

Agenda Trust Board – Open Session

Date	31/10/2019
Time	9:00 - 11:40
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins
Apologies	Derek Sandeman, Steve Harris

- 1**
9:00 **Chair's Welcome, Apologies and Declarations of Interest**
To note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
- 2** **Minutes of Previous Meeting held on 26 September 2019**
- 3** **Matters Arising and Summary of Agreed Actions**
To discuss any matters arising from the Minutes, and to agree on the status of any actions assigned at the previous meeting.
- 4** **Quality, Performance and Finance**
Quality includes: clinical effectiveness, patient safety, and patient experience
- 4.1**
9:15 **Staff Stories**
To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.
- 4.2**
9:30 **Briefing from Chair of Quality Committee for review (Oral)**
Cyrus Cooper, Non-Executive Director
- 4.3**
9:35 **Briefing from Chair of Audit and Risk Committee for review (Oral)**
Simon Porter, SID/Non-Executive Director
- 4.4**
9:40 **Briefing from Chair of Strategy & Finance Committee for review (Oral)**
Jane Bailey, Non-Executive Director
- 4.5**
9:45 **Integrated Performance Report for Month 6 for review**
To review the Trust's performance as reported in the Integrated Performance Report and the Quarterly Patient Safety Report.
Sponsor: Jane Hayward, Director of Transformation & Improvement
- 4.6**
10:25 **Finance Report for Month 6 for review**
Sponsor: David French, Chief Financial Officer

- 5 Strategy and Business Planning**
- 5.1 Trust Winter Plan for approval**
10:35 Sponsor: Paula Head, Chief Executive
Attendees: Jacqui McAfee, Director of Operations for Elective Services and
Duncan Linning-Karp, Director of Operations for Emergency Services
- 6 Corporate Governance, Risk and Internal Control**
- 6.1 Feedback from Council of Governors' meeting 8 October 2019 (Oral)**
10:50 Sponsor: Peter Hollins, Trust Chair
- 6.2 EU Exit Briefing for review**
11:00 Sponsor: Paula Head, Chief Executive
Attendee: Jacqui McAfee, Director of Operations for Elective Services
- 6.3 Board Assurance Framework (BAF) 2019/20 Quarter 2 Update for review**
11:10 Sponsor: Paula Head, Chief Executive
Attendee: Charlie Helps, Interim Company Secretary
- 6.4 Review of Standing Financial Instructions 2019-20 for approval**
11:25 Sponsor: David French, Chief Financial Officer
Attendee: Ian Howard, Deputy Director of Finance
- 6.5 Register of Seals, and Chair's Actions for ratification**
11:30 In compliance with the Trust Standing Orders, Financial Instructions, and the
Scheme of Delegation.
Sponsor: Peter Hollins, Trust Chair
- 7 Any other Business**
11:35 To raise any relevant or urgent matters that are not on the agenda
- 8 To note the date of the next meeting: 28 November 2019, in the
Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH**
- 9 Exclusion of press, public, and others**
The public and representatives of the press may attend all meetings of the
Trust, but shall be required to withdraw upon the Board of Directors resolving
as follows "that representatives of the press, and other members of the public,
be excluded from the remainder of this meeting as publicity would be
prejudicial to the public interest by reason of the confidential nature of the
business to be transacted."

10 **Items circulated to the Board for reading**

1 October 2019

Press Release: Staff and patients to take part in second scrap car rally for cancer charity

3 October 2019

Press Release: Doctors trial new vaccine to protect babies against life-threatening respiratory infections

4 October 2019

Follow-up to patient story at Trust Board – thank you message from parent

9 October 2019

Press Release: Doctors say lack of data 'may put overweight children at risk' during surgery

14 October 2019

Press Release: NHS staff from across Hampshire join forces to showcase future of healthcare

16 October 2019

Press Release: Southampton expert says home genetic testing kits "shouldn't be used for healthcare decisions"

21 October 2019

Press Release: Southampton clinicians use new gel injection to reduce side effects for prostate cancer patients

23 October 2019

Press Release: Researchers find whooping cough bacteria “lurks silently” in healthy people

11 **Follow-up discussion with governors**

11:40

12 **Meeting with PwC, in the Conference Room, Heartbeat Education Centre**

11:55

13 **Lunch**

13:10

Minutes Trust Board – Open Session

Date	26 September 2019
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins
Present	Jane Bailey, David Bennett, Gail Byrne, Cyrus Cooper, Jenni Douglas-Todd, David French, Steve Harris, Jane Hayward, Paula Head, Caroline Marsall, Simon Porter, Mike Sadler and Derek Sandeman
In Attendance	Adrian Byrne, Charlie Helps, 3 staff members and 3 members of the public
Apologies	None
Minutes	Vicky Boland

1 Chair's Welcome, Apologies and Declarations of Interest

The Chairman welcomed those present, noted apologies and asked for any new declarations of interest in matters on the Agenda. No conflicts of interest with items on the Agenda were declared.

2 Minutes of Previous Meeting held on 30 August 2019

The minutes of the previous meeting were agreed as a true and fair representation of the business transacted subject to two minor typographical errors in paragraphs 4.4 (last sentence of improving patient journeys) and 4.7 (last sentence).

3 Matters Arising and Summary of Agreed Actions

To discuss any matters arising from the Minutes, and to agree on the status of any actions assigned at the previous meeting.

Action 80) Defect work orders - This would be discussed as part of the closed agenda.

Action 42) UHS change champions - The mission statement was being launched during September. Action closed.

Action 81) Workforce reports - This action continued.

Action 63) Integrated performance report - Workforce - The Human Resources (HR) metrics were being reviewed to ensure that there was assurance at every level. They would be reviewed and discussed at the Workforce Committee and Divisional Performance meetings. Action closed.

Action 66) Safeguarding annual report - It had been agreed that a formal update on safeguarding would be provided six-monthly as standard with the option to increase this to quarterly if required. Action closed.

Action 61) Patient story - GB was meeting the patient's parents within the next few weeks and would ensure that the story was shared with the nurses in child health. Action closed.

Action 64) Integrated performance report - Emergency department (ED) - The receptionists "red flag" list was being reviewed. Action closed.

Action 65) Integrated performance report - Maternity indicators - This would be discussed as part of the next maternity update to the Quality Committee. Action closed.

Action 38) Overnight patient moves - This would be discussed at the October Quality Committee. Action closed.

All other actions were confirmed as complete.

4 Quality, Performance and Finance

Quality includes: clinical effectiveness, patient safety, and patient experience

4.1 Patient Story

The patient was unable to attend therefore there was no patient story this month.

4.2 Briefing from Chair of Strategy & Finance Committee for review (oral)

Jane Bailey, Non-Executive Director

JB summarised the items considered at the September meeting of the Strategy and Finance Committee:

- A review of the latest financial position for month five.
- A review of Cost Improvement Programmes (CIPs) for 2019/20. The Committee received a detailed update on the proportion of income and cost-saving CIPs identified. Length of stay (LoS) schemes were identified as an area of risk.
- Two business cases from Solent Acute Alliance were received. These would be discussed at the closed session.

4.3 Briefing from Chair of Charitable Funds Committee for review (oral)

Jenni Douglas-Todd, Non-Executive Director

JD-T summarised the items considered at the September meeting of the Charitable Funds Committee:

- A discussion of charitably funded projects threshold for overruns - a small working group would be formed to agree on thresholds. The group would also review the funding of maintenance or revenue costs and underwriting for major appeals that do not raise sufficient funds.
- The revamp of the Charity website.

- The charity funds management committee - A review of the committee terms of reference was undertaken and more detailed reporting against the charity strategy was requested.
- Volunteering opportunities - Divisional Heads of Nursing had been asked for ideas and this was being considered in more detail.
- A presentation from the Individual Giving Officer.
- Safeguarding of charity staff, lone working and visitors.

CC welcomed any nominations for the Queens Award for Voluntary service. JD-T advised that two volunteers were being considered for the award.

4.4 **Integrated Performance Report (IPR) for Month 5 for review**

Sponsor: Jane Hayward, Director of Transformation & Improvement

IPR 2019-20 for Month 5

Improving patient journeys

CM highlighted that the percentage of patients on an open Referral to Treatment (RTT) pathway (waiting list) had worsened by 2% in month. She advised that the Trust was behind with the validating of data due to additional data being added to pathways, and was bringing in an external company to assist with this to provide more robust data.

PTH asked whether any opportunities had been identified during the NHS Improvement (NHSI) visit on flow and same day emergency care. CM advised that UHS were the second of 14 trusts visited but that a formal report was expected once all visits were completed by the end of September 2019. Some areas of good practice had been identified to share with other trusts.

MS queried the circumstances in which two patients had waited longer than a year for treatment (RTT) and the consequences for those patients waiting longer than 62 days for cancer treatment. CM said that the two patients had been treated in month and that delays related to delays at the start of the pathway and patient choice.

The reasons for patients waiting longer than 62 days for cancer treatment varied as did the longevity of breaches, the longest of which was 104 days. MS added that there were a number of national issues impacting on performance that affected all hospitals, yet UHS' position had deteriorated and requested an explanation of this. CM outlined the factors that were affecting performance including NHS pension issues and the impact of this on the ability to run 7-day services as UHS utilised clinician time out of hours, which other hospitals did not. PTH sought an update on progress towards a solution to the pension issue. PHe and SH provided an overview of national investigations and local system discussions to find a solution.

Supporting healthy lives

MS highlighted some inconsistencies between the Hospital Standardised Mortality Ratio (HSMR) data in the IPR and the Learning from Deaths report shared with the Board.

PTH highlighted the increase in staff sickness absence. SH provided an update on the actions being taken to address this.

Leading-edge research, education and innovation

The 10% reduction in NIHR CRF & BRC publications in 2019/2020 due to the loss of clinical academic staff was highlighted. DS advised that this was due to a number of senior staff retirements particularly in respiratory but recruitment was underway. CC added that recruitment of academic staff was an issue nationally however the joint research strategy board was working to improve this.

DS noted that the commercial research performance had decreased significantly due to capacity issues. Solutions were being considered.

Quarter 1 Patient experience summary report

GB introduced the report noting that it had been presented to the Quality Committee. The timing of reporting was being reviewed to ensure the information provided to the Board was as up to date as possible.

MS highlighted the reduction in complaints per 1000 units. This was attributed to a number of complaints becoming complex concerns. GB added that a recent quality improvement project had improved processes within complaints resulting in an improvement in response times and the quality of responses.

JD-T asked whether the Trust offered exit interviews to volunteers to understand the reasons for the retention issues. GB advised that there were a number of factors affecting retention of volunteers but exit interviews were not currently offered. This would be considered.

JB noted the number of complaints received that related to smoking. DS provided a summary of the actions required for the UHS to become smoke-free. PHe advised that the Director of Estates had sought a solution for the current problem at the main entrance.

4.5 Finance Report for Month 5 for review

Sponsor: David French, Chief Financial Officer

DAF presented the month five Finance report, noting for August that:

- The Trust delivered a surplus of £0.2m, £0.6m better than Plan. Year to date the Trust was reporting a £0.1m surplus which was £2.5m better than Plan. Income was better than Plan. Pay costs were £0.8m worse than Plan, with £1.5m related to backdated medical staff pay award offset in part by an in year nursing agency VAT reclaim.
- CIP delivery was on Plan at £3.1m for the month, which remained £1.4m behind Plan year to date. £39.7m CIP had been identified against a target of £40m.
- Capital expenditure was £14.2m against a planned spend of £15.6m year to date. £1.1m of this shortfall related to the General Intensive Care Unit (GICU) build although the project was on schedule. The Trust was forecasting additional expenditure in the energy efficiency project as a result of national funding being received.
- The Trust would re-forecast its financial position at the end of month six. This would be discussed at the closed session of the October Trust Board.

PTH highlighted the receipt of national funding for energy efficiency schemes and queried if the Trust had received an update on funding for the singleton theatre. DAF advised that this had not been received but was being discussed with the South East region Finance Director.

CC sought clarification of the balance between elective and non-elective activity required to improve the Trust's financial position. DAF provided an overview of the measures being taken to improve the balance.

5 Strategy and Business Planning

5.1 UHS Digital Strategy for approval

Sponsor: Jane Hayward, Director of Transformation & Improvement

Attendee: Adrian Byrne, Director of Informatics

The strategy had been reviewed in detail at the September Trust Board Study Session.

DB felt that the strategy required additional work to ensure that the clinical input, governance structure, financial assumptions and benefits, and the process for decision making was clear. The strategy should also be shared with the Sustainability and Transformation Partnership (STP). PHe advised that capital constraints were likely to occur however the Trust did not want to base its strategy on this and that the decision-making process would be developed separately alongside clinicians. MS added that the strategy appeared to lack the patients' perspective.

The Board agreed with the clear vision and the direction of travel that the strategy provided. Additional work was required alongside clinicians, nurses and patients to develop this work further in line with the Trust's clinical strategy.

Decision

The Board resolved to support the vision and direction of the UHS Digital Strategy.

6 Corporate Governance, Risk and Internal Control

6.1 Register of Seals, and Chair's Actions for ratification

In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Delegation.

Sponsor: Peter Hollins, Trust Chair

PTH reported actions taken in month on behalf of the Board.

Decision

The Board ratified the actions taken in month.

7 Any other Business

To raise any relevant or urgent matters that are not on the agenda

New staff members

MS commended CMs message about new staff members and highlighted the use of yellow badges for new nurses.

Winter planning

PHe provided an overview of winter planning and the pressures expected this year. A detailed update would be provided at the October Board meeting to provide assurance to the Board of the plans and mitigations in place.

Governor elections

PTH provided an update on the recent governor elections noting that 38 candidates were nominated resulting in all 8 vacancies being filled. The Lead Governor, Bob Purkiss was re-elected. Amanda Turner was not re-elected as non-clinical and support staff governor on this occasion. New governor induction would take place on 30 September 2019.

Learning from Deaths 2019-20 Quarter 1 Report

MS again highlighted some inconsistencies between the HSMR data in the IPR and the Learning from Deaths report and suggested that page three of the latter be reviewed.

Mike Sadler, Non-executive director

MS was leaving UHS after five years as a Non-executive director. PTH thanked MS on behalf of the Board for his hard work for the Trust particularly as Chair of the Quality Committee and added that he would be greatly missed.

Caroline Marshall, Chief Operating Officer

CM was retiring from UHS after six years on the Trust Board. PTH thanked CM on behalf of the Board for her contributions as a clinician, manager, Chief Operating Officer and human being. She would also be greatly missed.

8 To note the date of the next meeting

Thursday 31 October 2019, in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH

List of outstanding action items – Trust Board Open Session

Agenda item	Assigned to	Deadline	Status
Trust Board – Open Session 30/08/2019 4.5 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports 2018-19 for review and Action Plans 2019/20 for approval			
81.	Workforce Reports	<ul style="list-style-type: none"> ● Bailey, Jane ● Byrne, Gail 	25/09/2019 ■ Overdue
<p><i>Explanation action item</i> Reports related to workforce to be considered as a whole, as part of JB's review of the Board and its Committees. A specific update on progress in respect of long term illness and disability to be made in February 2020.</p>			
Trust Board – Open Session 30/08/2019 4.4 Integrated Performance Report for Month 4 for review			
80.	Defect work orders	<ul style="list-style-type: none"> ● French, David ● Head, Paula 	31/10/2019 ■ Pending
<p><i>Explanation action item</i> PHe to feedback to DAF in relation to Board comments on defect work orders. To be discussed at a future Strategy & Finance Committee or Quality Committee.</p>			

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: Integrated Performance Report 2019/20 Month 6			
Category	Quality, Performance, and Finance		
Agenda item	4.5		
Sponsor	Director of Transformation and Improvement		
Author	Trust Performance Manager		
Provenance	The Integrated Performance Report is reviewed monthly by the Board of directors		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for REVIEW.		
Relevant strategic goals	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people's needs.	✓ Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • BAF10 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status 		
Impact assessments	n/a		
Other standards affected	n/a		

Integrated KPI Board Report Digest

Improving patient Journeys

September was a challenging month for UHS across both the elective and non-elective pathways. Despite this we saw some improvements in ED performance and largely remained on Opel 2/3. We also saw improvements in 62 day cancer wait performance.

Non elective length of stay remained at 6.4 days in September. Delayed transfers of care increased in September to 7.2% against a target of 3.5%. This represented a continued deterioration in Delayed Transfers of Care performance however, towards the end of the month some improvements were made and these have continued into October. We have continued to work closely with system partners and we are working together to ensure we have additional capacity in the winter months.

Adult bed occupancy has been consistently higher this summer compared to last summer at around 95%, adult midday occupancy dropped slightly in August to 93.2% which is similar to occupancy the same time last year. While we managed to close some adult and paediatric beds we did not close the number predicted and saw a significant number of cardiology outliers into medical beds.

Additional patients have been emergency admissions. We have had a 7% growth in emergency attendances, and a 4.3% increase in non-elective spells (year to date) accounting for the additional inpatients this summer. Nationally ED attendances are still increasing. In September Emergency department attendances decreased slightly but continued to be above last year's levels, non-elective admissions were also higher. While we have seen a reduction in Length of Stay in some care groups particularly Medicine for Older People and Surgery we did not see the level of improvement needed in September.

The number of patients for theatre cancelled and not readmitted in 28 days remained low.

In September we started a new long length of stay process in division B involving a senior challenge process from the Integrated Discharge Bureau and COO team to reinvigorate efforts to reduce LOS. We are running this as a pilot which will be reviewed in October and if successful will be rolled out trust wide. Separately the organisation is reviewing what external support will help us more quickly reduce LOS. NHSI/E continues to provide support to the process.

While we have not met the trajectory we did see further improvements in emergency access performance in September. Type 1 performance in September was 79% and we ranked 5th of 8 Major Trauma Centre peers (8th being worst). Local delivery system performance was at 86.9% in September against a target of 90.0%. The main factors in improvement were the additional junior doctor numbers, and the improved minor injury performance. The recovery plan is being delivered based on the recommendations of Matthew Cooke, a national clinical advisor. This is being monitored fortnightly with the national team and a new system plan has been agreed with weekly CEO oversight.

Percentage of patients on an open RTT pathway (waiting list) who have waited less than 18 weeks in September is at 82.24% and is trending downwards not achieving the target of >92%.

The external company commissioned to undertake waiting list validation is due to commence at the end of October to enable more confidence in the true underlying picture of the waiting list. Anaesthetic shortages continue to impact access to theatre and the pension's issues which affect both clinic capacity and theatre sessions are not yet resolved.

There were six patients waiting longer than 52 weeks at the end of September spread across a range of specialties, there were two in Gynaecology. Princess Anne continues to have one theatre unavailable due to maintenance work which continues to challenge the service with their capacity and demand.

The waiting list size continues to increase nationally; in July it sat at 4.4 million and was increasing by 10,000 per month.

6 week diagnostic performance is trending upwards not achieving trajectory, currently at 2.9% against a target of <1% waiting over 6 weeks in September. This is due to endoscopy and neurophysiology capacity. Nationally 3.8% of patients are missing the six week target.

Average weeks waited for first outpatient appointment was showing a consistent reduction but has shown a dramatic increase this September back up to levels similar to last year.

Overall performance of the 62 day cancer wait metric improved in August to 75.1%. The number of first cancer treatments decreased by 14% in August and there was a 4% increase in emergency referrals for cancer. This is in accordance with national trends to increase the number of patients referred and reduce the percentage diagnosed in the referral cohort. UHS was ranked 7th (10th being worst) out of a peer group of 10 similar size teaching hospitals. Pathways across all tumour sites have been affected by diagnostic capacity of all modalities due to consultant workforce shortfall, and also patient choice due to the holiday season, as well as late referrals from other units. UHS continues to work closely with the Wessex cancer alliance and NHSI.

31 day cancer waiting time performance has not achieved the target and continues a downward trend. Performance was at 89.3% in August against a local trajectory of 94.7%. This is a reflection of theatre capacity as well as complex radiotherapy pathways which require a long time to plan. We are starting to outsource some radiotherapy work to improve these waiting times.

2 week GP referral cancer waiting time performance remains high, achieving target for the sixth month in a row, currently at 96.1% in August against a target of 93%. This is a significant improvement on the same period last year.

Delivering value based health and care

Cost per Weighted Activity Unit (WAU) is the headline productivity metric used within the Model Hospital. Costs are adjusted for local variations in the cost of providing healthcare using the Market Forces Factor (MFF). In 2017/18 UHS cost per WAU was £3,358 which is in quartile 1 (the lowest 25% in the nation), the national median for 2017/18 was £3,486.

The Model hospital in association with the GIRFT team has now published up to date clinical metrics for 7 surgical Specialties, these will be updated at regular intervals in the year for trust to monitor and review.

Getting it right first time (GIRFT) is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. At UHS 21 out of 33 clinical specialties has been visited. With 19 of these now having a clinically lead quality improvement and specialty lead investigation programmes agreed with the GIRFT central team.

The latest national data (July 2019) showed a median CHPPD for similar size (clinical output) trusts as 4.47 for registered nurses and 9.0 overall, UHS was at 3.23 and 8.6 respectively that month.

For the last 9 months the trust has achieved the target for complaints closed within 35 days, in September we achieved 81% against a target of 70%.

Supporting healthy lives

New C.difficile cases are below the limit in September with 3 against a limit of 5, of these none were deemed a lapse in care. We are level with limit of cases year to date with 30 cases against a limit of 30.

There was 1 SIRI presented at Significant Incident Scrutiny Group (SISG) in September – C.difficile Outbreak and HCAI Death on D4. This was also presented at Southampton CCG SIRI Panel and Closed. Learning included: environmental cleaning, commode cleaning, staffing and condition of the environment.

There were two moderate harm medication related incidents reported in September 2019. There is one incident relating to an overdose of paracetamol administered to a patient which is currently being investigated and will be reviewed by SISG at UHS. The second incident involves a patient being discharged home with another patient's medicine, resulting in re-admission to hospital after doses were taken by the patient at home. Both incidents will be reviewed by the medicines safety group.

9 national reports were published in September 2019 and all were reviewed by the clinical effectiveness team. No areas of concern were identified.

Patients screened for risky behaviours in September (alcohol consumption and smoking) remain stable well above target (currently 96% against a target >80%). Of those found to have moderate or high alcohol dependence 86% were given relevant advice or a referral to specialist services in September, this performance is stable not achieving the target 90% (last achieved December 2018). Of those found to smoke who were given advice or offered medication performance in August was 87% below the target 90%. CQUIN funding has been awarded for further Medicines Management Team members for the duration of the CQUIN – until the end of

March 2020. This will allow for some out of hours and weekend work targeting specific areas that there is currently low uptake on. These members will predominately focus on the tobacco advice and offering of medication as it is felt that there is a robust enough system in place currently focussed on the alcohol elements of the CQUIN. We have also now set up a weekly report to inform all members of how we are doing within the quarterly milestone so that focus can be moved if required. There is similarly a monthly Tobacco meeting to discuss any concerns so that any escalations are dealt with in a timely manner.

Building an expert and inclusive workforce

In UHS ward-based areas, total nursing staff vacancies have decreased by -1.07% since last month. Registered nurse vacancies in ward-based areas have also decreased this month (by -3.09% since last month). These changes are due to promotion of RNs, relocation of staff and reduction in contracted hours mainly following return from maternity leave, however to offset this 66 FTE newly qualified nursing and 26.3 FTE Overseas nurses have acquired their PINs.

Some key targets have been missed for staff turnover and appraisals. Sickness absence rates have increased for the fourth month and are now above target. CHPPD has increased but this is likely due to a change in where we are gathering data from compared to last month. UHS has seen improvements in rates of employment for BAME Band 7+. Additionally, the position for the following is stable: statutory and mandatory training compliance (with 10 of 12 measures meeting target).

Being agile in meeting people's needs

Estates helpdesk requests did not achieve the target in September (7th month in a row), currently at 81.0%. Unresolved help desk requests remain stable well below target, in September we had 801 against a target <1000. Unresolved requests over 30 days old decreased to 209 in September, 9 above the target <200. Percentage defect work orders completed on time met the target >85% in September. The percentage of statutory and mandatory jobs completed on time improved this month and continues to meet the target 95%. The EFCD team have looked at the effect of not performing some maintenance tasks in a timely manner and considered how this impacts patients.

A simple comparator of the failure rate of toilets has been selected. In September the figure was 0.49%.

Immunology and Histopathology requesting and acknowledgement continues its increase. Total requesting in UHS is at 90.5% and acknowledgment is at 92.8% steady with previous months.

UHS patient logins to My Medical Record remained high in September following the surge in June linked to a new registration method, patient registrations has plateaued and showed a slight decline over the last two months. The plan is to increase to 100,000 by the end of this year.

Leading edge research, education and innovation

In Q2 2019/20 UHS was ranked 6th for non-weighted and 5th for weighted CRN recruitment against a target of being in the top 10 and top 5 respectively.

In Q2 UHS are currently ranked 14th for contract commercial study recruitment, which whilst an improvement against previous recent performance (up from 16th), is still not meeting our target of being in the top 10, which has prompted a specific focus on improving our commercial performance.

Comparative CRN recruitment performance by specialty was on target in Q2 2019/20 with 52% specialties ranking as predicted (in the top 5 or top 10 based on prior performance).

Proportion of commercial studies closing in 18/19 FY on time and to recruitment target ended the year below the 80% target at 71% in Q4; however this was an improvement on the 17/18 performance of 57%. In Q2 2019/20 this metric is currently at 58%, but we anticipate that this will improve significantly by year end.

Proportion of non-commercial studies closing on time and to recruitment target in Q2 is currently at 47% but again we anticipate that this will improve significantly by year end.

Clinical study set up and recruitment (in particular for the commercial portfolio) has been impacted by capacity constraints across the research infrastructure and by pressures within the clinical services, in particular with regards to pharmacy capacity to set up and deliver clinical trials. Concerns have been escalated to Trust Executives.

The year to date NIHR CRF & BRC publications in 2019/2020 is currently 137 (10% less than same time last year), related to a loss of clinical academic staff. This is a major concern for our next BRC and CRF applications. Actions are currently in progress that will require Trust support in due course.

Integrated KPI Board Report

covering up to

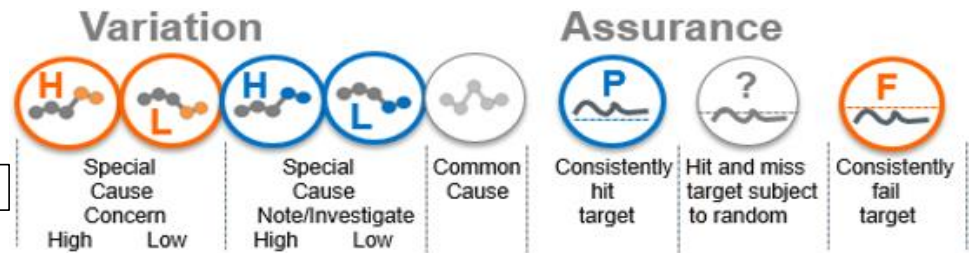
Sep 2019

Executive Sponsor - Jane Hayward, Director of Transformation

Jane.Hayward@uhs.nhs.uk















Report Guide

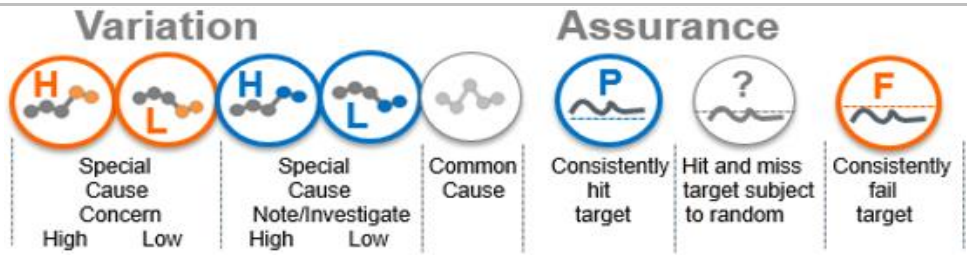
Chart Type	Example	Explanation
Cumulative Column		A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates.
Cumulative Column Year on Year		A cumulative year on year column chart is used to represent a total count of the variable throughout the year. The variable value is reset to zero at the start of the year because the target for the metric is yearly.
Line Benchmarked		The line benchmarked chart shows our performance compared to the average performance of a peer group. The number at the bottom of the chart shows where we are ranked in the group (1 would mean ranked 1st that month).
Line Percentiles		A line percentiles chart is used to represent the distribution of a variable. The 50th percentile shows the median value, we also show the 5th, 25th (lower quartile), 75th (upper quartile) and 95th centiles.
Control Chart		<p>A control chart shows movement of a variable in relation to its control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they</p> <ul style="list-style-type: none"> -Go outside control limits -Have 6 points in a row above or below the mean, -Trend for 6 points, -Have 2 out of 3 points past 2/3 of the control limit, -Show a significant movement (greater than the average moving range).
Variance from Target		Variance from target charts are used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target.














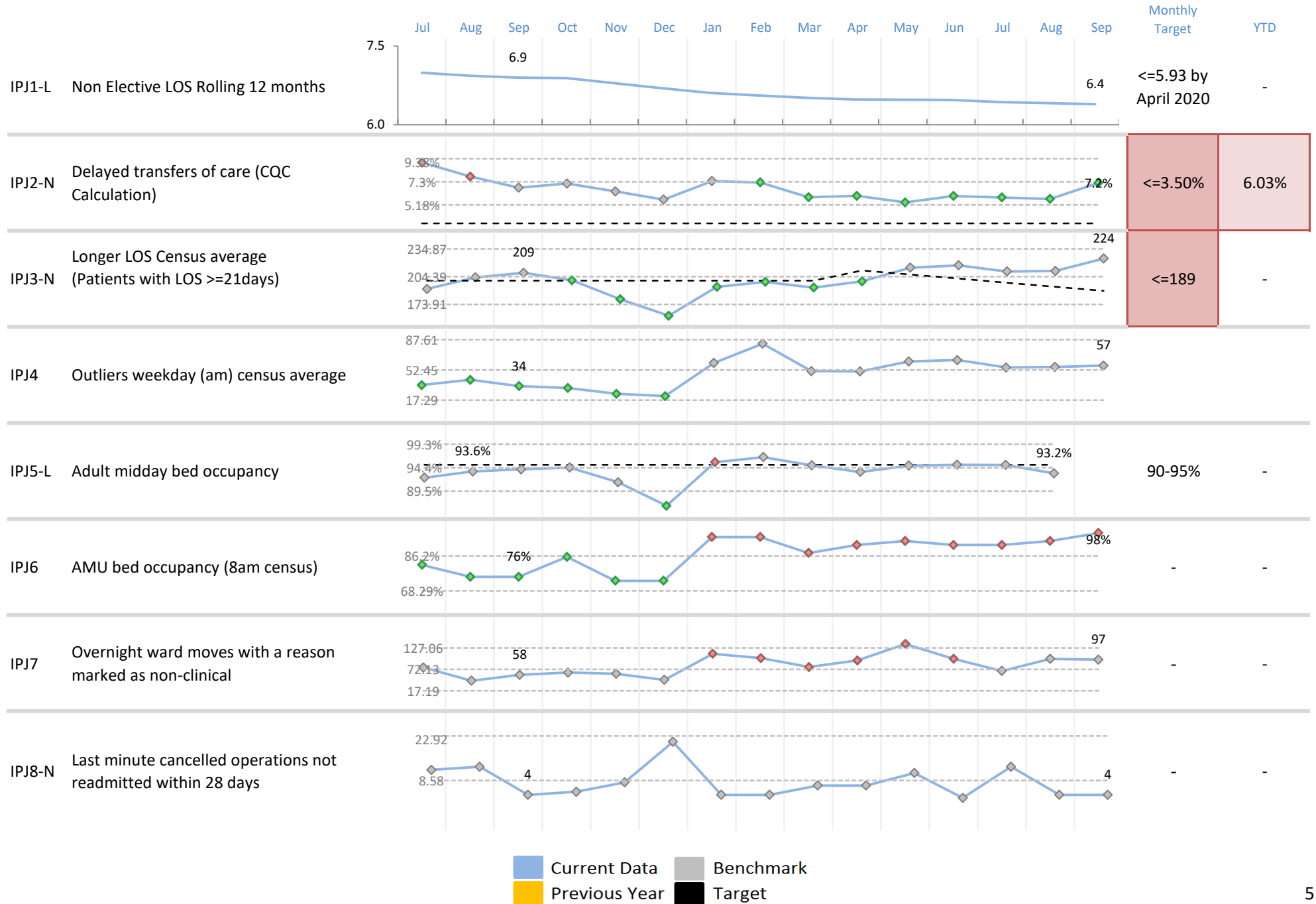
Under development

Improving Patient Journeys

IPJ ID	Description	Variation Icon	Assurance Icon
IPJ1-L	Non Elective LOS Rolling 12 months	-	-
IPJ2-N	Delayed transfers of care (CQC Calculation)		
IPJ3-N	Longer LOS Census average (Patients with LOS >=21days)		
IPJ4	Outliers weekday (am) census average		-
IPJ5-L	Adult midday bed occupancy		
IPJ6	AMU bed occupancy (8am census)		-
IPJ7	Overnight ward moves with a reason marked as non-clinical		-
IPJ8-N	Last minute cancelled operations not readmitted within 28 days		-
IPJ9	Percentage patients spending less than 4hrs in ED - UHS Type 1		-
IPJ10	Percentage patients spending less than 4hrs in ED - UHS Total (includes SGH all types and Lymington)		-
IPJ11-L	Percentage patients spending less than 4hrs in ED - Local Delivery System		
IPJ12	Same Day Emergency Care (SDEC)	-	-
IPJ13-N	Time to initial assessment - 95th Centile UHS Total	-	-
IPJ14-N	Time to treatment - Percentiles UHS Total	-	-
IPJ15-N	Total time spent in ED - Percentiles UHS Total	-	-



Indicator ID	Description	Variation Icon	Assurance Icon
IPJ16-N	% Patients on an open 18 week pathway (within 18 weeks)		
IPJ17-N	Total number of patients on a waiting list	-	-
IPJ19-N	% of Patients waiting over 6 weeks for diagnostics		
IPJ20	Average weeks waited for first outpatient appointment		-
IPJ22-L	62 day cancer wait performance		
IPJ23-L	31 day cancer wait performance		
IPJ24-N	Urgent GP referrals seen in 2 weeks		
IPJ25	Snapshot of waits > 104 days	-	-
IPJ26	28 Day Faster Diagnosis	-	-

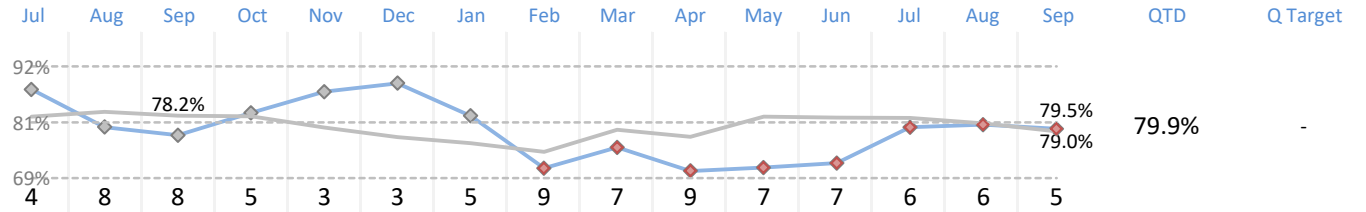


Percentage of patients spending less than 4 hours in ED

IPJ9 SGH Main ED (Type 1 and UCH)

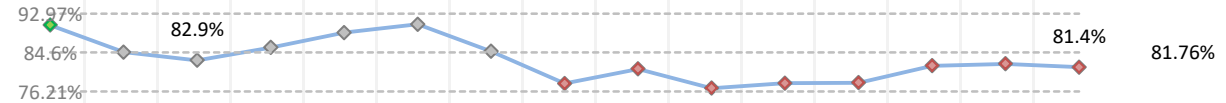
Major Trauma Centres (Type 1)

Rank of 11, (8 from May 19 onwards)->



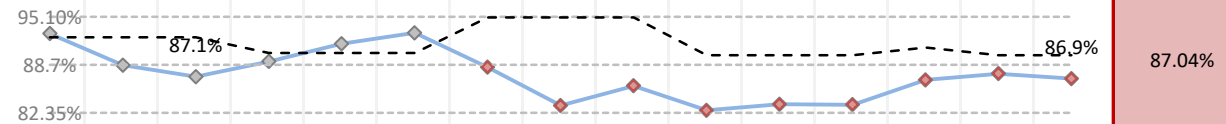
IPJ10

UHS Total (includes SGH all types and Iymington)



IPJ11-L

Local Delivery System

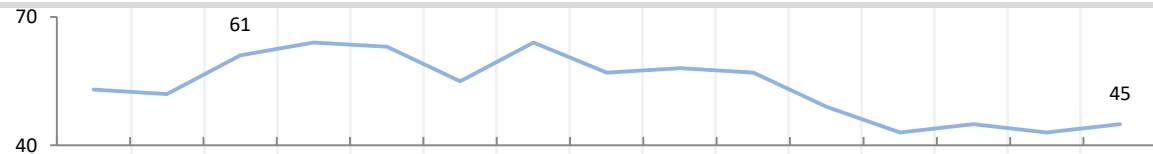


IPJ12 Same Day Emergency Care (SDEC)

Awaiting national data definition

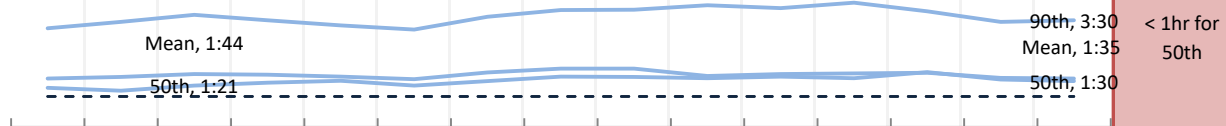
IPJ13-N

Time to initial assessment - 95th Centile UHS Total



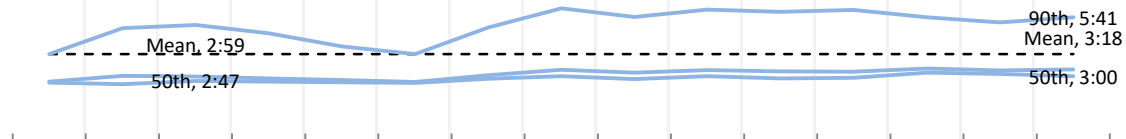
IPJ14-N

Time to treatment - Percentiles UHS Total

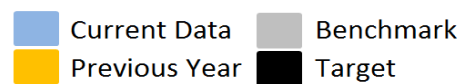
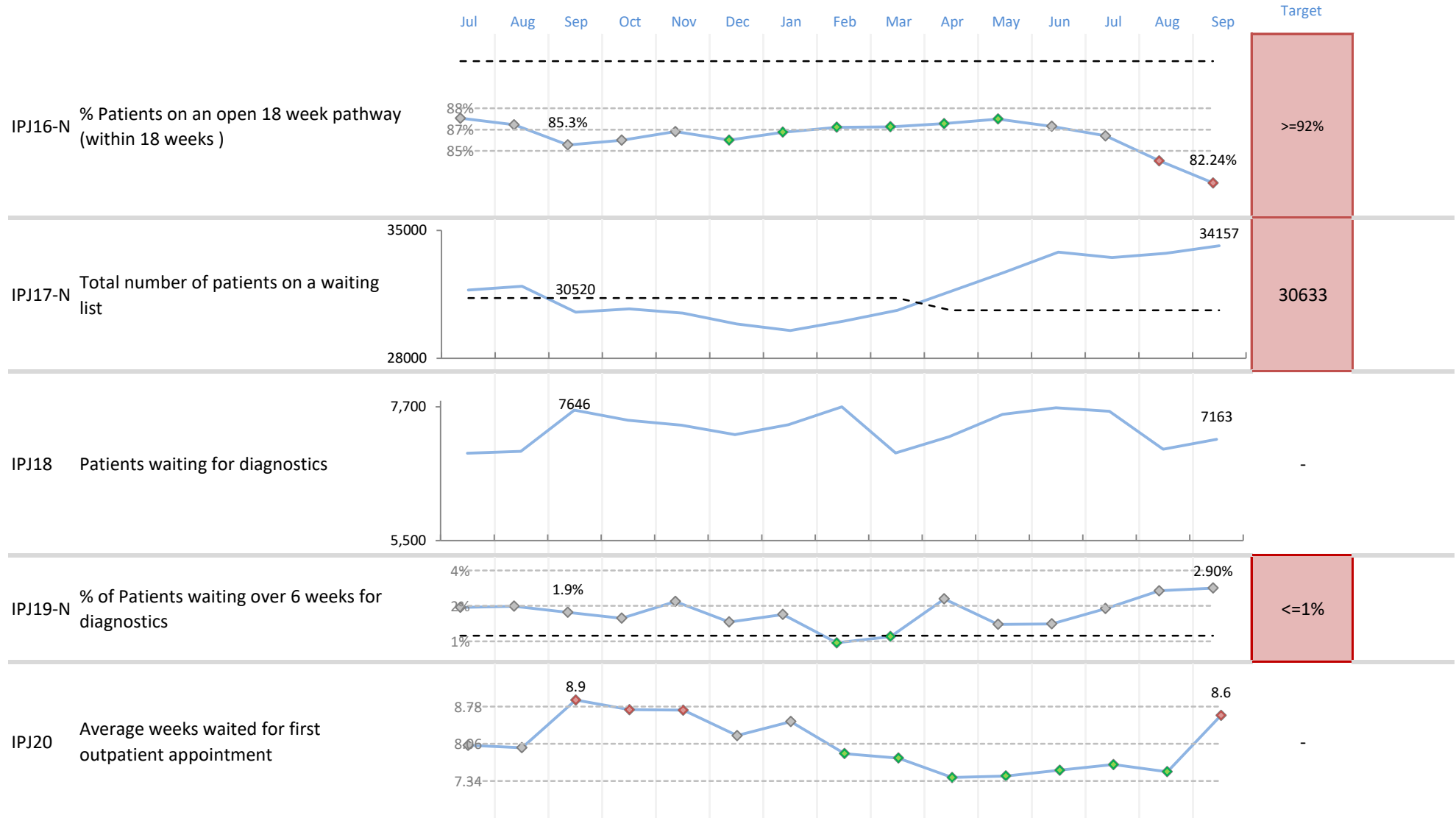


IPJ15-N

Total time spent in ED - Percentiles UHS Total

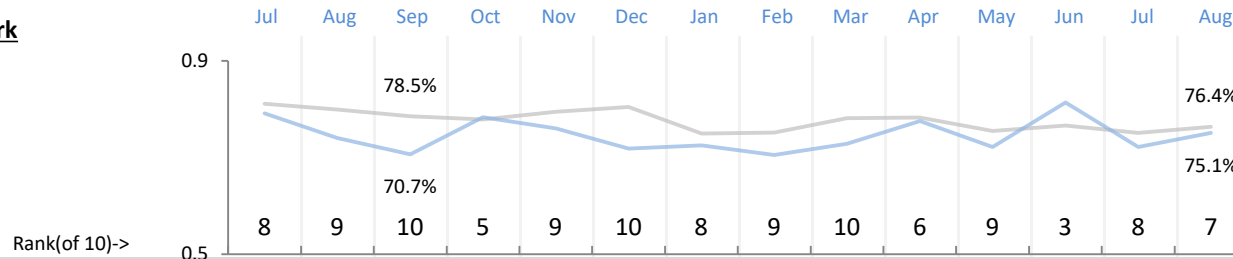


■ Current Data ■ Benchmark
■ Previous Year ■ Target



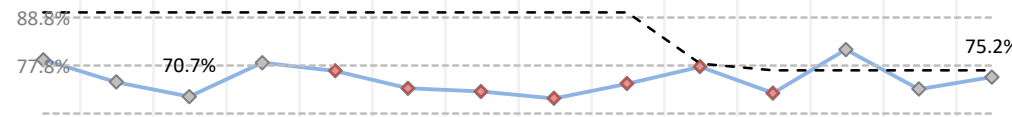
62 Day Performance Benchmark

IPJ21 Teaching Hospitals vs. UHS Total



IPJ21 UHS Total performance is taken from NHS Statistics numbers which are static as opposed to the performance shown in IPJ22 which is updated as data is validated.

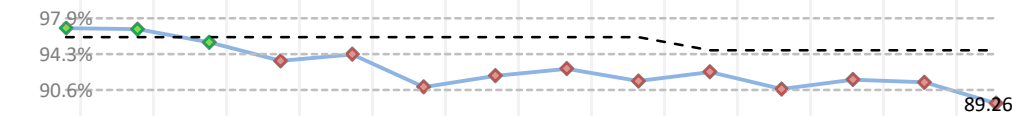
IPJ22-L 62 day cancer wait performance



=>77%	2 of 151	74%
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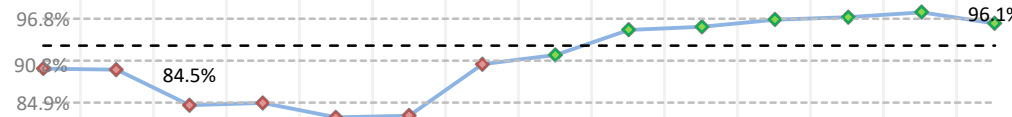
1 of 13 tumour sites achieved 62 day target in July.

IPJ23-L 31 day cancer wait performance



=>95%	43 of 801	90%
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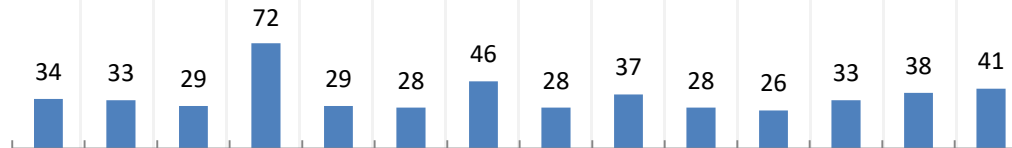
IPJ24-N Urgent GP referrals seen in 2 weeks



=>93%	0 of 1707	97%
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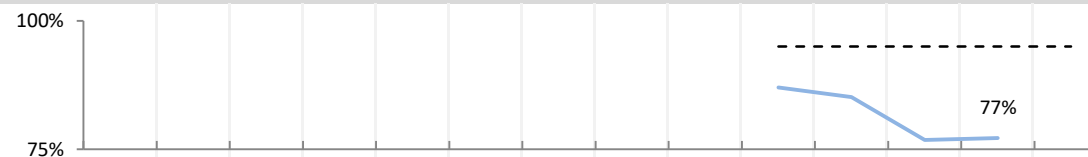
12 of 13 tumour sites achieved 2 week target in July.

IPJ25 Snapshot of waits > 104 days



-	-	-
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IPJ26 28 Day Faster Diagnosis



=>95%	#N/A	#N/A
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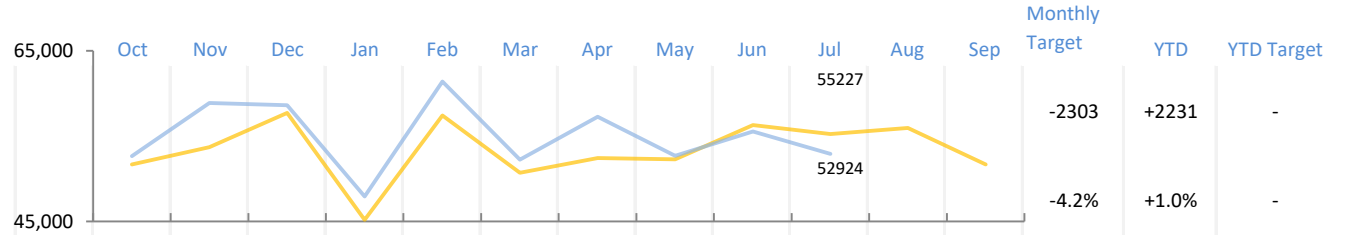
IPJ26 - this KPI is being shadow monitored by UHS in preparation for national submissions beginning April 2020. There is no update this month





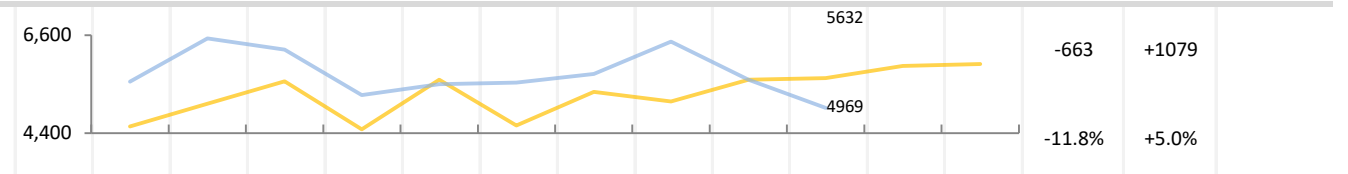
■ Current Data ■ Benchmark
■ Previous Year ■ Target

VB10 Face to Face OPA

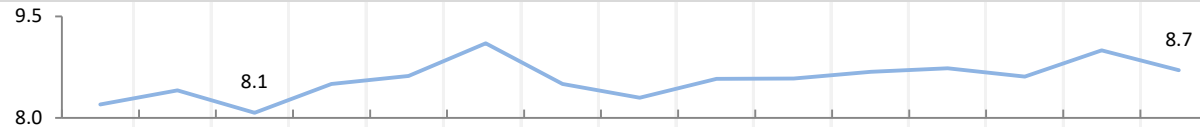


VB10/VB11: This currently excludes mymedical record contacts.

VB11 Non-Face to Face OPA

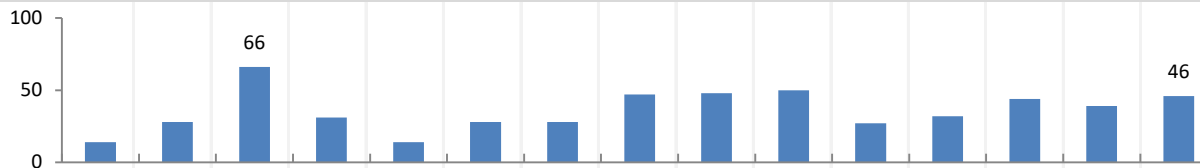


VB12 Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)

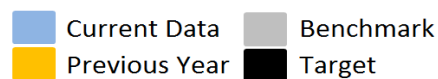
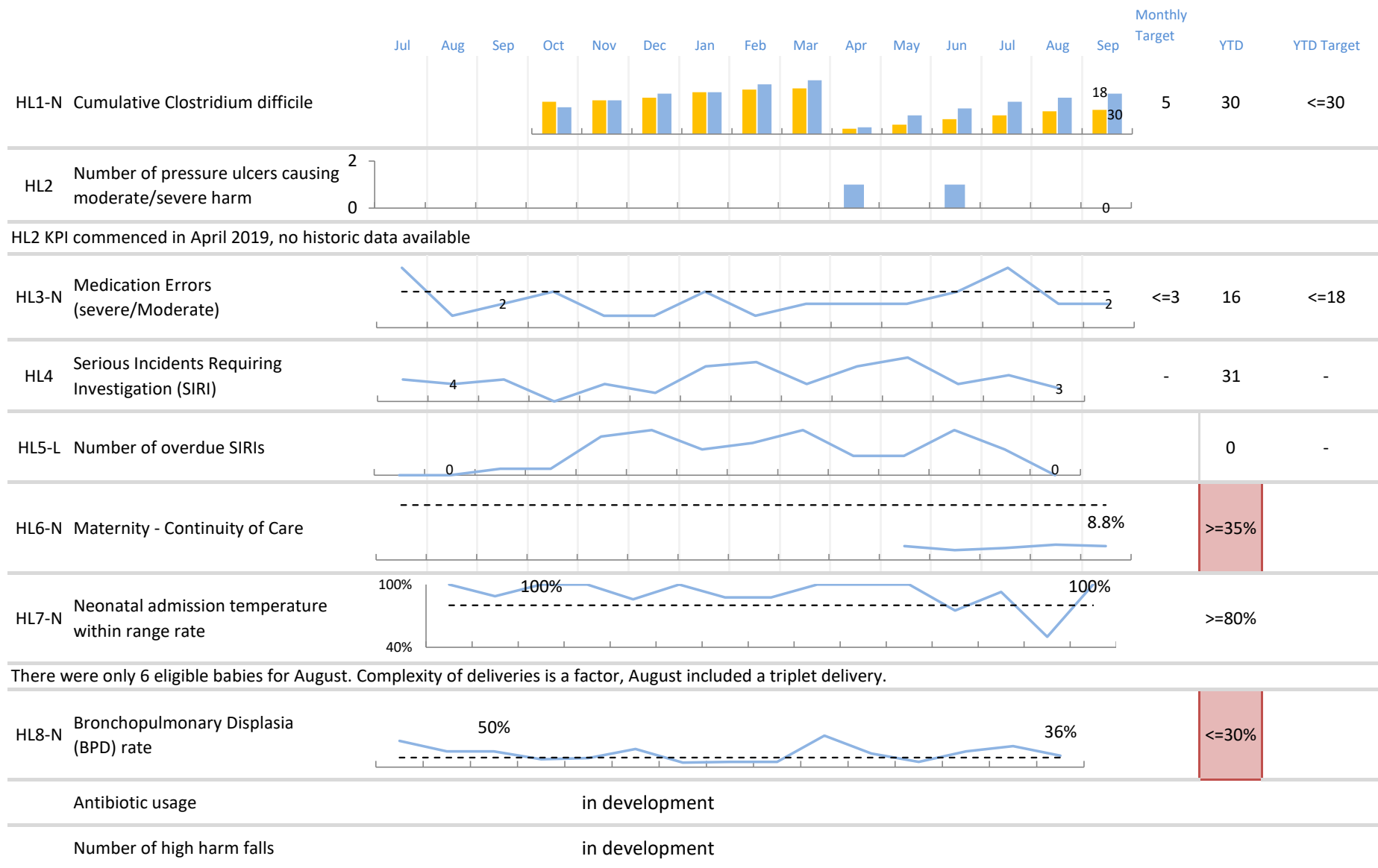


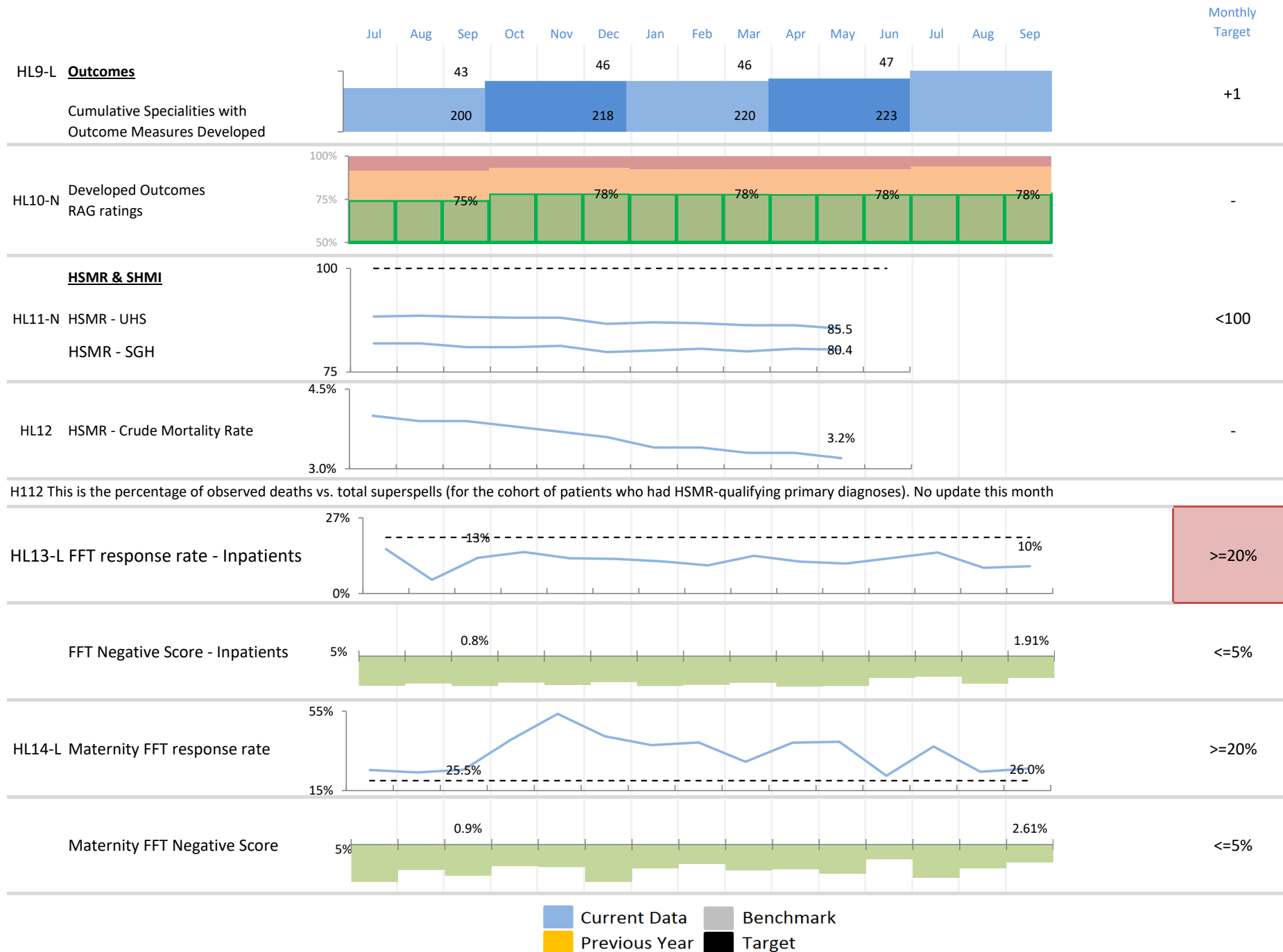
VB12 The total CHPPD rate in the Trust has increased from last month to RN 5.3 (previously 5.5), HCA 3.3 (previously 3.2) overall 8.7 (previously 9.0). The CHPPD for ward based areas in the Trust has decreased from last month to RN 3.9 (previously 4.0) HCA 3.5 (previously 3.6) overall 7.4 (previously 7.6).

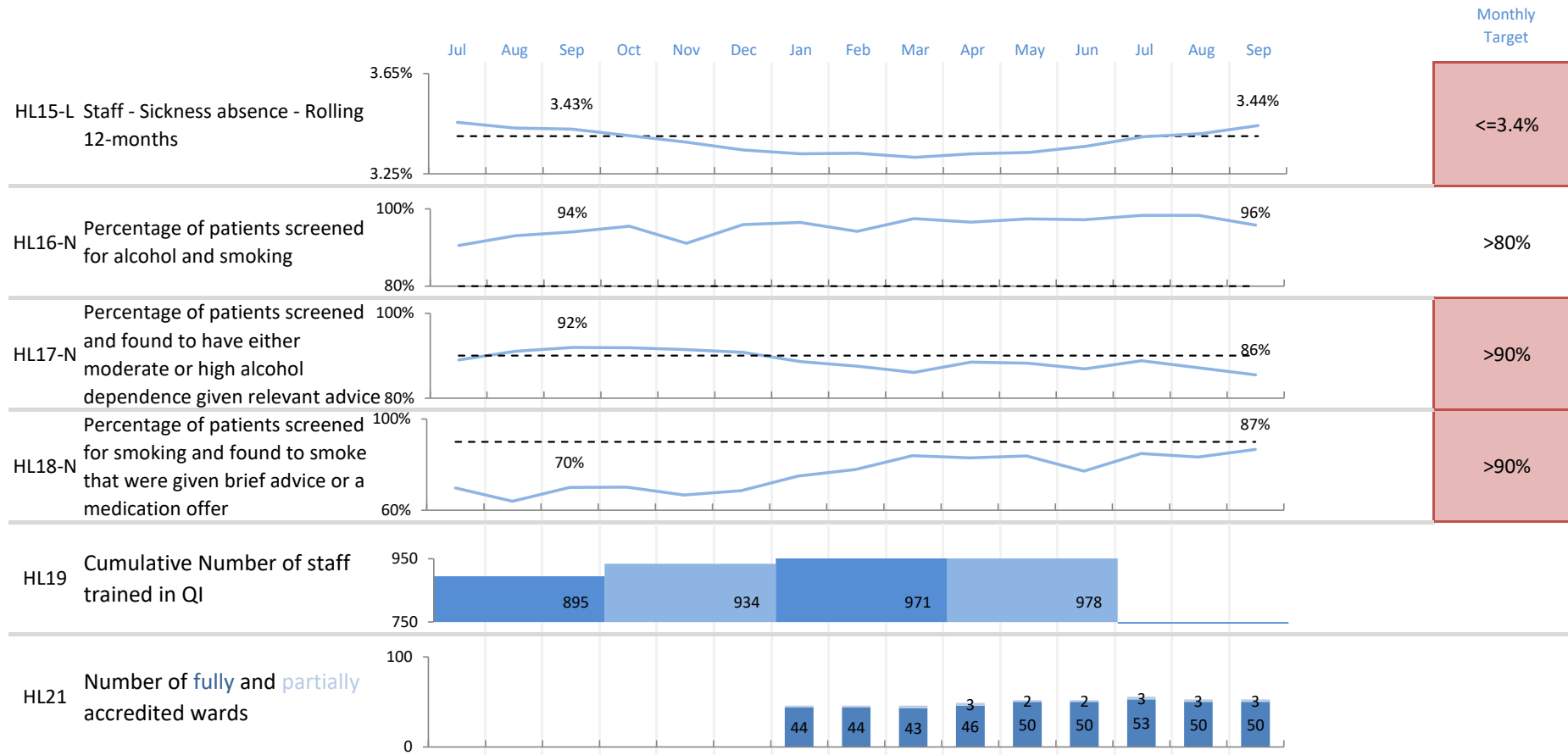
VB13 Red Flag staffing incidents

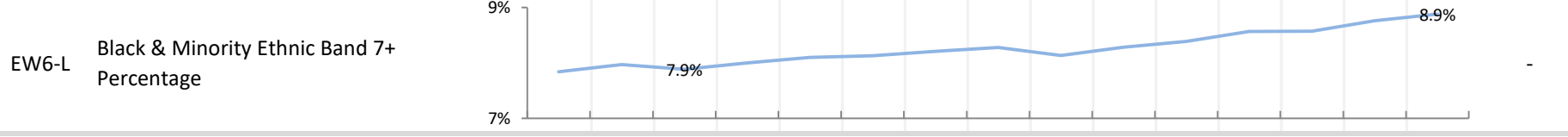
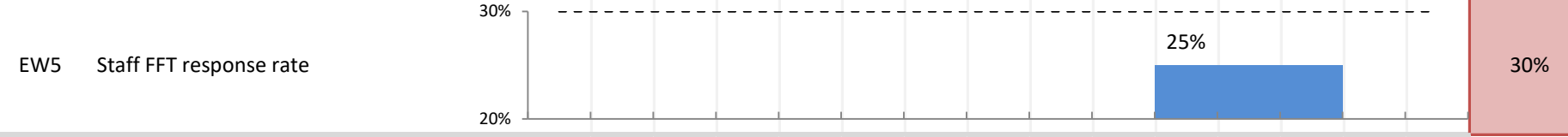
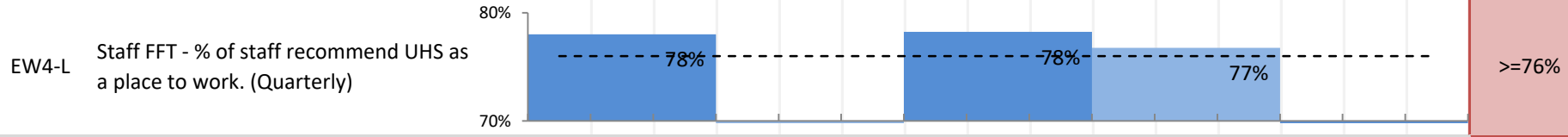
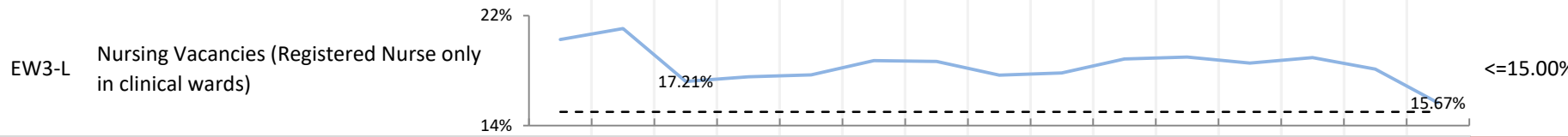
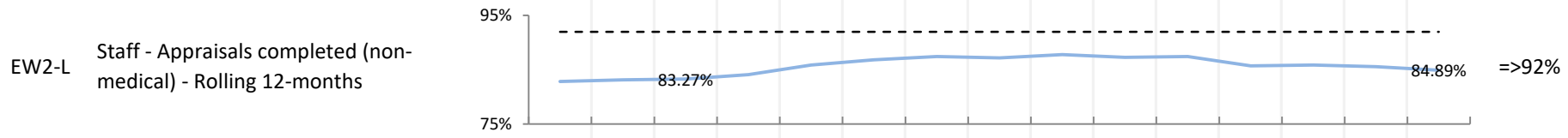
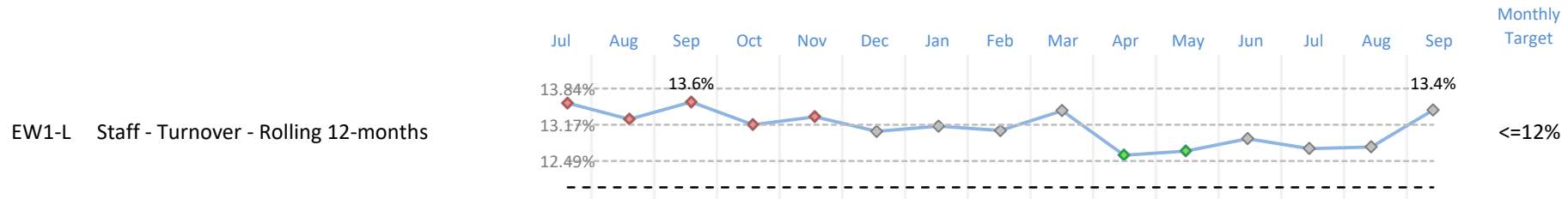


■ Current Data ■ Benchmark
■ Previous Year ■ Target

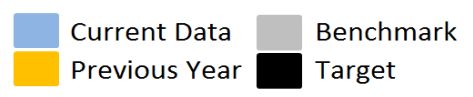




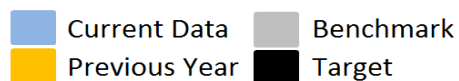
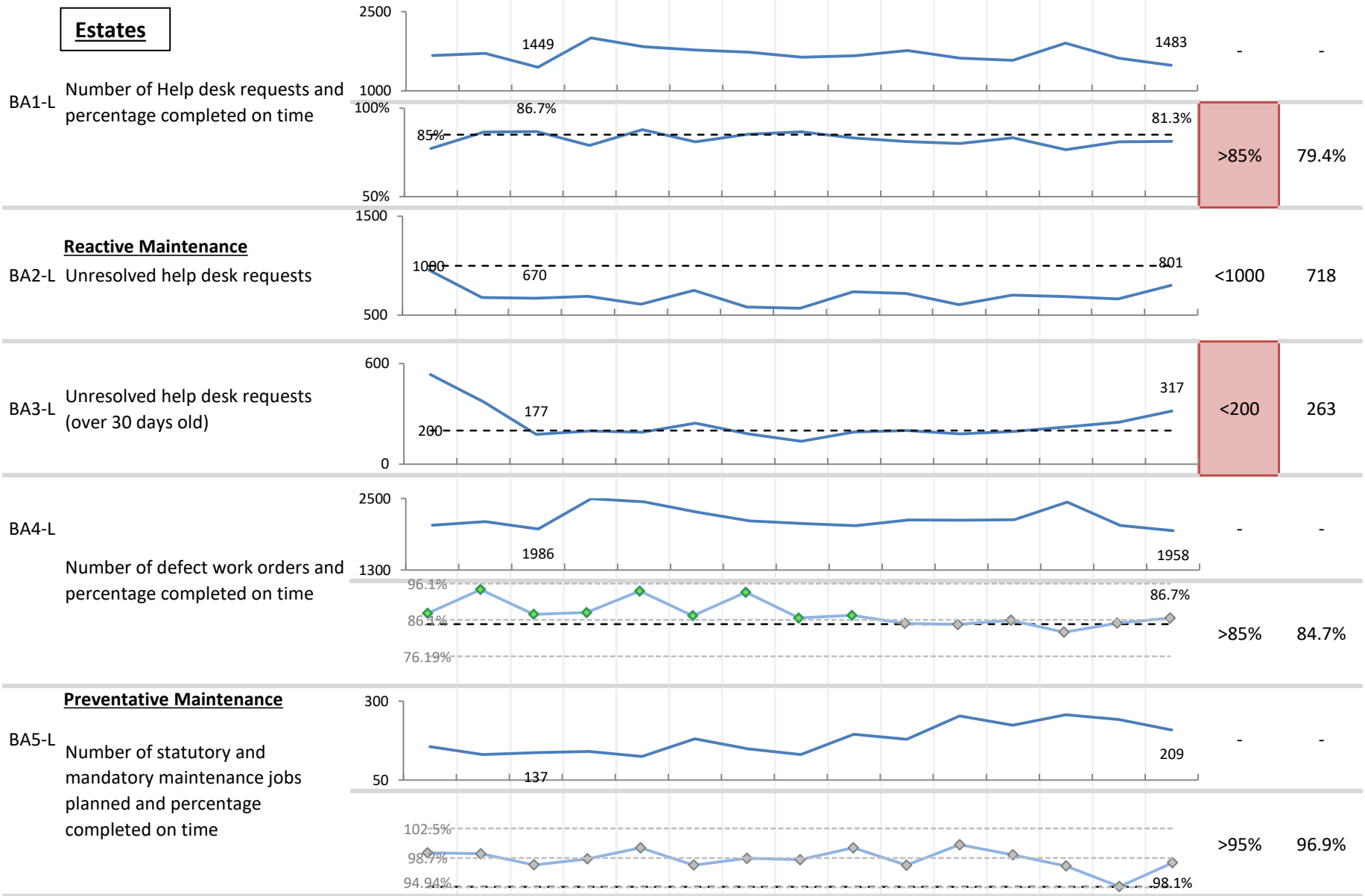


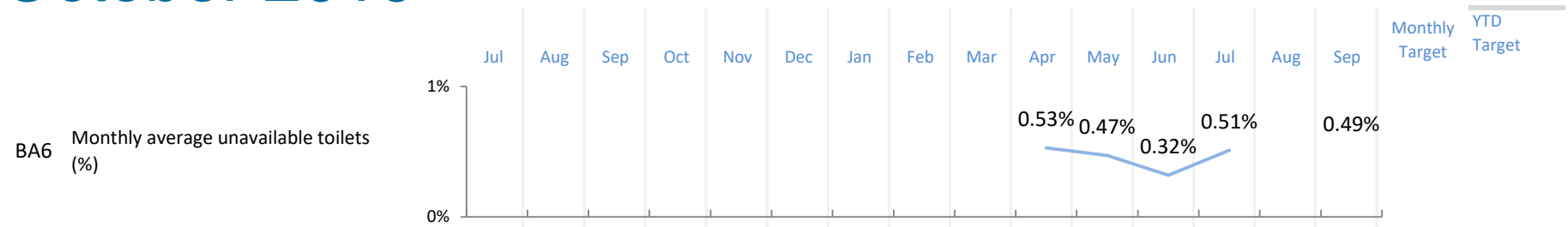


EW6 UHS has a target of 15% Band 7+ BME staff by 2023.

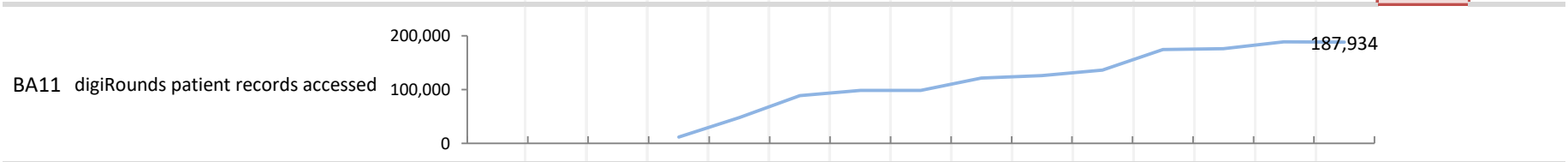
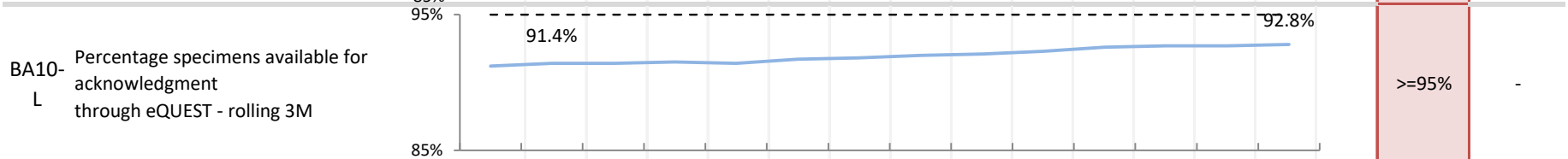
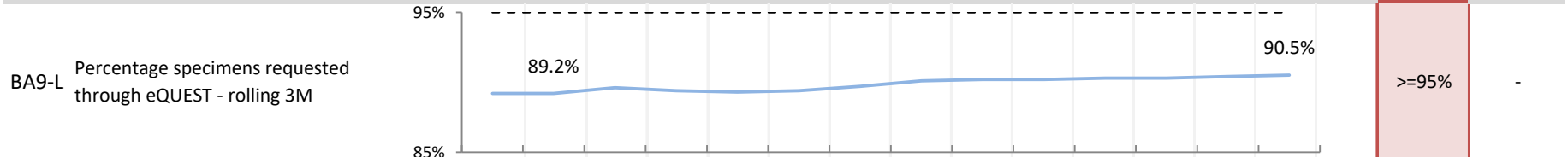
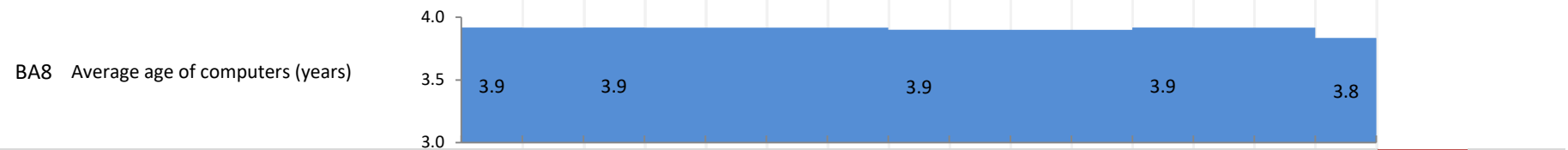
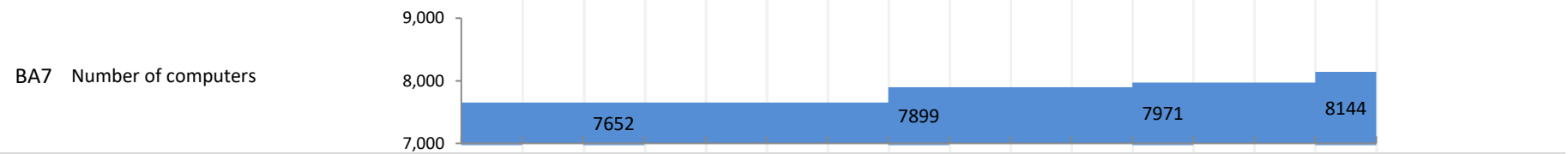


Estates





BA6 - This KPI is intended to be a proxy of the impact of maintenance work that is not completed on patients and staff.

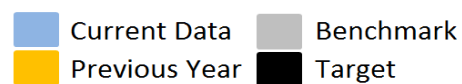
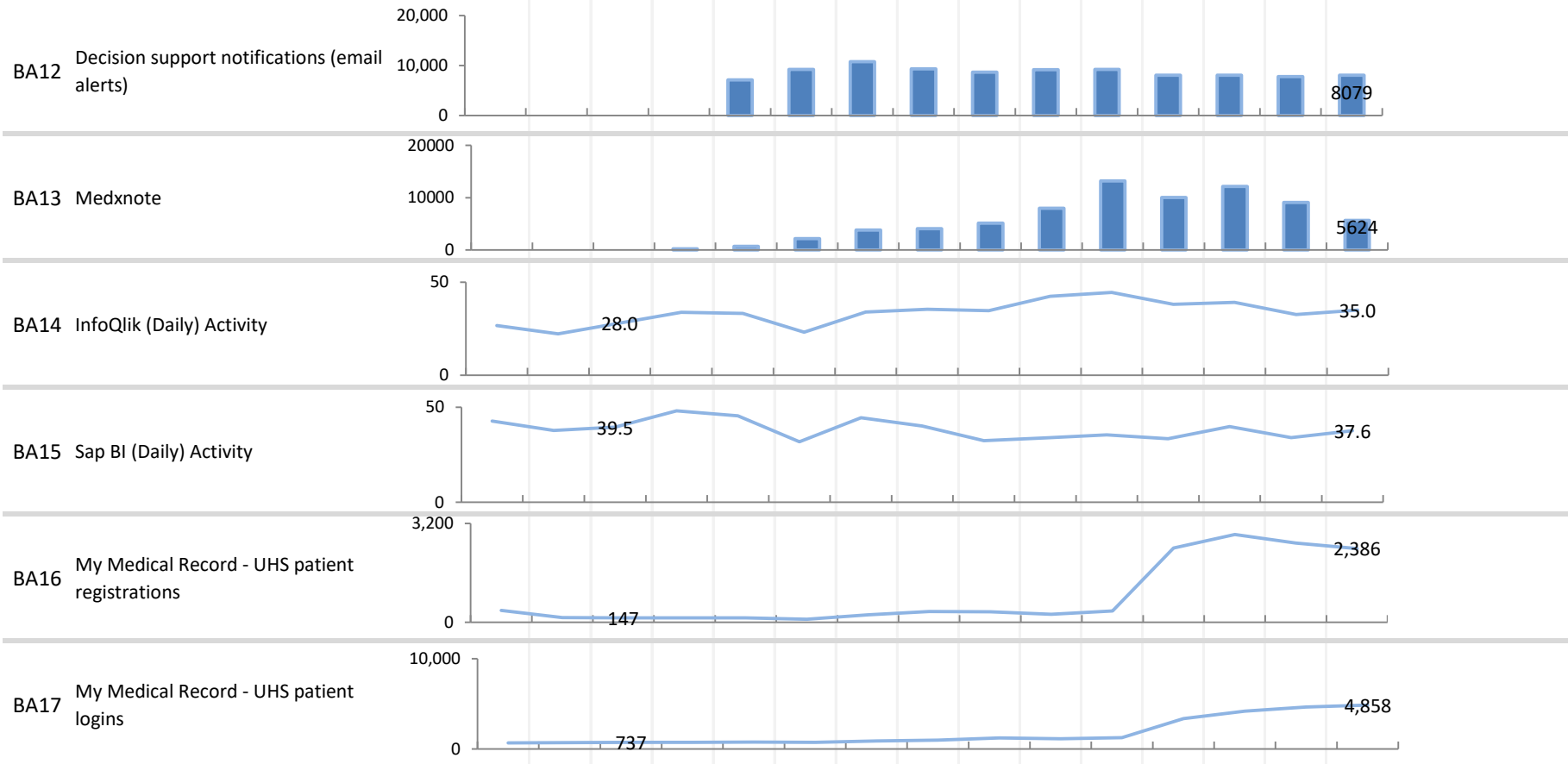


■ Current Data Benchmark
■ Previous Year Target

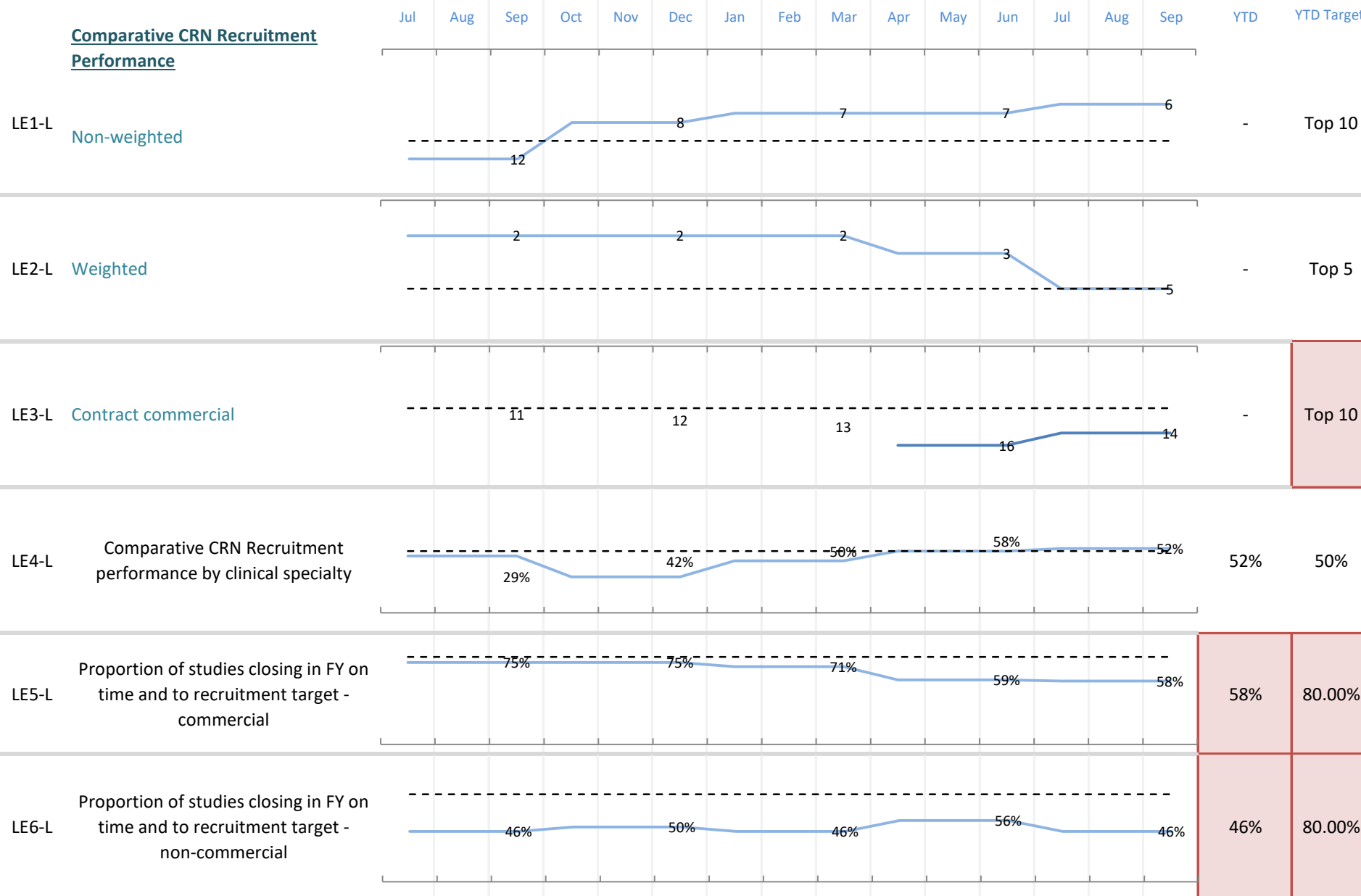
October 2019

Monthly Target

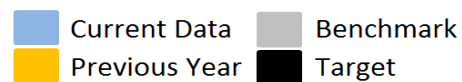
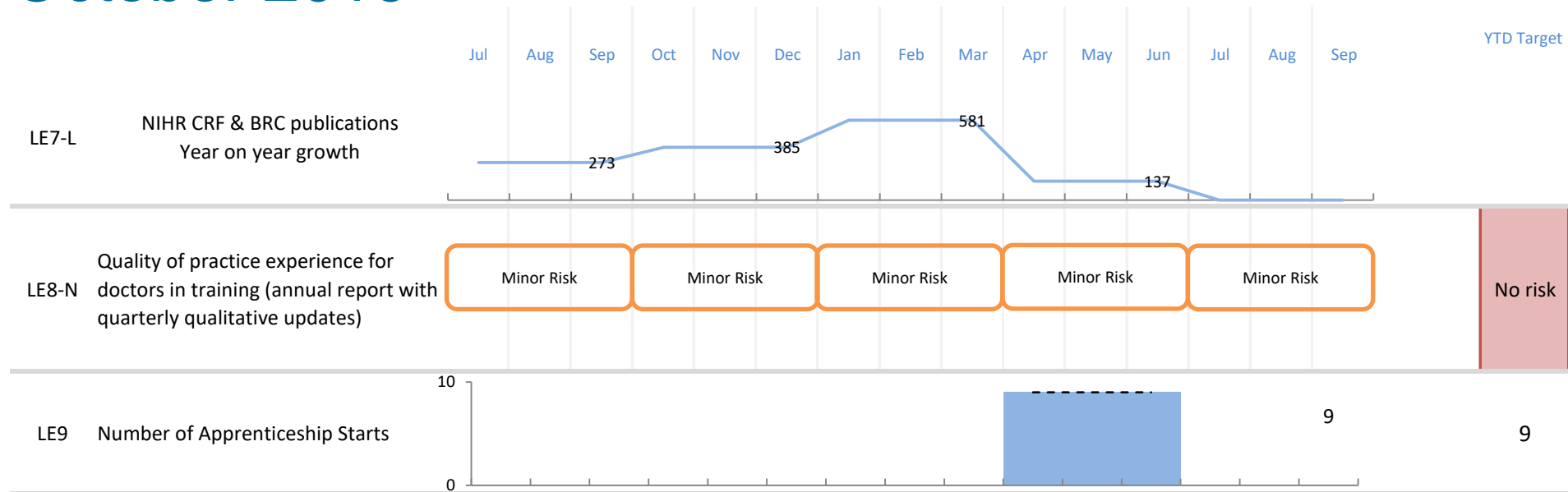
eQuest Results Alerts Sent



Comparative CRN Recruitment Performance



■ Current Data ■ Benchmark
■ Previous Year ■ Target



- The NHS Patient Safety Strategy. Safer culture, safer systems, safer patients was released in July 2019. Link to document: NHS safety strategy. UHS is developing our own UHS patient safety strategy. A safety culture workshop is planned for early December.
- Two Never Events reported in this quarter: retained swab and the incorrect patient received an injection. The patient with the retained swab required a return to theatre. The other patient came to no harm. Key learning and urgent actions were implemented in both cases. The theatre team developed an theatre action card for a theatre lock down when a swab is missing and have recently won a patient safety award from the Wessex AHSN. There has been work on improving the compliance and engagement with stop points for safety and 'ask not tell' in Radiology led by Christina Rennie.
- There were 10 new SIRI cases and 2 Never events reported to SISG and 1 infection prevention SIRI During this period we report 0 new ophthalmology SIRI's but did report a SEC.
- The trust continued to not meet the 95% target for VTE assessments. An IT solution to remind and assist doctors to complete the VTE risk assessment to allow an easy access opportunity to JAC from Charts has now been rolled out and will be monitored through thrombosis committee. An initial improvement was seen and work now needs to focus on areas that are prescribing directly through JAC and not via CHARTS.
- Work continues to develop guidance to standardise the definition of harm for patients on RTT or cancer pathways who are waiting for treatment outside of agreed national standards, a paper has gone to Quality committee to approve process.
- RCA's completed for 12 hour trolley breeches in ED (these are predominately mental health patients) are now being clinically reviewed to ensure there are no clinical, patient safety or safeguarding concerns and that learning is identified where relevant.
- In relation to lying and standing blood pressure (BP) – Safetrack has been updated to capture clinical reasoning for non-completion. This now needs to be audited to establish further planning. Further updates are ongoing to improve compliance with completion. Education ongoing for lying and standing BPs including Health care assistant competencies.
- The pharmacy team have redesigned how they measure medicines reconciliation to ensure it captures all eligible patients and matches the updated national definition. The data from July onward represents this new method of analysing admissions. A focused review of areas where rates are significantly lower than the trust target and current average is underway. This will be reported to Div C governance in October with an action plan developed.
- Southampton City CCG have funded a Acute Kidney Injury (AKI) nurse led follow up clinic as one of their 2019/2020 QUIPP. This is already supporting a reduction in readmissions and improve safety netting for those with AKI stage 2 and 3.
- Incident report rates have continued to remain greater than the 35 per 100 bed days. Which is line with a positive reporting culture.
- Full time Falls lead in post until April 2020 To support the Falls CQUINN work. The CQUIN is worth £800K and focuses on postural BP's being taken, a review and rationale for hypnotics being given and ensuring that those who require a mobility aide have one provided in a timely way.
- In the first week of October UHS took part in a national NHSI audit to check the skin of every adult and child inpatient over 3 days. Results have been submitted to NHSI.
- The data shows that we are grading our incidents moderate and over, this is pre-validation by managers and they are often re-graded at this time.

Quarterly Patient Safety Report Aug 19 – Oct 19

Patient safety dashboard

Work Stream	Indicator	Annual Target				QTD	YTD
			Jun-19	Jul-19	Aug-19		
High Harm Falls	High Harm Falls - Omissions or Deviations	3	2	0	2	2	
	Total High Harm Falls	55	2	3	4	7	
Pressure Ulcers	Category 3 and above pressure ulcers per 1000 bed days - Omissions or Deviations	<0.3	0.05	0.10	0.11	0.11	0.10
	Category 2 pressure ulcers per 1000 bed days	<0.3	0.29	0.31	0.27	0.29	0.28
VTE	% of patients that have a VTE risk assessment upon admission	>=95%	92.68%	92.30%	91.33%	91.83%	91.98%
	% of patients that receive appropriate thromboprophylaxis (taken from Safety Thermometer)	>=95%	91.92%	89.50%	90.45%	89.98%	91.46%
Safety Thermometer	Harm Free Care	>=95%	98.97%	98.53%	97.37%	97.94%	98.04%
Medication Errors	A reduction in the number of medication related incidents that occur as a result of a failing in the discharge process	Reduction	8	9	12		
	80% of medicine reconciliations within 48 hours of admission	80% reconciliation	86%	70%	67%		
Infection Prevention & Control	MRSA post 48 hour cases	0	1	0	0	0	1
	C difficile cases	64	5	5	3	8	25
SIRIs	Never Events	0	1	1	0	1	5
	95% SIRIs Reported within 2 working days	>=95%	100.00%	100.00%	100.00%	100.00%	95.00%
	SIRIs overdue by 60 days	0	7	4	0	4	17
Incident Reporting	Incidents per 1000 bed days	>35	39.71				
	% of incidents identified as moderate and over	<=4%	5.58%	6.24%	5.02%	5.65%	5.16%

			Q1
Sepsis Contract	90% of patients appropriately screened on admission in ED.	90%	100%
	90% of patients with red flag sepsis in ED receive IVAB within 60 minutes of diagnosis.	90%	86%
	90% of patients who meet criteria for sepsis screening were screened for sepsis for all acute inpatient wards (including AMU and ASU).	90%	100%
	90% of patients with red flag sepsis in adult inpatient wards receive IVAB within 60 minutes.	90%	84%

Nursing and midwifery staffing hours - September 2019

Report notes

Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers.

Enhanced Care (also known as Specialling)

Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.

If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)

This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the speciality, interventions, acuity and dependency levels of the patients being cared for.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Over the summer months some ward beds have temporarily changed speciality to support seasonal changes in demand - these bed changes are often swift in nature and for short periods of time so are not always reflected accurately in the data. For September there have been additional beds supported for Cardiovascular patients on E7 which are not reflected in the numbers.

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	Registered nurses CHPPD	Unregistered Staff CHPPD	CHPPD Overall	Comments
C4 (Solent ward)	Day	1398	1209	1002	1482	86%	148%	3.5	4.9	8.4	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
C4 (Solent ward)	Night	1058	816	690	1299	77%	188%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
C6	Day	2736	2793	148	143	102%	97%	7.3	0.3	7.7	Safe staffing levels maintained.
C6	Night	1982	2123	0	77	107%	Shift N/A				Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Day	694	679	374	201	98%	54%	7.6	2.1	9.7	Safe staffing levels maintained; Staffing appropriate for number of patients.
C6 (Teenage Cancer Trust unit)	Night	672	606	0	145	90%	Shift N/A				Safe staffing levels maintained; Staffing appropriate for number of patients.
D2	Day	1285	1557	1343	900	121%	67%	4.5	3.1	7.6	Safe staffing levels maintained.
D2	Night	690	971	736	816	141%	111%				Safe staffing levels maintained.

D3	Day	1582	1476	718	908	93%	126%	3.9	2.6	6.6	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D3	Night	1013	1014	675	744	100%	110%				Safe staffing levels maintained.
Surgical high dependency unit	Day	2121	1845	374	313	87%	84%	15.6	2.5	18.1	Safe staffing levels maintained; Beds flexed to match staffing.
Surgical high dependency unit	Night	2070	1829	336	278	88%	83%				Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Day	4995	4243	1158	798	85%	69%	25.6	4.2	29.7	Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Night	5075	3971	847	535	78%	63%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Day	4481	4302	1119	784	96%	70%	24.9	3.8	28.7	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Night	4144	4065	690	482	98%	70%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Day	3910	3433	364	320	88%	88%	25.4	2.5	27.8	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Night	3768	3262	345	336	87%	97%				Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Day	5070	4655	916	751	92%	82%	27.0	3.7	30.7	Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Night	4407	4084	704	462	93%	66%				Safe staffing levels maintained; Beds flexed to match staffing.
E5A	Day	1230	1045	664	811	85%	122%	3.2	2.3	5.5	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
E5A	Night	690	656	345	380	95%	110%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
E5B	Day	1307	1131	798	825	87%	103%	3.6	2.4	6.0	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
E5B	Night	690	679	345	411	98%	119%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
E8	Day	2188	1688	1714	1711	77%	100%	3.3	3.5	6.8	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
E8	Night	1035	1036	1145	1149	100%	100%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
F11	Day	1891	1427	781	885	76%	113%	4.2	3.3	7.5	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
F11	Night	690	690	690	805	100%	117%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
F6	Day	2208	1588	576	1405	72%	244%	3.2	2.9	6.1	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
F6	Night	1036	889	690	799	86%	116%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.

F5	Day	1887	1525	944	1284	81%	136%	3.5	2.9	6.4	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
F5	Night	1033	941	685	782	91%	114%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
Acute medical unit	Day	3501	3588	3175	3072	103%	97%	5.1	4.2	9.3	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
Acute medical unit	Night	3451	3521	2400	2883	102%	120%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Patient requiring 24 hour 1:1 nursing in the month.
D5	Day	1276	1241	1611	1542	97%	96%	2.4	3.1	5.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D5	Night	1035	768	891	1122	74%	126%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Patient requiring 24 hour 1:1 nursing in the month.
D6	Day	1102	1090	1478	1332	99%	90%	2.5	3.1	5.7	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D6	Night	690	690	915	869	100%	95%				Safe staffing levels maintained.
D7	Day	716	760	1209	1079	106%	89%	3.1	3.4	6.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D7	Night	679	690	345	472	102%	137%				Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
D8	Day	1027	1119	1466	1488	109%	102%	2.7	3.5	6.2	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D8	Night	691	796	924	953	115%	103%				Increased night staffing to support raised acuity; Safe staffing levels maintained by sharing staff resource.
D9	Day	1204	1283	1665	1512	107%	91%	2.6	3.4	5.9	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D9	Night	1035	774	927	1177	75%	127%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
Respiratory high dependency unit	Day	1911	1243	356	416	65%	117%	13.7	5.2	18.9	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
Respiratory high dependency unit	Night	1725	1093	345	460	63%	133%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
C5	Day	1049	822	777	865	78%	111%	4.1	3.5	7.5	Safe staffing levels maintained; Non-ward based staff supporting areas.
C5	Night	686	719	345	439	105%	127%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
D10	Day	1125	865	1285	1168	77%	91%	2.9	3.6	6.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D10	Night	690	667	690	690	97%	100%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.

F7	Day	702	721	1245	1243	103%	100%	2.4	3.3	5.6	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
F7	Night	679	690	690	702	102%	102%				Safe staffing levels maintained.
G5	Day	1069	1062	1776	1682	99%	95%	2.1	3.3	5.4	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G5	Night	690	694	1035	990	101%	96%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
G6	Day	1064	1154	1774	1846	109%	104%	2.4	3.7	6.2	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G6	Night	690	725	1035	1012	105%	98%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
G7	Day	707	702	1389	1559	99%	112%	3.4	6.8	10.2	Staffing plan set higher than national standards; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
G7	Night	690	690	1035	1261	100%	122%				Staffing plan set higher than national standards; Patient requiring 24 hour 1:1 nursing in the month.
G8	Day	1051	1129	1790	1648	107%	92%	2.2	3.2	5.4	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G8	Night	690	690	1035	1024	100%	99%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
G9	Day	1048	1102	1741	1734	105%	100%	2.4	3.6	6.0	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G9	Night	690	724	1035	1012	105%	98%				Support workers used to maintain staffing numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
Paediatric high dependency unit	Day	1528	1133	0	19	74%	Shift N/A	8.8	0.1	8.8	Non-ward based staff supporting areas; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1035	1005	0	0	97%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	1797	1473	528	551	82%	105%	7.1	3.6	10.7	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Paediatric medical unit	Night	1320	1092	647	740	83%	114%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Paediatric assessment unit	Day	1468	327	409	208	22%	51%	18.4	7.3	25.6	Relocated to ED during the month - not fully reflected in the figures.
Paediatric assessment unit	Night	1057	335	148	54	32%	37%				Relocated to ED during the month - not fully reflected in the figures.
Paediatric intensive care unit	Day	6049	4707	630	512	78%	81%	26.0	2.9	28.9	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5519	4508	518	529	82%	102%				Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
Piam Brown ward	Day	3176	2866	107	104	90%	97%	15.1	0.4	15.5	Non-ward based staff supporting areas; Safe staffing levels maintained.
Piam Brown ward	Night	1024	1067	0	0	104%	Shift N/A				Safe staffing levels maintained.

E1	Day	2055	1536	690	401	75%	58%	10.6	2.6	13.2	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
E1	Night	1380	1322	343	301	96%	88%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
G2	Day	750	735	0	0	98%	Shift N/A	9.4	0.0	9.4	Safe staffing levels maintained.
G2	Night	707	709	0	0	100%	Shift N/A				Safe staffing levels maintained.
G3	Day	2346	1787	1222	697	76%	57%	7.8	3.0	10.9	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Summer bed flexing - safe staffing levels maintained.
G3	Night	1623	1271	671	495	78%	74%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Summer bed flexing - safe staffing levels maintained.
G4	Day	2368	1940	1267	592	82%	47%	7.3	2.5	9.9	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Summer bed flexing - safe staffing levels maintained.
G4	Night	1639	1233	704	506	75%	72%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Summer bed flexing - safe staffing levels maintained.
Bramshaw women's unit	Day	1452	966	1206	852	67%	71%	5.6	4.2	9.8	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Summer bed flexing - safe staffing levels maintained.
Bramshaw women's unit	Night	690	690	690	391	100%	57%				Safe staffing levels maintained.
Neonatal unit	Day	6852	4480	1640	1095	65%	67%	9.2	2.4	11.5	Band 4 staff working to support registered nurse numbers; number of cots adjusted to support safe staffing
Neonatal unit	Night	5277	3680	1320	1002	70%	76%				Band 4 staff working to support registered nurse numbers; number of cots adjusted to support safe staffing
Maternity service	Day	8202	7579	3160	2171	92%	69%	5.2	1.6	6.8	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Maternity service	Night	5145	4758	2004	1519	92%	76%				Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Cardiac high dependency unit	Day	4847	4059	1378	1341	84%	97%	13.9	4.0	18.0	Staff moved to support other wards.
Cardiac high dependency unit	Night	3661	3483	660	849	95%	129%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
Coronary care unit	Day	1472	1533	859	938	104%	109%	6.9	4.4	11.3	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
Coronary care unit	Night	1321	1360	880	876	103%	100%				Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
D4	Day	1803	1411	818	1144	78%	140%	3.4	3.5	6.9	Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
D4	Night	763	721	660	1015	94%	154%				Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
E2	Day	1594	1227	801	1159	77%	145%	3.9	3.5	7.3	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
E2	Night	693	697	330	553	101%	168%				Staff moved to support other wards.

		1986	1212	582	1378	61%	237%	2.7	3.3	6.1	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
E3 Green	Day										
E3 Green	Night	671	678	1309	923	101%	71%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
E3 Blue	Day	1645	953	704	1173	58%	167%	2.9	3.7	6.6	Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month.
E3 Blue	Night	660	596	649	782	90%	120%				Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month.
E4	Day	1983	1738	697	1232	88%	177%	5.2	3.7	8.9	Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month.
E4	Night	880	1178	528	818	134%	155%				Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month.
Acute stroke unit	Day	1461	1510	2634	2617	103%	99%	2.8	5.2	8.0	Band 4 staff working to support registered nurse numbers.
Acute stroke unit	Night	990	850	1650	1716	86%	104%				Band 4 staff working to support registered nurse numbers.
Neuro Regional transfer unit	Day	1188	885	359	531	75%	148%	6.2	5.6	11.8	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Neuro Regional transfer unit	Night	660	521	594	739	79%	124%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E Neuro	Day	1858	1632	1096	1268	88%	116%	3.7	3.3	7.1	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E Neuro	Night	1309	1133	979	1189	87%	121%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Hyper acute stroke unit	Day	1553	1187	359	687	76%	192%	7.9	5.0	12.9	Band 4 staff working to support registered nurse numbers.
Hyper acute stroke unit	Night	1315	946	330	665	72%	201%				Band 4 staff working to support registered nurse numbers.
D neuro	Day	1856	1414	1822	2186	76%	120%	3.2	5.0	8.2	Additional staff used for enhanced care - Support workers.
D neuro	Night	1320	1155	1650	1774	88%	108%				Additional staff used for enhanced care - Support workers.
SPI F4 Neuro	Day	1620	1317	691	1073	81%	155%	3.6	3.4	6.9	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
SPI F4 Neuro	Night	990	924	990	1030	93%	104%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Brooke ward (trauma and orthopaedic)	Day	1127	1001	567	627	89%	111%	3.3	2.5	5.8	Safe staffing levels maintained; Staff moved to support other wards.
Brooke ward (trauma and orthopaedic)	Night	1035	702	345	678	68%	197%				Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
Trauma Assessment Unit	Day	509	465	364	512	91%	141%	6.0	6.3	12.3	Staffing appropriate for number of patients.
Trauma Assessment Unit	Night	330	330	330	330	100%	100%				Increased night staffing to support raised acuity; Use of band 2 twilight to support afternoon/evening admissions.

F1	Day	2381	1768	1823	2229	74%	122%	3.6	4.7	8.2	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F1	Night	1725	1465	1674	2018	85%	121%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F2	Day	1628	1387	1981	2179	85%	110%	3.0	4.9	7.9	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
F2	Night	990	836	1320	1518	84%	115%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
F3	Day	1573	1404	1503	1626	89%	108%	3.2	4.4	7.6	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
F3	Night	990	803	1319	1451	81%	110%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Staff moved to support other wards.
F4	Day	1379	1146	1163	852	83%	73%	3.6	2.9	6.6	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
F4	Night	990	682	660	617	69%	94%				Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: Finance Report 2019-20 Month 6			
Category	Quality, Performance, and Finance		
Agenda item	4.6		
Sponsor	Chief Financial Officer		
Author	Gavin Hawkins, Assistant Director of Finance		
Provenance	This monthly paper provides an update on our financial position This paper is discussed at TEC, S&FC and Trust Board on a monthly basis.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for DISCUSSION. The purpose of this paper is to give an update on the financial position of the Trust through the year.		
Relevant strategic goals	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services 		
Impact assessments			
Other standards affected			

2019/20 Finance Report - Month 6

Report to:	Board of Directors & Strategy & Finance
	October 2019
Title:	Finance Report for Period ending 30/09/2019
Author:	Gavin Hawkins, Assistant Director of Finance
Sponsoring Director:	David French, Chief Financial Officer
Purpose:	Standing Item
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In September 2019, the Trust delivered a surplus of £0.4m, £0.2m better than Plan. Year to date the Trust is reporting a £0.5m surplus which is £2.7m better than Plan. Under the single oversight framework, the Trust has delivered a score for Finance and Use of Resources of '1'.
2. When non-recurrent items are excluded the year to date position is a £2.1m deficit. Non-recurrent items include a reclaim of VAT paid on agency nursing invoices in 18/19..
3. The main themes seen in M6 were:
 - Income was £0.1m worse than Plan. Clinical income was not as strong as in previous months, plus car parking and overseas patient income were £0.3m behind Plan collectively.
 - Pay was £0.2m worse than Plan in month mainly due to undelivered CIP.
 - Total CIP delivery was £1m behind Plan at £2.5m for the month, which remains £2.4m behind plan year to date. This was offset by lower than Plan levels of clinical supplies spend in the month.
4. The cash position was £27.2m above Plan at £73.8m, as the overdue £16m NHS England invoice from prior year was settled in September. The above Plan position has primarily been driven by:
 - I&E Position better than plan, and cash start point better than assumed at the time the cash plan was agreed
 - Additional PSF re 18/19 over and above that assumed at the point the Plan was finalised
 - Settlement of high value invoices in-month from NHS England resulting in better than plan Receivables position
5. Looking forward to the end of 2019/20, the Trust is facing risks relating to:
 - CIP delivery, including unidentified CIP
 - Underlying run-rate of expenditure exceeding income
 - Clinical income shortfall due to consultant workforce capacity relating to pensions taxation
 - The current forecast suggests a full year out-turn of a surplus (excl PSF) in the range £1m - £6m, with the mostly likely outcome £3.5m, compared to the control total of £17m surplus. This position would result in non-achievement of PSF in Q4, and potentially Q3, which would restrict cash availability to support our 3-year capital programme.



Finance: I&E Summary

Total clinical income was £0.2m worse than Plan, although the Plan was increased to reflect income CIP delivery in the month. In total £6.2m of productivity schemes have been recognised to M6.

In month non elective activity was estimated to be £1m above Plan, net of full blended payment reduction. Elective activity was estimated to be £0.8m below Plan reflected across a number of specialities, including Gynae due to ongoing PAH theatres refurbishment.

Substantive and bank pay combined was £0.6m above Plan offset by below Plan agency spend of £0.4m, reflecting an overall pay bill overspend of £0.2m.

Total non-pay excl pass through drugs & devices was £0.5m underspent in the month due to lower than planned clinical supplies expenditure offset in part by un-delivered CIP and subcontracting expenditure.

Overall CIP delivery was £1m behind Plan with £2.5m delivered. See slide 12 for further detail.

Metric	2019/20		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	1.51	3	3
Liquidity rating	17.84	1	1
I&E Margin Rating	1.18%	1	2
I&E Margin Variance Rating	0.63%	1	1
Agency Variance from ceiling	58.26%	1	1
Use of Resources Average Metric		1.40	1.60
Use of Resources Final Metric		1	2

	Current Month			Year to Date			Full Yr	Ave Done	To Do	
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m			
NHS Income: Clinical	52.2	52.0	0.2	313.3	313.0	0.3	A	630.6	52.2	52.9
Pass-through Drugs & Devices	9.3	9.2	0.1	55.3	55.7	(0.4)	G	115.2	9.3	9.9
Other income Other Income excl. PSF	9.2	9.3	(0.2)	53.6	59.2	(5.7)	G	105.0	9.9	7.6
Total income	70.6	70.5	0.1	422.1	427.9	(5.8)	G	850.8	71.3	70.5
Costs Pay-Substantive	38.7	39.3	0.6	232.3	236.6	4.3	A	461.0	39.2	37.4
Pay-Bank	2.0	2.1	0.0	11.6	13.1	1.4	R	22.8	2.2	1.6
Pay-Agency	1.1	0.8	(0.4)	6.7	2.9	(3.8)	G	14.1	0.5	1.9
Drugs	1.1	1.3	0.2	7.2	7.8	0.6	R	14.2	1.3	1.1
Pass-through Drugs & Devices	9.3	9.2	(0.1)	55.3	55.7	0.4	A	115.2	9.3	9.9
Clinical supplies	6.1	5.4	(0.8)	36.1	36.1	0.0	A	65.5	6.0	4.9
Other non pay	9.0	9.2	0.1	57.1	57.3	0.1	A	105.1	9.5	8.0
Total expenditure	67.4	67.1	(0.2)	406.4	409.5	3.1	A	797.9	68.1	64.7
EBITDA	3.2	3.4	(0.2)	15.7	18.4	(2.7)	G	52.9	3.1	5.8
EBITDA %	4.6%	4.8%	(0.2%)	3.7%	4.3%	(0.6%)		6.2%		
Depreciation	1.9	2.0	0.1	11.2	11.9	0.7	R	22.6	2.0	1.8
Non Operating Income/Expenditure	1.1	1.0	(0.1)	6.6	6.0	(0.7)	G	13.3	1.0	1.2
Control Total Surplus / (Deficit)	0.2	0.4	(0.2)	(2.1)	0.5	(2.7)	G	17.1	0.1	2.8
Memo - Other technical items:										
Prior Period Adjustment - PSF 2018/19		-	0.0		0.9	(0.9)	G			
Provider Sustainability Funding	0.8	0.8	0.0	4.4	4.4	0.0	G	12.7	0.7	1.4

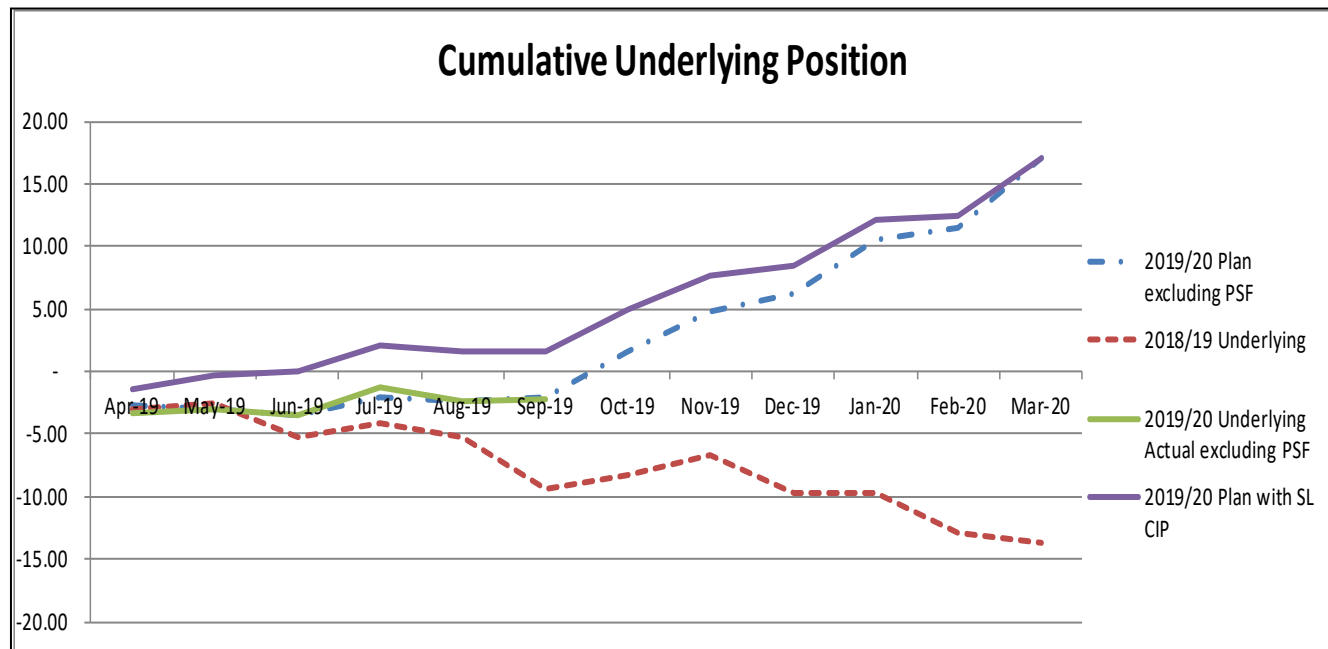
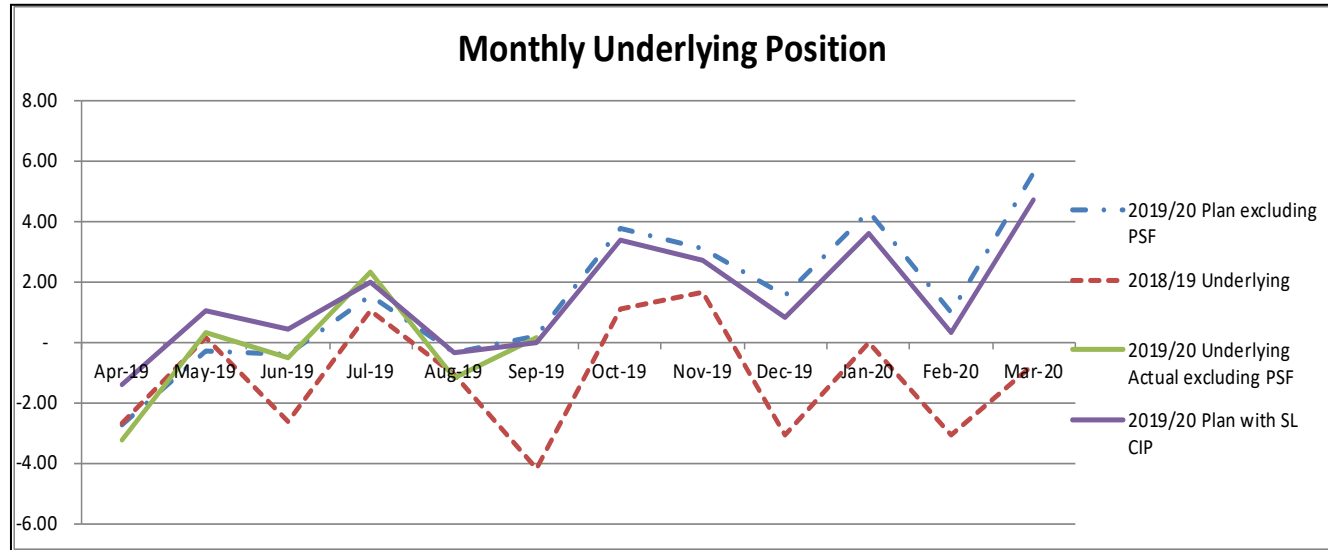
Underlying Run Rate Position

These graphs show the actual underlying position was on NHSI Plan in the month and year to date.

It also shows an alternative presentation of the Plan phasing assuming that the £40m CIP target is delivered equally each month through the year. In September 2019 the CIP Plan was £0.3m higher vs a Straight-line CIP Plan.

The finance team have agreed a contract payment phasing that is later than assumed in the Plan, which gives a £0.3m benefit per month for the first 6 months. This benefit unwinds from month 7 onwards so is a timing difference only.

All figures in these graphs exclude PSF including the amount received as a prior year adjustment.



Underlying Run Rate Position

This graph shows potential scenarios for 2019/20 out-turn, as shared with Trust Board as part of the 2019/20 planning process.

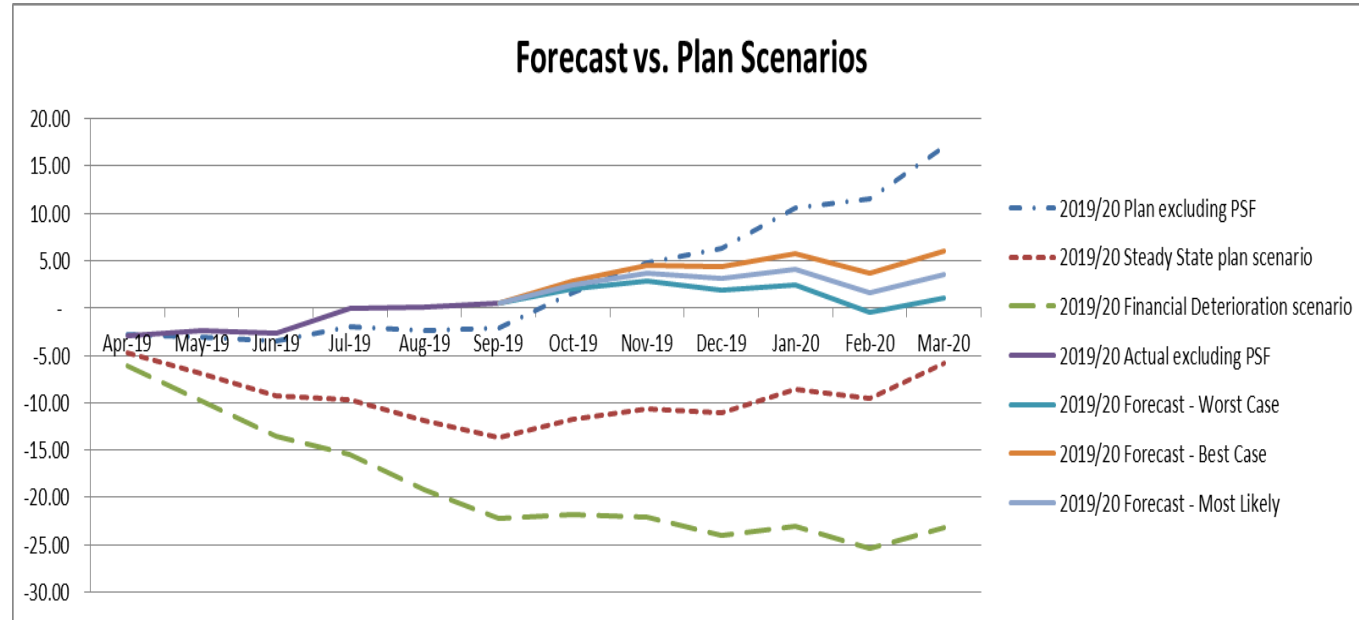
Currently the forecast is based on estimates post Q2, which includes 4 months of "final cut" income data.

The financial forecast is a range of:

- Best Case - £6m surplus
- Most Likely - £3.5m surplus
- Worst Case - £1m surplus

This incorporates uncertainties and risks in H2 relating to:

- Investment in ED to support 4 hour performance
- Investment in schemes to enhance winter flow
- Investment in additional bed capacity, expected to be fully off-set by income
- Investment in consultancy, expected to be fully off-set by income
- Risk of winter pressures on elective activity, particularly in Division D
- Commissioner payment challenges, particularly local non-elective activity
- CIP delivery

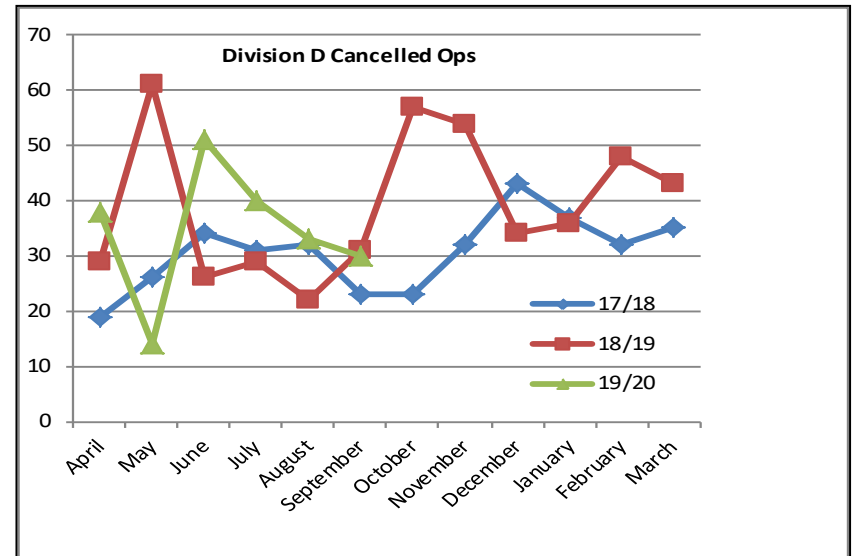
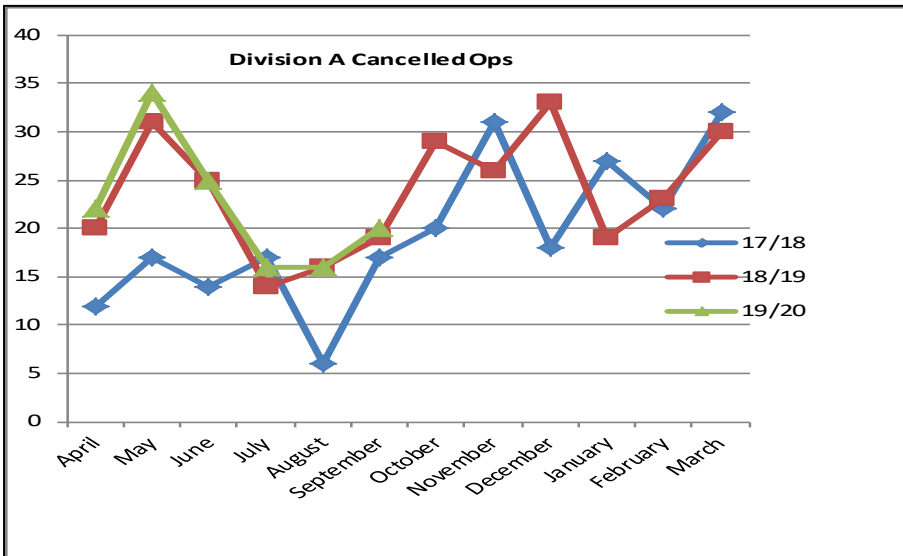
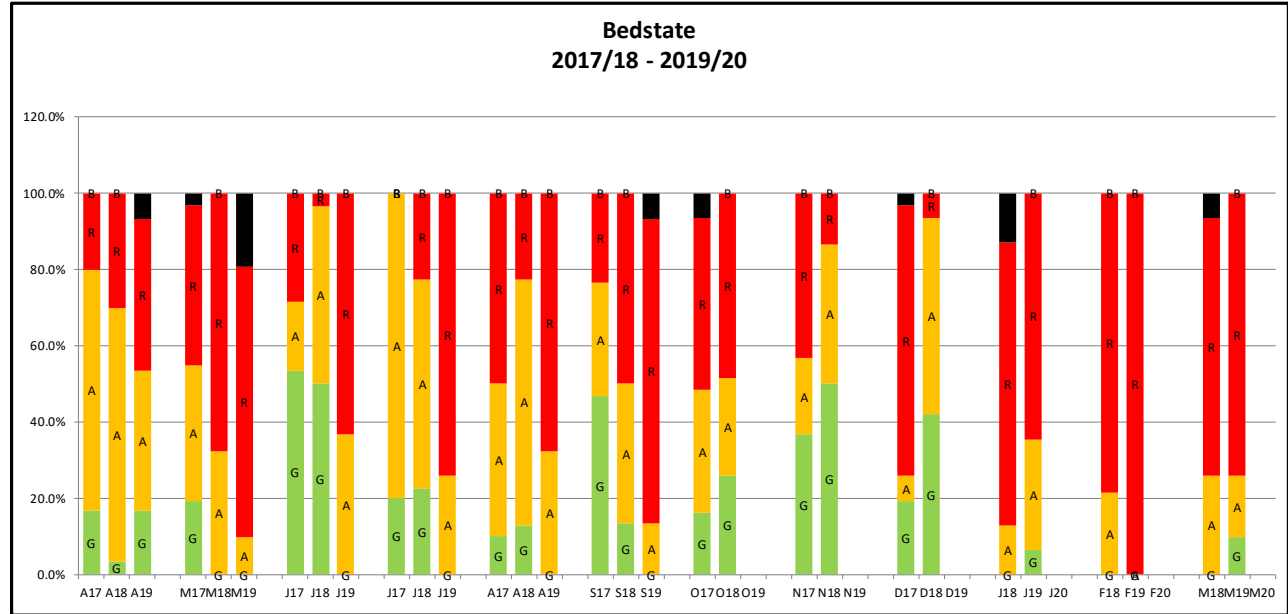


Bedstate – 3yr Comparison

The bed state data for September shows that for approx 80% of days, the Trust bed state was Red, with some days at Black and no periods at Green, which illustrates how busy the hospital has been.

Medicine beds (8) remain closed on Bramshaw and ward E7 (18-20) continues to be managed by CV&T as an interim measure to offset current demand.

On the day cancellations for non-clinically reasons shown below for Divisions A & D comparing 2017/18, 2018/19 & 2019/20.



Clinical Income

The chart shows estimated clinical income in Sept 2019.

Non-elective in-patient activity was above planned levels and a provision has been taken against the impact of the blended payment system for emergency care. Elective income was below planned levels in the month, continuing the trend seen over the year.

Out-patient activity was below planned levels in the month with some areas under review due to potentially 'un-outcomed' clinics.

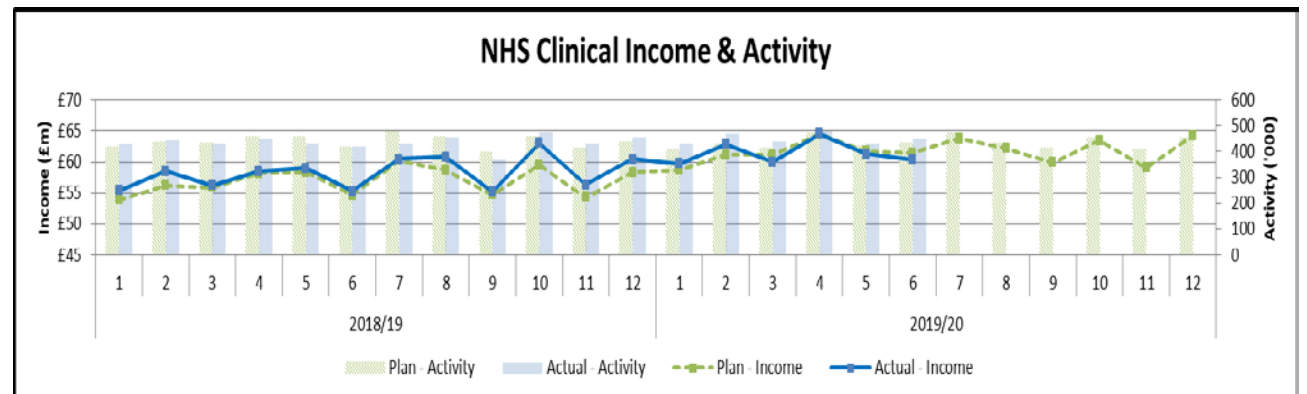
Pass-through drug and device income, within exclusions, was slightly lower than planned levels although this was offset by reduced expenditure.

The Trust continues to provide for commissioner challenges and CQUIN failure which will be resolved as data and reports become available.

Note the clinical income plan has been adjusted for income CIP delivery.

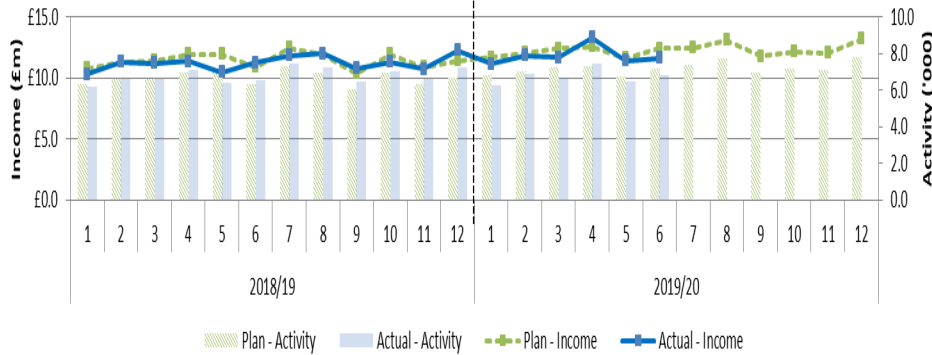
(Fav Variance) / Adv Variance

POD GROUP	2018/19	2019/20				2019/20			Monthly Run Rate	
	YTD Actuals £000s	Annual Plan £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	Done	To Do
NHS Clinical Income										
Elective Inpatients	£65,831	£147,523	£72,742	£70,995	£1,748	£12,423	£11,643	£779	£11,832	£12,755
Non-Elective Inpatients	£92,342	£199,870	£98,173	£107,655	(£9,482)	£15,844	£17,184	(£1,340)	£17,942	£15,369
Blended payment adjustment	£0	£0	£0	£(2,162)	£2,162	£0	£(349)	£349	£(360)	£360
Outpatients	£36,003	£81,420	£39,692	£41,139	(£1,447)	£6,935	£6,647	£288	£6,856	£6,713
Other Activity	£57,166	£128,756	£63,520	£64,185	(£665)	£10,400	£10,772	(£373)	£10,697	£10,762
CQUIN	£7,265	£8,375	£4,120	£4,239	(£119)	£683	£688	(£5)	£706	£689
Blocks & Financial Adjustments	£3,968	£13,555	£10,203	£1,746	£8,456	£1,787	£486	£1,302	£291	£1,968
Other Exclusions	£1,961	£46,419	£24,820	£25,198	(£378)	£4,119	£4,087	£32	£4,200	£3,537
Prior month adjustment	£0	£0	£0	£0	£0	£0	£843	(£843)	£0	£0
Subtotal NHS Clinical Income	£264,536	£625,917	£313,269	£312,994	£276	£52,191	£52,002	£189	£52,166	£52,154
Pass-through Exclusions	£55,749	£115,237	£55,287	£55,693	(£407)	£9,260	£9,192	£69	£9,282	£9,924
Total NHS Clinical Income	£320,285	£741,154	£368,556	£368,687	(£131)	£61,451	£61,193	£258	£61,448	£62,078
Non NHS Clinical Income										
Private Patients		£6,082	£3,236	£2,264	£972	£475	£463	£12	£377	£636
CRU		£2,500	£1,248	£1,257	(£9)	£208	£209	(£1)	£209	£207
Overseas Chargeable Patients		£1,412	£708	£654	£54	£118	£(56)	£174	£109	£126
Total Non NHS Clinical Income		£9,994	£5,192	£4,175	£1,017	£801	£616	£185	£696	£970
Grand Total	£320,285	£751,148	£373,748	£372,862	£886	£62,252	£61,809	£444	£62,144	£63,048

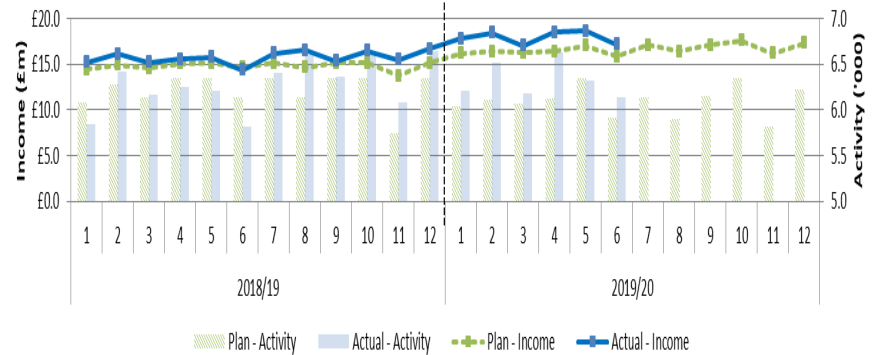


Clinical Income

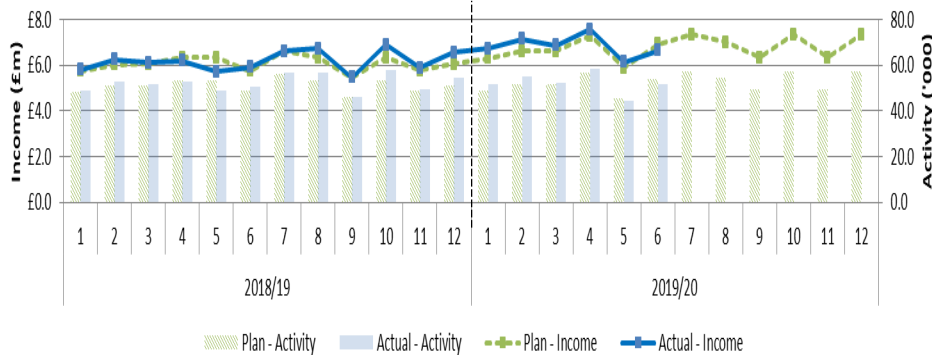
Elective spells



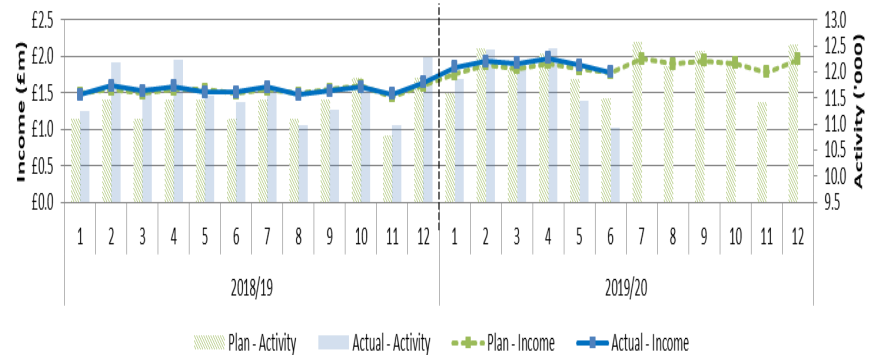
Non elective spells



Outpatients



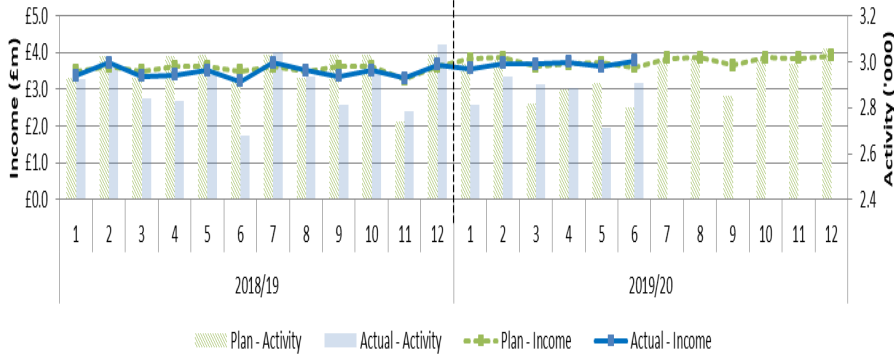
A&E



Clinical Income

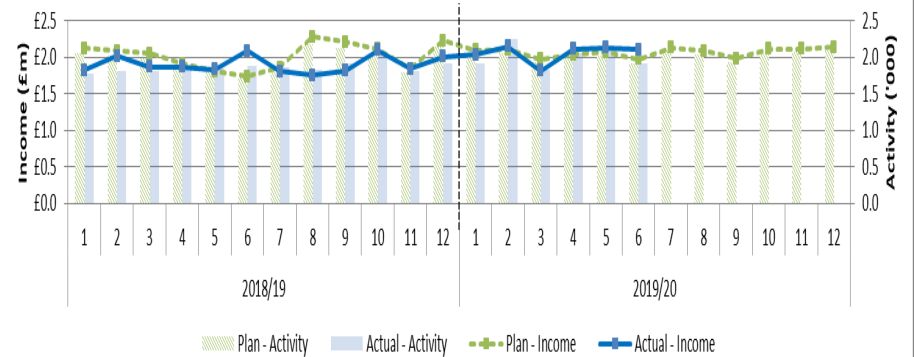
Adult critical care

In month +104 activity, +£176,517
YTD -266 activity, -£213,634



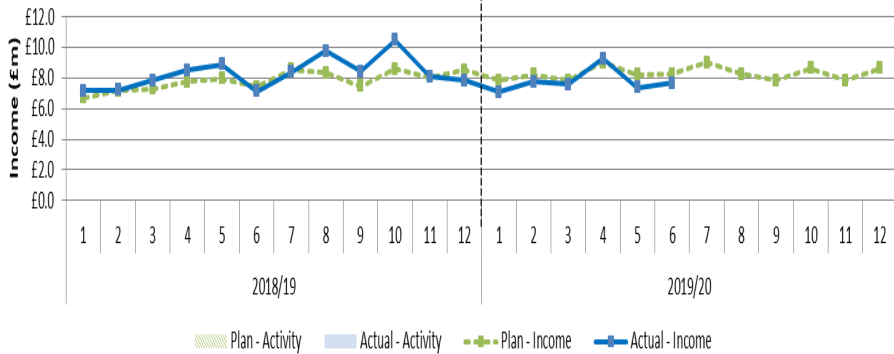
Neonatal & paediatric critical care

In month -8 activity, +£134,399
YTD +51 activity, +£95,019



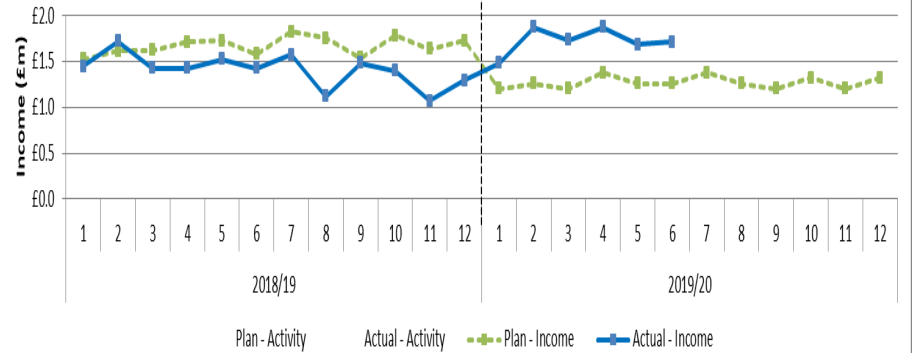
Tariff excluded drugs

In month -£559,072
YTD -£2,513,492



Tariff excluded devices

In month +£455,060
YTD +£2,806,223



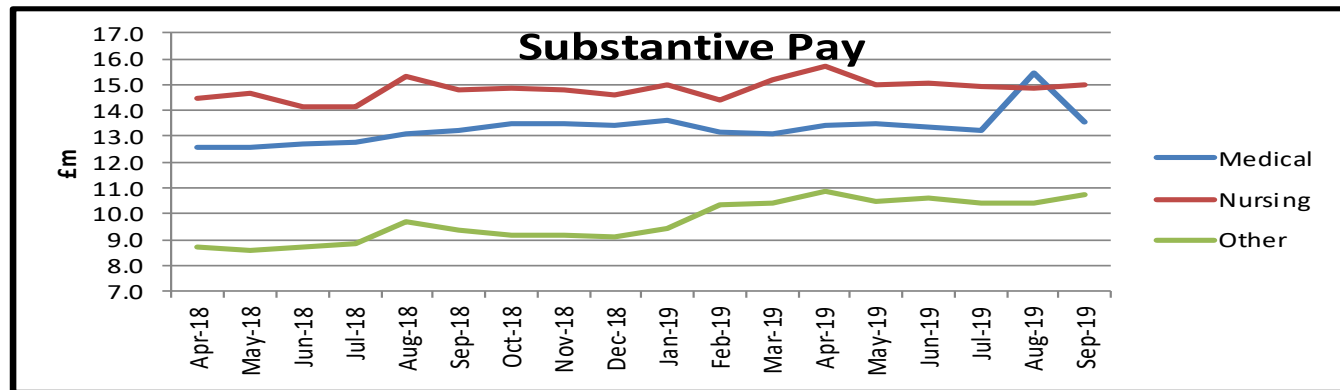
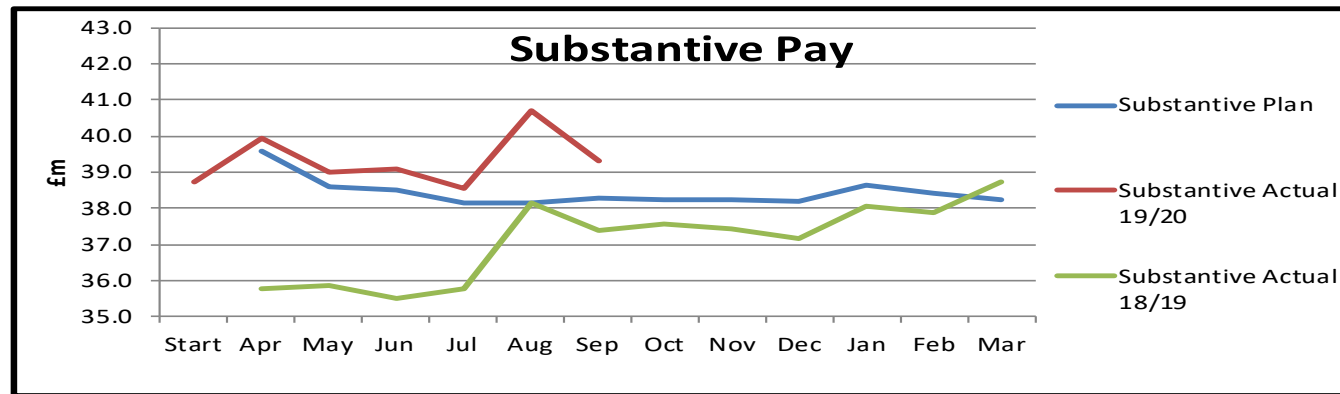
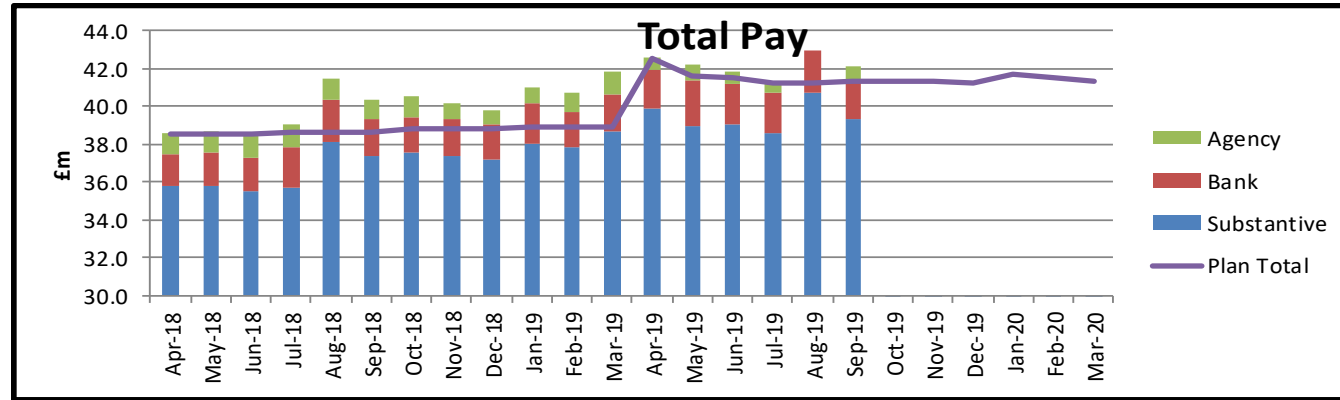
Substantive Pay Costs

Total pay expenditure in September 2019 was £42.1m.

This compares favourably to August 2019 by £0.2m once the backdated spend in August is adjusted, despite approx. £0.1m of bank holiday enhancements being included in September payroll.

In terms of position vs Plan in the month was £0.5m adverse. This is largely due to unidentified/undelivered pay CIP against the pay CIP target agreed at the start of the financial year. Post Q2 close, the annual CIP targets will be adjusted to reflect current pay, non-pay and income splits.

Recruitment Control Panel (RCP) is still meeting weekly to validate new and replacement posts.



Temporary Staff Costs

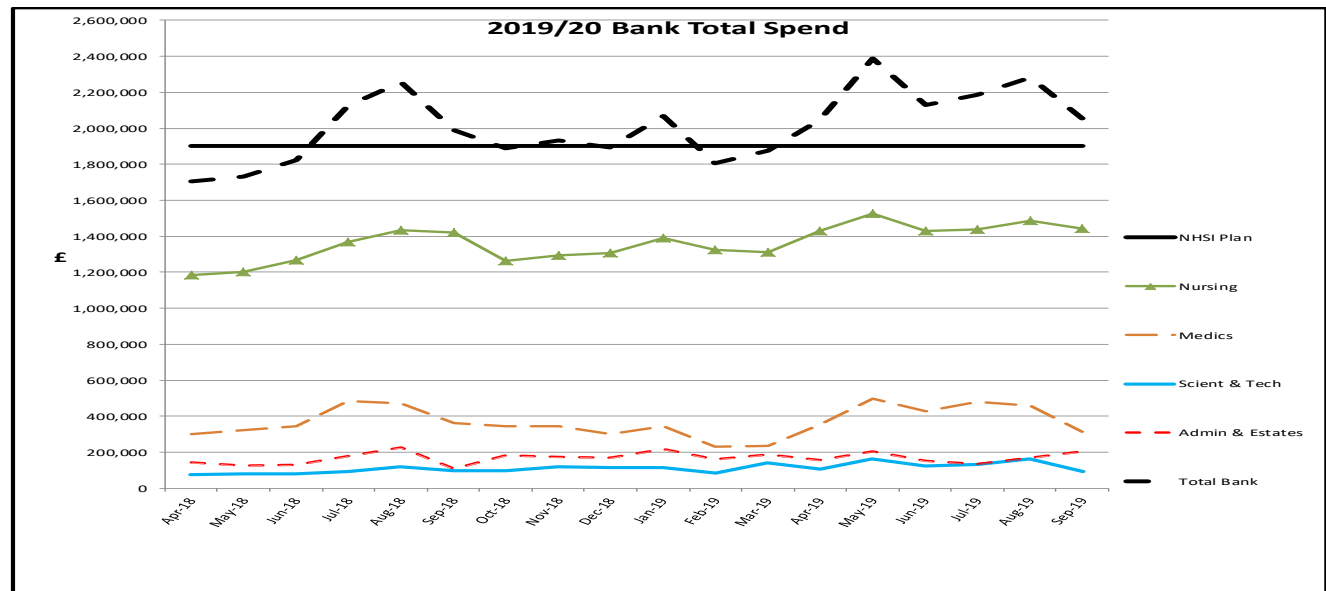
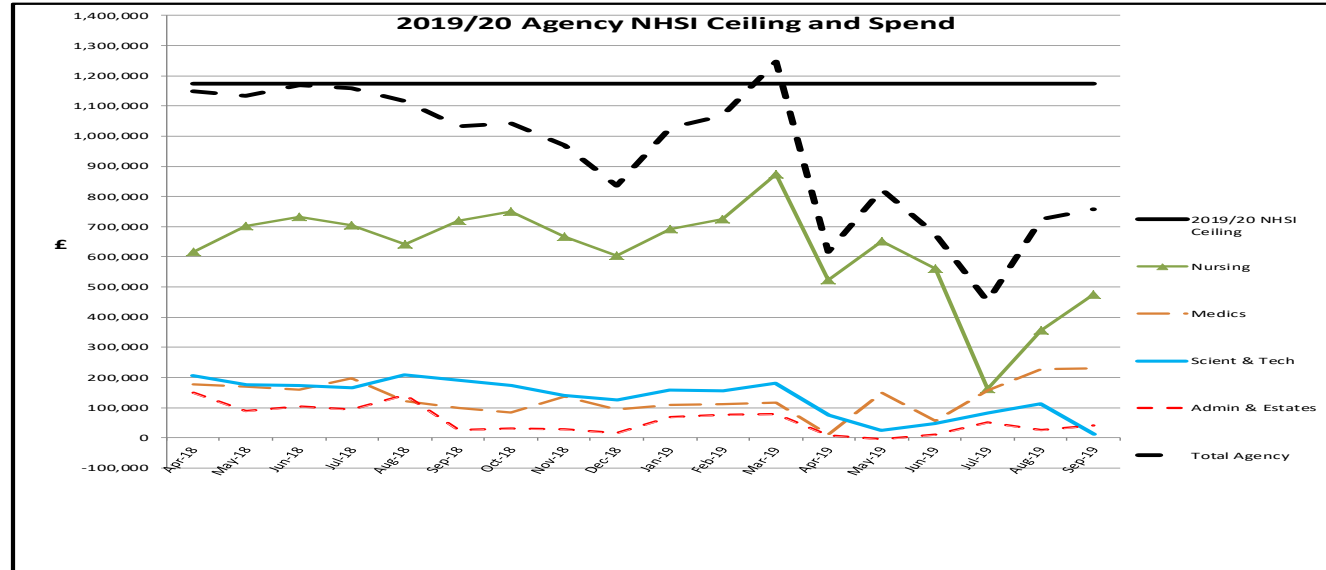
Overall agency spend in September 2019 was £0.8m.

Expenditure on Thornbury increased by £10k in September 2009 at £57k. However, this is £150k lower than September 2018.

Expenditure on bank staff was £2.1m in September, £0.2m lower than that spent in August 2019.

In overall terms, expenditure on flexible staffing was £0.3m lower than Plan in September 2019.

In an initiative to manage temporary staffing more tightly, Savings Board has agreed a proposal to manage nursing headcount headroom to no more than 23%. This project is sponsored by the Director of Nursing.



Cost Improvement Programme

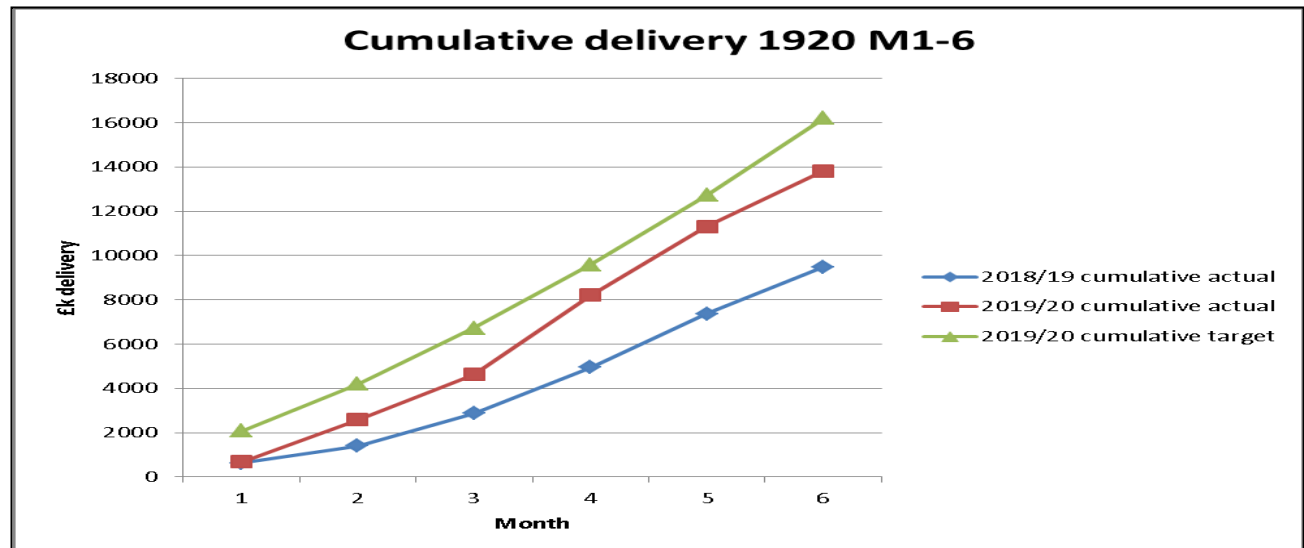
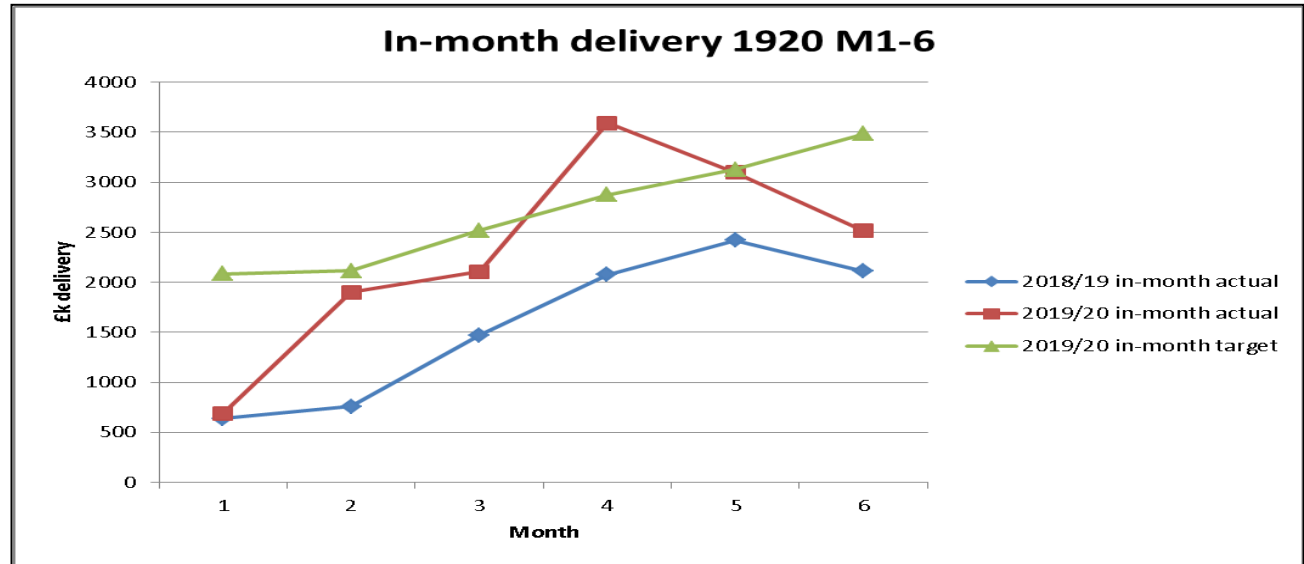
CIP delivery in September 2019 was £2.5m against a Plan of £3.5m.

Income CIP scheme award continues to be high due to strong income performance, although it slowed in M6.

Year to date the Trust is £2.4m behind Plan for 2019/20 although monthly delivery is tracking higher than that previously delivered.

Fortnightly CIP run rate meetings will still focus on the income & expenditure position of each Division vs Plan, and also CIP performance at Care Group level.

Going forward Care Groups have been asked to highlight risks and any mitigations to discuss at the CIP meetings with Execs to firm up the delivery for 2019/20.



Cost Improvement Programme

The Trust has identified CIP of £39.9m, within £0.1m of the £40m target.
Identification increased by £0.2m from August 2019.

Of the total identified, £29.7m/74% is planned to be recurrent and £10.2m/26% non-recurrent. The full year effect of the programme has grown by £1.5m to £8.5m from August 2019, taking the total recurrent savings impact of the 2019/20 schemes to £38.2m.

Focus in the next 4 weeks is on:

- Ensuring delivery of identified schemes to avoid any slippage
- Reviewing non-recurrent schemes for opportunities to make recurrent
- Continuing to discuss risks and mitigations of any identified schemes.

This table outlines the main themes of identified CIP to date. Length of stay schemes will either result in expenditure reductions through closing beds or increases in income from utilising spare beds.

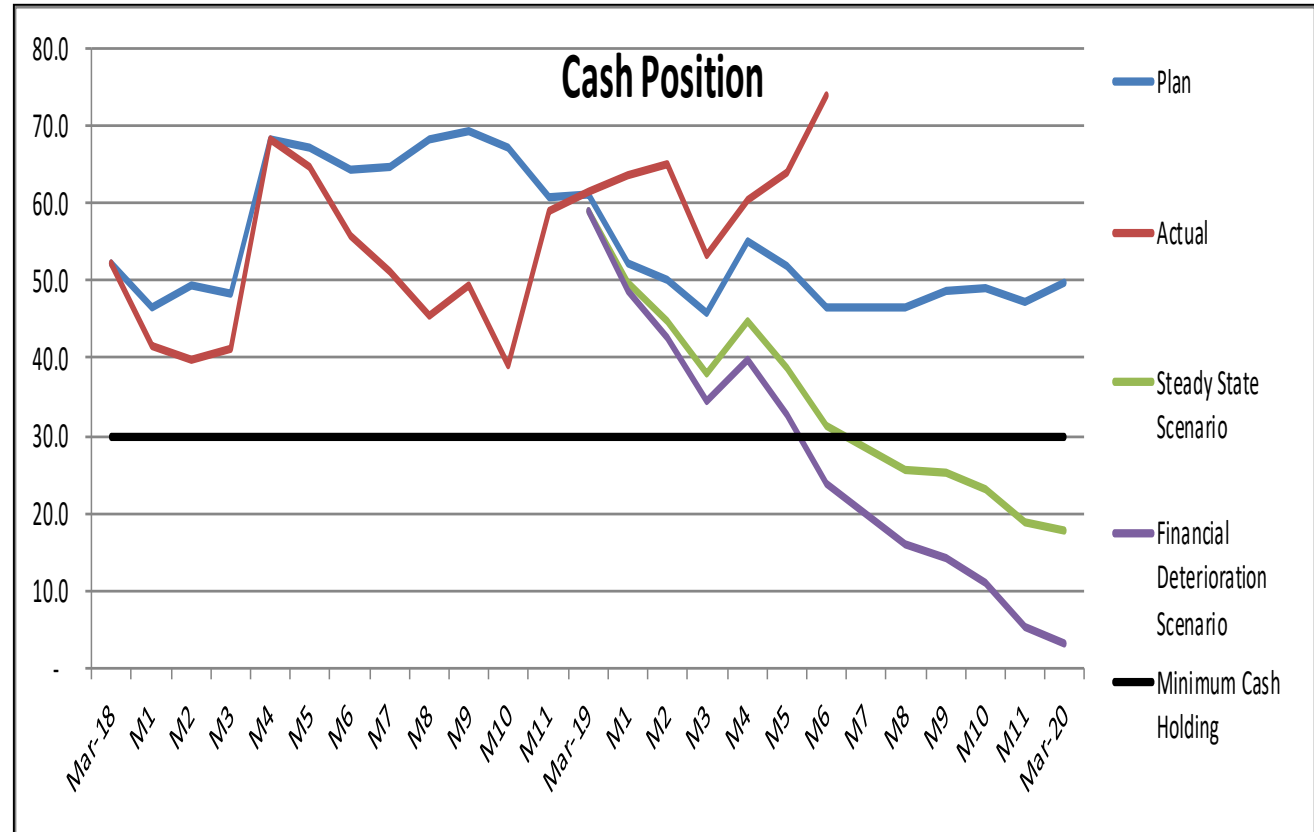
Division	CIP Target £k	Total CIP £k	Gap £k	Identification %
Division A Total	8,998	8,567	431	95%
Division B Total	7,954	8,291	(337)	104%
Division C Total	6,569	6,658	(89)	101%
Division D Total	8,428	9,226	(798)	109%
Total Clinical Services	31,949	32,742	(793)	102%
Chief Finance Officer	377	609	(232)	162%
Estates Facilities & Capital Development	1,892	1,916	(24)	101%
Transformation	163	187	(24)	115%
Chief Operating Officer	379	388	(9)	102%
Human Resources	312	312	0	100%
Informatics	453	200	253	44%
Clinical Governance	173	110	63	64%
Training, Development & Workforce	248	211	37	85%
Chief Executive	54	25	29	46%
Trust HQ Total	4,051	3,958	93	98%
Central Schemes	4,000	3,198	802	80%
UHS total	40,000	39,898	102	100%

	Workforce	Length of stay	NHS income	Other income	Non pay	Total
UHS total	6,457	5,820	15,200	4,967	7,454	39,898
Profile of identification	16%	15%	38%	12%	19%	100%
Recurrent £	2,046	5,820	14,649	1,275	5,905	29,695
Recurrent % of total theme value	32%	100%	96%	26%	79%	74%
Non Recurrent £	4,411	0	551	3,692	1,549	10,203
Non Recurrent % of total theme value	68%	0%	4%	74%	21%	26%

Cash

The cash balance was £73.8m at the end of September, £27.2m above. This is primarily due to:

- 1) Settlement of a £16m NHS England over-performance invoice from 2018/19.
- 2) Payables balances remaining higher than anticipated due to delays in invoice payment, although overdue invoices continue to reduce.
- 3) Year-end I&E position finishing £2.5m above the forecast from which the cash Plan was derived combined with the in year I&E position being better than plan.
- 4) Receipt of PSF bonuses for 18/19 £9.5m in excess of what was assumed in the Plan.
- 5) Capital expenditure below Plan by the end of M6, offset by slippage in ability to draw down funds on PDC-funded schemes.



Capital Expenditure

(Fav Variance) / Adv Variance

Scheme	Month			Year to Date			Full Year			
	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Original Plan £000's	Revised Plan £000's	Latest Forecast £000's	Var (from revised) £000's
Childrens Hospital	100	16	(84)	633	412	(221)	1,893	1,196	1,174	(22)
E D Adult Resus	250	61	(189)	325	86	(239)	1,509	1,501	1,017	(484)
IT Schemes	450	386	(64)	3,417	3,227	(190)	7,450	7,220	7,763	543
Wave 3 STP Digital	0	0	0	26	0	(26)	4,422	26	0	(26)
Strategic Maintenance	450	215	(235)	1,954	1,784	(170)	4,000	4,000	4,000	0
Medical Equipment Panel	35	154	119	375	515	140	2,100	2,100	2,100	0
GICU Expansion	350	822	472	3,550	2,964	(586)	13,614	12,122	11,132	(990)
Refurbish Eye Theatre	0	0	0	0	0	0	1,177	60	115	55
Energy Efficiency	200	144	(56)	200	259	59	2,223	1,473	1,667	194
New Theatres E level	325	(157)	(482)	2,408	1,672	(736)	3,637	3,236	2,312	(924)
Urology Day Unit	225	238	13	1,834	1,591	(243)	2,173	2,177	2,047	(130)
Steam Project	0	2	2	103	111	8	2,126	103	611	508
Princess Anne Theatre Ventilation	20	(46)	(66)	281	462	181	580	355	355	0
Spend to Save	10	2	(8)	115	32	(83)	1,104	847	832	(15)
Radiotherapy Equipment	250	245	(5)	699	681	(18)	658	834	924	90
Divisional / Donated Equipment	150	93	(57)	362	310	(52)	1,350	1,350	1,373	23
Decorative Improvements / Staff Fund	120	7	(113)	176	29	(147)	625	741	718	(23)
Other Projects	502	619	117	2,692	2,726	34	6,006	4,472	5,083	611
Total Excluding Finance Leases	3,437	2,801	(636)	19,150	16,861	(2,289)	56,647	43,813	43,223	(590)
Finance Leases-ISS	200	0	(200)	1,937	1,584	(353)	5,815	4,880	6,436	1,556
Finance Leases-Other	0	39	39	3,173	3,040	(133)	2,000	3,433	3,733	300
Total Capital Expenditure	3,637	2,840	(797)	24,260	21,485	(2,775)	64,462	52,126	53,392	1,266
Donated Asset Additions	(263)	(263)	0	(1,578)	(1,578)	0	(3,043)	(2,796)	(2,796)	0
Total Net CDEL Expenditure	3,374	2,577	(797)	22,682	19,907	(2,775)	61,419	49,330	50,596	1,266

Following a review of the capital programmes a revised plan of £43.8m was submitted to NHS Improvement. This was a reduction of £12.1m compared to the original plan, £7m of which was related to delays in the receipt of national funding.

Spend at month 6 was less than the revised plan. The timing of equipment spend on E level Theatres and Urology Day Unit accounts for part of the underspend. A reallocation of shared building costs to other Projects on E level Theatres and PAH Theatre Ventilation accounts for the negative spend in the month. GICU spend is forecast to be less than the revised plan, which relates to cash-flow timing only and will slip into 20/21.

We are now forecasting CDEL spend in the range £46.4m to £52.8m, with £50.6m the most likely.

Statement of Financial Position

(Fav Variance) / Adv Variance

Payables balances have stabilised since year-end. The back-log of outstanding payments continues to be addressed. The number of unpaid invoices continues to reduce but remains a critical issue to resolve for the accounts payable team. The reduction has slowed due to temporary staff turnover, but there are projects being undertaken to further address this.

Fixed assets value is now closer to Plan as a result of a £2.6m impairment of software non-current assets following the revaluation of assets related to the purchase of EMIS software.

Statement of Financial Position	2018/19 Actuals £m	2019/20			
		YTD Plan £m	YTD Act £m	YTD Var £m	Full Year Plan £m
Fixed Assets	372.4	376.5	373.9	(2.6)	403.7
Inventories	16.5	16.2	15.2	(1.0)	16.2
Receivables	105.9	71.3	76.2	4.9	75.5
Cash	61.5	46.7	73.8	27.2	49.8
Payables	(110.5)	(82.7)	(99.3)	(16.7)	(82.7)
Current Loan	(3.3)	(4.6)	(3.4)	1.2	(4.6)
Current PFI and Leases	(7.0)	(4.4)	(7.4)	(3.0)	(4.4)
Net Assets	435.6	419.1	429.1	9.9	453.5
Non Current Liabilities	(18.2)	(18.3)	(18.1)	0.2	(18.3)
Non Current Loan	(14.6)	(11.6)	(13.0)	(1.4)	(12.0)
Non Current PFI and Leases	(33.0)	(34.1)	(29.6)	4.5	(34.6)
Total Assets Employed	369.8	355.2	368.4	13.2	388.7
Public Dividend Capital	211.0	218.6	211.0	(7.7)	223.7
Retained Earnings	125.0	111.0	123.5	12.5	139.5
Revaluation Reserve	33.8	25.5	33.8	8.4	25.5
Other Reserves	0.0	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	369.8	355.2	368.4	13.2	388.7

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: Trust Winter Plan			
Category	Strategy and Business Planning		
Agenda item	5.1		
Sponsor	Chief Executive		
Author	Duncan Linning-Karp, Director of Operations, Emergency Care		
Provenance	Report to Trust Board. Previously considered at October 2019 TEC		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for APPROVAL. The purpose of this report is to present the Trust's Winter Plan to the Trust Board for approval.		
Relevant strategic goals	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input checked="" type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input checked="" type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services 		
Impact assessments	N/A		
Other standards affected	CQC, Regulatory compliance		

Trust Winter Plan

1. Introduction or Background

The Trust's Winter Plan is submitted to the Trust Board along with this cover paper. The winter plan is for approval.

2. Analysis and Discussion

Each year the Trust develops a winter plan to manage the increase in non-elective flow while balancing the need to maintain elective activity (particularly for patients with cancer or who have waited a long time for their operations).

This year modelling suggests that the Trust will need an additional 45-60 beds, above the swing capacity open last year, in order to maintain emergency flow. The winter plan outlines the additional beds that will be opened and includes mitigations in case the winter is worse than predicted.

It also outlines how we will continue to ensure patient safety and experience is maintained, how we will support our staff throughout the winter and the key risks. Finally, it outlines some key metrics that will be monitored throughout the winter to help inform decision making, particularly about opening or closing additional capacity.

3. Conclusion

The Trust's winter plan provides assurance about how the hospital will be managed over the winter, including mitigations if the need for additional beds is greater than expected. The appendices provide details of both the Trust's and the system's plans.

4. Recommendation

The Board is asked to approve the Winter Plan

University Hospital Southampton NHS Trust Winter Plan

Executive Summary

The Trust wide Winter Plan sets out UHS's arrangements for the winter period. Winter should be recognised as a period of increased pressure due to the increased clinical acuity of many patients combined with capacity demand on resources within the trust. In addition, the winter period often brings with it untoward events such as widespread infectious diseases including flu and Norovirus. Winter should not be considered an unusual event nor is it an emergency.

Each year UHS experiences increased pressure in patient flow.

UHS's plan prepares the organisation for winter with support from the Health and Care Community locally to:

- create the capacity to meet increased demand
- focus on admission avoidance schemes and ambulatory care pathways
- Link the Trust Winter Plan to the System Resilience Plan
- Robustly performance manage the system to maintain quality, activity, safety and experience

Much of this plan echoes the access and flow improvement plan work that has been ongoing over 2019 combined with schemes to demand manage attendances and admissions.

The top interventions to deal with increased winter pressure may be summarised as:

- The improvement of medical capacity and decision making within the ED department through investment in the medical model and increase in specialty teams pulling directly into admission and assessment areas e.g.: ASU, Cardiac, Gynae, Oncology and trauma
- The prevention of overcrowding in ED through the increased streaming patients to services outside of the department eg: SDEC and emergency clinics
- The reduction of LOS through the adoption of best practice
- The reduction of DTOCs from circa 7% to <4%
- The reduction and avoidance of admissions through partnership working
- The re-designation of day case capacity to provide additional IP beds, with a plan to create 45+ more adult inpatient beds at UHS and a challenge to our partners to create more capacity

Details of the plans follow below.

Emergency Department Trajectory

UHS has been asked for predicted emergency department performance for the months of November and March. We have currently submitted to NHSI/E a performance trajectory of 85% for both these months.

Emergency Department Approach

UHS's emergency department will experience increased pressures over winter. Using themes that have been recurrent in recent years, these are likely to manifest as:

- Increased case mix of frail patients who experience difficulties in winter months (increased demand)
- Increased demand at times of holidays when patients delay receipt of treatment and/or expose themselves to increased risk of injury/illness (increased demand)
- Decreased support and availability in primary care GP through during winter holidays and patients that decide not to use alternative services (increased demand)
- Reduced flow and inpatient bed availability increasing exit block (reduced capacity)

Based on demand modelling, the following are predicted as particular periods of pressure:

- o October half term (28 Oct 2019 – 1 Nov 2019)
- o Early Jan 2020 (specifically the first 15 days of the month)
- o Feb half term (17 Feb 2020 – 21 Feb 2020)

A number of responses to this increase in pressure are incorporated into the ED improvement program already underway and these will be maintained alongside a number of winter specific actions:

- A revised approach to site escalation to match national framework
- Proactive over-recruitment of medical staff
- Embed & expand direct admission pathways for speciality areas
- Introduction of point of care testing in the Emergency Department (ED) and AMU across 7 days a week for all new admissions with acute respiratory illnesses (estimated to save 13.8 beds per annum)
- Completion of works to the new resus area for ED in December 2019
- Conversion of "old" resus area to provide more majors accommodation
- Reduce demand on ED through increased streaming of patients to primary care service areas where appropriate and to externally based community services.
- A review of senior manager on-call arrangements, including introduction of DCD-specific daily support for issues

Bed Occupancy

Forecast demand has been modelled based on anticipated adult bed requirement throughout the year.

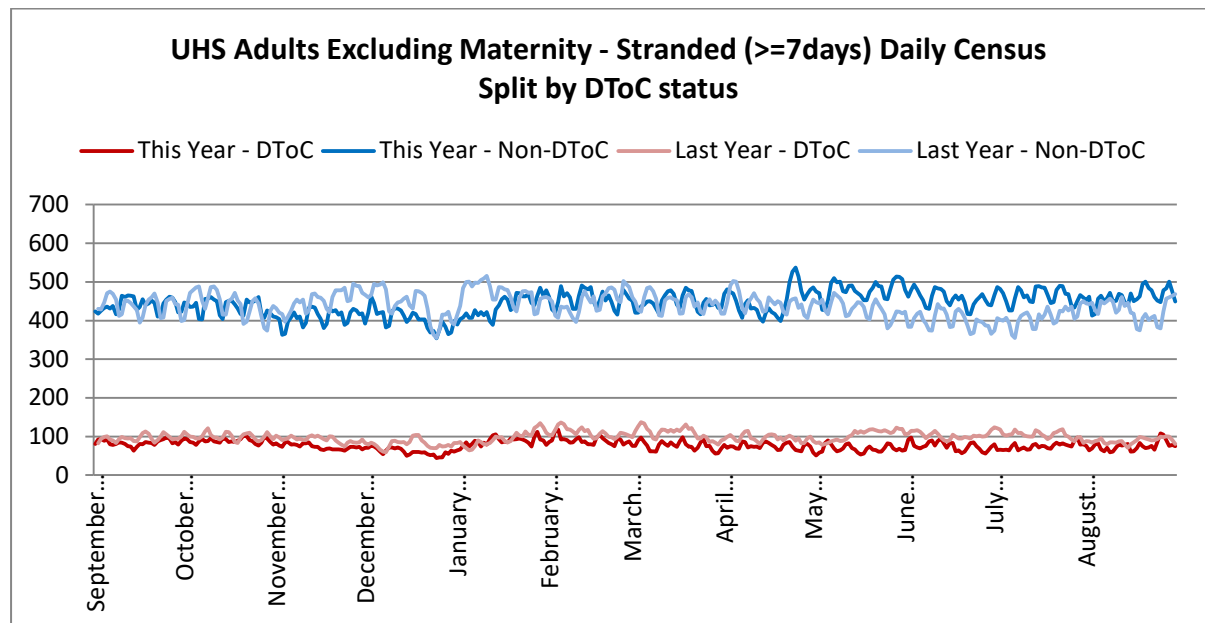
Non elective admissions have risen 6.45% over the past 12 months and ED attendances, based on discharge from Main ED and GP streaming have increased by 9%. Based on YTD Non elective LoS the model forecasts a bed shortfall of circa **60 beds** over 2018/19 levels for unscheduled care over winter & over and above the swing capacity that is regularly used.

Reducing length of stay and maintaining flow

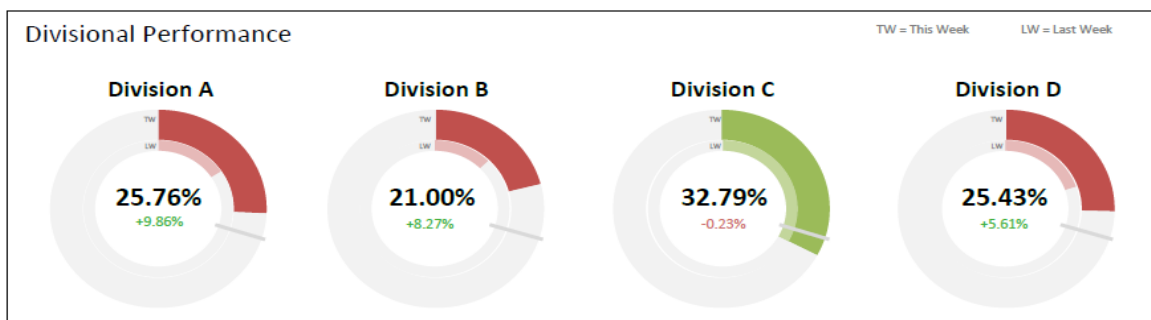
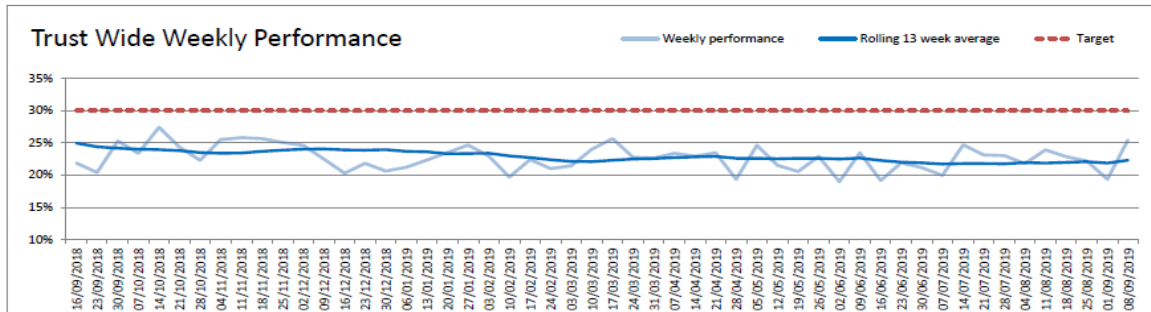
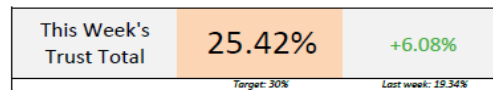
There are already a number of initiatives underway. LOS improvements, as shown below, give some confidence in the continuation of the actions already in place although the pace of change on has slowed with 0.2 days being delivered on average across the bed base. In order to manage the increased pressures over winter a further 0.5 day decrease in LoS for all beds would be required. We are engaging PWC to do urgent scoping work with us, and over the next 3 weeks will plan implementation to drive this length of stay reduction.

Trust wide length of stay adult (excluding labour ward and off site locations, non-elective)

We have not seen the reduction in length of stay this year that we were planning or expecting:



The Trust's performance on Home for Lunch also remains below trajectory:



For the winter period actions will be taken to re-energize this work with an increased focus on patients with a longer length of stay (LoS). Specifically

- Revised focus on long length of stay patients, with clinical lead ownership and weekly exec oversight.
 - 500 spells per month >14 days / 300 spells > 21 days
 - 2 days reduction in LoS for pts in cohort 14-21 days = 30 beds / 4.3 days reduction in LoS = 75 beds
 - 3 days reduction in LoS for pts in cohort > 21 days = 30 beds /7 days LoS reduction required to deliver 75 beds
- Targeted PWC work to identify further opportunities in the above cohort from November
- Enhanced support from clinical support services (Therapies, Pharmacy etc.) to improve flow across seven days, particularly in Medicine
- Renewed approach to cohorting medical patients effectively to reduce impact of outliers
- Extension of discharge lounge areas to 7 days
- Ongoing embedding of the SAFER bundle, supported by the rollout of electronic whiteboards and a refocus of Integrated Discharge Bureau priorities.

Support our staff

Pressure on staff due to capacity has been a growing issue in UHS over the last year. Record

ED attendance, coupled with other capacity issues, has driven an increased level of stress and workplace demands on our workforce. Recent feedback from our change champions identified this as the number 1 theme, which is also mirrored by comments received in our Q2 Staff Friends and Family Test (FFT).

The predicted significant growth in winter demand will place further strains on our staff and in particular those in clinical, support and managerial positions that are linked to patient flow through the hospital.

The Trust intends to take the following steps to try to protect staff health and wellbeing:

- Use appropriate bank and temporary resources to plug gaps and ensure staffing is safe. Continue regular safe staffing meetings to best allocate resources. Continue to drive up the level of bank only contract use through NHSP to reduce reliance on our own staff doing extra shifts.
- Invest in extra security in the emergency department to help further protect staff safety during busy times
- Ensure our managers encourage staff to programme in annual leave over the winter so staff get a suitable break
- Significantly drive up levels of communication about the UHS 'Live Well and Inspire' health and wellbeing programme including a focus on the support available to staff and also how staff can take steps to look after the health during difficult periods.
- Continue to ensure our staff feel thanked and valued during winter for their efforts
- Increase executive and senior manager visibility during the winter period
- Continue the great 'reminder to be kinder' campaign initiated by Gail Byrne (Director of Nursing and OD) and reinforce its importance during winter.

Winter bed “swing” capacity

UHS has defined 2 phases of swing capacity to meet predicted demand.

Phase 1 is in essence the normal swing capacity used annually with **Phase 2** stepping up the reallocation of beds as IP unscheduled capacity over & above that previously given, specifically the whole of the surgical day unit (SDU).

The temporary availability of space within the Child health footprint has supported the organisation in this regard for 2019/20 alongside:

- re-designation of early AM outpatient in west wing space for patient assessment 07:30 -09:30 daily
- Commissioning the radiology day care unit January 2020 (4-6 patients per day)

Phase 1 – November 1st-January 13th – Capacity used in previous winters

Location	Hosting	Pt Group	Beds
T&O	T&O	Medical cardiology /heart failure	18
Bramshaw	W&C	Low acuity	6
SDU	Theatres	Low acuity / next day discharge	6/12
Trauma assessment	T&O	All care needs	8
Cath lab day unit	CV&T	Low acuity / next day discharge	6

Neuro day unit	Neuro	Low acuity / next day discharge	2
			52

Phase 2 – 13th January - 30th April (with March end review) – Additional capacity to previous winters

Location	Hosting	Pt Group	Beds
E level PAH	TBC	F7	12
SDU	Theatres	All care needs	11
TYA Daycase	Oncology	Oncology overflow	4
Care Home Select	External	Potential additional medical / MOP	10
			37

Phased 3 – Extreme capacity escalation

Location	Pt Group	Impact	Beds
Frailty unit	MOP	ED flow	6
SDU additional beds	Surgery	Surgical activity	11
Endoscopy	Tbc	Diagnostic and therapeutic activity / JAG	10
Recovery	See flu plan	Theatre flow	6
Iodiine rooms	Non-elective admissions	Oncology license	2
C7	Non-elective admissions	Closes chemo service	12
Sleep study rooms	Low care only (access)	Loss of sleep studies	2
			49

Nursing cover

The Director of Nursing and the Divisional Heads of Nursing are developing plans to staff the additional areas. This will be through a combination of moving Trust staff and agency, ensuring that no one area in the organization goes below a pre-agreed level of Trust nurses.

Medical cover (including PAH)

1. Junior doctor cover for PAH: there will be specific cover for PAH medical identified in the OOH rota with clear communication of role, expectations and escalation plan.
2. Respiratory Team 4 will run December to April; this will be a consultant-led AMU based team to enhance the care and pathways for patients presenting with acute respiratory illness.

3. Additional 'pop-up' medical team - consultant led on West wing in-patient team to assist other in-patient teams avoid excessive numbers of patients (flow with in teams generally slows down when in-patient numbers per team exceed 25 patients)
4. Divisional/Care group led discharge team – initially a pilot to scheme to drive discharge early in the day. A multidisciplinary team with assist with HMR completion, pharmacy liaison, appropriate use of the discharge lounge. This will support flow with the aim of debulking the ED early in the day.
5. Peer review of all in-patients with LoS more than 7 days. The Division/Care group will work with clinical leads and teams to support pathways for patients with admissions beyond 7 days. There will be a forensic approach to discharge pathways.
6. Additional weekend consultant-led ward rounds in January and February to support flow and early discharge.
7. Hot clinics – specialties to support early review of patients using the GP space. This will support admission avoidance in the ED.

Patient safety and experience

There are a number of risks to quality and safety in opening extra capacity which we will seek to mitigate in our winter plans. We recognise that these risks are more significant by not planning for additional in patient capacity in winter. Strong clinical leadership, sensitivity to operations and reporting of incidents and near misses will be vital in ensuring that staff are supported to raise safety concerns. Staff will feel listened to and supported by divisional and trust leadership to continue to focus on quality and safety over the winter period.

Agreeing the case mix for patients on each new capacity area will allow us to consider staffing models in a more sophisticated way; including medical cover, Allied Health Professionals and other support staff and ensure that patients are safely placed in the organisation. In order to safely staff new capacity we will need to use some additional agency staff. We will utilise wherever possible NHSP who have experience of working in the trust and are sometimes our own staff. We are committed to having a core group of UHS staff on each area and a designated ward leader from UHS staff to ensure that quality care is delivered across all areas. We will use our existing systems of monitoring both safe staffing and quality assurance. We will continue to have oversight of safe staffing on a daily basis. Clear clinical ownership of each new area with matron support will allow us to support staff to maintain quality standards.

Our planned areas allow us to continue to prioritise same sex accommodation and areas will have separate toilet and washing facilities for males and females.

We recognise that there are significant risks to patients if there is overcrowding in ED and have developed processes and escalation pathways to support ED in times of pressure. In line with our operational escalation plans we would only use 'boarding' (the movement of patients to wards without a bed available) in exceptional circumstances e.g. major incident, after agreement from the Director of Nursing. We will seek to minimize corridor queueing in ED wherever possible.

Cancellations

All elective admissions are prioritized the day in advance by a senior anesthetist / surgeon. They are graded as Priority 1, 2 or 3. The lists are then returned to the relevant Care Groups by lunchtime the day before surgery, who then have an opportunity to challenge the priority if they disagree. At the 4pm Site meeting the Head of Operations or Director of Operations will, with others in the room, make a decision about the next day's elective programme. Decisions are communicated to the relevant Care Groups and theatres. At 7.45 on the day of surgery that day's admissions for ICU and HDU are again reviewed in Site with the ICU consultant and a decision is taken based on available ICU / HDU beds and predicted discharges whether to go ahead, hold the patients while more information is sought (e.g. confirmation of discharges) or cancel. The rest of the day's operating is then reviewed again, and a decision is taken whether to cancel patients, hold until further information (e.g. an updated bed state) or cancel.

Patients are graded in clinical priority. However, other factors (particularly whether they have been cancelled before, or are a potential 52 week breach) are also taken into account.

Risk	Mitigation
Inability to find enough nurses	Plans have been costed to include a level of high cost agency. DHNs developing detailed staffing plans. Vacancy rate across medicine has gone from 35% to 20% in the last year.
Loss of elective capacity (particularly day cases)	Mitigation plans to allow 45 day cases a day through. Daily average currently 40-50. With clear list booking and increasing the use of Lymington throughput should be maintained
Length of stay reduction less successful than planned	Develop a clear set of KPIs with those supporting on length of stay to ensure delivery
Need for additional beds higher than planned (e.g. severe flu season)	Plans in Phase 3, while highly undesirable, offer some mitigation in the event of an unexpectedly severe spell
Staff engagement and satisfaction suffers	Develop plan with comms and HR

Finance

System level investment is still being confirmed. However, the Trust has agreed to invest the following to support winter:

Initiative	Time period	Revenue Costs above Plan
ED Medics	Nov19-Mar20	£244,755
Div B – other (extend pathology testing)	Nov19-Mar20	£66,478
External Agency (reduce DTOCs)	Nov-19	£20,000
Pharmacy (NOMADs)	Nov19-Mar20	£7,500
Therapies (length of stay pilot)	Nov19-Mar20	£20,259
Surgery (extend ASU Direct)	Nov19-Mar20	£26,667

Site	Nov19- Mar20	£20,649
Div D bed management	Nov19- Mar20	£86,220
Totals		£492,528
PwC cost		£36,000
Internal UHS LOS resource		£86,000
ED Nursing	Dec19- Mar20	£296,256
ED junior medics costs in RR but above funded plan	Oct19- Mar20	£420,000
Grand Total		£1,330,784

Community & Partner Schemes

At a system meeting on 4th October UHS met with community and healthcare partners to agree a portfolio of measure to deliver winter resilience. A follow up meeting is scheduled for 29th October to update against actions. A summary of the actions includes:

Refocus efforts on repatriation

- Relieve pressure on UHS tertiary beds (9-12 beds)

Paediatric ED attendances:

- Growth in paediatric ED attendances. Analysis to understand reasons for increase in demand & inform further demand management opportunities

Ambulance non-conveyance:

- To clarify SCAS see, treat and convey model covers all ambulance conveyances
- Explore opportunity to increase OT's as part of ambulance crews to increase 'see and treat
- Work with SCAS to identify any 'gaps' in local support/services which could be addressed to reduce conveyances to acute hospitals

Utilisation of LNFH:

- SHFT to continue to work with SCAS to increase utilisation of LNFH Improved patient transport at ED front door to increase transfer of appropriate patients to Lymington New Forest Hospital

High Intensity Users (HIUs):

- Expand existing schemes to support ED HIUs ensuring that each person has a care plan in place accessible to all. Lead identified to co-ordinate whole system high intensity user group to ensure comprehensive programme and consistent processes in place.

Flu immunisation:

- Explore opportunity for UHSFT to undertake flu immunisations, particularly given focus on respiratory.

Same Day Emergency Care Unit (SDEC):

- Explore opportunity to scale-up SDEC and community support services to turnaround more people at front door. To ensure a consistent approach across S&SWH.

Enhanced Health in Care Homes:

- Identify if the roll-out of the 'core offer' to care homes can be delivered at a faster pace across Southampton and South West Hampshire

Increase weekend discharges:

- Scope and cost provision of in-reach leads to 7 days

Enhance reablement capacity over winter period :

- Scope opportunity to shift OT resource from acute to community
- Scope enhanced reablement capacity to provide additional capacity to facilitate timely discharge and support people at home

QDS double-up packages:

- Explore the provision of bridging and live in options

Trusted Assessor – Care Homes:

- Accelerate implementation of trusted assessors

Enhanced Primary Care Support:

- Scope opportunity for enhanced primary care support to integrated community teams

Access to Voluntary Sector:

- Scope opportunities for working with volunteers to facilitate discharge and support people at home

Increase utilisation of existing community beds:

- Increase use of first available bed rather than offering choice (SW Hampshire)

Nursing home beds:

- Explore the potential to block purchase nursing home beds
- Explore role of community support team to support homes to provide additional care

Additional Bed Capacity:

- Scope and cost an additional 6-8 beds at LNFH over winter period
- Assess feasibility of dedicated community ward in Princess Anne Hospital (E level)
Workforce recruitment to commence now

Additional UHS schemes

Divisional teams have met to consider a number of interventions over winter that will enhance flow and drive discharge

Elective Phasing & Mitigation for the loss of SDU

Reducing elective activity plans will follow previous year's plans for the 6 week period from the end of December and throughout January. The week prior to Christmas will incorporate scheduling procedures with longer LOS for the early part of the week, and reducing routine inpatient elective activity by approximately 50% on 22nd and 23rd December in order to assist with the aim of achieving 80% bed occupancy on Christmas Eve. This reduction in routine activity will continue between Christmas and New Year

During the first two weeks of January the Divisions will not schedule any routine inpatient surgery however they will continue to book cancer, urgent and day case surgery.

A summary of the impact of designating SDU as IP capacity over the winter has been carried out.

Under normal circumstance SDU processes between 60-70 patients per day for theatres or for interventional radiology. A series of pathway redesigns have been proposed by the team using west wing OP space and holding / recovery bays in John Atwell and green bay within SDU. As a result UHS should be able to deliver circa 40 -45 pts per day if admissions are phased. The opening of the radiology day case area in January will support delivery of a further 5-6 who currently go via SDU.

Ambulance Handover

The Trust continues to work closely with SCAS to ensure that handover times and the impact of ED overcrowding and pressure are minimized.

ED capacity and demand is visible at all time to the Operations center showing the number of patients in A&E, time to triage and first assessment, anticipated receiving specialty, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait . This "at a glance" gives an early warning across the trust as to where pressure is building for beds and local actions can be taken early to ensure that flow is maintained.

Christmas

This year Christmas Eve, where UHS commonly has increased discharges, falls on a Tuesday. Normal staffing rosters should apply on Monday 23rd and Tuesday 24th to ensure patients are ready to go. Increased capacity from transport providers will be requested to ensure that demand is matched at this important time.

Inclement Weather

The local resilience forum (LRF) produce a multi-agency weather plan and ULHT has a Snow and Adverse Weather that includes advice for staff on preparedness, adverse weather warnings and actions for different levels of escalation.

IP&C

Last winter saw capacity being compromised by outbreaks of norovirus & a failure to isolate patients quickly. Lessons have been learned and for this year demand will be managed with

an effective communications plan and the site instigated outbreak meetings will be held in line with the policy. The Infectious Outbreak / Incident Policy including Major Outbreak will be followed and invoked throughout this winter.

Additional investment is also being made in additional biomedical staff to run respiratory virus and norovirus testing 7 days a week and 8-8 Mon- Friday to give same day results to support patient flow and also run batches overnight.

Influenza

The Trust has a comprehensive flu plan.

Vaccinations will commence in October .Incentives and a wider media campaign is amongst some of the changes in the plan which is built on best practice taken from other Trusts and national guidance

Operating Frameworks and escalation

Throughout the winter period, as with any other time, operational flow through the sites will be managed by the Operations Centre.

Operational Flow (Bed Meeting) times have already been reviewed, amended and re launched throughout the day so that situation reporting can come out consistently.

Communications Plan

This will contain key messages for the public to promote “choose well messages” and for staff around areas such as SAFER.

Major Incident

The major incident plan will be updated to reflect these changes.

Impacts Measure

A number of key metrics have been identified as an early warning to indicate success of the plan or not.

The metric are also an easy way to communicate quickly with staff so that they can see where their stepping up an action may make a real difference to flow. It is proposed that these metrics are communicated several times a week via e mail and staff net. They will be monitored in real time and help to inform decisions, including if further beds need to be opened, additional support from community partners sought, or indeed if additional capacity can start to be closed.

Level of DTOCs	<4%
Number of bed days lost to	200

Norovirus	
Number of patients >21 days	162 (March 2020)
Number of medical outliers	<65
4 hour ED performance	No days sub 75%
Number of patients waiting repatriation	<8
Step down delays from ICU	0
Number of surgical cancellations (<24 hrs)	<16 p/w
Number of 12 hr breaches (non-mental health)	0

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: EU Exit Briefing			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.2		
Sponsor	Chief Financial Officer		
Author	Jo Hall, Head of Operations		
Provenance	Trust Board		
Classification	This Report is unclassified.		
Purpose	The paper is presented for REVIEW.		
Relevant strategic goals	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input checked="" type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider 		
Impact assessments	N/A		
Other standards affected	N/A		

1. Introduction or Background

Since 2016, when the UK voted in a referendum to leave the European Union, the Government has been negotiating a withdrawal agreement; however, if the Withdrawal Agreement is not passed by Parliament a potential default position is a 'no deal' EU-Exit on 31st October 2019.

The EU Commission has made clear that, in the event of a 'no deal' exit, it will impose full third country controls on people and goods entering the EU from the UK.

The cross-government planning assumption has therefore been revised to prepare for the potential impacts that the imposition of third country controls by member states could have.

In accordance with guidance from the Department of Health, the Trust has prepared itself with the intention to avoid any disruption of services to patients or supplies, the details of which are addressed below.

2. Analysis and Discussion

Since March 2019, when an extension was granted by the EU for the UK to continue negotiations, the Department for Health and Social Care has reflected on lessons learned and have broadened the national planning assumptions to include the whole health system, not just acute providers.

They have also noted that communication to NHS frontline staff and the public on the planning assumptions, appropriately managed, would be effective in managing the public expectations of the health service.

In September 2019, National workshops commenced, run by DHSC representatives, to communicate the key messages to support regional and system preparedness. The message was clearly stated that Trusts should adopt a "business as usual" stance to managing EU-exit and manage the process through existing business continuity arrangements. An Operating model for EUexit response has been made clear with central control and coordination, and a single point of contact for each region for escalation. Daily information gathering (SITREP) has been linked with winter resilience reporting in an effort to streamline assurance requests to providers. The UHS response is being led by the Emergency planning response and resilience (EPRR) team under the guidance of the COO team.

The ability to maintain supply routes remain a focus for the national team. Key messages relating to the actions to maintain supplies were shared, which include; express freight routes which are nationally procured and key supplier engagement maintained nationally. The testing of transport plans to maintain flow at local ports is continuing and remains a risk.

The national advice on all supplies and medicines remains as it was in March 2019; do not stockpile locally. The national team have created buffer stocks held centrally and there are processes already in place to manage stock shortages which should be followed. If these fail then issues should be escalated regionally. The impact on community services is considered to be a significant risk both for supplies and workforce.

Following the national workshop, the EPRR team re-commenced the EUexit meetings from the end of September. Meeting weekly, representatives from each Divisional team, and work streams give updates from their local and national briefings and any issues are identified to be escalated to the regional centre.

All work streams have been reviewed and all actions taken as advised by the national teams. The work streams are:

- Pharmacy
- Supplies/ Procurement
- Medical devices
- Non clinical goods and services
- Workforce
- Reciprocal healthcare and overseas visitors charging
- Clinical trials and research
- NHS Blood and Transplant
- Data
- Communications

In accordance with national guidance the EPRR team have confirmed that all business continuity plans have been reviewed and tested.

Following Caroline Marshall's retirement from the Trust, David French has taken on the role of Trust nominated SRO until the new COO joins and establishes in role. David is supported in daily submissions by the COO team.

The Trust communications team has provided updates to staff and has linked with national colleagues to maintain a consistent message to the public.

The Trust began formal daily (SITREP) submissions on Monday 21st October 2019 with no issues reported.

3. Conclusion

The Trust is well prepared for EU exit, on the current information provided.

The weekly assurance meetings will continue to inform the SITREP and escalation to region as required with the knowledge and support of the COO team and the SRO.

Communication to staff and patients will continue in line with national guidance to maintain confidence in the trusts position to maintain services.

Testing of multiple incident management will take place to confirm the Trusts resilience when managing a complex scenario (EU-exit/winter/major incident).

4. Recommendation

Trust Board is asked to review and note the update.

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: Board Assurance Framework 2019 Quarter 2 Update			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.3		
Sponsor	Chief Executive		
Author	Jane Hayward, Charlie Helps		
Provenance	The Board Assurance framework Risk Register was considered and updated by executive leads prior to the 18 October Executive Performance Management Group at which the risks were calibrated and moderated for consistency.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for REVIEW. The Board is recommended to review the status of BAF Risks, the actions being taken to manage or mitigate them, and the veracity of evidence provided. The Board may wish to seek additional assurances if necessary.		
Relevant strategic goals	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people's needs.	✓ Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	All		
Impact assessments	There is no negative impact assessed in relation to this paper.		
Other standards affected	<ul style="list-style-type: none"> • NHSI compliance • CQC Well-led Framework 		

Board Assurance Framework 2019 Quarter 2 Update

1. Introduction

BAF Risks are the risks identified in relation to the Board's Strategic Goals. They are long-term risks, and are less volatile than operational risks. The Board would therefore not expect to see exaggerated variation from one month to the next. However, a downward trend in risk across each of the Goals is the intended outcome of the risk management actions being taken.

2. BAF Risk Register

The BAF Risk Register is attached. Note that the 'Actions to Take' and 'By Date' have been added.

3. Changes since Q1 (July) Report

The following changes have occurred since the Q1 Report to the Board:

<p>BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: Controls added • Evidence: Evidence added 	<p>BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6.</p> <ul style="list-style-type: none"> • Risk Scores: Residual score increased from 15 to 20 • Controls: No change • Evidence: No change <p>Comment: The residual score has increased due to the demand/capacity differential in services.</p>
<p>BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: • Evidence: <p>Comment: The financial outlook has improved since the previous report.</p>	<p>BAF04 – Reduced access to resources compromises the quality of services.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: Controls added • Evidence: Evidence added <p>Comment: The demand/capacity differential has a deleterious effect across the Strategic Goals.</p>
<p>BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: No change • Evidence: No change 	<p>BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: Control added • Evidence: Evidence added
<p>BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: No change • Evidence: No change 	<p>BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: No change • Evidence: No change
<p>BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent</p>	<p>BAF010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status.</p>

<p>NHS Provider.</p> <ul style="list-style-type: none"> • Risk Scores: No change • Controls: Controls added • Evidence: Evidence added <p>Comment: This risk has more management actions attached to it than at the time of the previous report.</p>	<ul style="list-style-type: none"> • Risk Scores: Residual score has increased from 6 to 15 • Controls: Controls added • Evidence: Evidence added <p>Comment: The residual score has increased due to the demand/capacity differential in pharmacy.</p>
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4. Recommendation

The Board is recommended to review the status of BAF Risks, the actions being taken to manage or mitigate them, and the veracity of evidence provided. The Board may wish to seek additional assurances if necessary.

5. Appendices

- BAF Risk Register is attached.

BAF Risk	Risk Category	Risk Appetite	Target Score	Inherent Score	Residual Score	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence	Actions to Take	By Date
BAF01 - Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways	Partnerships	Open	9	16	12	<ul style="list-style-type: none"> Members of Sustainability and Transformation Board PHe leading Hampshire and Isle of Wight Strategy Review PHe leading Wessex Cancer Alliance PHe leading Pathology Reconfiguration Board PHe chairing Radiotherapy Network Member of Wessex Academic Health Science Network UHS is a member of Southampton Better Care Board and West Hampshire Local Delivery System Board Strategy and Finance Committee monitoring Joint Committee in Common being established to sign off HIOW response to LTP 	<ul style="list-style-type: none"> Solent Acute Alliance Board is no longer in place Partnerships Governance Framework in development Absence of Legislative Framework for future ways of working including Integrated Care Systems Absence of Legislative framework for Joint Committees Role of local Boards of Directors in an ICS 	<ul style="list-style-type: none"> Board Minutes for all meetings described in Controls (+) Joint Committee in Common Terms of Reference (+) Draft Long Term Plan response (+) 	<ul style="list-style-type: none"> None identified 	<ul style="list-style-type: none"> Deliver LTP Response Influence establishment of radiology network Influence establishment of Stroke Network PHe to chair STP networking group, reviewing work of all networks Agree governance arrangements of ICP 	31/12/2019
BAF02 - Failure to deliver Regulatory requirements results in License breach and a loss of local control with an enforced change in leadership, impacting on Goals 1 to 6	Compliance	Minimal	3	20	20	<ul style="list-style-type: none"> Agreed trajectories with CCGs IPR Board Committee scrutiny NHSI Performance Framework meetings Implementing NHS Constitution EPMG oversight NHSI performance phone calls and COO weekly calls Strategy and Finance Committee monitoring 	<ul style="list-style-type: none"> Organisational Governance Action Plan not yet complete 	<ul style="list-style-type: none"> Failing trajectories (IPR) (-) Challenged provider status (-) Provider Licence G6 & FT4 (+) 	<ul style="list-style-type: none"> None identified 	<ul style="list-style-type: none"> Ongoing RTT/ Cancer focussed monitoring of trajectory External help to validate entire waiting list Develop winter plan Work with partners across health community on demand management, admissions prevention, improved discharge/ flow ED action plan agreed with NHSI Cancer action plan and trajectory Targeted improvement work supported by Wessex Cancer Alliance Complete Organisational Governance Action Plan 	15/10/2019 30/11/2019 15/10/2019 Ongoing 31/03/2020

BAF03 - Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme	Finance/VFM	Cautious	6	20	12	<ul style="list-style-type: none"> • EPMG monthly oversight • SFIs and new business rules restrict recruitment, spend capital, etc. • CIP programme headed by new director role (AA) • Management consultancy on productivity issues (e.g. theatre) • Agreed budgets signed off • Control total agreed with his • Agreed commissioning contracts to cover additional activity • Strategy and Finance Committee monitoring • 3-year Capital forecast and prioritisation process 	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Monthly Finance Report (+) • SFIs (+) • Fortnightly financial run-rate and CIP performance meetings with Divisions (+) • Board scrutiny (+) • Board Committee scrutiny (+) 	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Ongoing monitoring • Planning for new financial architecture 	31/03/2020
BAF04 - Reduced Access to resources compromises the quality of services	Quality Patient Experience	Minimal	3	20	20	<ul style="list-style-type: none"> • Stratifying patients to target those at high risk to minimise potential harm • Creating increased capacity (Lymington) • Recruitment strategy • Working with CCGs to create other pathways • Quality summit actions, incl. cancer delayed pathway review • Thematic reviews of SIRIs • Quality Committee monitoring • Winter Plan 	<ul style="list-style-type: none"> • Ability to monitor non-Constitutional pathways • Lack of capacity to fully mitigate risk • Lack of ability to engage Consultants to engage in additional activity due to tax/pension issues • Overall theatre/other capacity • ED physical estate and workforce capacity • Medical staff not uniformly escalating concerns • Systems unable to ensure next-step on patient pathway always followed-up • Demand exceeds supply 	<ul style="list-style-type: none"> • QGSG monitoring (+) • EPMG (+) • Ophthalmology Executive Board (+) • Weekly ED performance meeting led by CEO (+) • Complaints SIRI Mortality Review Group (+) • IMEG (+) • Patient safety team (+) • GIRFT monitoring (+) • Outcomes report CQC report (+) 	<ul style="list-style-type: none"> • Inability to monitor all pathways • Full demand and capacity modelling, particularly in out-patients 	<ul style="list-style-type: none"> • Open urology Day Unit • Opened 1 additional theatre • Opening additional beds for winter • Appointed Clinical Lead for Proactive Safety • Appointing a Clinical Lead for Flow • External support for Major Flow programme • Out-patients Strategy • Building 8 additional theatres & additional ITU beds • Develop network care as per Clinical Strategy 	30/11/2019 31/08/2019 01/01/2020 01/09/2019 Ongoing 01/11/2019 Ongoing 2022 Ongoing
BAF05 - Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care	Quality Patient Safety	Averse	0	25	20	<ul style="list-style-type: none"> • Daily staffing meetings for nursing to ensure wards are safely staffed • Annual WF review against national guidance (to Trust Board) • Proactive recruitment and retention initiatives in place • Apprenticeships • Strategy and Finance Committee monitoring 	<ul style="list-style-type: none"> • Limited funding due to HEE funding shift • Significant drop in nursing student applicants to Southampton University • Reduction in workforce capacity due to national pensions/ tax issue • Capacity issues for radiography and some technicians 	<ul style="list-style-type: none"> • Staffing meetings reported to Divisional Boards (+) • Reports to Trust Board (+) • Internal Audit of Workforce 2018 (+) • Presentations to Trust Board Study Sessions (multiple) (+) 	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Participating in system wide supply board with Directors of Nursing and implementing actions • Recruited 20 nurse apprenticeships this year • Continuing with overseas pipeline – on going • Rolling our CLIP model (to support placements) • Increasing the amounts of HEI suppliers for our future workforce, particularly in hard to recruit nurses, Radiographers, health scientists, theatre staff • Participating in Repair – On-going • Participating in wave 5 retention collaborative – on-going 	31/12/2019 30/09/2020 31/12/2019 31/12/2019

BAF Risk Register

BAF06 - Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services	Compliance	Minimal	3	12	12	<ul style="list-style-type: none"> Members of Sustainability and Transformation Board PHe leading system-wide response to LTP Reference BAF04 for capacity controls Trust Clinical Strategy approved, focussing on development of clinical networks 	<ul style="list-style-type: none"> Reference BAF04 HloW response to LTP being developed Future of Specialist Commissioning funding sources unknown 	<ul style="list-style-type: none"> Reference BAF04 & BAF01 (+) 	<ul style="list-style-type: none"> Reference BAF04 & BAF01 	<ul style="list-style-type: none"> Reference BAF04 & BAF01 	Reference BAF04 & BAF01
BAF07 - Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care	Quality Patient Safety	Averse	0	15	15	<ul style="list-style-type: none"> Staff engagement monitored through Annual Staff Survey Divisional and Care Groups have action plans for improvement Red-flag incidents reported and monitored "Deliver safe and timely care" Appraisal rates monitored Leadership training and development Freedom to Speak Up Guardians Culture Survey Safety Strategy refresh Wellbeing programme Supporting staff policy Mental Health Policy Occupational Health and EAP Wellbeing discussion in appraisal Stress risk assessment process Staff survey action plans 	<ul style="list-style-type: none"> High vacancy levels in some areas Increased and rising levels of demand Systematic approach to individual conduct and behaviour and the "human factor" Culture Survey not complete Safety Strategy Refresh not yet complete Universal early warning system based on a number of indicators 	<ul style="list-style-type: none"> Staff Survey by Care Group & Ward-level identifies hotspots) (+) Number of leadership development opportunities taken up (+) Management of red flag incidents (+) Appraisal rates (+) Sickness absence rates (+) Staff FFT and free text comments Staff accessing EAP and Occupational Health (+) Qualitative feedback from forums, change champion and unions (+) 	<ul style="list-style-type: none"> Real time data on engagement levels (annual engagement score only available) 	<ul style="list-style-type: none"> Hold staff listening events Respond to actions identified by the Trust change champions Culture survey Safety First Campaign Review of Caldicott Guardian cases and learning Agree future model / strategic direction for Quality Improvement and True North aim of outstanding for CQC Implement model 	<p>30/11/2019 30/11/2019</p> <p>31/01/2010 31/03/2020 31/12/2019</p> <p>31/12/2019</p> <p>01/01/2020</p>
BAF08 - Lack of inclusion and diversity results in the failure to get the best from every individual	Workforce	Open	12	12	12	<ul style="list-style-type: none"> EDI Strategy approved by Board of Directors Annual Reporting of national WRES Data and action plan to Board Annual Reporting of national WDES Data and action plan to Board Equality, Diversity and Inclusion Strategy Trust staff networks established Inclusive talent-management programmes set up Staff Networks Recruitment and Selection training and process Dignity at work procedures Quality Committee monitoring 	<ul style="list-style-type: none"> Absence of EDI Annual Plan to support strategy implementation 	<ul style="list-style-type: none"> Trust Board reports (+) Action Plans (+) National benchmarking (+) 	<ul style="list-style-type: none"> Variable recording of protected characteristics on ESR 	<ul style="list-style-type: none"> Implement WRES and DWES action plans Develop and implement overall EDI action plan Promote declaring of protected characteristics Support the development of the One Voice BAME network 	<p>31/03/2020</p> <p>31/03/2020</p> <p>31/03/2020</p> <p>31/12/2019</p>

BAF Risk Register

BAF09 - Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider	Compliance	Minimal	3	15	15	<ul style="list-style-type: none"> • Governance Action Plan • Director of Financial Improvement and Productivity added to Executive Team • Partnership agreements between Executives and Divisions • Quality Committee monitoring • Director of Workforce attending Board • New COO appointed • Long Term Plan Implementation Framework 	<ul style="list-style-type: none"> • Governance Action Plan not yet completed • Demand on senior leadership by STP 	<ul style="list-style-type: none"> • Achievement of Corporate Objectives monitored quarterly (+) • 6-monthly review of Corporate Objectives (+) • Compliance with provider Licence (+) • CQC compliance status (+) • Organisational Governance Action Plan (+) 	<ul style="list-style-type: none"> • None identified 	<ul style="list-style-type: none"> • Ref: Governance Action Plan • Complete review of Board working and Committees • Complete review of Executive management group arrangements 	31/11/2019
BAF10 - Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status	Workforce	Open	12	6	15	<ul style="list-style-type: none"> • LCRN performance monitoring • Joint research strategic board activity monitoring • Strategic plan for research • Quality Committee monitoring 	<ul style="list-style-type: none"> • Unsighted on rejected activity • Pharmacy capacity • BRCs for renewal • CRN funding flat or declining nationally • EU Exit threat to access to European research funding • Gaps in key succession planning for senior academics (national shortfall) • Lack of sufficient dedicated research space • Dedicated clinical bioinformatics programme 	<ul style="list-style-type: none"> • Performance report to NIHR national monitoring team (+) • JRSB & Board of Directors (+) • Second highest ranked recruiting LCRN teaching hospital in UK (+) • Monthly report to Board on % of BAME staff at Band 7+ (+) • WRES & WDES outcome data (+) • Staff survey data regarding equality (+) • Results of Gender pay gap reporting (+) • Pharmacy backlog of trials >50 (-) 	<ul style="list-style-type: none"> • Not measuring rejected activity due to capacity constraints • Real time data on diverse staff group engagement • Data on engagement and experience generally only available annual in staff survey 	<ul style="list-style-type: none"> • Develop action plan with R&D and Pharmacy to resolve capacity constraint • Develop aligned strategy with University of Southampton and other key partners • BRC reapplication Joint Steering Board • Workshop to resolve creation of clinical bioinformatics data hub 	<p>31/01/2020</p> <p>01/03/2020</p> <p>01/11/2019</p> <p>31/12/2019</p>

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: Review of Standing Financial Instructions 2019/20			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.4		
Sponsor	Chief Financial Officer		
Author	Ian Howard, Deputy Director of Finance		
Provenance	Standing Financial Instructions were last reviewed in October 2018 and are due for review.		
Classification	The report is taken in private because it is a draft, intended for future publication.		
Purpose and recommendation	<p>The paper is presented for APPROVAL.</p> <p>The Standing Financial Instructions require an annual review and update. This paper outlines the key changes proposed.</p> <p>The Audit & Risk Committee has reviewed and recommends the changes to the SFIs presented in this paper.</p> <p>Trust Board is asked to approve the proposed changes to the Standing Financial Instructions.</p>		
Relevant strategic goals	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider 		
Impact assessments	None		
Other standards affected	N/A		

Review of Standing Financial Instructions 2019/20

1. Introduction or Background

The Trust's Standing Financial Instructions require review on an annual basis. They were last reviewed in October 2018.

In particular, this review includes updates that are required as a result of any proposed governance changes, the Finance and Procurement system and the Financial Improvement programme.

Changes as a result of the future incorporation of Wessex Procurement Ltd will need to be considered at the point of going live, with a review to the following Audit & Risk Committee. This is likely to be January 2020.

2. Analysis and Discussion

The main changes to the SFIs are outlined below:

Section	Section Title	Overview of change	Rationale for change
1.1.3, 4.2, 4.7	Various	Add reference to NHS FT Annual Reporting Manual	Update to refer to latest NHS guidance
3.2	Operating Plan and Budget Setting process	Addition of new section outlining the Operating Plan and Budget Setting process.	The process for setting the financial plan and annual budgets was not clearly identified in the previous version.
3.3	In-Year Adjustments to Budgets	Addition of new section	The process for In-Year Adjustments to Budgets was not clearly identified in the previous version.
3.4.5	Budgetary Delegation	New clause outlining that budget holders will need to sign off their annual budget	Making the sign-off of budgets explicit in the SFIs
3.5.4 – 3.5.6	Budgetary Control and Reporting	Addition of Recruitment Control Panel, Savings Board and control over Consultant business cases	New financial governance introduced as part of the Financial Improvement programme
3.8	In-Year Business Cases	Addition of new section	Ensuring clarity over how in-year business cases are approved
6.2.1	Fees and Charges	Add in sentence re. Alternative contracting methodologies.	Previous SFIs specify use of Payments by Results (PbR) contracting methodology. Increasingly we are moving away from a standard PbR contract. This change gives the CFO flexibility to agree alternative payment arrangements.
7.2	Thresholds Tender Guide / Placing Contracts / Waivers	Adjust wording to refer to Annex rather than detailing limits in the text.	Move approval limits to Trust Authorisation Framework in Annex 4
7.8.2, 7.8.3	Extensions to Contracts	Add explanation on extensions to building and construction contracts – can be approved by Director of Estates where within business case. If out of scope of business case – requires new case / further approval.	To add clarity to events such as changes / extensions to construction contracts.
7.9.1	Quotation and Tendering Procedures	Add in 10% tolerance from final estimate to final total scheme cost	Previous SFIs mention “wide discrepancy”. This change is to clarify what is meant by “wide”, which is open to interpretation.
9.2.4	Staff Appointments, Terminations and changes	Add in requirement for agency engagement to be in line with NHS Improvement rules	Changing NHS requirements – SFIs need to cover adherence to these rules

9.2.9	Staff Appointments, Terminations and changes	Replace section 2.9 with local terms and conditions being approved via Pay Steering Group	Updating SFIs that are out of date with current arrangements
10.2	Requisitioning and Ordering Goods and Services	Additional text to confirm Trust "No Purchase Order No Pay" policy, plus CFO responsibility for maintaining a list of exceptions	As part of the new Finance and Procurement System, we implemented stricter enforcement of the No PO No Pay policy. The additional text in the SFIs is to reflect current practice.
12.2	Approval of Capital Business Cases	Remove table of approval limits for incorporation into new Annex 4	Aim to move all approvals into a single annex to simplify and improve clarity.
20.1.1	Risk Management	Update paragraph to reflect Risk Management and Internal Control policies.	Trust has updated Risk Management policies, SFIs updated to match current approach.
12.2.4	Approval of Capital Business Cases	Amend limit of where spend is in excess of original plan. Remove reference to "maximum of £150k".	Amended to give clarity to meaning, as was causing issues with interpretation.
12.6.3	Property (Land and Buildings)	Amend acquisition of property below £250k to be approved by TIG (rather than CEO)	Acquisition of property is part of TIG core business.
12.2.8 – 12.2.9	Approval of Capital Business Cases	Addition of clauses relating to the approval of charitably funded business cases. Cases < £100k and where revenue consequences can be managed within current budget, approval is Charity Board and Divisional Management Team. Where this criterion is not met, approval is via TIG.	Providing additional clarity about how Charitably funded business cases are approved.
12.2.10	Approval of Capital Business Cases	New clause outlining CFO responsibility for choosing best source of finance once a case is approved.	Clarifying whose responsibility it is to determine how to finance i.e. whether to lease or buy
12.2.11	Approval of Capital Business Cases	New clause outlining responsibility of "leasing sub-committee" for approving renewal / direct replacement of leases.	Governance in place as delegated by TIG. SFIs being updated to reflect current practice.
Annex 4	Contracting for Income	Add Commercial Director ability to sign income contracts up to £60k	Commercial Director is often negotiating contracts for additional income as part of their responsibilities. Addition of limit gives equal authority to DDOs.
Annex 4	Trust Authorisation Framework	Addition of new annex – bringing Trust approval mechanism into one place (removing from section 12 and including in annex). Details of changed approval levels outlined below.	Aim to move all approvals into a single annex to simplify and improve clarity.
Annexes 1 - 4	Various	Annexes re-numbered. Limits (e.g. procurement, contracting etc.) pulled out of main text and included in Trust Authorisation Framework.	Aim to move all approvals into a single annex to simplify and improve clarity.

Other changes around tidying up language and terminology are not explicitly outlined above, but included in the appendix.

Trust Authorisation Framework:

We are proposing changes to the approval levels of Trust groups (e.g. TIG/TEC), in line with the revised Trust governance. However, the SFIs currently have approval levels incorporated throughout the document. The idea is to bring these approval levels into one agreed framework in annex 4, making it easier for staff to understand the limits that are relevant to them.

In terms of governance of Trust Committees, we are proposing:

1. Trust Investment Group (TIG) becomes the primary executive decision making body for the Trust, with revised membership (Executives and DDOs) and Terms of Reference to reflect that. TIG would have a limit of up to £1m for revenue expenditure and £2.5m for capital expenditure, where expenditure is managed within the Trust Board approved Capital Plan.
2. Trust Executive Committee (TEC) does not have limits beyond TIG, but remains responsible for agreeing new and replacement consultant posts.
3. Savings Board (reporting to TEC) becomes formally incorporated into the Trust governance, with a revenue limit of £500k.
4. Recruitment Control Panel (reporting to Savings Board) becomes formally incorporated into the Trust governance framework, with responsibility for recruitment approval as per agreed terms of reference.
5. CEO and CFO limits for capital without going through TIG are reduced to £150k.

We note that the Trust governance structure is currently subject to review by Non-Executive Directors and Trust Board. The SFIs and Trust Authorisation Framework will need to be updated to implement any approved recommendations from the review.

Trust Non-Pay Authorisation Limits:

Prior to the introduction of the Finance and Procurement System, we described that the new system operates in a different way to the previous system. Rather than each individual employee having a system limit, instead each cost centre has an approver at set approval levels, as outlined below:

CURRENT		First Approver	Second Approver	Third Approver	Fourth Approver	Fifth Approver	Sixth Approver	Seventh Approver
Finance and Procurement System - Rulesets								
Rule 1	Divisional Hierarchy	5k approver	10k approver	75k approver	100k approver	250k approver	1m approver	Unlimited approver
Rule 2	R&D Hierarchy	5k approver	25k approver	100k approver	250k approver	Unlimited approver		
Rule 3	THQ Hierarchy	5k approver	75k approver	250k approver	1m approver	Unlimited approver		
Rule 4	Other Hierarchy - including capital, estates	75k approver	250k approver	1m approver	Unlimited approver			

This hierarchy was established in this way in order to match within existing approval levels. However, it has resulted in a number of operational problems, including:

- Insufficient system users in each level (each cost centre must have a named approver at each level), meaning difficulty in identifying an appropriate approver.
- Insufficient system users at each level to cover annual leave. The system needs an alternative approver of the same level. Approvals cannot be escalated to a higher level (as it effectively moves the escalated employees approval level down).
- The hierarchy is long, meaning increased time and number of people signing off before requisition is approved, thereby increasing the time taken to approve orders. For example, under the Divisional Hierarchy a £90k requisition would need to go through four levels of approval.

In summary, the current approval hierarchy does not facilitate the rapid processing and approval of orders for goods and services in the finance and procurement system.

We are therefore proposing amendments to the approval hierarchy, with the aim of reducing the time taken to process orders, receipt goods and make payments. The proposal is outlined below:

PROPOSAL							
Finance and Procurement System - Rulesets		First Approver	Second Approver	Third Approver	Fourth Approver	Fifth Approver	Sixth Approver
Rule 1	Divisional Heirarchy	5k approver	25k approver	75k approver	250k approver	1m approver	Unlimited approver
Rule 2	R&D Heirarchy	5k approver	25k approver	100k approver	250k approver	Unlimited approver	
Rule 3	THQ Heirarchy	5k approver	25k approver	75k approver	250k approver	1m approver	Unlimited approver
Rule 4	Other Heirarchy - including capital, estates	75k approver	250k approver	1m approver	Unlimited approver		

We believe this would result in significant operational efficiencies, and accelerate the approval of orders.

In order to maintain this approvals hierarchy, we are proposing a new set of financial limits for each grade of staff. This would allow each staff member to be slotted into the appropriate approver level of the hierarchy.

Whilst there are increases in the approval limits, the system does have increased controls over usage of those limits:

- No invoices (with known exceptions) will be paid without a valid purchase order
- No supplier will be paid without authorised set-up
- Although limits have increased, for example £250k limit for DDO, invoices will already have been approved by three levels of the hierarchy (rather than approving in isolation in previous system)
- Revised limits are commensurate with responsibility and accountability of role and grade
- Post-event controls through budget holder meetings and run-rate meetings
- Employees will only be able to approve against the set cost centre for which they are named in the hierarchy, rather than any cost-centre in the previous system
- SFIs state that purchases must already be included within the budget available.

This structure also removes the anomaly where many of the previous approval limits were not in the new hierarchy, meaning many employees in practice have an approval level lower than the limit suggests.

The Chief Financial Officer limit has increased to unlimited, as currently if the Chief Executive is on annual leave there is no ability to authorise invoices above £1m. For the same reason, we have increased the number of employees with a limit of £1m.

Band	Previous Limit	New Limit
All Staff		
Bands 1 – 4	£0	£0
Band 5	£1,000	£5,000
Band 6	£1,000	£5,000
Band 7	£5,000	£5,000
Band 8a	£10,000	£25,000
Band 8b	£25,000	£25,000
Band 8c	£50,000	£75,000
Band 8d	£75,000	£75,000
Band 9	£100,000	£250,000
Trust Board / Directors		
Chief Executive	£999,999,999 *	Unlimited
Chief Financial Officer	£999,999,999 *	Unlimited
Chief Operating Officer	£1,000,000	£1,000,000
Other Executive Board Director	£250,000	£1,000,000
Deputy Director of Finance	£500,000	£1,000,000
Finance		
Director of Procurement	£150,000	£250,000
Assistant Director of Finance	£150,000	£250,000
Financial Controller	£150,000	£250,000
Head of Financial Accounting	£100,000	£75,000
Treasury Manager	£10,000	£5,000
Head Cashier +	£10,000	£5,000
Materials Manager	£10,000	£5,000
Pharmacy		
Chief Pharmacist	£150,000	£250,000
Estates & Capital Development		
Director of Estates & Capital Development	£250,000	£250,000

3. Conclusion

In summary, the system has additional control and processes. We are recommending that we amend our approval levels to take into account the additional control within our ordering process, in order to maximise the operational efficiency of the system.

Please note contents page will be updated following final approval.

4. Recommendation

- The Audit & Risk Committee approved the changes to the SFIs presented in this paper, subject to Trust Board ratification.
- Trust Board are asked to approve the proposed changes to the Standing Financial Instructions.
- Trust Board is asked to note that any revisions as a result of the incorporation of Wessex Procurement Ltd will need to come back to the Audit & Risk Committee and Trust Board prior to the next annual review.

5. Appendices

- Standing Financial Instructions – final version (contents page to be updated following final Trust Board approval).

Standing Financial Instructions

Version:	Final 2019-20 Version
Authorisation Committee:	Trust Board
Date of Authorisation:	01 November 2019
Signature of authorising Committee:	Peter Hollins, Trust chairman
Ratification Committee (Category 1 documents):	N/A
Date of Ratification (Category 1 documents):	N/A
Signature of ratifying Committee Group/Chair(Category 1 documents):	N/A
Lead Job Title of originator/author:	Chief Financial Officer
Name of responsible committee/individual:	David French
Date issued:	1 November 2019
Review date:	1 October 2020
Target audience:	All Divisions/Directorates
Key words:	Trust powers; Trust Board; Chairman; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)
Main areas affected:	All Divisions/Directorates
Consultation:	Audit and Risk Committee Trust Executive Committee
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	55
Type of document:	Level 1

Standing Financial Instructions

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STANDING FINANCIAL INSTRUCTIONS (“SFIs”)

1. INTRODUCTION

1.1 General

- 1.1.1 University Hospital Southampton NHS Foundation Trust (“the Trust”) became a Public Benefit Corporation on 1st October 2011, following authorisation by NHS Improvement (formerly Monitor), the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the “NHS 2006 Act” or “2006 Act”).
- 1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust’s Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).
- 1.1.3 The *Single Oversight Framework* details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in *The Audit Code for NHS Foundation Trusts*, *NHS Foundation Trust Annual Reporting Manual* and the *Department of Health Group Accounting Manual (DH GAM)*, all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.
- 1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust’s financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the “Scheme of Delegation”).
- 1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its hosted organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.
- 1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the CFO must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust’s Standing Orders of the Board of Directors (as well as the separate Standing Orders of the Council of Governors).
- 1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee’s dismissal.
- 1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit and Risk Committee for referring action or ratification. All members of

the Board and staff have a duty to disclose any non-compliance with these SFIs to the CFO, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

- 1.2.1 The Board of Directors exercises financial supervision and control by:
- a) Formulating the financial strategy;
 - b) Requiring the submission and approval of budgets within specified limits;
 - c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
 - d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."
- 1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.
- 1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive, Chief Financial Officer (CFO)

- 1.2.4 The Chief Executive and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.
- 1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.
- 1.2.6 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Chief Financial Officer

- 1.2.7 The CFO is responsible for:
- a) These SFIs and for keeping them appropriate and up to date;

- b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
- c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:
 - i) Provision of financial advice to other members of the Trust Board and employees;
 - ii) Design, implementation and supervision of systems of internal financial control;
 - iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

Board of Directors and Employees

- 1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:
- a) The security of the property of the Trust;
 - b) Avoiding loss;
 - c) Exercising economy and efficiency in the use of resources;
 - d) Conforming to the requirements of NHS Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

- 1.2.9 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.
- 1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

2. AUDIT

2.1 Chief Financial Officer

- 2.1.1 The CFO is responsible for:
- a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS Improvement's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

- b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;
- c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);
- d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit and Risk Committee. The report(s) must cover:
 - i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit and Risk Committee;
 - ii) Any major internal financial control weaknesses discovered;
 - iii) Progress on the implementation of internal audit recommendations;
 - iv) Progress against plan over the previous year;
 - v) A detailed work-plan for the coming year.

2.1.2 The CFO and designated auditors are entitled without necessarily giving prior notice to require and receive:

- a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
- c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
- d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

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

2.2.2 Internal Audit will review, appraise and report upon:

- a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- b) The adequacy and application of financial and other related management controls;
- c) The suitability of financial and other related management data including internal and external reporting and accountability processes;
- d) The efficient and effective use of resources;
- e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)
 - ii) Waste, extravagance, inefficient administration;
 - iii) Poor value for money or other causes;
 - iv) Any form of risk, especially business and financial risk but not exclusively so.
 - f) The adequacy of follow-up actions by the Trust to internal audit reports;
 - g) Any investigations / project work agreed with and under terms of reference laid down by the CFO;
 - h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;
 - i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.
- 2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.
- 2.2.4 The Head of Internal Audit (or equivalent title) will normally attend Audit and Risk Committee meetings and has a right of access to Audit and Risk Committee members, the Chairman and Chief Executive.
- 2.2.5 The reporting system for internal audit shall be agreed between the CFO, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DH Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."
- 2.3 External Audit**
- 2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit and Risk Committee.
- 2.3.2 Audit and Risk Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.
- 2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.
- 2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.
- 2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.
- 2.3.6 Prior approval must be sought from the Audit and Risk Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors.

Competitive tendering is not required and the CFO is required to authorise expenditure.

2.4 Fraud, Corruption and Bribery

- 2.4.1 In line with their responsibilities, the Chief Executive and CFO shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority standards.
- 2.4.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.
- 2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist (“LCFS”), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Authority anti-crime Standards.
- 2.4.4 The LCFS shall report to the CFO and shall work with staff in the NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority anti-crime Standards, the anti-fraud manual and the NHS Counter Fraud Authority’s Investigation Case File Toolkit.
- 2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Counter Fraud Authority.
- 2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.
- 2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit and Risk Committee.
- 2.4.8 In accordance with the Raising Concerns Policy, the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by the NHS Counter Fraud Authority.
- 2.4.9 The Trust will report annually on how it has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the CFO shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

- 2.5.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to the NHS Counter Fraud Authority’s standards.

- 2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (“LSMS”) as specified in the NHS Counter Fraud Authority anti-crime standards.
- 2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.
- 2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD), who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Operational Plan and Budgets

- 3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Board of Directors and to the Council of Governors the annual “Operational Plan” which takes into account financial targets and forecast limits of available resources. The Trust Operational Plan will contain:
- a) A statement of the significant assumptions on which the plan is based;
 - b) Details of major changes in workload, delivery of services or resources required to achieve the plan;
 - c) The Financial Plan for the year;
 - d) Such other contents as may be determined by NHS Improvement.
- 3.1.2 The annual Operational Plan must be submitted to NHS Improvement in accordance with NHS Improvement’s requirements.
- 3.1.3 The CFO will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Board of Directors. Such a budget will:
- a) Be in accordance with the aims and objectives set out in the Trust Operational Plan;
 - b) Accord with demand, workforce and capacity plans;
 - c) Be produced following discussion with appropriate budget holders;
 - d) Be prepared within the limits of available funds;
 - e) Identify potential risks;
 - f) Be based on reasonable and realistic assumptions; and
 - g) Enable the Trust to comply with the whole regulatory framework for FTs.
- 3.1.4 The Trust Operational Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.
- 3.1.5 The CFO shall monitor financial performance against budget, and report to the Board of Directors.
- 3.1.6 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

- 3.1.7 The CFO has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Operating Plan and Budget Setting Process

- 3.2.1 The Chief Financial Officer will submit to the Board of Directions a paper outlining the annual budget setting process for the year. This will include a baseline formed from a set of clearly defined assumptions.
- 3.2.2 Each Department and Director will be asked to submit a list of Business Cases and cost pressures for consideration in budget setting, as part of the Strategic Review process. Only approved business cases will be incorporated into delegated budgets. Funded business cases will require approval as per the Trust Approval Framework in Annex 4, section 1.
- 3.2.3 The Chief Executive and Chief Financial Officer will set an annual process for approving cases to be incorporated into the budget and Operational Plan.
- 3.2.4 Each Department and Director will be asked to provide assumptions for the setting of the Trust's Production Plan (income Plan). These will be considered alongside external factors including Commissioner plans in order to set the Trust's income budget.
- 3.2.5 The Chief Financial Officer will set a Cost Improvement Programme (CIP) savings target, delegated to each budget holder.
- 3.2.6 The Chief Financial Officer may set reserves to cover unknown cost pressures at the planning stage, which may then subsequently be delegated in-year.

3.3 In-Year Adjustments to Budgets

- 3.3.1 The Chief Financial Officer may authorise budget virements in the following circumstances:
- a) To reflect an in-year business case approved by the relevant committee;
 - b) To distribute reserves set to cover cost pressures that were unknown at the planning stage;
 - c) To reflect where the distribution of income and expenditure has materially changed from the original plan, where this is net neutral. For example, to reflect the reality of CIP delivery where this changes materially from the original planning assumption
- 3.3.2 Budget virements for in-year business cases can only be allocated on an overall neutral basis, to ensure the budget remains balanced to the Operational Plan. Additional expenditure will require funding via additional income assumptions, release of reserves or additional savings in another part of the budget.

3.4 Budgetary Delegation

- 3.4.1 The Chief Executive, through the CFO, 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;
 - e) Achievement of planned levels of service;
 - f) The provision of regular reports.
- 3.4.2 Except where otherwise approved by the Chief Executive, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.
- 3.4.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.
- 3.4.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive or the CFO.
- 3.4.5 Budget Holders are expected to sign their acceptance of their annual expenditure budget.

3.5 Budgetary Control and Reporting

- 3.5.1 The CFO will devise and maintain systems of budgetary control. These will include:
- a) Monthly financial reports to the Board of Directors in a form approved by the Board of Directors, containing sufficient information to allow the Directors of the Board to ascertain the financial performance of the Trust. This may include the following:
 - i) Income and expenditure to date, showing trends and the forecast year-end position;
 - ii) Movements in working capital;
 - iii) Movements in cash;
 - iv) Capital project spend and projected outturn against plan;
 - v) Explanations of any material variances from budget;
 - vi) Details of any corrective action where necessary and the Chief Executive's and/or CFO'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 and workforce budgets;
 - d) Monitoring of management action to correct variances; and
 - e) Arrangements for the authorisation of budget transfers and virements.
- 3.5.2 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Chief Executive, other than those provided for within the budgeted workforce establishment. Any

expenditure required beyond budgeted establishment will require an in-year business case.

- 3.5.3 The Chief Executive is responsible for identifying and implementing cost improvement programmes (“CIPs”) and income generation initiatives in order to deliver a budget that will enable compliance with NHS Improvement’s Use of Resources regime.
- 3.5.4 The Chief Executive will incorporate a “Savings Board” responsible for ensuring delivery of the Cost Improvement Programme. The “Savings Board” will have Terms of Reference agreed by the Trust Executive Committee.
- 3.5.5 The Chief Executive will incorporate a “Recruitment Control Panel”, responsible for approving recruitment as per Terms of Reference agreed by the “Savings Board”. All new appointments will be considered by the “Recruitment Control Panel”.
- 3.5.6 All new Clinical consultant appointments will require the approval of the Trust Executive Committee.

3.6 Capital Expenditure

- 3.6.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.7 Performance Monitoring Forms and Returns

- 3.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms and returns are submitted to “NHS Improvement.” The performance figures reported to the Board of Directors should reflect the same figures, though not necessarily presented in the same format.

3.8 In-Year Business Cases

- 3.8.1 It is expected that most business cases will be identified during the setting of the Trust Operational Plan and therefore Budget Setting Process. These cases will then be sent for approval at an appropriate point during the year.
- 3.8.2 Any case with a capital implication will be considered in section 12 and outlined in Annex 4, section 1.
- 3.8.3 Revenue cost only business cases will be subject to the approval as outlined in Annex 4, section 1.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

- 4.1 The CFO, on behalf of the Trust, will:
 - a) Prepare annual financial accounts and corresponding financial returns in such form as NHS Improvement and HM Treasury prescribe;
 - b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS Improvement as to their technical accounting content and information/data shown therein, before submission to NHS Improvement.

- 4.2 The Associate Director of Corporate Affairs will prepare the Annual Report in accordance with the guidance in the NHS Foundation Trust Annual Reporting Manual.
- 4.3 The Trust's Annual Report, Annual Accounts and financial returns to NHS Improvement must be audited by the external auditor in accordance with appropriate international auditing standards.
- 4.4 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors, or by the Audit and Risk Committee (when specifically delegated the power to do so, under the authority of the Board of Directors).
- 4.5 The Annual Report and Accounts (including the auditor's report) is submitted to NHS Improvement (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.
- 4.6 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.
- 4.7 The Director of Nursing will prepare the Annual Quality Report in the format prescribed by NHS Improvement/Care Quality Commission and in accordance with the NHS Foundation Trust Annual Reporting Manual. .
- 4.8 The Chief Executive and Chairman shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Report" under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

- 5.1.1 The CFO 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 Audit and Risk Committee of the Board of Directors will review banking arrangements periodically.
- 5.1.3 The Audit and Risk Committee will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

- 5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.
- 5.2.2 The CFO is responsible for:

- a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.
- b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;
- c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;
- e) Monitoring compliance with NHS Improvement or DH guidance on the level of cleared funds;
- f) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO 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, including the overdraft limit if applicable;
- b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

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

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and 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 CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the "Payment by Results" ("PbR") financial regime determined by the DH where applicable. The CFO may agree alternative payment mechanisms with Commissioners.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health

or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

- 6.2.3 All Employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.
- 6.2.4 Contracts must conform to the strategy and operational plans of the Trust and shall be approved according to the limits specified at SFI Annex 4, section 3.
- 6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

- 6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.
- 6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;
- 6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	Approval
Up to £10,000	Deputy Director of Finance
Up to £100,000	CFO
£100,000 plus	Audit and Risk Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit and Risk Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the audit and risk committee should be presented to the Trust board for noting.

6.4 Security of Cash, Cheques and other Negotiable Instruments

- 6.4.1 The CFO is responsible for:
 - a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
 - b) Ordering and securely controlling any such stationery;
 - c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
 - d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
- 6.4.2 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.
- 6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the CFO.

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

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

- 7.1.1 The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders

7.2 Thresholds Tender Guide / Placing Contracts / Waivers

- 7.2.1 The tables outlined in the Trust Authorisation Framework in Annex 4, Section 5 outlines the correct procurement process to be followed relative to value and the type of product or service being purchased.

- 7.2.2 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders must be recorded.

- 7.2.3 Subject to the limits outlined in Annex 4, Section 4, the Director of Procurement, Director of Estates, Director of Informatics and Chief Pharmacist may sign and place contracts on the Trust’s behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting Contract Ratification Document for all Formal Local & EU Tenders

- 7.2.4 The waiving or variation of the competitive tendering and quotation procedure can be approved subject to the limits outlined in Annex 4, Section 5.

7.3 Electronic Tendering

- 7.3.1 All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal where practicable.

- 7.3.2 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.8.2. Issue of all tender documentation should be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules.

- 7.3.3 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

7.4 Manual Tendering – General Rules

- 7.4.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:
- a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing 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 tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.
- 7.4.2 Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.4.3 and 7.4.4 below.
- 7.4.3 Every tender for building and engineering works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.
- 7.4.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.5 Receipt, Safe Custody and Record of Formal Tenders

- 7.5.1 All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.
- 7.5.2 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.
- 7.5.3 The appropriate officer shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.6.

7.6 Opening Formal Tenders

- 7.6.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened by two officers designated by the officer as appropriate.
- 7.6.2 Every tender received shall be stamped with the date of opening and initialled by two of those present at the opening.
- 7.6.3 A permanent record shall be maintained to show for each set of competitive tender invitations despatched:
- a) The names of firms/individuals invited;
 - b) The names of and the number of firms/individuals from which tenders have been received;
 - c) The total price(s) tendered;

- d) Closing date and time;
- e) Date and time of opening; and
- f) The persons present at the opening shall sign the record.

7.6.4 Except as in SFI 7.6.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

7.6.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure set out in SFI 7.6.4 above unreasonable.

7.7 Admissibility and Acceptance of Formal Tenders

7.7.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the CFO or nominated officer.

7.7.2 Tenders received after the due time and date may be considered only if the CFO or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The CFO, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

7.7.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the CFO or nominated officer be regarded as having arrived in due time.

7.7.4 Materially 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 supplier 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 under SFI 7.7.2.

7.7.5 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

7.7.6 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

7.7.7 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 remain strictly confidential and kept in safekeeping by an officer designated by the CFO.

7.7.8 Where only one tender/quotation is received the CFO /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

- 7.7.9 All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.
- 7.7.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.9.1 below).
- 7.7.11 All tenders should be treated as confidential and should be retained for inspection.

7.8 Extensions to Contract

- 7.8.1 In all cases where optional extensions to contract are outlined at the time of tendering, approval will be required as if it were a new contract.
- 7.8.2 Variations to building and engineering contracts shall be authorised by the Director of Estates, facilities and Capital Development. These variations shall not be authorised if doing so would result in exceeding the values within the capital project approved business case. Where a variation does result in the capital project approved business case financial value being exceeded then further approval shall be required from the appropriate authorising body. These values are subject to the tolerances contained in these SFIs.
- 7.8.3 Where building and engineering contracts are being varied to include new pieces of work outside the scope of the original business case then a new business case will be required to be approved prior to this variation being issued.

7.9 Quotation & Tendering Procedures – Building and Engineering Contracts

- 7.9.1 Quotation & Tendering Procedures Summary - Building and Engineering Contracts
- a) Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2.
 - b) Tender documents will be issued by the office of the Director of Estates & Capital Development. Tenders for contracts estimated to exceed £500,000 (excluding VAT) will be returned to the Chief Executive's office, otherwise tenders will be returned to the Director of Estates & Capital Development's office who will arrange for them to be opened in accordance with the SFIs of the Trust.
 - c) No tender shall be considered which bears any mark or name indicating the sender.
 - d) Tender lists for building and engineering works will be compiled by the Director of Estates & Capital Development from "Constructionline" the Trust's approved list of Contractors.
 - e) Before obtaining Tenders for the execution of any work the Director of Estates & Capital Development will arrange for a final estimate to be prepared. This should include works, VAT, fees, equipment and any other costs. The pre-tender estimate for the works element only should be stated on the tender return forms.
 - f) Where there is a wide discrepancy (>10%) between the final estimate and the final total scheme cost involving an increase in expenditure

this is to be reported by the Director of Estates & Capital to the CFO for further instructions.

- g) The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.
- h) A quotation/tender return form will be completed by the relevant project manager. It will include the scheme name, pre-tender estimate, names of contractors invited, date of invitation and date and time of return. According to the limits of delegation, it will be sent to the Director of Estates & Capital Development / Head of Operational Estates Maintenance/ Head of Estates Projects or the Chief Executive for the opening of the tenders in accordance with these SFIs.
- i) Adjudication must be made in accordance with SFI 7.7. A tender ratification prepared by the Design Team and endorsed by the Project Manager should be submitted to the Director of Estates & Capital Development for approval or to seek authorisation, according to delegated limits.
- j) Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.
- k) All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contract, this should include presenting it to the Associate Director of Corporate Affairs to meet the requirement for signing and sealing where required.
- l) The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit and Risk Committee regularly.

7.10 Quotation & Tendering Procedures – Goods and Services Contracts

- 7.10.1 Financial limits for placing goods and services contracts are outlined in Annex 4, Section 4.
- 7.10.2 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.
- 7.10.3 The Director of Informatics is authorised to place contracts for Informatics Contracts only.
- 7.10.4 The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2
- 7.10.5 A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 3.
- 7.10.6 Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise the opportunity through the national Government Contracts Finder portal and must subsequently ensure the respective award is also published.
- 7.10.7 Where the total contract value exceeds the published OJEU Thresholds then the Trust is committed to EU Regulations and conducting an EU compliant procurement process.

7.11 Waiving or Variation of Competitive Tendering/Quotation Procedure

- 7.11.1 Where goods, services and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Contracts will be required for all waivers over £25,000.
- 7.11.2 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders must be recorded. Reporting of a waiver will only be necessary in the case of a single tender action.

7.12 Quotation & Tendering Procedures Summary - Contracts

- 7.12.1 Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.
- 7.12.2 No Pre Qualifications stages should be conducted for below OJEU threshold quotations/tenders in accordance with Public Contract Regulation 2015 (Regulation 111)
- 7.12.3 Quotations will be obtained by and returned to the Director of Procurement for single purchases where the estimated value does not exceed the limit specified in SFI 7.2.
- 7.12.4 Tenders shall be invited for all purchases of goods and/or services to be supplied over a period of time where the estimated contract value exceeds that specified in SFI 7.2.
- 7.12.5 Tenders will be issued by the Director of Procurement and shall incorporate standard NHS Terms and Conditions of Contract.
- 7.12.6 After tenders/quotations have been opened, the Director of Procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.7.
- 7.12.7 A Contract Approval Document and Ratification Report prepared by the Procurement Team should be submitted to the Director of Procurement for approval or to seek authorisation from the Chief Executive/Trust Board, according to delegated limits.
- 7.12.8 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.
- 7.12.9 All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit and Risk Committee on a six monthly basis highlighting all waivers over £25,000 and those over £75,000 approved by the CEO.
- 7.12.10 Where a competitive tender ratification process has already been conducted for goods or equipment and approved within the delegated levels, authority is given to the Director of Procurement to approve any subsequent lease contract award for the same goods or equipment.
- 7.12.11 In accordance with the Public Contract Regulations 2015 (Regulations 106 and 110) the Trust has a legal obligation to ensure that they advertise any new contract opportunity over £25,000 through the new national

Government Contracts Finder portal and must subsequently ensure the respective award is also published. All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and publication to the Government Contracts Finder.

- 7.12.12 All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source To Contract System. Any exceptions to this are at the discretion of the Director of Procurement.

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

- 8.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.
- 8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of Health or NHS Improvement are mandatory for Service Contracts.
- 8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.
- 8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.
- 8.1.5 In discharging this responsibility, the Chief Executive should take into account:
- (a) Costing and pricing (in accordance with Payment by Results or alternatively agreed payment mechanism) and the activity / volume of services planned;
 - (b) The standards of service quality expected;
 - (c) The relevant national service framework (if any);
 - (d) Payment terms and conditions;
 - (e) Amendments to contracts and non-contractual arrangements; and
 - (f) Any other matters relating to contracts of a legal or non-financial nature.
- 8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff.

- 8.1.7 The CFO shall produce regular reports detailing actual and forecast income.
- 8.1.8 The CFO shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.
- 8.1.9 The authorisation limits for signing service contracts are set out in Annex 4, Section 4.

8.2 Involving Partners and Jointly Managing Risk

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

8.3 Tendering (where UHS is a competing body)

- 8.3.1 Where UHS participate in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.
- 8.3.2 Delegated authority limits associated with tendering are outlined in Annex 4, section 3.
- 8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to TEC for noting.
- 8.3.4 Staff who participate in a tendering exercise must notify the Strategy team and follow processes in accordance with the "Bidding for Contracts" policy (available on Staffnet).

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Appointments & Remuneration Committee

- 9.1.1 The Trust Board shall establish an Appointments & Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.
- 9.1.2 Any Trust Board post and some Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.
- 9.1.3 Appointments to senior management or Director posts above the salary of the Prime Minister (currently circa £150k) must be referred to NHS Improvement and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

- 9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Recruitment Vetting Panel (if applicable) and provided the post is within the limit of his approved budget and affordable staffing limit. He/she may also regrade employees after consultation with their Human Resources Business Partner and job evaluation has taken place in accordance with Trust policy.
- 9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short-term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off-payroll engagements must be approved by the CFO prior to contract signature.
- 9.2.3 All contracts of employment including recruitment, promotions and terminations will be transacted via ESR (Electronic Staff Record) by Self Service or where applicable through the appropriate HR team. Please see the Staffnet Quick Guide to HR processes for guidance.
- 9.2.4 All staff employed by the Trust will be issued a contract of employment. All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place. Engagement of agencies should also be in line with prevailing NHS Improvement requirements and rules.
- 9.2.5 A termination of employment form must be submitted by the employee's line manager through manager self service on ESR before the termination date.
- 9.2.6 Any appointments should follow the Trust Recruitment Policy found on Staffnet.
- 9.2.7 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.
- 9.2.8 In the event that redundancy cannot be avoided the Trust shall:
- i) Develop selection criteria based upon the agreed Trust Organisational Change Policy which includes affordability, and
 - ii) Complete the Trust redundancy approval form and submit to the HR Business Partner.
- 9.2.9 Changes to, and or creation of, local terms and conditions will be a matter for Pay Steering Group. Where necessary, for major changes, it may be appropriate for this to be authorised by either Trust Remuneration Committee or Trust Board,
- 9.2.10 The Trust must seek approval from NHS Improvement before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

- 9.3.1 The Director of Human Resources shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with current agreements.
- 9.3.2 The CFO is responsible for the agreement to and management of the Payroll Contract with outside providers.
- 9.3.3 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contractual) 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.
- 9.3.4 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

- 10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.
- 10.1.2 Council of Governors will be consulted on significant transactions – see Annex 2.

10.2 Requisitioning and Ordering Goods and Services

- 10.2.1 The Chief Financial Officer will set out:
 - a) The list of managers who are authorised to place requisitions for the supply of goods and services, via an approvals hierarchy; and
 - b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 4, Section 2.
- 10.2.2 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 Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.
- 10.2.3 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition.
- 10.2.4 The Trust operates a "No Purchase Order No Pay" policy. All orders require a Purchase Order prior to being place. The Chief Financial Officer will maintain and monitor a list of exemptions, including:
 - a) Invoices relating to the previous financial system;

- b) Pay overs i.e. HMRC , Pensions, child support, court fees;
- c) Salary sacrifice;
- d) Opticians;
- e) Inter NHS Recharges;
- f) General personal reimbursements;
- g) Litigation;
- h) Local Authority costs;
- i) Translation costs;
- j) Payments controlled in other systems e.g. JAC for Pharmacy

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

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

10.3.2 The CFO will:

- a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;
- b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
 - i) **Authorisation:**
 - a list of Directors and Employees able to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged
 - ii) **Certification:**
 - goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
 - 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 and are reasonable;
 - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
 - where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders

and negotiated prices and terms and that such checks are evidenced;

- in the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- instructions to employees regarding the handling and payment of accounts within the Finance Department;
- c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except where a prepayment is agreed).

10.3.3 Prepayments are only permitted where the financial advantages outweigh the disadvantages. In such instances:

- a) 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/her commitments;
- b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;
- c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;
- d) The CFO must approve the proposed arrangements before those arrangements are contracted; and
- e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.4 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

- a) All contracts (other than for 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 CFO in advance of any commitment being made;

- b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the Chief Executive;
- c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;
- d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;
- e) Petty cash records are maintained in a form as determined by the CFO;
- f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and
- g) All requisitions must be approved in line with the Trust Authorisation Framework.
- h) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

- 11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.
- 11.1.2 The total amount of the Trust's borrowing must be affordable within NHS Improvement's Single Oversight Framework for Trusts.
- 11.1.3 Any application for a loan or overdraft facility must be approved by the Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.
- 11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the CFO.
- 11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Operational Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

- 11.2.1 The amount of Public Dividend Capital at the point in time when the former NHS Trust became an authorised Foundation Trust will become the initial PDC of the FT to be held on the same conditions.
- 11.2.2 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

- 11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.
- 11.3.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and oversee all investment transactions by the Trust. The Treasury Management Policy shall set out the guidelines and shall be approved by the Audit and Risk Committee.
- 11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.
- 11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Audit and Risk Committee on an annual basis.
- 11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Board through the Audit and Risk Committee.
- 11.3.6 The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
- 11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the Treasury management policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Audit and Risk Committee.

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

12.1 Capital Investment

- 12.1.1 The Trust will establish a Trust Investment Group comprising at least 4 executive directors and chaired by the Chief Financial Officer to oversee its allocation of capital investment. The Director of Transformation will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Operational Plan and the Capital Investment Plan.
- 12.1.2 The Investment Group will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year.

12.2 Approval of Capital Business Cases

- 12.2.1 Approval of capital business cases will follow the approval limits outlined in the Trust Approval Framework in Annex 4, Section 1.
- 12.2.2 Defined groups with specific approval limits are as follows:

<i>Programme allocations within Capital Plan</i>	<i>Group/ individual responsible for approval</i>
<i>Backlog Maintenance</i>	Director of Estates & Capital Development/ Head of Operational Estate Maintenance

Replacement leases	Leasing sub-committee
Health & Safety	Health & Safety Manager
<i>Infrastructure, Development Infrastructure, Space Issues, Defects Resolution, Fire Safety, Advanced Design Fees, Contingency</i>	Director of Estates & Capital Development
Medical Equipment	Medical Equipment Panel
Information Systems	Information Systems Steering Group
Theatre Instrumentation	Director of Operations, Division A

- 12.2.3 Delegated capital limits refer to overall contract values, regardless of the form of funding (e.g. lease, capital up-front, bullet payment or managed service contract).
- 12.2.4 The delivery of capital schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £150k or more than 10%, then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting. In situations where the additional expenditure increases the cost of the scheme beyond the approval limit of the original authorising body, that authorising body may approve the additional expenditure but will report such to the body with which the approval limit for the revised total scheme cost resides.
- 12.2.5 Minor changes to the Trust's IISS managed service contract, up to a maximum value of £100k, can be approved by the Deputy Director of Finance. All changes must be reported to the Trust Investment Group.
- 12.2.6 The Trust Investment Group will set out and periodically review and update the format and minimum required content of business cases. This will typically include:
- a) An option appraisal of potential benefits compared with known costs;
 - b) Ensuring an appropriately detailed analysis of expenditure and income flows is undertaken, including documented responses from purchasers as appropriate and risk analysis testing the assumptions made; and
 - c) An analysis of the project's discounted cash flow, based on an agreed rate of return.
- 12.2.7 The Trust Investment Group will report on major issues to Trust Executive Committee and Trust Board via the capital section of the monthly Finance Report and within the quarterly capital update.
- 12.2.8 The Southampton Hospital Charity, or other charities, may choose to donate assets to the Trust. For values less than £100k, and where the revenue consequences of the expenditure (e.g. maintenance) can be managed within existing budgets, the capital can be authorised by the Charity Board and the revenue consequences can be authorised by the Divisional Management Team.

- 12.2.9 For charitably funded initiatives for more than £100k, or where additional revenue budget is required to cover on-going costs, a case should be submitted to the Trust Investment Group.
- 12.2.10 Once capital is approved, the Chief Financial Officer is responsible for choosing the most appropriate source of finance, aligned to the Trust Treasury Management policy.
- 12.2.11 Finance leases reaching the end of their contractual term are included as Capital expenditure. The Trust Investment Group has authorised the Leasing Sub-Committee to manage and approve the buy-out and/or direct replacement of leases. Where new equipment is required, a business case needs to go to Trust Investment Group for approval before a decision on whether to lease or direct purchase can be made.

12.3 Private Finance Initiative

- 12.3.1 Proposals for Private Finance must be submitted to the Trust Investment Group for approval or review prior to request for approval by Trust Board if required.

12.4 Asset Registers

- 12.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of advice from the CFO concerning the form of any register and the method of updating. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.
- 12.4.2 The CFO shall prepare procedural instructions on the disposal of assets.
- 12.4.3 Additions to the fixed asset register must be clearly identified to the associated senior service user/ owner and be validated by reference to:
- a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
 - b) stores, requisitions and wages records for own materials and labour including appropriate overheads.
- 12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.
- 12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

- 12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.
- 12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. 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; and
 - g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
- 12.5.3 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.
- 12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.
- 12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.
- 12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.
- 12.5.7 Whenever practicable, assets should be marked as Trust property.
- 12.5.8 Inventories shall also be maintained and receipts obtained for:
- a) Equipment on loan;
 - b) All contents of furnished lettings.

12.6 Property (Land and Buildings)

- 12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and Trust Executive Committee.

- 12.6.2 The following matters related to property must be approved by the Trust Board:
- a) An Estate Strategy;
 - b) Acquisition of freehold property over £250,000 (excluding VAT); and
 - c) Acquisition of property where the total value of the agreement is over £250,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.
- 12.6.3 Property purchases, licences and leases up to £250,000 each (excluding VAT) may be authorised by the Trust Investment Group, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.
- 12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:
- a) Details of the consideration or lease payments;
 - b) Details of the period of the lease;
 - c) Details of the required accounting treatment;
 - d) Annual running costs of the property;
 - e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;
 - f) The results of property and ground surveys;
 - g) Professional advice taken and the resultant cost;
 - h) Details of any legal agreement entered into;
 - i) Any restrictive covenants that exist on the property; and
 - j) Planning permission.
- 12.6.5 Any property acquisition should be in accord with, Department of Health guidance.
- 12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive.
- 12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.
- 12.6.8 Trust Board approval must be obtained for the disposal of any property over £250,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:
- a) The proceeds to be received;
 - b) Any warrants or guarantees being given; and
 - c) Independent valuations obtained.
- 12.6.9 The disposal must be effected in full accord with Estate code.
- 12.6.10 Disposals of protected assets require the approval of NHS Improvement.
- 12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework require the approval of NHS Improvement.

- 12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £250,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

- 13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First In first Out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.
- 13.1.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of the Deputy Chief Pharmacist; and the control of fuel oil the responsibility of the Director of Estates.
- 13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Head of Supply Chain wherever practicable, stocks should be marked as Health Service property.
- 13.1.4 The CFO, in conjunction with the Director of Procurement and Supply Chain, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:
- a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;
 - b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.
- 13.1.5 Stocktaking arrangements shall be agreed with the CFO and shall specify:
- a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;
 - b) That there shall be a physical check covering all items in store at least once a year;
 - c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

- d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;
 - e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.
- 13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.
- 13.1.7 The Director of Procurement shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.
- 13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).
- 13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the CFO and recorded.
- 13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store.
- 13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

- 14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.
- 14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:
- a) Establish whether it is needed elsewhere in the Trust;
 - b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.
- 14.1.3 All unserviceable articles shall be:
- a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;
 - b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed

or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued at over £100k (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DH Group Accounting Manual and prepare a register.

14.2.2 The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See Trust Counter Fraud & Corruption Policy and Procedures).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Counter Fraud & Corruption Policy and Procedures.

14.2.4 The CFO is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by The NHS Counter Fraud Authority.

14.2.5 The Directorate or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register. Losses and special payments are defined at Annex 1.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Chief Executive, supported by the Director of Informatics, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to

ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1984; 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 ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

- 15.1.2 The CFO shall be satisfied 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.
- 15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
- 15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.
- 15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:
- a) Systems acquisition, development and maintenance are in line with the Trust's Information Strategy;
 - b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
 - c) Finance staff have access to such data;
 - d) Have adequate controls in place; and
 - e) Such computer audit reviews as are considered necessary are being carried out.
- 15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

The Trust Information Strategy Steering Group (ISSG) has an approval limit of £300k for projects. It will be at the discretion of the Director of Informatics or other senior Informatics managers whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

- 16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.
- 16.1.2 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, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.
- 16.1.3 The CFO will 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 it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.
- 16.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.
- 16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
- 16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.
- 16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines.

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

- 17.1.1 The Trust is the sole corporate Trustee of Southampton Hospital Charity (registered charity number 1051543), and is responsible for the management of funds it holds on trust. Although the management processes may overlap with those of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.
- 17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management and governance of funds held on trust.
- 17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.
- 17.1.4 The Trust Board hereby nominates the Director of Nursing, who has executive responsibility for the Charitable Funds team, to have primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.
- 17.1.5 The Trust shall ensure the establishment of the Southampton Hospital Charitable Funds Committee, to which it delegates the majority of its Trustee role as set out in the Committee's Terms of Reference.

17.2 Administration of Charitable Funds

- 17.2.1 The CFO shall:
- a) Authorise any transaction of funds between investment vehicles;
 - b) Oversee the preparation and procedure of the annual accounts and the annual audit.
- 17.2.2 The Charity Funds Manager shall:
- a) Arrange for the administration of all existing charitable funds including clear electronic and paper record keeping in accordance with the recommendations of internal and external audit;
 - b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;
 - c) Produce codes of procedure covering the financial management of funds held;
 - d) Ensure funds are held within designated or restricted accounts in accordance with charity law;
 - e) Periodically review the funds and any subsidiary funds, rationalise funds within statutory guidelines, and report changes to the Southampton Hospital Charitable Funds Committee;
 - f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;
 - g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

- h) Report income and expenditure totals on a monthly basis to the Director of Nursing and to the Southampton Hospital Charitable Funds Committee at the quarterly meetings;
- i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;
- j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Southampton Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising & Incoming Funds

17.3.1 The Director of Southampton Hospital Charity shall:

- a) Introduce and enforce policies, systems and procedures to ensure that officers of the Trust are informed as to how to proceed when offered funds that donors' intentions are recorded and that formal receipting and thanking procedures are in place;
- b) Prioritise fundraising projects/appeals and prepare plans for agreement with the Southampton Hospital Charitable Funds Committee;
- c) Market and promote fundraising while maintaining a unified brand and adhering to charity regulations;
- d) Build, maintain and utilise donor records in accordance with the Data Protection and Freedom of Information Acts;
- e) Work in close partnership with other charities supporting the hospital, performing a liaison role where appropriate;
- f) Build and maintain a staff team and network of volunteers and funders;
- g) Generate continuous and unrestricted income in order to become sustainable;
- h) Alert the Charitable Funds Committee to any irregularities regarding the use of the charity's name or its registered charity number;
- i) Ensure that adequate insurance is in place for all fundraising activities.

17.4 Investment Income

17.4.1 Investment will be the responsibility of Southampton Hospital Charitable Funds Committee or if appropriate will be devolved to a sub-committee (to include the Charity Chair, the CFO, and the Charity Funds Manager and/or appropriate replacements when required).

17.4.2 Its responsibilities will include:

- a) Ensure that investment is in accordance with the Charity's investment policies;
- b) Commission any required investment advisors;
- c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;
- d) Report any significant concerns to the Trust Board;
- e) Review and recommend to the Trust Board the appointment of investment advisors every three years.

17.4.3 The Charity Funds Manager will:

- a) Report investment performance to the Southampton Hospital Charitable Funds Committee;
- b) Minute investment decisions;
- c) Allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Day to day management of individual expenditure is delegated to the Charity Funds Manager and in turn to the individual charitable fund holders, within the limits set out in these instructions.

17.5.2 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.3 A connected multiple order could be for example:

- a) The refurbishment of a room where several suppliers are involved
- b) An ECG machine and its trolley
- c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.4 **Levels of Authority**

No expenditure can take place without the approval of the Charity Funds Manager.

£	Orders can only be processed once the following people give their authority
Up to £10,000	The Fund Holder + One other authorised signatory from the relevant fund
£10,001 - £75,000	As above + The appropriate Care Group Manager
£75,001 - £100,000	As above + The appropriate Divisional Director of Operations
Over £100,000	As above + The Southampton Hospital Charitable Funds Committee (reported to the Trust Board)

For matters outside the Divisional Structure:

- The appropriate line manager takes the place of the Care Group Manager.
- The CFO takes the place of the Divisional Director of Operations.

17.5.5 Points to note:

- a) If the Fund Holder is absent from work for an extended period of time, an alternative signatory on the fund that holds the next senior position in the Trust (to the Fund Holder) may authorise expenditure.
- b) In cases where, for example the Fund Holder and the Care Group Manager are one and the same, the Charity Funds Manager can exercise discretion to accept authorisation from fewer signatories, subject to the minimum of two.
- c) If anyone seeking to authorise the expenditure of charitable funds is in any doubt whether the proposed expenditure is legitimate charitable expenditure, they should contact the Charity Funds Manager.

17.5.6 Where the expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.6 Asset Management

17.6.1 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure.

17.6.3 The Trust shall:

- a) Be responsible for insuring, safeguarding and protecting all equipment and must pay its operating, maintenance costs, and all other costs arising from the day to day running of the equipment, including any insurance;
- b) Be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The Charity Funds Manager will be responsible for updating an annual risk register for agreement by the Southampton Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

- a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;
- b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;
- c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;
- d) External risks – e.g. public perception and adverse publicity, government policy;
- e) Compliance with law and regulation – e.g. breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers, and any other person associated with the activities of the Trust are made aware of, and comply with, the Trust's Business Conduct Policy. This policy details the conduct and behaviour expected of individuals with regard to:

- a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;
- b) Conduct by an individual in a position to influence purchases;
- c) Employment and business which may conflict with the interests of the Trust;
- d) Relationships and loyalties which may conflict with the interests of the Trust;
- e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Associate Director of Corporate Affairs for inclusion in the Register of Interests.

- 18.2** The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

- a) Bribe another person by offering, promising, or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so.
- b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Anti-fraud, Bribery and Corruption, Business Conduct and Whistle Blowing policies, available via staffnet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

- 19.1** The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS Improvement / DH guidelines. The delegated responsibility for holding

and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	Director of Estates & Capital Development
Building & Engineering Contracts	Director of Estates & Capital Development
Estate Maintenance Contracts	Head of Operational Estate Maintenance
Maintenance Contracts	Director of Procurement
Clinical Contracts	Director of Contracting
Contracts for goods and services other than the above	Director of Procurement

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Associate Director of Corporate Affairs for a register to be maintained.

- 19.2** The records held in archives shall be capable of retrieval by authorised persons.
- 19.3** Records and information held in accordance with latest NHS Improvement / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or CFO. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

- 20.1.1 The Chief Executive shall ensure that the Trust has a sound system of risk management and internal control set out in strategy, policy, and procedural documentation. The functioning and efficacy of the system of internal control and risk management shall be monitored and assessed for suitability by the Board of Directors and its duly established committees.
- 20.1.2 The risk management and associated policies shall include:
 - a) A process for identifying and quantifying risks;
 - b) The authority of all managers with regard to managing the control and mitigation 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 residual risk;
 - d) Contingency plans to offset the impact of adverse events;
 - e) Audit arrangements including internal audit, external audit, clinical audit and health and safety reviews.

The existence, integration and evaluation of these elements will provide a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current NHS guidance.

20.2 Insurance

- 20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements
- 20.2.2 The Associate Director of Corporate Affairs shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.
- 20.2.3 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents against insurance provision on the third-party liability scheme.
- 20.2.4 The Associate Director of Corporate Affairs shall ensure timely reporting of losses and the submission of claims against insurance provision on the third-party liability scheme in line with the agreed limits set in these SFIs.
- 20.2.5 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents and losses and the submission of claims against insurance provision.

20.3 Clinical Risk Management/CNST

- 20.3.1 The Director of Nursing shall:
 - a) Provide a central point of contact within the Trust for NHR/CNST issues;
 - b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the Trust within the excess of £3k will be notified to the Head of Litigation and Insurance Services for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the University Hospital Southampton NHS Foundation Trust as the defendant.

Up to £500k	DCD or DHoN or DDO
£501k - £1.5m	DCD and DHoN and shared with an Executive Director (usually Medical or Nursing)
>£1.5m	DCD and DHoN and shared with at least two Executive Directors and the CEO for final review and approval then reported to Trust Board

The DH must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made against legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Litigation Authority, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is University Hospital Southampton NHS Foundation the act provides that UHS is exempt from repaying their “own” costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Director of HR.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Director of HR and the CFO. In certain cases, additional approval should be sought from NHS Improvement and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Director of Human Resources advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	Approval
Up to £30,000	Director of Human Resources
£30,001 to £100,000	Chief Executive
£100,000 plus	Trust Board

22.4 NHS Improvement must be consulted before making any special payments that are novel, contentious or repercussive. The Director of HR, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against legal advice must be approved by the Trust Board.

23. WHOLLY OWNED SUBSIDIARIES, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Wholly Owned Subsidiaries

23.1.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

23.2 Hosted Bodies, Partnerships and Collaborations

23.2.1 Hosted bodies are organisations for which UHS provide services under a service level agreement (SLA). The arrangements for administration of hosted bodies are managed by the Commercial Development Team. UHS also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

23.2.2 Dependent on the terms of the SLA, memorandum of understanding or equivalent, these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding or equivalent should be referred to on a case by case basis.

Annex 1

Writing-Off of Losses and Special Payments

LOSSES:

1. Losses of cash due to:
 - a. theft, fraud etc.
 - b. overpayment of salaries etc.
 - c. other causes
2. Fruitless payments
3. Bad debts and claims abandoned in relation to:
 - a. private patients
 - b. overseas visitors
 - c. other
4. Damage to buildings, property etc. due to:
 - a. theft, fraud etc.
 - b. other

SPECIAL PAYMENTS:

5. Compensation under legal obligation
6. Extra contractual to contractors
7. Ex gratia payments in respect of:
 - a. loss of personal effects
 - b. clinical negligence with advice
 - c. personal injury with advice
 - d. other negligence and injury
 - e. severance payments on termination of employment
 - f. other employment payments
 - g. patient referrals outside the UK and EEA Guidelines
 - h. other
 - i. maladministration, no financial loss
8. Extra statutory and regulatory

Annex 2

Significant Transaction

The Trust is obliged to report significant transactions to NHS Improvement (the independent regulator of NHS Foundation Trusts) prior to entering the transaction. Such transactions may take the form of major investments such as PFI's, incorporation of Wholly-Owned Subsidiaries, long term contracts for the provision of services or acquisitions or mergers with other NHS organisations or private sector companies.

The Trust would require both Trust Board and the Council of Governors to approve all significant transactions prior to submission to NHS Improvement.

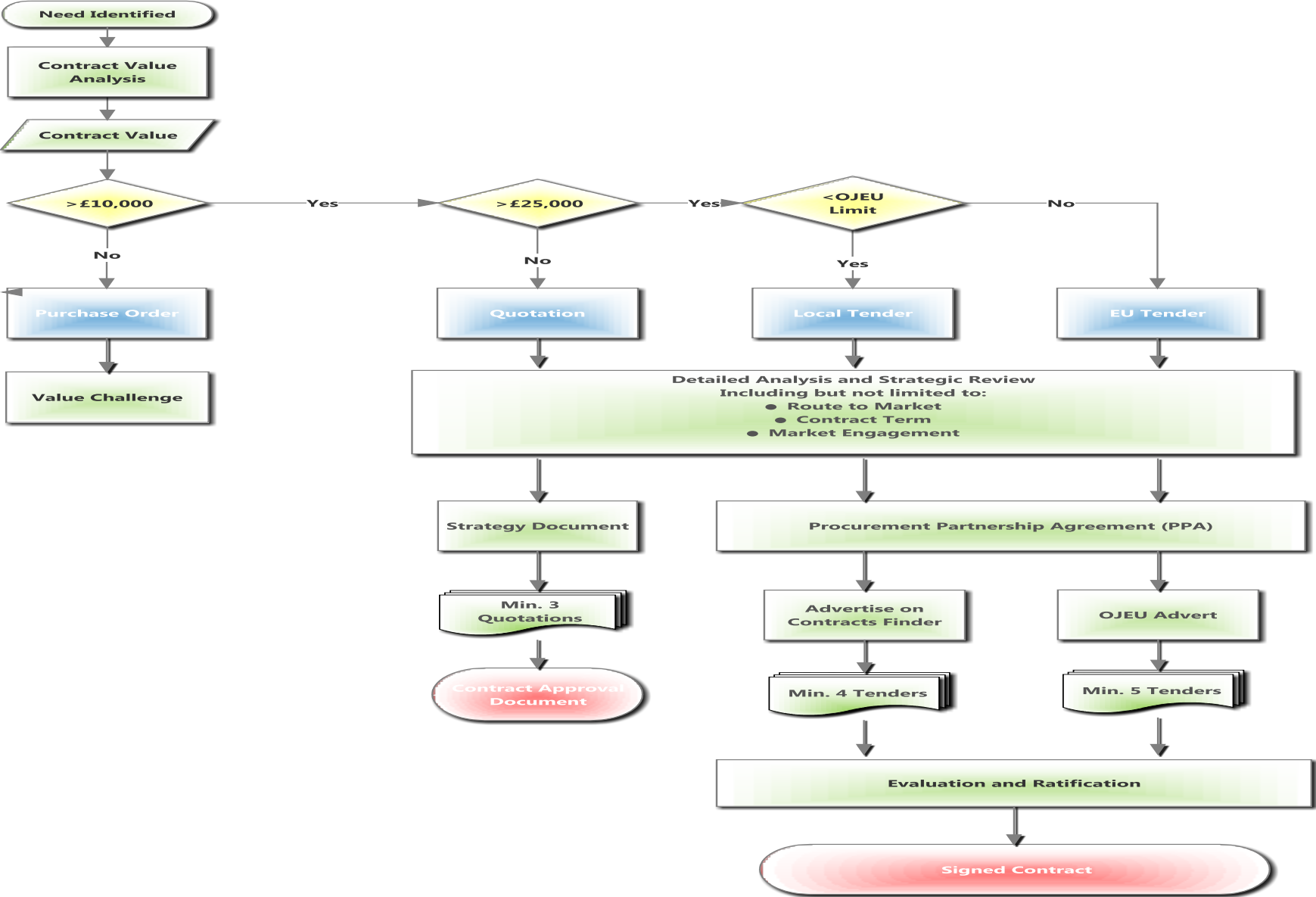
Significant transactions are defined by NHS Improvement as being equivalent to a 10% change in any one of the following three financial criteria:

1. Gross Assets
2. Attributable Income
3. Capital

The full details of the NHS Improvement guidance on significant transactions can be found in Annex 13 of the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts (published November 2015).

Annex 3

Competitive tendering flowchart



Annex 4 – Trust Authorisation Framework

Section 1 – Authorisation Bodies and Limits

Group	Revenue		Capital	
	Revenue Cases (with no Capital)	Revenue implications of Capital (gross annual additional cost)	Capital (gross value) for schemes in Trust Board approved Capital Plan	Capital (gross value) for new schemes (not in Capital Plan)
Divisional Management Boards	Utilisation of existing expenditure budget only.	Up to £100k, where this is managed within current revenue budget.	Up to £150k, where this is within annual Capital allocation for Division. All capital expenditure to be reported to TIG	£0
Defined groups as outlined in Capital section of SFIs	N/A	£0k	Up to £150k. All capital expenditure to be reported to TIG.	£0
Recruitment Control Panel	Recruitment of new posts and some replacements - as per Terms of Reference. Reporting into Savings Board	N/A	N/A	N/A
CEO or CFO	Up to £100k additional expenditure budget.	£0k	Up to £150k. All capital expenditure to be reported to TIG.	Up to £150k. All capital expenditure to be reported to TIG.
Savings Board	Up to £500k additional expenditure budget, reporting into TEC.	N/A	N/A	N/A
Trust Investment Group	Up to £1,000k additional expenditure budget.	Up to £1,000k	£0k to £2,500k. Unless approved by group above. All schemes over £2,500k should include a recommendation from TIG before Board review. Property acquisitions, leases and licences <£250k	£0k to £2,500k where individual scheme not in Capital plan but managed within overall Capital plan budget.
Trust Executive Committee	All schemes above £1,000k should go to TEC for noting. New consultant business cases Replacement clinical consultant cases for noting	All schemes above £1,000k should go to TEC for noting.	All schemes above £2,500k should go to TEC for noting.	All schemes above £2,500k should go to TEC for noting.
Strategy & Finance Committee	All schemes above £1,000k should go to S&FC for review and recommendation to Trust Board.	All schemes above £1,000k should go to S&FC for review and recommendation to Trust Board.	All schemes above £2,500k should go to S&FC for review and recommendation to Trust Board.	All schemes above £1,500k should go to S&FC for review and recommendation to Trust Board.
Trust Board	Over £1,000k	Over £1,000k	Over £2,500k. Any proposed major scheme with FT compliance arrangement Property acquisitions, leases and licences > £250k	Over £1,500k. Any proposed major scheme with FT compliance arrangement
NHS Improvement	N/A	N/A	Any proposed major scheme within FT compliance arrangements	Any proposed major scheme within FT compliance arrangements

Annex 4 – Trust Authorisation Framework

Section 2 – Non-Pay Authorisation Framework

Finance and Procurement System - Rulesets		First Approver	Second Approver	Third Approver	Fourth Approver	Fifth Approver	Sixth Approver
Rule 1	Divisional Hierarchy	5k approver	25k approver	75k approver	250k approver	1m approver	Unlimited approver
Rule 2	R&D Hierarchy	5k approver	25k approver	75k approver	250k approver	1m approver	Unlimited approver
Rule 3	THQ Hierarchy	5k approver	75k approver	250k approver	1m approver	Unlimited approver	
Rule 4	Other Hierarchy - including capital, estates	75k approver	250k approver	1m approver	Unlimited approver		

Authorised Non-Pay Expenditure Limits	
Band	LIMIT £
All Staff	
Bands 1 – 4	£0
Band 5	£5,000
Band 6	£5,000
Band 7	£5,000
Band 8a	£25,000
Band 8b	£25,000
Band 8c	£75,000
Band 8d	£75,000
Band 9	£250,000
Trust Board / Directors	
Chief Executive	Unlimited
Chief Financial Officer	Unlimited
Chief Operating Officer	£1,000,000
Other Executive Board Director	£1,000,000
Deputy Director of Finance	£1,000,000
Finance	
Director of Procurement	£250,000
Assistant Director of Finance	£250,000
Financial Controller	£250,000
Head of Financial Accounting	£75,000
Treasury Manager	£5,000
Head Cashier +	£5,000
Materials Manager	£5,000
Pharmacy	
Chief Pharmacist	£250,000
Estates & Capital Development	
Director of Estates & Capital Development	£250,000

Annex 4 – Trust Authorisation Framework

Section 3 – Contracting for Income – Financial Limits

NON NHS	
All limits exclude Value Added Tax where applicable.	
Lifetime Contract value	Approval
Up to £60,000	DDO / Commercial Director
£60,001 - £300,000	CFO
£300,001 to £1.5million	Chief Executive
£1.5million plus	Trust Board

Lifetime Contract value (NHS)	
Service Level Agreements	
Up to £10,000,000	Director of Contracting
Up to £200,000,000	Director of Transformation
Over £200,000,000	Chief Executive

Delegated authority limits associated with tendering to provide services				
	Divisional Director of Operations	Tender Steering Group	CEO	Trust Board
Total value range	<£50k	<£12.5m	<£25m	>£25m
Annual value	£20k pa	<£5m pa	>£5m<£10m pa	>£10m pa

Annex 4 – Trust Authorisation Framework

Section 4 – Placing of Expenditure Contracts

Contract Value (Excl VAT)	Type of Contract	Authorisation To Place or sign Contract
Up to £10,000	Goods & Services	Director of Estates, Director of Procurement, Director of Informatics, Chief Pharmacist, CFO
£10,000 - £250,000	Goods & Services	Director of Estates, Director of Procurement, Director of Informatics, Chief Pharmacist, CFO
£250,001 - £499,999	Goods & Services	Chief Executive
Over £500,000	Goods & Services	Trust Board/Chairman
Up to £499,999	Building & Engineering	Director of Estates / Head of Estates Maintenance, CFO
£500,000 - £999,999	Building & Engineering	Chief Executive
Over £1,000,000	Building & Engineering	Trust Board/Chairman

Based on gross expenditure, not off-set with income.

Annex 4 – Trust Authorisation Framework

Section 5 – Authorisation Framework for Procurement and Tendering of expenditure Products & Services Procurement

Contract Value (Excl VAT)	Quotations/Tenders for Goods & Services	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	No formal tender requirement	0	Purchase Order
£10,000 - £75,000	Quotation	3	Up to £24,999 -Purchase Order Over £25k - Contract
£75,001 - published OJEU Limit (as advised by procurement)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
>published OJEU Limit (as advised by procurement)	OJEU Tender	4	Contract as specified in Tender and Purchase Order

Threshold limits represent the contract's lifetime value e.g. a 5 year contract of £25,000 per year requires

Building and Estates Engineering Procurement

Contract Value (Excl VAT)	Tender for Building & Engineering	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	No formal tender requirement	0	Purchase Order
£10,000 - £75,000	Quotation	3	Up to £24,999 -Purchase Order Over £25k - Contract
£75,001 - £499,999	Formal Local Tender	3	Contract as specified in Tender and Purchase Order
£500,000 - published OJEU Limit (as advised by procurement)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
>published OJEU Limit (as advised by procurement)	OJEU Tender	4	Contract as specified in Tender and Purchase Order

Waiving or Variation of Competitive Tendering/Quotation procedure:

Type Of Contract	Monetary Value (Excl. VAT)	Authorisation To Place or sign Contract
Products /Services Building/Engineering/Works Contracts/Consultancy Services	Up to £75,000	Director of Estates, Director of Procurement, Director of Informatics, Head of Estates Maintenance
As above	£75,001 - £499,999	Chief Executive
As above	Over £500,000	Trust Board

Report to the Trust Board of Directors dated Thursday, 31 October 2019			
Title: Register of Seals, and Chair's Actions			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.5		
Sponsor	Chairman		
Author	Charlie Helps, Company Secretary		
Provenance	This is a regular report to notify the Board of use of the seal and actions taken by the Chairman in accordance with the Scheme of Delegation for ratification.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for RATIFICATION.		
Relevant strategic goals	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services 		
Impact assessments	None		
Other standards affected	<ul style="list-style-type: none"> • Monitor NHS Foundation Trust Code of Governance (probity, internal control) • UHS Standing Financial Instructions and Scheme of Delegation 		

Register of Seals, and Chair's Actions

1. Signing and Sealing

- 1.1 **Loan Agreement** executed as a Deed between University Hospital Southampton NHS Foundation Trust (the Lender) and UHS Estates Limited (the Borrower) to support the costs of building the General Intensive Care Unit expansion. Seal number 181 on 30 September 2019.
- 1.2 **Supplemental Lease (Agreement to Vary) and Licence for Alterations** (for works outside the premises) between University Hospital Southampton NHS Foundation Trust (the landlord), The Maggie Keswick Jencks Cancer Caring Trust (the tenant) and Maggie's Trading Limited relating to Maggie's Centre, Southampton General Hospital, Tremona Road, Southampton. The Supplemental Lease agreement, supplemental to the Original Agreement Lease dated 12 June 2019, is to allow Maggie's Centre to connect to an existing Storm Water Drain which is outside their demise area and on hospital land. Seal number 182 fixed to the Licence for Alterations on 24 October 2019.

2. Chair's Actions

The Board has agreed that the Chair may undertake some actions on its behalf. The following actions have been undertaken by the Chair. All awards of contract are subject to a full tender process.

- 2.1 **Single Tender Action for Cardiovascular & Thoracic consumables** from Medtronic, to cover six months price agreement pending completion of full tender process, at a cost of £576,220 excluding vat.

3. Recommendation

Trust Board is recommended to ratify the Chair's Actions.