 hour standard, reduction in 12 hour attendance waits and ambulance handover times to support reduction in ambulance delays. Weekly Exec lead meetings in place to monitor progress 2) 0 -72hr Workstream - SDEC and assessment unit models to avoid admission where possible and reduce LoS 3)Everyday matters - to improve and expedite discharge and reduce LoS to create flow and capacity 4) Pt flow - Clinical Site *Fortnightly regional meetings to discuss the plans and progress	4	5	20	**Reviewed June 2024** * Working with system partners focussing on reducing ED attendances and sign posting patients to alternative care pathways via NHS 111. Dependent on primary care urgent care strategy; ongoing planning * GP minor illness pilot is in place at both Frimley and Wexham. Working with system partners and primary care to continuously improve this service to maximise benefit through winter * Parallel work underway, overseen through the UEC strategy group reporting to UEC Board, UCC agreed to be located in Slough and Aldershot aim for opening service for MiMi November 2023. Completed with review underway for 2024/25. To conclude this review through the 2024/25 ICS UEC Board in Q.2 2024/25. * Continued focus on eliminating ambulance handover waits through use of agreed Ambulance Handover SOP with supported escalation for nursing cover or booking of ambulance technicians to care for patients when queues do occur * Continued working with ECIST with focus on discharge pathways to improve flow and reduce overcrowding in ED * Review of better use of SDEC pathways to stream patients either directly to SDEC's or quickly from ED to specialist services * Improved volume to front door GP service, aiming for >15% * IPS agreed and shared with the Trust, education and comms plan to be completed * EPIC ED dashboard in progress with escalation triggers * Surgical SDEC opened at WPH March 23 * Frailty Assessment trolleys returned at FPH March 23 and opened at WPH in April 23 - completed however high risk for OOH capacity crisis * Reintroduction of EAC model underway through NEL improvement plan - November 2023 * Fit 2 Sit cubicles Majors implemented to reduce loss time for ambulance handover	4	2	8	Chief Operating Officer	Sep-24	Quality Assurance Committee
8	SA 2	**Completion of Annual Appraisal** Completion of Annual Appraisal and Health and Wellbeing conversation Risk of lack of completion of annual appraisal in line with organisational targets Risks adversely effecting staff and performance and development Impact of Covid-19 on appraisal compliance	Locally Identified Risk	Jan-20	4	4	16	* Recording of annual appraisal completion (and ratings) on ESR * Monthly reporting of completion rates to senior managers * Open access MaST System provides matrix completion data * Reporting to: Operational People Committee Quality & Performance	3	2	6	**Reviewed June 2024** * Steady improvement in Appraisal compliance rates, Non Medical 85% Medical at 95% compliance both at/above threshold * L&OD reviewing entire Appraisal process. Appraisal policy going through ratification * Look to remove once policy has been approved	4	1	4	Chief People Officer	Sep-24	People Committee
9	SA 4	**FPH RAAC Roof planks/tiles** The natural deterioration of FPH RAAC roof planks which are in c60% of the hospital since it was built in 1974, results in a limited life expectancy such that NHSEI require these as well as RAAC present in the walls to be eliminated by 2030. RAAC planks will deteriorate over time and this can be exacerbated by: water pooling in gutters and leaking roofs lead to softening of roof RAAC planks and corrosion of the rebar, roof planks damaged due to excess weight on the roof due to the installation of new plant and equipment on the roof or existing plant and other objects with excess weight, roof planks damaged due to people walking on the roof, roof planks damaged due to snow and ice. Therefore there is a risk of injury or death to patients, visitors, and staff due either to delamination of a roof plank whereby a part of it falls, or a sheer collapse with no warning due to limited bearing on the concrete support beam..	Survey and annual risk assessment by structural engineer. NHSI/E action plan including a deadline of 2035 to remove RAAC planks. Trust identified as one of 3 high priorities	Aug-20	5	5	25	* RAAC Planks Programme established to manage the risk with 2 projects: Maintaining Safety, & Contingency planning * Remedial works in response to structural surveys have been undertaken since 2012 at a cost of c£5m prior to 2020/21. Programmes of remedial works have been undertaken in 20/21 and 21/22. £9.5m programme of remedial works for 2022/23 has been completed. * Surveys have been carried out by structural engineers who have highlighted high priority areas for remediation works. Annual routine surveys of all RAAC Planks commenced and were completed for 2022/23, including 'hard to access' areas * Trust Estates and Facilities staff and contractors including the fire brigade have been made aware of the issue and correct ways to access the roof. * A Roof access policy has been developed to ensure that loading on the roof is kept to a minimum. * There is a detailed RAAC Plank programme risk register	5	4	20	**Reviewed June 24** * Works to support end bearings is one site and the rolling programme of full fail safe works continue alongside annual surveys of all unsupported planks * Regular Communications to all staff to raise awareness of warning signs so that these can be acted upon promptly have been undertaken and will continue. * A series of business continuity plans have been written. Exercises involving ICU have been undertaken and further exercises are planned in respect of FPH 'Streets'. Planning to continue in relation to large scale evacuation exercise to involve ICS and other key partners. *Following the completion of a Strategic Outline Case to eliminate RAAC, the Trust has now been included in the government's New Hospitals Programme with the prospect of a new FPH whereby RAAC can be eliminated. This means that works to maintain safety must continue until the new hospital can be brought into use. * M Block redevelopment is due to complete in December 24 with the upper floor wards becoming operational in early 2025. This will release 18 beds for RAAC plank decant to facilitate the rolling programme of fail safe works * 2024 annual report received which recommends installation of end bearing supports in all first floor wards that have RAAC planks, plus a rolling programme of failsafe works in all first floor wards starting with F1 (currently on site), F5 (in design), F11 (in design). Also the continuation of works in Theatres 9 and 10 (on site), CDS (on site), C block (completes in July 24, except the computer room) and outstanding works adjacent to theatres 3 and 4 (planned for new year). A programme of all other outstanding areas to then follow as decants allow. * End bearings and high risk planks in F5 and F11 have been added to this programme following Gurney's 2024 report.	5	2	10	Chief Strategy Officer	Jul-24	Finance & Investment Committee

10	**SA 6**	**Cyber Security** A large scale cyber-attack could shut down the IT network and cause major disruption to the availability of essential patient and other information for a prolonged period	Strategic Objectives	**Oct-21**	4	4	16	* Regular review of Trust plans by NHS Digital • Data Security and Protection Toolkit compliance with cyber security IG requirements • Oversight by IG Committee • Internal Audit annual review of Toolkit evidence • Regular Trust staff cyber risk awareness campaigns • Proactive alerts and response from Trust Cyber Team on NHS Digital CareCERT alerts specific to RDU • Trust Cyber Team hold Cyber accreditation and have CPD as part of Appraisal/PDP * Host based intrusion prevention systems * Anti-malware installed on all managed devices SCCM Central Patch Management * Policies Standards & Procedures * Web filtering * Network Monitoring * Annual penetration testing * Vulnerability management * Web Application firewall * Assurance dashboard to increase visibility of the network with a single, near real time view to better manage vulnerabilities, remediation and compliance • Multi Factor Authentication (MFA) being rolled out to all staff to reduce the risk of compromised email accounts	3	3	9	**Reviewed June 2024** * Large number of unsupported and Legacy systems are being managed as part of the Trust decommissioning programme of work with additional security controls implemented to lower risk of a security breach • We are continuing to work closely with the EME team on ensuring medical devices will meet all necessary security requirements • Cyber Security training to be increased and form part of the refreshed IG mandatory training requirement for all staff. • Incident response plans finalised with EPRR – tabletop exercise undertaken but will continue to be built upon. • Work being undertaken to improve compliancy to the Data Security and Protection Toolkit (DSPT) moving closer to a "standards met" status • Multi Factor Authentication to be expanded to privileged network accounts and access to all remote systems to bring in line with NHS England policy change • Data backup infrastructure being reviewed due to legacy solution not performing optimally and the requirement for immutability of data to be met. Due to the ongoing nature of the Cyber threat, and constantly changing threat landscape it is recommended that the risk should remain on the corporate risk register – there will be a continual programme of work with the Trust cyber security team to address new threats as they arise	3	3	9	Chief Executive	Aug-24	Audit Committee
11	**SA 5**	**Medium term implications of financial environment** There is uncertainty in the medium term outlook which may adversely impact the Trust financially, with a risk that the Trust will be unable to meet its breakeven control total in the current and future years. Pressures include inflation continuing to run significantly higher than funding levels, and although Covid funding has largely ceased the Trust is still incurring a higher cost base following the pandemic. NHS Funding uplifts uncertain beyond next election	Financial	May-24	5	4	20	* Monthly financial reporting through EPODG and Financial Investment Committee * Monthly Finance meetings with cost centre managers and directorates with increased focus forecast out turn and future years * Medium term financial model, with regular reiterations * Procurement support to all contracts to ensure optimal management of inflationary risks * Clearly articulate pressures not covered by funding envelope • Uncertainty that transformation can be delivered at sustainable cost	5	3	15	**Reviewed June 2024** * Ensure alignment of planning assumptions with ICB * Development of next FHFT medium term Strategy • Keep abreast if changing financial regime requirement and influence regionally and nationally where possible	5	3	15	Chief Financial Officer	Jul-24	Finance & Investment Committee & Trust Board
12	SA 5	**CIPS & Transformation Plans & Benefits Realisation** The Trust has a CIP target of £45m for 2024/25. Targets include a mixture of Directorate and Transformational schemes. At the beginning of the May £41.4m of plans had been identified with £16.4m fully developed and £24.7m with plans in progress. The risk of not delivering the full savings target would be that the Trust will not be able to remain within its breakeven financial envelope for the year.	Financial	May-24	5	4	20	* Weekly CIP & Efficiency meetings are held with directorates chaired by COO or CFO with attendance of PMO and directorates. * Monthly reporting of CIP and Efficiencies to EPODG and Financial & Investment Committee. * Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board	4	3	12	**Reviewed June 2024** * The current forecast CIP delivery is in line with plan with 72% expected to be delivered recurrently * PMO, Finance Business Partners and directorates meet on a weekly basis and prioritises those directorates who are behind plan. * Additional CIP and efficiencies continuously being sought (including benchmarking and learning from ICBs in more formal turnaround) * Review of further opportunities with ICB System Sustainability group • ICS focus on strategic priorities including overseeing pan-ICS work streams to deliver financial balance and service changes and greater scale and pace than could be delivered by organisations individually	3	2	6	Chief Financial Officer	Jul-24	Finance & Investment Committee & Trust Board
13	**SA 5**	**Operational Pressures Adversely Impacting Financial Performance.** There is a risk that operational pressures result in higher length of stay (LoS) for patients than planned which in turn leads to higher numbers of open escalation beds and increased agency staffing. There is a risk if the Trust falls being its financial plan that it has restrictions placed upon it either at a system or regulator level.	Financial	May-24	5	4	20	* Daily management of pressures though operational teams including bed capacity and flow * Weekly meetings with ICB colleagues on operational pressures * Demand and capital plans mapping bed requirements throughout year including planned ward closures / openings * Clear articulation of financial consequences of excessive LoS (and consequential impact on elective capacity) * Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board	5	4	20	**Reviewed June 2024** * Further engagement with neighbouring ICBs on discharges (additional risk their financial pressures will disincentivise discharging patients in our hospitals) * Maximise use of community and virtual ward capacity * De-escalation plan implementation	3	2	6	Chief Financial Officer	Jul-24	Finance & Investment Committee & Trust Board
14	SA 5	**Reduction of Financial Freedoms** There is a risk if we do not achieve a financial break-even, additional controls will be put in place by NHSE.	Financial	May-24	4	4	16	* Current submitted plan does not deliver breakeven but was submitted in alignment with system position. * Monthly financial reporting through to EPODG and Financial Investment Committee to Trust Board * CIP & Efficiency meetings / processes * Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board * Reporting to ICB Finance & Performance Committee * Collaboration with ICB on overall financial position	4	2	8	**Reviewed June 2024** * Continue with all current controls / actions throughout 2024/25. * Identification of further areas for CIP and Efficiencies, including learning from neighbouring ICBs in even worse financial positions * Continue with budget holder training which begun in 2023/24. * Roll-out of no PO, no pay is being implemented over the summer. * Increased oversight from sub-board committees of actions being taken.	2	2	4	Chief Financial Officer	Jul-24	Finance & Investment Committee & Trust Board
15	**SA 1**	**Aseptic Preparation Suite** The pharmacy aseptic suite at Wexham Park makes individualised chemotherapy for patients having cancer treatment. The unit structure no longer meets the technical requirements and has been assessed as high risk by the NHS Quality Control service. Additionally the two isolators are reaching the end of their useful life and require replacement on order to maintain the service. A replacement of the unit and isolators is required as failure of the unit would result in the Trust not being able to treat cancer patients with chemotherapy.	Locally identified risk	Feb-23	4	4	16	* Completion of actions as advised by the QC inspection including remedial works to the current unit. * Progression of design works to support the business case for a replacement unit * Monthly inspections of fabric of the unit with remedial actions prioritised as necessary	4	3	12	**Reviewed June 2024** * Outline case on options to improve either the Aseptic Unit itself and/or options for a regional hub model for this service has been discussed at EPOD through May and June 2024. Trust is actively looking at capital options (including a modular unit). EPOD will consider this final case option in July 2024. * Revise contingency plans for unit in the event of the need to complete remedial works or failure of testing - this is now completed and shared with the Executive Team in May 20224. * Completed revised daily to strategic staff planning process - June 2023 * Close monitoring of situation and regular national quality inspections in place	4	3	12	Chief Operating Officer	Jan-24	Quality Assurance Committee

16	SA 1,2 &3	**Industrial Action** No imminent resolution of the junior doctor dispute, placing continued reliance on consultants and other staff to cover during IA. Consultants have balloted on IA and a proportion of FHFT consultants have stated they will not cover IA for less than the BMA rate card. We may be unable to provide safe cover for the Trust during IA or could be forced to pay unaffordable rates to consultants (the BMA rates are an increase of approximately 100% over current rates). There is a wider risk of disruption across various professions balloting to strike and that the ongoing IA will impact morale as well as patient care and waiting lists. Further risk as from 10/8/23, Trusts no longer able to utilise locums to backfill people on strike	Locally identified risk	May-23	4	5	20	Mitigations include * local negotiation with the JLNC to ensure that consultants support critical areas for Junior Doctor IA. * Optimising use of locums, SAS Doctors, nurse practitioners and other staff. * Extensive strike planning led by EPRR team. * Comparable planning ongoing for consultant strikes. * HR planning including the Pay Assurance Group oversight of IA rates for appropriate roles, including alignment with other Trusts in the region and nationally. * Additional initiatives to support morale and wellbeing through the periods of IA and IA recovery.	4	2	8	**Reviewed June 2024** * Continued implementation of mitigation measures during each strike round with review of effectiveness and any residual risk * Business continuity plan in place for Doctors strikes and currently BAU * Monitoring the potential of nursing actions * Monitor the progression of the Agenda for Change payscales - inline with the general election * Monitor the progression of new Junior Dr strikes	4	2	8	Chief People Officer	Jun-24	People Committee
17	SA 1	**Water & Drainage Systems** Due to an aging estate and a concurrent program of redevelopments, extensions and revisions to the water and drainage system to accommodate expanding services, there is a risk to the integrity and safety of the water and drainage systems across the trust sites. Water and drainage systems can be a reservoir for infections which can impact patient and staff safety, access, experience, and trust and confidence in our services	Locally identified risk	Jun-23	4	4	16	* Water Safety Group meeting monthly (with increased frequency as required). * WSG reporting to Built Environment Committee, reporting to HICC, reporting to QAC. * Quarterly and annual IPC reporting of HAIs, to CGC, QAC, Execs and Trust Board * Well established process of reporting, SII, and outbreaks as required. * Access and use of regional and national expert advice as required. * IPC BAF reported to Board by exception * Continual surveillance and reporting of trends/risk/concerns by IPC team * Monthly Capital Group Meeting reviewing all change/development requests with involvement and consideration of IPC impact * Existing refurbishment program to replace and refit aging and out of date sinks, drains and environment (eg removal sensor taps and TMV) * Authorised Water Engineer role in post * Proactive programme of water flushing and testing across site (legionella and pseudomonas) * Enhanced testing for augmented care areas (ITU, once, renal) * Use of tap filters to support legionella risk as short term measure * Point of use signage promoting appropriate use of available sinks * Hand hygiene audits and inspections regularly undertaken IPC audits and inspections * Availability of alcohol gel * Appropriate use of PPE and glove reduction program * Active program of system inspection and maintenance * Housekeeping team undertaking cleaning of sinks and showers, faucets as daily task	4	4	16	**Reviewed June 2024** * Removal of all dead legs (section of pipework with no active flow) where accessible - underway and ongoing. * Increased consideration and risk assessment for alterations and extensions to existing water/drainage system as part of Capital Group Meeting and impact creation of dead legs/disruption of biofilms * Drainage surveys being completed and blockages removed * Rationalisation of sinks in clinical areas being undertaken * Ongoing CPE Outbreak meetings at WPH , although reduced frequency since August due to redcuing incidents and time requred for remaining actions. Meetings attended by National lead from New Hosp Prog, regional UKHSA and IPC and local estates/leads impacted. * Increased IPC training and support in key areas, along with audit and inspections. * Local comm prepared for key areas (eg Eden ward, W5/6/7/8) with regard to sink rationalisation and increased screening, alcohol gel use after hand wash. * Business case approved for increased surveilance and testing of CPE (to include admission/discharge of Eden, W5/6/7/8) * Trial of disolvable hand towels within high risk area (maternity) to help reduce incident of blockages * Review and consideration for waterless environments (currently ITU and Interventional Radiology scoping options) * Scoring reviewed - whilst initial actions and interventions appear to show decreasing incidents in previously identified high risk areas, consequence and likelihood remain 4x4.	4	2	8	Chief Nurse / Chief Executive	Jun-24	Quality Assurance Committee
18	SA 2	**Board Stability** There are risks to Board stability arising from a high turnover of executive directors and imminent NED departures which will impact on the continuity and experience of the Trust Board	Workforce	Aug-23	4	4	16	* There is an opportunity to increase diversity and enhance the board skills mix through director recruitment * An experienced interim Director of Finance is in place until a substantive appointment is made. The previous Director of Finance continues to be employed at FHFT which ensures a link with legacy financial information * Deputy Directors & Corporate teams * Key posts of Director of Finance & Chief Nursing Officer appointed to, commence January 24	4	2	8	**Reviewed June 2024** * Most of the senior positions within the board are now recruited to with interims in place for CEO and COO * Awaiting the arrivial of the new CEO expected end of August	4	2	8	Chief Executive	Jul-24	People Committee
19	SA 4	**Capital and resourcing to address bulit asset compliance** There is a risk that there will be insufficent capital to undertake all remedial and mitigation works necessary to ensure that the Trust's built in assets and infrastructure achieve an acceptable level of performance.		Jun-24	4	4	16	*Continuous confirmation of prioritisation of spend especially where existing commitments may enable the shifting of captal *Further developent of the capital priortisation process introduced in 2023/24 *On-going invetment in specialist resource within the Trust to provde greater internal focus on compliancy issues at senior levels in the Trust *Greater emphasis on the importance of compliancy and investment and infrastruture as part of the prioritisation of works in the bulit environment *Improved data collection and investment in digital approaches to monitoring perfromance (linked to the New Frimley Park Hospital MVP of "smart hospital" and NHP "levelling up" agendas	4	4	16	**New Risk** - June 2024	4	2	8	Chief Strategy Officer	Sep-24	Finance and Investment Committee

20	**SA 1 & 3**	**<u>Gp Referral and Advice & Guidance Management</u>** 3 processes to manage integration of GP referrals and A&G requests between ERS (Electronic Referral System) and EPIC for onward clincial management - Referal upload to EPIC - live since July 22 - Triage return to GP - live since September 22 - Advice and Guidance management - live since 18/12/23 - inconsistent error recording Risk related to:- - inconsistent daily 'bot' productivity - 33% reduction in daily productivity since EPIC Upgrade in Aug 23, causing delays in referral upload and downstream processes. - significant backlog in triage comments being fed back to primary care - Insufficient 'bot' resource since the reduction in productivity post EPIC upgrade Any delays in any part of the process affects communcation with primary care, with possible clinical and Trust reputational risk		Dec-23	3	5	15	* Daily uploads for all processes for onward automation processes * Daily error reports to identify any referrals/traige or requests that fail or are deferred in process * Manual action to manage errors * 2ww referrals prioritsed throughout the automation and manual error process * Triaged referrals rejected by clinician prioritised in triage proces	3	3	9	**Reviewed June 2024** * Full validation exercise to review all referrals on ERS comparing to EPIC to idenfify any gaps * Prioritisation of rejected and 2ww referrals in triage process * Manual error management when reported. * Bots have been stable and productive for an extended period - significantly reduced interruption/downtime - Development of API direct integration between ERS and EPIC in summer 2024 should provide greater consistency and less manual intervention	3	1	3	Chief Operating Officer	Jun-24	Quality Assurance Committee

Report Title	Standing Financial Instructions
Meeting and Date	Public Board Meeting Friday 5th July 2024
Agenda Item	14.
Author and Executive Lead	Stephen Jones (Director of Operational Finance), Charles Porter (Deputy Chief Financial Officer), Kish Sidhu (Chief Financial Officer) – Executive Lead.
Executive Summary	The Standing Financial Instructions are submitted for approval as part of the Annual Review. They have been reviewed by the Audit Committee on 20th May 2024.
Action	The Board is asked to approve the Standing Financial Instructions.
Compliance	The paper is presented to Board as part of the annual requirement to review the Standing Financial Instructions.

STANDING FINANCIAL INSTRUCTIONS

2024

Draft

Version Control Sheet

Version	Date	Author	Status	Comment
0.1		Director of Operational Finance	Draft	Changes made to reflect change of names, posts and references to Acts of Parliament.
0.2		Director of Operational Finance	Draft	Changes to Scheme of Delegation for authorization of expenditure (Appendix 4)
0.3		Director of Operational Finance	Draft	Changes within the tendering & procurement section to aid clarity Changes to Charitable Funds authorization limits
1.0	Nov 2018	Director of Operational Finance	Final	Ratified at Board
2.0	Feb 2020	Director of Operational Finance	Final	Approved at SLC February 2020
2.1	Mar 2020	Director of Operational Finance	Interim	Amendment to tables in appendices 1 and 3 to bring the thresholds for OJEU up to date and amendment of the period.
3.0	Mar 2021	Director of Operational Finance	Final	Amendments made to reflect changes in personnel over the last 12 months. Full list of changes can be found on page 92 Ratified at Audit Committee and Board meetings Feb/March 2021

4.0	APR 2022	Director of Operational Finance	Draft	Recognise IMS controls, update values for hospitality, approval to recruit process, recognising social value in procurements
5.0	Nov 2023	• Amendments to replace reference to Senior Leadership Committee with Trust Management Board • Scheme of Delegation section 3 amended to require CEO written approval for unbudgeted non-pay expenditure		

Document Location

Document	Location
Electronic	Trust intranet (ourplace)
Electronic	Trust internet (fhft.nhs.uk)
Paper	On request from Finance Department

FOREWORD

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

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

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

4. Any queries should be referred to the Chief Financial Officer who can delegate as appropriate.

1. INTRODUCTION

1.1 GENERAL

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

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and the requirements of the Independent Regulator in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

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

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

1.2 TERMINOLOGY

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

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

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

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

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

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

f) **"Chief Executive"** means the Chief Executive Officer of the Trust;

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

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

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

j) **"Chief Financial Officer"** means the Chief Financial Officer of the Trust;

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

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

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

n) "**NHS England (NHSE)"** is the name of the regulator governing NHS Foundation Trusts whose duties were formerly undertaken by Monitor. Any reference to documents, guidance or direction issues by NHSE will refer to either this body or its predecessor body;

o) "**Nominated Staff** means staff charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

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

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

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

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

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

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

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

1.2.2 Wherever the title Chief Executive, Chief Financial Officer, or other nominated staff is used in these instructions, it shall be deemed to include such other director or staff who have been duly authorised to represent them.

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

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Trust's Constitution - Standing Orders for the Board of Directors.

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

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

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

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

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

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

(b) avoiding loss;

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

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

1.3.7 Any contractor or staff 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. This empowerment must be explicitly documented and retained by the Chief Executive.

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

1.3.9 The Chief Financial Officer will be responsible for implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.

2. AUDIT

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

2.1 AUDIT COMMITTEE

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

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

2.1.3 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 an internal audit service provider is changed.

2.1.4 The Audit Committee shall appoint the Internal Auditors.

2.2 FRAUD, BRIBERY and CORRUPTION

2.2.1 In line with their responsibilities, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance with guidance issued by the Regulator or the NHS Counter Fraud Authority on fraud, bribery and corruption in the NHS.

2.2.2 The Chief Financial Officer is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, will ensure that the Trust cooperates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

2.2.3 The Trust will nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist, as specified by the NHS Counter Fraud Authority. The Trust will also appoint a Local Counter Fraud Champion (an internal employee) to support the Chief Financial Officer and the Counter Fraud Specialist in their responsibilities.

2.2.4 The Chief Financial Officer will ensure that the Trust's Local Counter Fraud Specialist has received appropriate training in connection with counter fraud measures and are accredited by the Counter Fraud Professional Accreditation

Board.

2.2.5 Where the Trust appoints a Local Counter Fraud Specialist whose services are provided to the Trust by an outside organisation, the Chief Financial Officer must be satisfied that the terms on which those services are provided are such to enable the Local Counter Fraud Specialist to carry out their functions effectively and efficiently and, in particular, that they will be able to devote sufficient time to the Trust.

2.2.6 The Local Counter Fraud Specialist shall report to the Trust's Chief Financial Officer and shall work with NHS Counter Fraud Authority as required.

2.2.7 The Local Counter Fraud Specialist and the Chief Financial Officer will, at the beginning of each financial year, prepare a written work plan outlining the Local Counter Fraud Specialist's projected work for that financial year.

2.2.8 The Local Counter Fraud Specialist shall be afforded the opportunity to attend Audit Committee meetings and other meetings of the Board of Directors, or its committees, as required.

2.2.9 The Chief Financial Officer will ensure that the Local Counter Fraud Specialist:

(a) keeps full and accurate records of any instances of fraud and suspected fraud;
(b) reports to the Board any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;
(c) has all necessary support to enable him to efficiently, effectively and promptly carry out his functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;
(d) receives appropriate training and support, as recommended by NHS Counter Fraud Authority; and
(e) participates as appropriate in activities which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

2.2.10 The Chief Financial Officer must, subject to any legal constraints, require all Staff to co-operate with the Local Counter Fraud Specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

2.2.11 The Chief Financial Officer must also prepare a "fraud response plan" that sets out the action to be taken both by persons detecting a suspected fraud and the local counter fraud specialist, who is responsible for investigating it.

2.2.12 Any Staff discovering or suspecting a loss of any kind must either immediately inform the Chief Executive and the Chief Financial Officer or the Local Counter Fraud Specialist, who will then 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, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the Local Counter Fraud Specialist.

2.2.13 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Financial Officer must immediately notify:

(a) the Board of Directors; and

(b) the auditor

2.3 CHIEF FINANCIAL OFFICER

2.3.1 The Chief Financial Officer is responsible for:

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

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

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

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

2.3.2 The Chief Financial Officer and appointed auditors (both internal and external) are entitled without necessarily giving prior notice to require and receive:

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

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

(c) the production of any cash, stores or other property of the Trust under staff control; and

(d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report upon:

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

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

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

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

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

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

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

2.4.4 The Head of Internal Audit shall be accountable to the 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 the *NHS Internal Audit Manual*.

2.5. EXTERNAL AUDIT

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

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

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

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

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

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

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

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

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

(g) to certify the completion of the audit;

(h) to express an opinion on the accounts;

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

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

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

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

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

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

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

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive and Chief Financial Officer will compile and submit to the Board an annual business plan. The annual business plan will contain:

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

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

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

3.1.2a The Annual Plan should be underpinned by the 5 year strategic plan prepared by the Director of Strategy and presented to the Board of Directors for approval by the Chief Executive.

3.1.3 At 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 5 year strategic plan;

(b) accord with workload and workforce plans;

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

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

(e) identify potential risks.

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

3.1.5 Staff shall provide the Chief Financial Officer with information as necessary for the compilation of such budgets, plans, estimates and forecasts.

3.1.6 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.

3.1.7 Operating surpluses may be used to:

(a) spend on revenue;

(b) meet locally determined health needs;

(c) build cash reserves for future investments;

(d) finance an investment or purchase;

(e) make payments on a loan.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive on the advice of 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; and
(f) the provision of regular reports.

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

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

3.3 BUDGETARY CONTROL AND REPORTING

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

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

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

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

(iii) summary balance sheet;

(iv) movements in working capital;

(v) capital projects spend and projected outturn against plan;

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

(vii) performance against any permissible borrowing or covenants;

(viii) details of any corrective action where necessary and the Chief Executive's and/or 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.

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

3.3.3 Each Budget Holder is responsible for ensuring that:

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

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

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

(g) the systems of budgetary control established by the Chief Financial Officer are complied with fully;

(h) any business or investment cases for further funding of budgets both capital or revenue or that may have indirect impacts on budgets must first be recommended by the business Development Group that is chaired by the Chief of Strategy, shown in Appendix 6

3.4 CAPITAL EXPENDITURE

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

3.5 MONITORING RETURNS

3.5.1 The Chief Executive is responsible for ensuring that:

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

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

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

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

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

4. ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

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

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

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

5. BANK ACCOUNTS

5.1 GENERAL

5.1.1 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.

5.1.2 The Board shall approve the banking arrangements.

5.2 BANK ACCOUNTS

5.2.1 The Chief Financial Officer is responsible for:

(a) bank accounts;

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

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

5.3 BANKING PROCEDURES

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

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

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

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

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

5.3.3 All funds shall be held in accounts in the name of the Trust. No staff other than the Chief Financial Officer shall open any bank account in the name of the Trust.

5.4 TENDERING AND REVIEW

5.4.1 The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

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

6.1 INCOME SYSTEMS

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

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

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

6.2 FEES AND CHARGES

6.2.1 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice will be taken as necessary.

6.2.2 All staff 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.

6.3 DEBT RECOVERY

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

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

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

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The 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 or electronic records;

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

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

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

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

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes.

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

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

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

7. CONTRACTS WITH COMMISSIONERS

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

7.2 In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions;

(c) billing systems and cash flow management;

(d) any other matters of a financial nature;

(e) the contract negotiation process and timetable;

(f) the provision of contract data;

(g) amendments to contracts.

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

7.4 The Chief Financial Officer shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

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

8. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND STAFF

8.1 REMUNERATION AND TERMS OF SERVICE

8.1.1 In accordance with Standing Orders the Board shall establish a Performance and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting for Executive Directors and senior staff above the Agenda for Change pay scales (ie VSM staff).

8.1.2 The remuneration and allowances to the Chair and Non-Executive Members of the Board will be determined by the Council of Governors in accordance with the Foundation Trust Constitution and guidance issued by NHS England.

8.2 FUNDED ESTABLISHMENT

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

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

8.3 STAFF APPOINTMENTS

8.3.1 No director or staff may engage, re-engage, or regrade staff, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment (there may be instances where recruitment above funded establishment may be agreed if staff turnover and vacancy levels will mean overall budgets are not breached); and

(c) complying with any prevailing regulatory guidance

8.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for those staff outside of national NHS terms and conditions.

8.4 PROCESSING OF PAYROLL

8.4.1 The Chief People Officer shall maintain procedural instructions for delivery of the Trust's payroll function. These procedures shall be compliant with employment legislation, the Data Protection Act and HM Revenues and Customs regulations.

8.4.2 The Chief People Officer is responsible for:

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

(b) the final determination of pay;

(c) making payment on agreed dates;

(d) agreeing method of payment;

e) maintaining and enforcing the Trust's under and overpayments policy and seeking to recover any overpayments in line with that policy.

8.4.3 The Chief People Officer will issue instructions regarding:

(a) verification and documentation of data, including time records where appropriate;

(b) the timetable for receipt and preparation of payroll data and the payment of staff. All staff shall be paid by bank credit transfer, unless otherwise agreed by the Chief People Officer;

(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 staff;

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

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

(j) pay advances and their recovery;

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

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

8.4.4 The Chief Financial Officer will issue instructions regarding the maintenance of regular and independent reconciliation of pay control accounts.

8.4.5 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 People Officer's instructions and in the form prescribed by the Chief People Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of resignation, termination or retirement. Where staff fail to report for duty in circumstances that suggest they have left without notice, the Chief People Officer must be informed immediately.

(d) ensuring all staff absences are appropriately authorised. In the event of unauthorised absence, the line manager is responsible for notifying payroll services to ensure payment for unauthorised absence is prevented or recovered.

e) submitting all employee-related updated promptly to avoid under or overpayment and to ensure that staff records are accurate and up to date for their area of responsibility. These requirements include, but are not limited to, new starters, changes to contract, and leavers.

(f) ensuring all time and attendance records, expense claims and other such notifications are appropriately checks and agreed as accurate before authorisation is given.

(g) ensuring that all rostering systems for their area of responsibility are accurately maintained, in accordance with Trust policy, to ensure correct and timely payments are made to appropriate staff.

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

8.4.7 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing.

8.5 CONTRACTS OF EMPLOYMENT

8.5.1 The Chief People Officer is responsible to the Trust Board for:

(a) ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation and NHS and local terms and conditions of service;

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

(c) The Chief People Officer will be responsible for ensuring the Trust has processes and procedures in place that ensure compliance with HM Treasury Guidance on Public Sector Exit Payments (see Appendix 7)

8.6 Use of Self-Employed Management Consultants and Contractors

8.6.1 The Chief People Officer shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors.

8.6.1a These procedures shall be compliant with NHSE caps and authorisation process for employing such staff.

8.61b These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or 'IR35'.

8.6.2 All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

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

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

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

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

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

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

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Associate Director of Procurement shall be sought. Wherever appropriate, the supply of goods and services shall be covered by a contract following a tender exercise.

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

9.2.3 The Trust's Associate Director of Procurement shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The 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.

9.2.4 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 (whole life costs) should be incorporated in standing orders and regularly reviewed (see Appendix 1);

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

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

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

(i) A list of directors/staff authorised to certify requisitions, orders, goods receipts or invoices.

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

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

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

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

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

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the 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 staff regarding the handling and payment of accounts within the Finance Department.

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

(f) ensure compliance with NHSE guidance on use of non-clinical agency and consultancy spend

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

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

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

(c) the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

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

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

(a) be consecutively numbered;

(b) be in a form approved by the 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.

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

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

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

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

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

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

(iii) where the Chief Executive has approved the order, in writing, being satisfied that the supplier represents the most appropriate choice.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Executive (or their delegated officer);

(f) all goods, services, or works are ordered on an official order, either in hard copy or electronic media. The only exception to this are requests for works and services executed in accordance with a contract or purchases from petty cash or purchases via a purchasing card, all of which will be pre-approved by the Chief Financial Officer;

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

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

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

(j) changes to the list of directors/staff 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.

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

9.3 LEGALLY BINDING AGREEMENTS (e.g. leases)

9.3.1 Any leases or rental agreements must be vetted by the Chief Financial Officer or their nominated deputy prior to agreement, to enable insurance issues and technical accounting treatment to be determined. The technical accounting review will determine whether the proposed agreement is within scope of IFRS16 and applicable revenue and/or capital accounting entries. All agreements must be within available revenue or capital budgets.

9.3.2 All lease agreements must be signed on behalf of the Trust by the Chief Financial Officer (or their nominated deputy) in addition to being accompanied by the usual order and duly authorised in accordance with SFIs.

9.4 EXPENDITURE ON DRUGS

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

9.4.2 The clinical criteria for the introduction of new drugs must be in accordance with the Trust's clinical policies and procedures.

9.4.3 The introduction of new drugs costing less than £25,000 per annum (full year effect) may be authorised by the Frimley Health Area Prescribing Committee, providing such costs can be met from within existing budget. Between £25,000 and £100,000 can be approved by the Medical Director, providing such costs can be met from within existing budget. Above these amounts, a business case needs to be made to the Trust Management Board. Any expenditure on drugs outside of these limits without prior approval is not authorised and is a contravention of Standing Financial Instructions

10. EXTERNAL BORROWING AND INVESTMENTS

The Chief Financial Officer will be responsible for the management of the Trust's cash flow.

10.1 EXTERNAL BORROWING

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

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

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

10.1.4 Any application for new borrowing will only be made by the Chief Financial Officer or by staff so delegated by the Board.

10.1.5 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by the Independent Regulator.

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

10.1.7 All long-term borrowing must be consistent with the plans outlined in the current 5 year strategic plan.

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

10.2 INVESTMENTS

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

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

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

10.3 FOREIGN EXCHANGE CONTRACTS

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

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

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

11. CAPITAL INVESTMENT, ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 The Chief Executive:

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

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

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

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

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

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

(ii) appropriate project management and control arrangements;

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

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

(d) that the business case is submitted and approved in accordance with delegated powers set out in Appendix 4;

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

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

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

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

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

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

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

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

11.2 ASSET REGISTERS

11.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the 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.

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

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

11.2.4 The Chief Financial Officer shall approve procedures for reconciling balances on protected property accounts in ledgers against balances on protected property registers.

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

11.3 SECURITY OF ASSETS

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

11.3.2 Asset control procedures (including protected property, non-protected assets, cash, cheques, negotiable instruments and donated assets) must be approved by the 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.

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

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

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

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

11.3.7 Private use of the Trust's assets

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

12. STORES AND RECEIPT OF GOODS

12.1 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to staff by the Chief

Executive. The day-to-day responsibility may be delegated by him to departmental staff and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical staff; the control of fuel oil of a designated estates manager.

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

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

12.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be an appropriate physical check at least once a year.

12.5 The designated manager/pharmaceutical staff 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.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNATIONS

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

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

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by staff (the Condeming Officer) 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 staff member authorised for the purpose by the Chief Financial Officer.

13.1.4 The Condemning Officer shall satisfy themselves 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.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

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

13.2.3 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, and

(b) the Local Counter Fraud Manager and

(c) the Local Security Management Specialist.

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

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

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

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

14. INFORMATION TECHNOLOGY

14.1 The Chief Executive, who is responsible for the accuracy and security of the digital financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(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 digital operations are separated from development, maintenance and amendment;

(d) ensure that an adequate management audit trail exists through our digital systems (including those obtained by external agency arrangements) and that such digital audit reviews as he/she may consider necessary are being carried out.

(e) ensure the Trust has a Data Protection lead.

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

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

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

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

(a) systems acquisition, development and maintenance are in line with corporate policies such as the Digital 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 digital audit reviews as are considered necessary are being carried out;

(e) any changes to such systems shall be notified to and approved by the Chief Financial Officer;

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

14.5 The Trust's Chief Information Officer and Chief Operating Officer are responsible to the Board for setting the Trust Digital Strategy and monitoring progress towards implementing that strategy.

14.6 All new systems must be approved by Digital Services Overview Group as to their suitability, value for money and compliance with any set strategy. For the avoidance of doubt, this approval is also required for new systems (or upgrades) acquired by any subsidiary or related party where they will be hosted on or be interoperable with the Trust's digital infrastructure.

15. PATIENTS' PROPERTY

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

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

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

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

15.3 The Chief of Nursing & Midwifery in consultation with 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.

16. CHARITABLE FUNDS - FUNDS HELD ON TRUST

16.1 INTRODUCTION

16.1.1 The discharge of the Charitable Fund's corporate trustee responsibilities are distinct from its responsibilities for corporate funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. In particular, the purchasing rules and delegated financial limits that apply to Trust purchasing also apply to charitable funds purchasing. These delegated limits, including the associated authorisation requirements, are summarised at Appendix 1-4 of these SFIs and variation to delegated limits are noted. Trustee responsibilities cover both charitable and non-charitable purposes. The Chief Financial Officer shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

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

16.1.3 The Board hereby nominates the Chief Financial Officer to have primary responsibility to the Board for ensuring that these SFIs are applied.

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

16.2 EXISTING CHARITABLE FUNDS

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

16.2.2 The Charitable Funds Committee as part of its remit review the funds in existence and make recommendations to the Charitable Fund's corporate trustees regarding the potential for rationalisation of such funds within statutory guidelines.

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

16.3 NEW CHARITABLE FUNDS

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

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

16.4 SOURCES OF NEW FUNDS

16.4.1 In respect of Donations, the Chief Financial Officer shall:

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

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

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

16.4.2 In respect of Legacies and Bequests, the Chief Financial Officer shall:

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

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

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

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

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

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

16.4.3 In respect of Fund-raising, the Director of Frimley Charity:

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

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

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

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

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

16.4.4 In respect of Charitable Fund's Trading Income, the Chief Financial Officer shall:

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

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

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

16.5 INVESTMENT MANAGEMENT

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

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

(b) the reporting of investment performance

16.6 DISPOSITION MANAGEMENT

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

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

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

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

(d) the avoidance of the use of Trust funds to discharge Charitable Fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Trust shall be discharged by Charitable Funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Charitable Funds;

(f) the definitions of "charitable purposes" as agreed with the Charity Commission.

16.7 BANKING SERVICES

16.7.1 The Chief Financial Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the Charitable Funds as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 ASSET MANAGEMENT

16.8.1 Assets in the ownership of or used by the Charitable Funds as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Charitable Fund. The Chief Financial Officer shall ensure:

(a) that appropriate records of all assets owned by the Charitable Fund as corporate trustee are maintained and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for.

16.9 REPORTING

16.9.1 The Chief Financial Officer shall ensure that regular reports are made to the Charitable Funds corporate trustees with regard to, inter alia, the receipt of funds, investments and the disposition of resources.

16.9.2 The Chief Financial Officer shall prepare annual accounts in the required manner which shall be submitted to the Charitable Funds corporate trustees within agreed timescales.

16.9.3 The Chief Financial Officer shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Independent Regulator and the Charity Commission for adoption by the Charitable Funds corporate trustees.

16.10 ACCOUNTING AND AUDIT

16.10.1 The Chief Financial Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 The Chief Financial Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year and will liaise with external audit and provide them with all necessary information.

16.10.3 The Charitable Funds corporate trustees shall be advised by the Chief Financial Officer on the outcome of the Charitable Funds annual audit. The Chief Executive shall submit the Management Letter to the Charitable Funds corporate trustees.

16.11 ADMINISTRATION COSTS

16.11.1 The Chief Financial Officer shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Finance, shall charge such costs to the appropriate trust accounts.

16.12 TAXATION AND EXCISE DUTY

16.12.1 The Chief Financial Officer shall ensure that the Charitable Funds liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17. INDUCEMENTS and DECLARATION OF INTERESTS

17.1 ACCEPTANCE OF GIFTS AND HOSPITALITY

17.1.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. Staff must comply with national guidance 'Standards of Business Conduct for NHS Staff and any guidance and directions issued by the Independent Regulator.

17.1.2 All staff will be responsible for notifying the Company Secretary who will record , any gift, hospitality or sponsorship accepted (or refused) by staff on behalf of the Trust.

17.1.3 Any offers for gifts, hospitality or sponsorship that do not comply with the Trust's Standard of Business Conduct Policy, should be courteously but firmly refused and the firm or individual notified of the Trust's procedures and standards.

17.2 DECLARATION OF INTERESTS

17.2.1 The Company Secretary shall be advised of declared pecuniary interests of members of the Board for recording in a register they will maintain for that purpose.

17.2.2 All other staff should declare any relevant interest in accordance with the standards of Business Conduct which should be updated annually.

17.3 PRIVATE TRANSACTIONS

17.3.1 Staff having official dealings with contractors or other suppliers of goods or services are prohibited from transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for defining retention periods and maintaining archives for all documents required to be retained.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

18.4 The Trust's arrangements for disclosure under the Freedom of Information Act shall be maintained by the Chief Financial Officer.

19. RISK MANAGEMENT & INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

19.2 The programme of risk management shall include:

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

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

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

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

(e) audit arrangements including internal audit; clinical audit; health and safety review;

(f) decisions on which risks shall be insured through arrangements with either the NHS Resolution Pooling Schemes or commercial insurers;

(g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts.

19.3 The Chief Executive in consultation with his designated staff shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board of Directors.

APPENDIX 1. PURCHASING AND TENDERING

1.0 INTRODUCTION

1.1 The Trust's Standing Financial Instructions (SFI's) set out procedures to be adopted in obtaining goods and services.

1.2 This supplementary procedure note deals with the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and detailed procedures in relation to purchasing and tendering and considers the correct authorisation procedures for the following stages of procurement:

1. Levels at which Procurement Activity must take place (Section 2)
2. Approvals required to commence Procurement activity (Section 3)
3. Approvals required to commit the Trust to expenditure (Section 4)
4. Approvals required to raise a Purchase Order and/or sign a Contract (Section 5)

2.0 LEVELS AT WHICH PROCUREMENT ACTIVITY MUST TAKE PLACE

2.01 The Trust must ensure that goods and services are procured in an efficient manner and are purchased at the most competitive price.

2.02 Tendering activity will depend on the whole life costs (this may include but is not limited to, cost of the goods or services, associated ongoing consumables, licences, service and maintenance, disposal costs) and will follow the route summarised in ***Table 1 of Appendix 3***

2.03 In addition to the Trust delegated tendering limits, attention must be paid to the regulations governing procurement laid down in UK Law. In all cases advice should be sought from the Associate Director of Procurement to ensure compliance with appropriate thresholds.

2.04 If the purchase has an IT component (this may include access to the Trust network, a provision of software or hardware) then authority for approval must also be given by the Digital Services Operational Group. If in doubt advice from the Digital Services department should be sought.

2.05 If the purchase involves the capturing or transmitting of patient identifiable data (PID) then authority for purchase must also be given by the Head of Information Governance.

2.1 COMPETITIVE AND NON-COMPETITIVE QUOTATIONS (Whole Life Costs £50,000 inc VAT and under)

Three competitive quotations must be obtained for all contracts and services where the value is expected to be between £10,000 and £50,000 including applicable VAT.

The lowest compliant quotation should be accepted, unless in exceptional circumstances when the requestor can demonstrate sufficient value for money in the higher priced quotation. In these circumstances, the decision making must be documented on the requisition and agreed with the Associate Director of Procurement or nominated deputy.

In such a process the lowest price quote should be accepted unless explicitly agreed with the Chief Financial Officer, through presentation of a formal business case.

2.2 COMPETITIVE TENDERING (Whole Life Costs over £50,000 inc VAT)

2.2.1 The Trust must ensure that goods and services are procured in an efficient manner at the most economically advantageous price either through a tender process or compliant use of existing national or local contracts. The standard method of procurement will be by competitive tender through the Trust's e-tendering solution for goods or services expected to cost in excess of £50,000 including VAT.

2.2.2 Staff must involve the Associate Director of Procurement or nominated Deputy in choice of supplier, price negotiation and in the procurement process for all goods and services. Where third parties are engaged to provide procurement support, this engagement must be under the direction of the Associate Director of Procurement or a nominated deputy.

2.2.3 Where the supplier being used is nationally or regionally approved, and/or they are providing a continuous supply in operational terms, it may be appropriate to use annual orders duly authorised as appropriate. Annual orders must include a clear schedule of the items being ordered, their agreed individual prices, an estimate of the volumes required of each item for the period of the order and hence an agreed total cost which must not be exceeded. The advice of the Associate Director of Procurement or nominated Deputy should be sought when establishing such annual orders to ensure that the correct format is applied and that value for money is obtained.

2.2.4 No single supplier or single annual order should be used for a period in excess of 12 months, where the costs incurred during that period are estimated to exceed £10,000, without the requisitioner demonstrating value for money. The advice of the Associate Director of Procurement or nominated Deputy should be sought. Where this advice is not sought or not acted upon the requisitioner must advise the Chief Executive in writing seeking waiver of this rule.

2.2.5 Where the lowest price offer is not being recommended a formal approval from the Chief Financial Officer is required, through a written case.

2.3 TENDERING PROCEDURES

2.3.1 Wherever possible tenders shall be advertised, issued and submitted on the Trust's e-tendering system and the Government Contracts Finder website.

2.3.2 In exceptional circumstances where the above is not practical or possible tenders may be received as hard copies. In this case all written tenders shall be addressed to the Chief Executive.

2.3.3 All invitations to tender on a competitive basis shall state that no written tender will be accepted unless submitted in either:-

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or the word "Tender", followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

b) in a special envelope supplied by the Trust to prospective tenders, and that tender envelopes/packages shall not bear the names or marks indicating the sender.

2.3.4 Every tender for building and engineering works, except any tender for maintenance work only, shall embody or be in the terms of the current Agreement for Minor Building Works issued by the Joint Contract Tribunal as appropriate.

For major projects, especially those run under P21+ or P33, the NEC Contract shall be used.

2.3.5 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package. Tenders submitted via e-tendering will be electronically date and time stamped.

2.3.6 The Trust shall designate staff, not from the originating department, to be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. Tenders submitted via e-tendering will remain electronically locked to all Trust staff until the end time for receipt of tenders has passed.

2.3.7 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of two members of staff at least one of which must be an Executive member of the Board.

Tenders submitted via e-tendering shall be opened by senior Procurement staff. The system shall automatically record the date, time and member of staff opening the tender.

2.3.8 Every tender received shall be recorded to show for each set of competitive tender invitations despatched: -

a) the names of all firms invited;

b) the names of and the number of firms from which tenders have been received, and the amount for each tender;

c) the date the tenders were opened; and

d) the record shall be signed by the persons present at the opening.

For tenders received via e-tendering this information will be electronically recorded.

2.3.9 Except as in paragraph 2.3.11 below a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, the final price shown shall be recorded. The record shall be initialled by two of those present at the opening.

Alterations to tenders submitted via e-tendering will be electronically marked.

2.3.10 A report shall be made in the record if on any one tender price alterations are so numerous as to render the procedure at paragraph 2.3.9 above unreasonable.

2.3.11 For procurements with whole life costs above £100,000 inc VAT, tenders received after the due time and date may be considered only if the Chief Executive decides that there are exceptional circumstances, e.g. where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenderers concerned. The Chief Executive shall decide whether such tenders are admissible and where re-tendering is desirable.

2.3.12 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may be regarded as having arrived in due time.

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

2.3.14 Necessary discussion with a tenderer of the contents of his tender, in order to elucidate technical, etc, points before the award of a contract, need not disqualify the tender.

2.3.15 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall be kept strictly confidential and held in safe custody by staff designated by the Chief Executive.

For tenders submitted via e-tendering, the tenders will remain electronically unopened.

2.3.16 In all competitive procurements, the most economically advantageous tender/quotation (MEAT) should be accepted taking into consideration any quantifiable and non quantifiable social value and environmental impacts

2.3.17 Where only one tender/quotation is sought and/or received, the Trust shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

2.4 CONDITIONS FOR WAIVER

2.4.1 The procurement of goods and services with whole life costs in excess of £10,000 inc VAT must be competed, subject to the exemptions detailed in 2.4.5. This requirement may, in exceptional circumstances, be waived.

2.4.2 A waiver represents exposure of financial risk to the organization and in all circumstances must first be agreed by the Board Member who has budget responsibility and then the Chief Financial Officer. The Waivers much be regularly reported to the Audit Committee for scrutiny.

The use of a competitive procurement exercise may be waived under the following circumstances, on application from the relevant Board Director based and approval of a waiver by the Chief Financial Officer:

a. there is only one supplier and no reasonably satisfactory alternative product/service;

b. competition would not be possible due to time constraints in unforeseen circumstances;

c. the work for practical reasons must be of the same manufacturer, for instance repairs/spare parts for existing equipment;

In regard to the sole supplier justification (point a above). This is not to be used as a reason for the continued use of an existing supplier, but only where there is justified specialist expertise that is only available from one source.

In regard to time constraints a failure to plan is not a reason for unforeseen circumstances

In each case the detail shall be documented and the authorisation counter-signed (this may be electronic counter signature through the Trust's e-procurement system) by the Associate Director of Procurement or nominated Deputy in confirmation of such circumstances.

2.4.3 Contracts can be awarded through a direct award process via a national or local framework agreement, without the need to produce a waiver, but this is at the discretion of the Associate Director of Procurement or a nominated deputy. In reviewing the use of a direct award approach, the following tests will be applied:

a) Does the framework agreement allow for direct awards?;

b) Does the Trust's requirement meet the pre-requisites for direct award within the framework being used?;

c) Can the Trust demonstrate value for money in taking the direct award approach, as opposed to running a competition within the framework agreement?

2.4.4 Waivers should be approved prior to placing a requisition on the Trust's e-procurement system. Waiver copies and associated documentation should be attached to the e-procurement requisition.

2.4.5 The competitive sourcing and associated waiver requirements, contained withing these SFIs, do not apply in the following unique exemptions:

• Where the specific requirement has already been competitively procured via a national or regional Procurement body on behalf of the Trust

• NHS Provider to NHS Provider contracts, where the award has been compliant with relevant UK legislation.

• Where there is only one possible supplier to provide goods/services in relation to an existing Trust owned asset (e.g., configuration work on an IT system or spare parts for a medical device), subject to the Trust being compliant with UK public sector procurement legislation

• Council Rates and Tax

• Planning Permission Fees

• Property Rental and Leases

• Nationally mandated or statutory payments, such as those to NHS Resolution and HMRC

• Memberships/subscriptions to national accrediting / auditing bodies, such as those with National Joint Registry and Care Quality Commission.

• Services from other public sector partners as part of the Trust's membership of a partnership arrangement (e.g., BSPS)

• Where the spend is dictated by patient choice (e.g., Optician dispensing vouchers)

• Losses and compensation payments

These exemptions are subject to periodic review and amendment via the Trust's Chief Finance Officer.

2.5 AUTHORITY TO WAIVER

Authority to waiver procurement activity as required by SFIs (i.e. above £10,000 whole life costs inc VAT) must be given as in ***Table 2 of Appendix 3***.

All waivers in excess of £500k and below £3m must be retrospectively reported to the Audit Committee.

In addition, a summary waiver report shall be prepared and submitted to the Audit Committee periodically

2.6 BREACHES TO COMPETITIVE PROCUREMENT REQUIREMENTS

In circumstances where the Trust has committed itself to expenditure, through the written commissioning of works or the acceptance of goods, without following the competitive procurement instructions contained within this Policy then a Breach form will need to be completed. The purpose of this form is to document the failure to follow the correct process and to capture any relevant learning.

Breaches will be reported in the same manner as waivers.

3.0 APPROVALS REQUIRED TO COMMENCE PROCUREMENT ACTIVITY

Goods and services with expected whole life costs in excess of £50,000 inc VAT, not available to compliantly direct order under a local or national contract or framework, must undergo a competitive procurement. Authority to begin such a procurement (pre-procurement approvals), if not within existing budget is shown in ***Table 3 of Appendix 3***. For contracts of a strategic nature, or where the contract value is expected to exceed £3m, the procurement strategy will need approval from the Trust Management Board , regardless of whether existing budget is in place.

4.0 APPROVALS REQUIRED TO COMMIT THE TRUST TO EXPENDITURE

4.1 Approval for expenditure is summarised in ***Table 3*** (spend approval) and ***Table 4*** (charitable fund spend approval) ***of Appendix 3***.

4.2 For all spend in excess of £100,000 inc VAT, a contract award paper, summarising the process and rationale for award to a supplier, must be submitted by the stakeholder to the highest approver in the relevant format. All contract awards shall be approved in line with the full potential value of the contract, including extensions. Subsequent extensions to the contract shall be approved in accordance with the financial value of the extension. The Associate Director of Procurement, or nominated deputy, shall be consulted in all contract award papers.

4.3 A Trust official Purchase Order must be raised using the Trust's e-procurement system following approval.

4.4 Goods that are managed by the Inventory Management System require ordering in a timely fashion in order to keep stocks to the lowest optimal quantity. Therefore, requisitions raised electronically via the Inventory Management System through the interface to the e-Procurement system shall be exempt from the approvals summarized in ***Table 3***

5.0 APPROVALS REQUIRED TO RAISE A PURCHASE ORDER AND/OR SIGN A CONTRACT

5.1 A Trust official order or Contract document must be raised for all committed expenditure. A Purchase card may be used in accordance with the Purchasing Card Policy. A purchase order or purchase card payment for committed expenditure shall only be placed once the approvals process relevant to the spend requirement has been properly completed. The Chief Financial Officer shall delegate this responsibility to appropriate Procurement staff.

5.2 Wherever possible, Purchase Orders and Contract documents should be raised under standard NHS Terms and Conditions.

5.3 Every contract for building and engineering works, should be embodied in a formal contract document which should conform to these Standing Financial Instructions. These formal contract documents should reflect any change in the terms and conditions of contract agreed following receipt of tenders.

5.4 No goods, services or works (other than works and services, executed in accordance with a contract and purchases from petty cash) shall be ordered except on an official order, which may be in hard copy or electronic media. Contractors shall be notified that they should not accept orders unless in an official format. Verbal orders shall be issued only in specific instances, the first being by staff designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation

Order". The second being by the use of official purchasing cards, by those designated to do so by the Chief Executive, and in accordance with the detailed guidance and limitations for the use of such cards as issued by the Chief Financial Officer.

5.5 The physical signing and e-signing of contracts may only be made by personnel in accordance with ***Table 5 of Appendix 3*** and only on completion of all approvals detailed in section 4.

5.6 The Trust operates a no-purchase order no pay policy. Within the exception of a narrow scope of expenditure, all non-pay spend should be against pre-approved purchase orders raised on the Trust's e-procurement system. The full details of this procedure and agreed exemptions, are contained within the Trust's Procurement Policy.

6.0 EXAMPLES – APPLYING APPENDIX 1

Ser	Requirement	Procurement Process Table 1	Pre-Procurement Approval Table 3	Waiver process Table 2	Spend Approval Section 4
6.1	Replacement IT hardware with expected whole life costs of £1.2m	Over UK Threshold – full tender or direct award under local or national framework if compliant	If no existing budget, stakeholder obtains approval to commence procurement activity, signed off by CIO. Further approval from DSOG.	If tender or framework process followed, waiver not required. If the process is waivered, Waiver must be raised and signed off by CEO. Waiver retrospectively reported to Audit Committee.	Signed off by the relevant Leadership Committee
6.2	£120k Maintenance contract for Surgical Robot. Waiver requested for sole (unique) supplier	Competitive tenders should be sought.	Existing budget, no pre-approval required	Waiver raised by stakeholder detailing valid reasons (same manufacturer), verified by Procurement. Waiver signed off by Chief Financial Officer	Signed off by Chief Financial Officer
6.3	Requirement to appoint a Contractor for new build - £3.2m expected costs	Under the Works UK threshold. Competitive tender through Trust e-tendering solution	Approval to commence activity from FIC	Tender or framework process followed, waiver not required If the process is waivered, Waiver must be raised and signed off by CEO. Waiver retrospectively reported to Audit Committee.	Signed off by FIC
6.4	Requirement for Medical Equipment circa £80k to be funded from charitable funds	Competitive tender through Trust e-tendering solution or direct award under local or national framework if compliant.	Approval to commence activity from relevant Director	Tender or framework process followed, waiver not required If the process is waivered, waiver must be raised and signed off by Chief Financial Officer	Signed off by Fund Holder, Director of Operational Finance, Director of Frimley Charity, Chief Financial Officer Chief People Officer.
6.5	Requirement for new contract for Linen and Laundry services. £10m for 5 year contract.	Full tender process or competition under local or national framework	Existing budget – no pre-approval required	Tender or framework process followed, waiver not required If the process is waivered, Waiver must be raised and approved by the Board before PO and award.	Signed off by Trust Board
6.6	Requirement for purchase of £120k cardiac implantable devices for business as usual. Under contract	Tender previously completed – this is existing spend under a current contract	Existing budget, no pre-approval required	Tender or framework process followed, waiver not required	Signed off by Chief Financial Officer

APPENDIX 2. HIERARCHY OF DELEGATED BUDGETARY AUTHORITY

Budgets Authorised	(£) Limit	Minimum level of Staff
Virement between non-pay budget lines within same Directorate	Up to 100k	Budget holder with authorisation from Head of Management Accounts
	Above £100k but less than £250k	Budget holder with authorisation from the Director operational Finance
	Above £250k but below £1000k	Budget holder with authorisation from the Deputy Chief Financial Officer
	Above £1000k	The Chief Financial Officer
Virement between pay budget lines within same Directorate	Up to 100k	Budget holder with authorisation from Head of Management Accounts
	Above £100k but less than £250k	Budget holder with authorisation from the Director operational Finance
	Above £250k but below £1000k	Budget holder with authorisation from the Deputy Chief Financial Officer
	Above £1000k	The Chief Financial Officer

Virements between Directorates always require Chief Financial Officer approval

Pay Expenditure Delegated Limits

	In Authorised Budget	Not in Budget
Commitment to incur costs as a result of a contract of employment (including temporary contracts), existing budgeted post	AD or Head of Service per Appendix £, table 3 (with reference to authorised establishment)	CFO & CEO & CPO
Commitment to incur costs as a result of a contract of employment (including temporary contracts), new post	Chief Financial Officer and Chief Executive and Chief People Officer (by authorising change to establishment)	Chief Financial Officer and Chief Executive and Chief People Officer (by authorising change to establishment)
Commitment to incur costs via Consultancy	< £10k Budget Holder, > £10k CFO	CFO
Commitment to incur costs via Agency	Budget holder / AD per Appendix 3, table 3	CEO (or delegated officer)

[For Charitable Funds spend up to £25,000 may be authorised by the Director of Operational Finance and the Director of Frimley Charity and up to £50,000 by the Director of Communications & Engagement], above this level requires Chief financial officer approval.

Non-Pay Expenditure Delegated Limits

	In Authorised Budget	Not in Budget
Non-pay	As per Appendix 3, table 3	CEO (or delegated officer)

Note that any likely overspending or reduction in income which cannot be met by virement must have CFO consent, then CEO approval.

APPENDIX 3. SUMMARY OF DELEGATED APPROVAL LIMITS

Table 1. Levels at which Procurement Activity must take place (Appendix 1, Section 2)

Whole life costs	£0 £10,000	£10,001 £50,000	£50,001 £139,688*	£139,688* and above
No formal activity	Yes			
Minimum Three Written Quotations or Compliant Use of Framework		Yes		
Full Tendering Process or compliant use of framework			Yes	
Full Tendering Process or Use of Framework Compliant with UK Law				Yes

** Tender thresholds as described in UK Law. Prevailing Threshold value currently £139,688 for Goods and Services and £5,372,609 for Works.*

Table 2. Authority to Waiver (Appendix 1, Section 5)

Whole life costs (inc VAT)	£10,001 £500,000	£500,001 £1m	£1m £3m	£3m and above
Chief Financial Officer	Yes			
Chief Executive Officer		Yes[1]		
Trust Management Board			Yes	
Trust Board				Yes

[1] All waivers between £500k and £3m must also be retrospectively reported to the Audit Committee. Waivers over £3m will need Board approval before PO and Award.

Table 3. Approvals required to commence[1] and commit Trust expenditure - Revenue or Capital (Appendix 1, Section 3 and 4)[2]

Whole life costs (inc VAT)	£0 - £25,000	£25,001 - £50,000	£50,001 £100,000	£100,001 £500,000	£500,001 £1m	£1m £3m	£3m £5m	Above £5m
Budget Holder	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Associate Directors		Yes	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Directors (inc CIO and Dir of Estates) and Exec Dirs			Yes	Yes*	Yes*	Yes*	Yes*	Yes*
Chief Financial Officer				Yes	Yes*	Yes*	Yes*	Yes*
Chief Executive					Yes	Yes*	Yes*	Yes*
Trust Management Board						Yes	Yes*	Yes*
FIC (Finance Investment Committee)							Yes	Yes*
Trust Board								Yes

[1] Approvals required to commence purchase are only required where there is no existing budget or where the existing budget will not cover the expenditure.

[2] Denotes that approval at a higher level will provide approval for all levels below in the shown hierarchy. It is therefore not necessary for all members of the hierarchy within the spend bracket to approve the spend. However, the relevant highest ranking approver MUST be the final authoriser.*

For clarity for the additional approvals required for expenditure not in budget, see Appendix 2 above.

In addition, authorisation may also be required at the following Groups:

Table 3a – Group Authorisation

Whole life costs	£0 £10,000	£10,001 £25,000	£25,001 £100,000	£100,001 £500,000	£500,001 upwards
Product Selection Groups (including Theatre PSG)	Yes[1]	Yes[1]			
Digital Services Operation Group	Yes[2]	Yes[2]			

[1] *For appropriate procurement falling under the Product Selection Groups remit*

[2] *For appropriate procurements falling under the Digital Services remit*

Table 4. Approvals required to commit Trust expenditure – Charitable Funds (Appendix 1, Section 4)

Whole life costs (VAT exempt)	£0 £10,000	£10,001 £25,000	£25,001 £100,000	£100,001 £500,000	£500,001 upwards
Fund Holder	Yes	Yes	Yes	Yes	
Director of Operational Finance and the Director of Frimley Charity		Yes	Yes	Yes	
Chief Financial Officer / Director of Operational Finance and the Director of Communications and Engagement			Yes	Yes	
Charitable Funds Committee				Yes	Yes
Trustees					Yes

Table 5. Physical Contract signature (Appendix 1, Section 5)

Whole life costs	£0 £10,000	£10,001 £100,000	£100,001 £500,000	£500,001 upwards
Budget Holder	Yes			
Associate Director Procurement or Director Operational Finance		Yes		
Relevant Executive Director			Yes	
Chief Executive Officer or Chief Financial Officer				Yes

APPENDIX 4

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.5	CHIEF EXECUTIVE (CE)	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.9	CHIEF FINANCIAL OFFICER (CFO)	Responsible for: Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.6	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.3.8	CFO	Form and adequacy of financial records of all departments.
2.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
2.2	CFO	Carry out all work to counter fraud and corruption in accordance with NHSE Directions.
2.3.1	CFO	Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption in accordance with NHSE Directions.
2.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
2.5	AUDIT COMMITTEE	Ensure cost-effective external audit.
3	CE CE CE CFO CFO CFO	Overall responsibility for business plans and budgets. Delegate budget to budget holders and submit monitoring returns. Ensuring compliance with NHSE requirements and ensuring adequate system of monitoring. Submit budgets. Monitor performance against budget, submit to Board financial estimates and forecasts. Devise and maintain systems of budgetary control.
4	CFO	Annual accounts and reports.
5	CFO	Banking arrangements.
6	CFO	Income systems.
7	CE	Negotiating contracts for provision of patient services.

SFI REF	DELEGATED TO	DUTIES DELEGATED
	CE CFO	Negotiating NHS contracts Regular reports of actual and forecast contract income.
8	BOARD CE / CHIEF FINANCIAL OFFICER REMUN. COMMITTEE	Agree terms of reference of Performance and Remuneration Committee Variation to funded establishment of any department. Report in writing to the Board its advice and its basis about remuneration and terms of service of directors and senior employees.
8.4	DIR OF PEOPLE	Payroll form and adequacy of payroll records and processes
9.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
9.2.3	CFO	Prompt payment of accounts.
9.2.6	CE	Authorise who may use and be issued with official orders.
10	CFO	Advise Board on borrowing and investment needs and prepare procedural instructions.
11	CE / CHIEF FINANCIAL OFFICER	Managing Capital investment programmes
11.1.4	CFO	Monitoring the capital programme.
11.1.2	FIC	Approval of schemes in the Annual and Capital Plan between £3m and £5m and recommendation to the Board on those not included within the plans.
11.3	CFO	Maintenance of asset registers.
11.3.7	LINE OR SENIOR MANAGERS	Use of Trust assets for private use.
11.3.1	CE	Overall responsibility for fixed assets.
11.3.4	ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
12	CFO	Responsible for systems of control over stores and receipt of goods.

SFI REF	DELEGATED TO	DUTIES DELEGATED
12.3	CFO	Identify persons authorised to requisition and accept goods from Supplies stores.
13.2	CFO	Prepare procedures for recording and accounting for losses and special payments
14	CE	Responsible for accuracy and security of computerised data.
15.2	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
16	CFO	Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Charitable Funds Committee if any).
18	CE	Retention of document procedures
19	CE	Risk management programme
19.3	CE	Insurance arrangements

FRIMLEY HEALTH NHS FOUNDATION TRUST - DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Staff as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

In all cases in the absence of the Chief Executive the Chief Financial Officer may deputise. In the absence of the Chief Financial Officer the Chief Financial Officer's deputy may deputise for the Chief Financial Officer.

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1. Management of Budgets Responsibility of keeping expenditure within budgets a) At individual budget level (Pay and Non Pay) b) At service level c) For the totality of services covered by Clinical / Executive Director d) For all other areas:	 Budget Manager Associate Director/ Head of Service Clinical/Executive Director or Chief Executive Chief Financial Officer or Appropriate Delegated Manager	SFIs Section 3
2. Maintenance / Operation of Bank Accounts	Chief Financial Officer	SFIs Section 5

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
3. Non Pay Revenue and Capital Expenditure / Requisitioning / Ordering / Payment of Goods & Services		SFIs Section 9
a) • up to £25,000 up to £50,000 up to £100,000	Budget Manager Associate Directors Directors (inc CIO, Dir of Estates, Dir of Pathology Services, Director of Operational Finance) and Executive Directors	In the case of items above £1m this applies to new commitments and does not need to apply to any regular recurrent spend
• from £100,001 to £500,000 • from £500,001 to £1,000,000	Chief Financial Officer / Nominated deputy CE Chief Executive	
£1m - £3m £3m to £5m • Above £5m	Trust Management Board FIC Trust Board	
b) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Only with written CEO approval (or delegated officer).	
c) Orders exceeding 12 month period	As (a) above for whole life of contract	
d) All contracts for goods & services and subsequent variations to contracts		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
4. Capital Schemes		
a) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Chief Financial Officer	
b) Financial monitoring and reporting on all capital scheme expenditure	Chief Financial Officer or Nominated Deputy CE	
c) Granting and termination of leases	Chief Financial Officer	
d) Contract Variations to capital projects	See Appendix 5 for full list	
5. Quotation, Tendering & Contract Procedures		
a) Waiving of Tenders on competitive quotations subject to SFIs		
below £500,000	Chief Financial Officer	SFIs Appendix 1 & Standing Orders Section 9 & Annex
£500,000 to £1m	Chief Executive	
£1m to 3m	Trust Management Board	SFI's Appendix 2
Over £3m	Trust Board	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
6. Setting of Fees and Charges		SFIs Section 7
a) Private Patient, Overseas Visitors, Income Generation and other patient related services.	Chief Financial Officer	
b) Price of NHS Contracts	Chief Financial Officer	
7. Engagement of Staff Not On the Establishment Engagement of Staff Not On the Establishment at AD level and above	AD's / Chief Financial Officer Chief Financial Officer / Chief Exec and Deputy Chief Exec	SFIs Section 8
a) Engagement of Trust's Solicitors	Nominated Executive Director	
b) Authorising engagement of Bank or Agency Staff • Medical Locums • Nursing • Clerical	Associate Director and above / Head of Service / Budget Manager Associate Director and above / Head of Service / Budget Manager Associate Director and above / Head of Service	
8. Expenditure on Charitable and Endowment Funds		SFIs Section 16
- Up to £10,000	Fund Holder	
- £10,001 to £25,000	Director of Operational Finance and the Director of Frimley Charity	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
- £25,000 to £100,000 - £100,001 to £500,000 - £500,001 upwards	Chief Financial Officer / Director of Operational Finance & Director of Communications & Engagement Charitable Funds Committee Trustees	
9. Agreements/Licences a) Preparation and signature of all tenancy agreements/licences with staff subject to Trust Policy on accommodation for staff b) Agreements with landlords on behalf of the Trust c) Extensions to existing leases d) Letting of premises to outside organisations e) Approval of rent based on professional assessment.	Accommodation Manager Director of Finance Chief Financial Officer Chief Financial Officer Chief Financial Officer	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
10. Condemning & Disposal		SFIs Section 13
a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively		
i) with current/estimated purchase price <£50	Head of Service	
ii) with current purchase new price >£50	Associate Director	
iii) disposal of x-ray films (subject to estimated income of £1,000 per sale)	Head of Radiology	
iv) disposal of x-ray films (subject to estimated income exceeding £1,000 per sale)	Head of Radiology and AD	
v) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)	Director of Estates	
vi) disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)	Director of Estates	
vii) any disposals >£5k	Executive Directors inc Director of Estates	
11. Losses, Write-off & Compensation		SFIs Section 13
a) Losses and Cash due to theft, fraud, overpayment & others	Chief Financial Officer (report to Audit Committee)	

	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
	Up to £10,000		
b)	Losses and Cash due to theft, fraud, overpayment & others £10,001 to £50,000	Chief Executive and Chief Financial Officer (report to Audit Committee)	
c)	Losses and Cash due to theft, fraud, overpayment & others over £50,000	Trust Board	
d)	Fruitless Payments (including abandoned Capital Schemes over £50,000)	Trust Board	
e)	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other	As a) b) & c) above	
f)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (eg fraud, theft, arson) or other	As a) b) & c) above	
g)	Compensation payments made under legal obligation, or ex gratia payments for clinical negligence in line with legal advice.	Chief Financial Officer	
h)	Extra Contractual payments to contractors Up to £50,000	Chief Financial Officer	
i)	Ex-Gratia Payments (except clinical negligence in line with legal advice)	As a) b) & c) above	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
j) Patients and staff for loss of personal effects	Chief Financial Officer	
k) For clinical negligence up to NHS RESOLUTION Excess Limit (negotiated settlement) in line with legal advice.	As a) b) & c) above	
l) For personal injury claims involving negligence where legal advice has been obtained and guidance applied Up to NHS RESOLUTION Excess Limit	Chief Financial Officer	
m) Other, except cases of maladministration where there was no financial loss by claimant Up to £50,000	Chief Financial Officer	
n) (i) Special severance payment applications which are below £100,000 and/or where the employee earns more than £150,000	Chief People Officer	
(ii) Special severance payment applications which are at or above £100,000 and/or where the employee earns more than £150,000	Ministerial Approval	
12. Reporting of Incidents to the Police		SFIs Section 2 & 13
a) Where a criminal offence is suspected i) criminal offence of a violent nature ii) other	AD or Duty Manager	
b) Where a fraud is involved	Chief Financial Officer or nominated Local Counter Fraud Specialist (LCFS)	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
13. Petty Cash Disbursements		
a) Expenditure up to £50 per item	Petty Cash Holder	SFIs Section 9
b) Reimbursement of patients' monies	Petty Cash Holder	SFIs Section 15
14. Receiving Hospitality Applies to both individual and collective hospitality receipt items. In excess of £50.00 per item received	Declaration required in Trust's Hospitality Register	SFIs Section 17
15. Implementation of Internal and External Audit Recommendations	Appropriate Executive Director	SFIs Section 2
16. Maintenance & Update on Trust Financial Procedures	Chief Financial Officer	SFIs Section 1
17. Investment of Funds (including Charitable & Endowment Funds)	Chief Financial Officer	SFIs Section 16
18. Human Resources & Pay		SFIs Section 8
a) Authority to fill funded post on the establishment with permanent staff.	Associate Director/Heads of Service	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
b) Authority to appoint staff to post not on the formal establishment.	Chief Executive / Chief Financial Officer / Chief People Officer	
c) <u>Additional Increments</u> The granting of additional increments to staff within budget	Chief People Officer or deputy	
d) <u>Upgrading & Regrading</u> All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure	Chief People Officer or deputy	
e) <u>Establishments</u> i) Additional staff to the agreed establishment with specifically allocated finance.	Chief Executive / Chief People Officer / Chief Financial Officer	
ii) Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive / Chief Financial Officer	
f) <u>Pay</u> i) Authority to complete standing data forms effecting pay, new starters, variations and leavers	HR Advisor	
ii) Authority to complete and authorise positive reporting forms	Associate Director/Head of Service	
iii) Authority to authorise overtime	Associate Director/Head of Service	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
iv) Authority to authorise travel & subsistence expenses	Associate Director/Head of Service/Budget Manager	
v) Approval of Performance Related Pay Assessment (not Executive Directors)	Executive Directors / Chief Executive	
g) <u>Leave</u>		
i) Approval of annual leave	Line/Departmental Manager	
ii) Annual leave - approval of carry forward (up to maximum of 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service).	Executive Director	
iii) Annual leave - approval of carry over in excess of 5 days but less than 10 days.	Chief Executive	
iv) Annual leave - approval to carry forward 10 days or more.	Chief Executive and Chairman	
v) Special leave arrangements	Associate Director/Head of Service and Chief People Officer in certain circumstances	Special Leave Policy

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
h) Sick Leave		
i) Extension of sick leave on half pay up to three months	Executive Director in conjunction with Chief People Officer	
ii) Return to work part-time on full pay to assist recovery	Executive Director in conjunction with Chief People Officer	
iii) Extension of sick leave on full pay	Chief Executive	
i) Study Leave		
i) Study leave outside the UK	Chief Executive	
ii) All other study leave (UK)	General Manager/Head of Service/Executive Director	
j) Removal Expenses, Excess Rent and House Purchases		
Authorisation of payment of removal expenses incurred by staff taking up new appointments (providing consideration was promised at interview) per the policy		
i) up to £5,000	Deputy HR Director / Head of Employee Services	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
ii) over £5,000	Chief People Officer	
k) <u>Grievance Procedure</u> All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Human Resources staff must be sought when the grievance reaches the level of General Manager	Chief People Officer	Trust Grievance Procedure
l) <u>Authorised Car & Mobile Phone Users</u> Requests for new posts to be authorised as car users Requests for new posts to be authorised as mobile telephone users	 Associate Director Associate Director	
m) <u>Entering into Fixed Term Contract</u>	Chief People Officer or their deputy	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
n) Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Associate Director	Retirement Policy
o) Redundancy	Chief People Officer	Redundancy Policy
q) Dismissal	Dismissing Staff	Disciplinary Procedures
19. Authorisation of New Drugs a) Estimated total yearly cost up to £25,000 b) Estimated total yearly cost between £25,001 and £100,000	Frimley Health Area Prescribing Committee Medical Director	SFI's Section 9
20. Authorisation of Sponsorship deals	Chief Executive, Medical Director, or Chief Financial Officer	
21. Authorisation of Research Projects	Chief Executive, Medical Director or Chief Financial Officer, the research having already been approved by the Health Research Authority (HRA) and NHS Research Ethics Committee as appropriate	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
	(national/regional bodies). Delegation Possible.	
22. Authorisation of Clinical Trials	Chief Executive or Medical Director, the trial having already been approved by the Health Research Authority (HRA) and NHS Research Ethics Committee as appropriate (national/regional bodies)	
23. Insurance Policies and Risk Management	Chief Executive & Chief Financial Officer	SFIs Section 19
24. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly. c) Medico - Legal Complaints Coordination of their management.	Chief of Nursing & Midwifery Associate Director/Head of Service/Executive Director Associate Director/Head of Service/Executive Director	
25. Relationships with Press a) Non-Emergency General Enquiries		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• Within Hours	Media and Communications Staff	
• Outside Hours	Admin on Call or Executive Director	
b) Emergency		
• Within Hours	Chief Executive or Executive Director	
• Outside Hours	Admin on Call or Executive Director	
26. Infectious Diseases & Notifiable Outbreaks	Admin on Call or Control of Infection Lead	
27. Extended Role Activities Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	Chief Executive or Chief of Nursing & Midwifery	Nurse/Midwives/ Health Visitors Act Midwives Rules / Code of Practice UKCC Code of Professional Conduct

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
28. Patient Services a) Variation of operating and clinic sessions within existing numbers • Outpatients • Theatres • Other b) All proposed changes in bed allocation and use • Temporary Change • Permanent Change • Contract monitoring & reporting	Chief Executive or Medical Director Bed Manager Chief Executive Chief Financial Officer	
29. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts & Insurance of Medical Staff. Work experience students	Chief People Officer Chief People Officer	
30. Review of fire precautions	Chief of Strategy	
	Chief of Strategy	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations		
32. Review of Medicines Inspectorate Regulations	Chief of Nursing & Midwifery	
33. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Clinical Director / Chief Financial Officer	
34. Review of Trust's compliance with the Data Protection Act	Chief Executive	
35. Monitor proposals for contractual arrangements between the Trust and outside bodies	Chief Executive	
36. Review the Trust's compliance with the Access to Records and Freedom of Information Acts	Chief Executive	
37. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	Chief Executive	
38. The keeping of the Register of Directors' Interests.	Company Secretary	SOs Section 6
39. Attestation of sealings in accordance with Standing Orders	Chief Executive	SOs Section 12

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
40. The keeping of a register of documents sealed.	Company Secretary	SOs Section 12
41. The keeping of the Hospitality Register	Chief Executive	
42. Retention of Records	Chief Executive	SFIs Section 18
43. Clinical Audit	Chief Executive	SFIs Section 19

Appendix 5

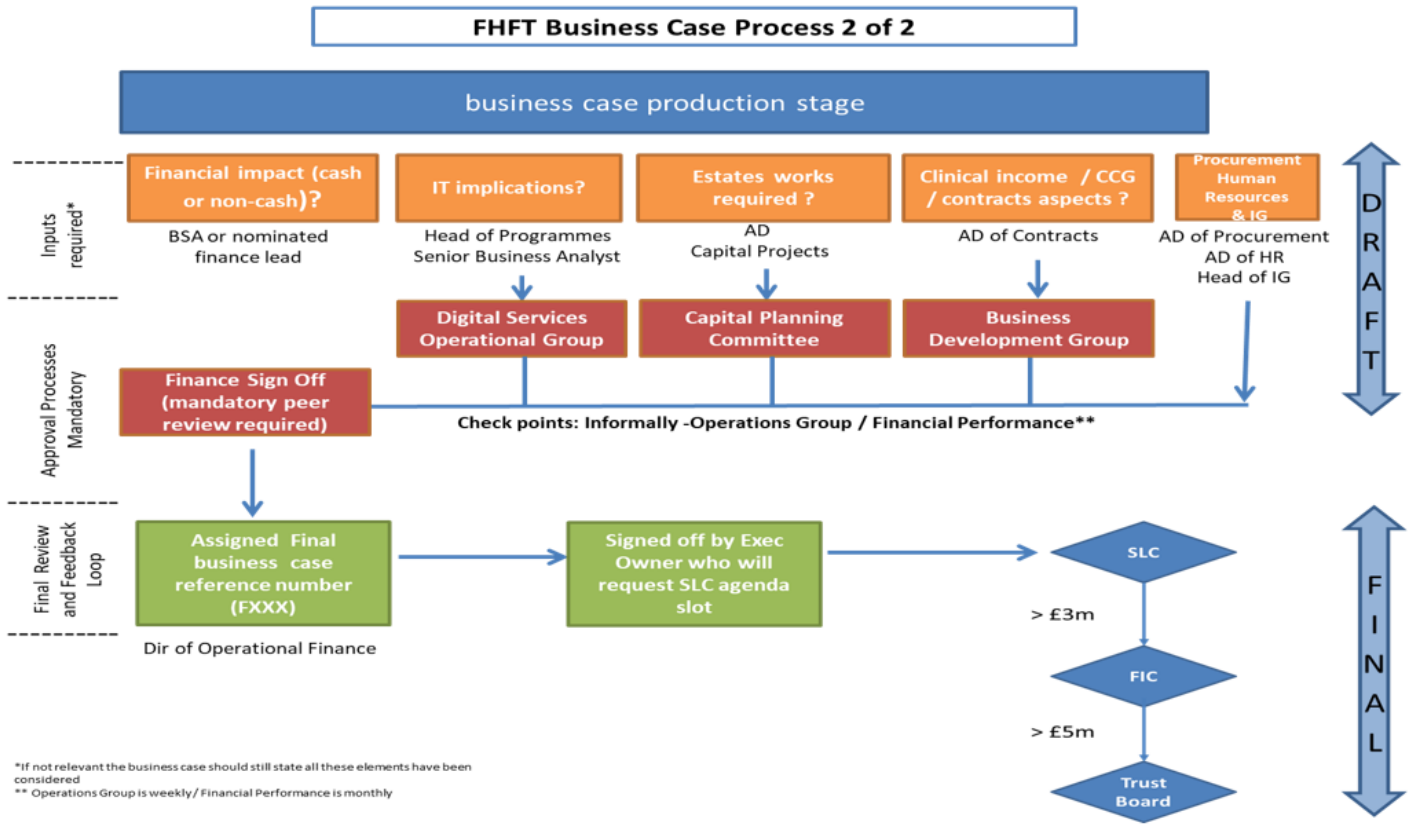
Delegated Authority for approval of contract variations for capital projects

Any contract variation with clinical or operational implications is to be recommended by the Clinical & Operational workstream or the workstream lead

Value of Variation	Approval process
£0 - £25k	Associate Director Capital and Project Director to approve – then report back to next Capital Management Group. Where cumulative value of variations exceeds £25k, approval to be sought from Chief Strategy Officer for estates projects, Chief of IT for IM&T projects and Chief of Nursing for EBME projects.
£25k - £100k	Where cumulative value of variations is up to £100k, approval to be sought from the SRO
£100k - £500k	Chief Financial Officer to approve.
£500k – £1,000k	Chief Executive and Chief Financial Officer to approve
£1,000 - £3,000k	Trust Management Board (TMB) to approve – upon agreement of the Chief executive and Chief Financial Officer
£3,000k - £5,000k	Finance and Investment Committee (FIC) to approve – upon recommendation from TMB
£5,000k +	Trust Board to approve – upon recommendation of FIC

Appendix 6

Investment Case Guidance and Process Flowchart



Appendix 7

HM Treasury Guidance on Public Sector Exit Payments: Use of Special Severance Payments

HM Treasury Guidance on Public Sector Exit Payments: Use of Special Severance Payments

The May 2021 guidance sets out the criteria the Trust must consider before making special severance payments, the control process and the transparency requirements.

Special Severance Payments are any payments on termination of employment which do not correspond to an established contractual, statutory or other right (for example, statutory and contractual redundancy pay or untaken annual leave). Some examples of the types of payment which are likely to constitute special severance payments include any payment reached under a settlement agreement, write-offs of outstanding loans and special leave such as gardening leave.

Special severance payments should be exceptional rather than routine. The Chief People Officer or Deputy will be responsible for ensuring that all relevant internal policies and procedures have been followed and all alternative actions have been fully explored and documented before an application is made for a special severance payment. They must also ensure that arrangements for special severance payments are fair, proportionate and lawful.

The process for applying for a special severance payment to HM Treasury is as follows:

- The Chief People Officer or Deputy (the sponsor) will be responsible for ensuring the Annex A proforma in the HM Treasury guidance is completed.
- The Chief People Officer or Deputy (the sponsor) will submit the completed proforma to the Chief Financial Officer or Deputy for approval.
- Upon approval, the Chief People Officer or Deputy will send proforma to the HM Treasury spending team for assessment.
- HM Treasury spending team will notify the sponsor of the outcome in writing.

Ministerial approval is required for special severance payment applications which are at or above £100,000 and/or where the employee earns more than £150,000. In these cases, the Chief Executive or Chair will be the sponsor, with support of Chief People Officer or Deputy as required.

No offers of special severance payments should be made before HM Treasury approval is received in writing.

In the case of settlement agreements, applications will only be approved by HM Treasury where the Trust demonstrates attempts have been made to resolve the dispute without recourse to a special severance payment and either legal advice recommends settling the claim or there is a clearly evidenced value for money case not to adopt the Government's default approach and settling is clearly the best course of action.

NHSE Guidance on Special Payments

On 19th April 2021, NHSE instructed Trusts to provide detail of any special payments which are above £95,000 and/or which could be classified as novel, contentious or could cause repercussions elsewhere in the public sector ('NCR'). The letter is attached. The detail of the special payments should be submitted to ENGLAND.assurance@nhs.net prior to payment being made. The Chief People Officer or Deputy should send details of the payment to NHSE/I when the Annex A proforma is issued to HM Treasury spending team.

Report Title	Annual Review of Committee Terms of Reference
Meeting and Date	Public Board of Directors, 5th July 2024
Agenda Item	15.
Author and Executive Lead	Hannah Farmhouse, Assistant Company Secretary Victoria Cooper, Acting Company Secretary Caroline Hutton, Interim Chief Executive
Executive Summary	This report presents the Board sub-committee terms of reference (ToR) for Board approval, following their annual review. The new versions of the ToRs can be found in the Reading Room and a summary of the amendments is attached. Once approved the new versions of the ToRs will be available on the Trust's website.
Action	The Board of Directors is asked to **APPROVE** the revised terms of reference for the Board sub-committees.
Compliance	Trust Constitution and Committee Terms of Reference.

Annual Review of Committee Terms of Reference

Summary of Amendments

Audit Committee

- Section 1 and 2- wording simplified.
- Section 4.3 – additional bullet point to reflect that the Committee will approve the annual cost of external auditor work to ensure value for money.
- Section 4.5 – wording added to reflect the assurance the People Committee will provide to the Audit Committee regarding the people strategy, freedom to speak up, safe working and EDI performance. Additional wording to reflect the Finance & Investment Committee's role in providing assurance to the Audit Committee on major investment decisions.
- Section 6 – job title change

Nominations Committee

- Section 5 – job title change

Performance and Remuneration Committee (PRC)

- Section 4 updated to align with the Executive Directors' Remuneration Policy and the responsibilities of the Trust with regards to the BSPS Chair employment contract.
- Section 6 – Job title change.

Quality Assurance Committee

- Update to the Board Committee membership under section 10.