University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	30/01/2024
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Break**
4	9:25	**Minutes of Previous Meeting held on 30 November 2023** Approve the minutes of the previous meeting held on 30 November 2023
5		**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.
6		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
6.1	9:35	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
6.2	9:40	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Dave Bennett, Chair
6.3	9:45	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
6.4	9:50	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
6.5	9:55	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

6.6 **Performance KPI Report for Month 9**

10:25 Review and discuss the report
Sponsor: David French, Chief Executive Officer

6.7 **Finance Report for Month 9**

10:55 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

6.8 **People Report for Month 9**

11:15 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

6.9 **Break**

11:35

6.10 **Maternity Safety 2023-24 Quarter 3 Report**

11:45 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Marie Cann, Maternity/Neonatal Safety Lead/Alison Millman, Safety & Quality Assurance Matron

7 **STRATEGY and BUSINESS PLANNING**

7.1 **Corporate Objectives 2023-24 Quarter 3 Review**

12:00 Review and feedback on the corporate objectives
Sponsor: David French, Chief Executive Officer
Attendees: Martin De Sousa, Director of Strategy and Partnerships/Kelly Kent, Head of Strategy and Partnerships

7.2 **Board Assurance Framework (BAF) Update**

12:10 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Lauren Anderson, Corporate Governance and Risk Manager

8 **CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL**

8.1 **Register of Seals and Chair's Actions Report**

12:20 Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

8.2 **Review of Standing Financial Instructions 2023-24**

12:25 Review and approve the SFIs
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Phil Bunting, Director of Operational Finance

8.3 **Finance and Investment Committee Terms of Reference**

12:30 Review and approve the Terms of Reference
Sponsor: Dave Bennett, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

8.4 **Quality Committee Terms of Reference**

12:35 Review and approve the Terms of Reference
Sponsors: Tim Peachey, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

9 **Any other business**

12:40 Raise any relevant or urgent matters that are not on the agenda

10 **Note the date of the next meeting: 28 March 2024**

11 **Resolution regarding the Press, Public and Others**

Sponsor: Jenni Douglas-Todd, Trust Chair
To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

12 **Follow-up discussion with governors**

12:45

University Hospital Southampton NHS Foundation Trust

Minutes Trust Board – Open Session

Date	30/11/2023
Time	9:00 – 13:00
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Duncan Linning-Karp, Deputy Chief Operating Officer (DL-K) (for J Teape) Ian Howard, Chief Financial Officer (IH) Femi Macaulay, Interim NED (FM) Tim Peachey, NED (TP)
In attendance	Martin De Sousa, Director of Strategy and Partnerships (MDeS) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) James Allen, Chief Pharmacist (JA) (item 5.12) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.2) Julie Brooks, Head of Infection Prevention Unit (JB) (item 5.13) Marie Cann, Maternity/Neonatal Safety Lead (MC) (item 5.9) Rosemary Chable, Head of Nursing for Education, Practice and Staffing (RC) (item 5.15) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 5.11) Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian (CM) (item 5.15) John Mcgonigle, Emergency Planning & Resilience Manager (JM) (item 7.1) Alison Millman, Safety & Quality Assurance Matron (AM) (item 5.9) Jenny Milner, Associate Director of Patient Experience (JM) (item 5.10) Emma Northover, Director of Midwifery (EN) (item 5.9) Danielle Sinclair, Deputy Emergency Planner (DS) (item 7.1) Julian Sutton, Interim Lead Infection Control Director (JS) (item 5.13) 1 member of the public (item 2) 5 governors (observing) 1 member of staff (observing) 5 members of the public (observing)
Apologies	Diana Eccles, NED (DE) Joe Teape, Chief Operating Officer (JT)

1. Chair's Welcome, Apologies and Declarations of Interest

The Chair welcomed attendees to the meeting. Tim Peachey informed the Board that he now sits on the combined Portsmouth Hospitals University NHS Foundation Trust and Isle of Wight NHS Trust board, following the recent organisational changes. There were no further interests to declare in the business to be transacted at the meeting.

The Chair provided an overview of her activities since October 2023, including visits to hospital departments, meetings with peers and other key stakeholders.

2. Patient Story

Karol Muir was invited to speak about her experience as a patient when she was diagnosed with neck and tongue cancer in early 2021. It was noted that:

- Ms Muir's experience was mixed with some poor experiences when given the diagnosis and by a staff member lacking compassion when addressing her claustrophobia.
- In other instances, Ms Muir received a good service such as when a mask was being made for her radiotherapy and her experience on the acute oncology ward.
- The Board acknowledged that kindness and compassion was very important.
- The Board also noted that it was important to hear both good and bad aspects of patients' experiences to enable the Trust to improve its services.

3. Minutes of the Previous Meeting held on 28 September 2023

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 28 September 2023, subject to one minor amendment to item 5.2.

4. Matters Arising and Summary of Agreed Actions

It was noted that all actions had either been completed or were not yet due.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Finance and Investment Committee

The chair of the Finance and Investment Committee was invited to provide an overview of the meeting held on 27 November 2023. It was noted that:

- The committee reviewed the Finance Report for Month 7 (item 5.5), much of which formed the basis of the Trust's submission for the second half of 2023/24.
- The committee examined the Trust's capital re-prioritisation plans along with proposals for 2024/25 and 2025/26.
- The Trust had identified £71.3m of Cost Improvement Programme schemes, which, when adjusted for risk, represented approximately £59m of savings. It was noted that the Trust was underweight in terms of recurrent savings.
- The committee reviewed the Trust's productivity on the basis of both the NHS methodology and a revised methodology, which took into account factors such as an appropriate rate of inflation. Under the NHS methodology, the NHS's underperformance was 16% compared to 2019/20 and the Trust was 18% below that in 2019/20. However, under the revised model, the Trust was under-performing by only 6-7%.
- The committee reviewed a proposal for an Integrated Care System-wide electronic patient record system.

5.2 Briefing from the Chair of the People and Organisational Development Committee

The chair of the People and Organisational Development Committee was invited to provide an overview of the meeting held on 22 November 2023. It was noted that:

- The committee reviewed the People Report for Month 7 (item 5.7). It was noted that the Trust's substantive workforce continued to grow and whilst

agency use was under control, there had been an increase in use of bank staff, particularly due to demands in the Emergency Department, mental health nursing and staffing of surge areas.
- It was noted that self-reporting of disabilities by staff and the rate of appraisals had both declined.
- The initial indication in terms of the response rate to the staff survey showed a lower response rate than in previous years.

5.3 Briefing from the Chair of the Quality Committee

The chair of the Quality Committee was invited to provide an overview of the meeting held on 27 November 2023. It was noted that:

- The committee reviewed the Trust's quality indicators and noted that the rate of falls and infections gave rise to concerns about the application of fundamentals of care principles. It was considered possible that the different focus during Covid-19 was a possible contributory factor.
- The Trust had reported an increase in the number of complaints, although much of this increase was due to a change in the criteria of what was deemed to be a complaint.
- The committee reviewed the results of the Experience of Care survey. Although the national picture had worsened, the Trust's position remained essentially as before.
- The Trust's approach to end-of-life care was generally very good, although consideration needed to be given to the delivery of mandatory training to all staff.
- In view of the general election due to take place before the end of 2024, it was considered likely that the Trust would receive an increased number of Freedom of Information Act requests.

5.4 Chief Executive Officer's Report

David French was invited to present the Chief Executive Officer's Report, the content of which was noted. It was further noted that:

- The Chancellor of the Exchequer had delivered his autumn statement on 22 November 2023, and although there were no specific announcements concerning the health and care sector, there was an expectation of increased public sector productivity. It was noted that the Government had previously announced £800m of additional winter funding for the NHS, although this was mostly repurposed existing funding.
- A proposed pay settlement for senior doctors was expected to be voted on by British Medical Association members.
- The Care Quality Commission had commenced a roll out of its new single assessment framework in the South region.
- The public hearings for module 2 of the UK Covid-19 Inquiry had commenced on 3 October 2023.
- The Trust had identified 181 cases of lung cancer through the Targeted Lung Health Check Programme. The financial impact of this programme was difficult to quantify, as it had led to a higher surgical workload, but reduced need for chemo- and radiotherapy. Other conditions had also been discovered through the screening programme.

5.5 Performance KPI Report for Month 7

Duncan Linning-Karp was invited to present the Performance KPI Report for Month 7, the content of which was noted. It was further noted that:

- In terms of benchmarking against other trusts, the Trust was in the top quartile in all areas except one.

- There had been 23 breaches of the target for long-waiters.
- The Trust was facing challenges in meeting the 31-day cancer treatment target due to increases in demand for radiotherapy and demand for prostate cancer treatment.

The Board noted the spotlight on the Emergency Department. It was further noted that:

- There had been a 17% increase in demand since 2019/20.
- The Trust was targeting 76% of type 1 patients being seen within four hours, but this would be challenging and dependent on the General Practitioners (GPs) working at the Emergency Department and on a reduction in the number of patients with no criteria to reside.
- The Trust was reviewing its processes to free up space and provide options to bypass the Emergency Department when individuals were referred by their GP. In addition, admission and discharge processes were also being reviewed.
- It was noted that the GP 'village' in the Emergency Department would be insufficient on its own to reach the 76% target.
- The biggest constraints in terms of performance were the speed of decision-making and the availability of beds.

5.6 Finance Report for Month 7

Ian Howard was invited to present the Finance Report for Month 7, the content of which was noted. It was further noted that:

- The Trust had submitted to the Integrated Care Board its plans for the second half of the financial year, which anticipated a revised end-of-year deficit of £31.5m.
- The Trust had a year-to-date deficit of £25m, although this was prior to receipt of anticipated additional funding for the costs of industrial action.
- The Trust was consistently delivering above the ceilings agreed for services under 'block' contracts, which meant that the additional activity was unfunded.
- The Trust's Elective Recovery performance remained good, and the resultant funding received was £4.5m above the Trust's plan.

5.7 People Report for Month 7

Steve Harris was invited to present the People Report for Month 7, the content of which was noted. It was further noted that:

- The workforce grew by 93 whole-time equivalents during the month, and the total workforce was 270 over the plan submitted to NHS England. This increase was driven in particular by newly qualified nurses still within the supernumerary period, increased temporary staffing and a small increase in sickness absence.
- Participation in the NHS staff survey was lower than that in previous years at around 40% compared to 55% during 2022/23.
- Turnover and sickness rates remained lower than the Trust's target levels.
- There continued to be a high demand for mental health nursing staff, and it seemed likely that a system approach would be necessary to address this issue.

5.8 Break

5.9 Midwifery, Neonatal and Obstetric Anaesthetic Workforce Report

Emma Northover, Marie Cann and Tim Peachey were invited to present the Midwifery, Neonatal and Obstetric Anaesthetic Workforce Report, the content of which was noted. It was further noted that:

- Oversight of the midwifery, neonatal and obstetric workforce was a requirement of the NHS Resolution Maternity Incentive Scheme. It was noted that the obstetric element of the report would be provided at the next Board meeting on 19 December 2023.
- The workforce faced a number of challenges, particularly in terms of recruiting to specialisms where there was a national shortage, and that activity in the service was unpredictable.
- The Trust had in place a number of strategies to recruit staff and was also focusing on growing its own workforce in terms of skills where these were unobtainable in the market.
- There were staff shortages in both maternity and neonatal teams. The maternity team was on a trajectory to fill its current vacancies and the shortages in the neonatal team were to be addressed through upskilling the Trust's own workforce.
- There had been a significant increase in the number of elective caesarean births, possibly driven by reduced confidence on the part of the public in maternity services due to recent media stories.
- Due to the nature of the Trust's services, it received a high number of high-risk patients, which placed further demands on its capacity.

5.10 Learning from Deaths 2023-24 Quarter 2 Report

Jenny Milner was invited to present the Learning from Deaths Report for Quarter 2, the content of which was noted. It was further noted that:

- In-patient deaths had fallen by 10% compared to the previous year, with deaths below the national average.
- Five cases had been referred to internal morbidity and mortality meetings.
- The Medical Examiner's Office and Bereavement teams had been moved into the same structure in order to reduce administration and to also reduce the number of calls to families.

5.11 Guardian of Safe Working Hours Quarterly Report

Diana Hulbert was invited to present the Guardian of Safe Working Hours Quarterly Report, the content of which was noted. It was further noted that:

- The Trust had been fined for the first time since 2016 due to seven breaches of the maximum 13-hour shift length. There was considered to be a possible issue with the handover process, which resulted in the breaches of shift duration.
- Suggestions had been sought from staff in order to improve the Trust's processes.

5.12 Medicines Management Annual Report 2022-23

James Allen was invited to present the Medicines Management Annual Report for 2022/23, the content of which was noted. It was further noted that:

- Over the course of the year, the Trust had improved its resilience in areas such as oncology pharmacy and had an increased focus on research. In addition, the aseptic site programme at Adanac Park was progressing.
- The Trust was facing challenges in terms of its IT infrastructure and in filling clinical trials.
- The next area of focus was to be on the storage of medicines.
- There had been flooding in radio-pharmacology, but there had been minimal impact due to interventions undertaken and use of mutual aid.

5.13 Infection Prevention and Control 2023-24 Quarter 2 Report

Julian Sutton and Julie Brooks were invited to present the Infection Prevention and Control Report for Quarter 2, the content of which was noted. It was further noted that:

- The Trust continued to not meet the national standards for E-coli and C-Diff, although it compared reasonably well with comparator organisations.
- Rapid gastro-intestinal testing continued to be of significant benefit in preventing norovirus outbreaks.
- Respiratory testing time had increased, and the amount of time required for a person to be deemed a Covid-19 contact had been increased.
- Approximately 50 patients had been impacted by a candida auris outbreak since March 2023. It was proving difficult to eradicate the source of the infections, and there was little understanding globally as yet of the pathogen.
- The importance of adhering to fundamentals of care principles was emphasised, as there had been a number of preventable incidents due to poor hygiene practices.
- The Hampshire and Isle of Wight Integrated Care Board was focusing on over-prescribing of antibiotics, particularly by GPs.

5.14 Annual Ward Staffing Nursing Establishment Review 2023

Rosemary Chable and Gail Byrne were invited to present the Annual Ward Staffing Nursing Establishment Review 2023, the content of which was noted. It was further noted that:

- It was a requirement for the Board to undertake a systematic ward staffing establishment review.
- The Trust's staffing levels were generally in line with expectations and staffing numbers have improved due to the Trust's success in recruiting new staff. However, the influx of new, less experienced members of staff was placing pressure on more senior members of staff.

When challenged on how staffing requirements were determined, it was noted that this assessment was based on analysis of data from multiple sources along with professional judgement.

5.15 Freedom to Speak Up Report

Christine Mbabazi was invited to present the Freedom to Speak Up Report, the content of which was noted. It was further noted that:

- Eighty-one cases had been raised in 2023/24.
- Consideration was being given to publishing lessons learned from some of the Freedom to Speak Up cases on the staff intranet.
- Additional support to line managers was also being examined such that staff were comfortable in approaching their managers, rather than utilising the Freedom to Speak Up process.
- Some groups, such as junior doctors and some ethnic minorities, were generally less likely to engage with the Freedom to Speak Up process.
- The Trust was recruiting more Freedom to Speak Up champions, especially from less engaged groups of staff.

6. STRATEGY and BUSINESS PLANNING

6.1 Board Assurance Framework (BAF) Update

The Board Assurance Framework Update was noted. It was further noted that the Board Assurance Framework was due to be discussed in detail at the Trust Board Study Session scheduled to take place on 19 December 2023.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

Duncan Linning-Karp and John Mcgonigle were invited to present the paper, 'Emergency Preparedness, Resilience and Response Delivery Group (EPRR-DG) – Assurance Report', the content of which was noted. It was further noted that:

- The Trust's preparedness had been assessed within ten domains, covering 62 core standards and multiple performance indicators within each.
- The Trust was fully compliant with 60 of the 62 standards and was therefore 'substantially compliant'.
- The main area for improvement was in preparedness for a mass evacuation of the hospital. The Trust was working through a scenario for a full evacuation.
- The Trust was also non-compliant in the area of a mass casualty scenario, as there had been new guidance released in this area. Work was ongoing to align with this new guidance.
- Training in incident management had been delivered to senior leaders.

8. Any other business

There was no other business.

9. Note the date of the next meeting: 30 January 2024

10. Items Circulated to the Board for reading

The item circulated to the Board for reading was noted.

11. Resolution regarding the Press, Public and Others

Decision: The Board resolved that, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the board of directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

The meeting was adjourned.

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/09/2023 6.2 Health and Safety Annual Report 2022-23				
1041.	Violence and aggression update	• Byrne, Gail • Harris, Steve • Machell, Craig	29/02/2024	Pending
	Explanation action item Gail Byrne, Steve Harris and Craig Machell agreed to schedule a further update in respect of violence and aggression at a future Trust Board Study Session.			

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**6.5**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**30 January 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Operational Update • National Audit Office qualification of DHSC accounts • External Recruitment Status • South Hampshire College Group • DHSC Consultation on New Nursing Spine Pay Points • NHS Providers Governance Survey 2023 • Intensive Care Society's 2023 National Awards			
Response to the issue:	The response to each of these issues is covered in the report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Any implications of these issues are covered in the report.			
Summary: Conclusion and/or recommendation	The Board is asked to note the report.			

Operational Update

January 2024 has been a very challenging month operationally for everyone within the Trust. Having safely navigated the period of industrial action by doctors in training between the 2nd and 8th January 2024, the Trust has experienced a period of heightened operational pressures which has seen record levels of patients within the hospital without criteria to reside (medically fit). These reached record levels on one day of 270 (over 25% of adult inpatient general acute bed base) coupled with significant infection outbreaks resulting in further wards closed (three at the time of writing) and closure of 23 bays across the wards. This in turn has caused a significant backlog of patients within the emergency department and has also sadly resulted in a significant increase in ambulance handover delays and queues within the adult emergency department footprint.

The Trust has continued to manage these pressures as best as it can through hospital incident management arrangements and significant oversight of available beds and discharges daily.

Unfortunately, the Trust has also had to cancel some elective operations due to lack of available beds despite all surge bed areas in the hospital being fully open.

The Chief Nursing Officer has also implemented a number of enhanced infection prevention measures including wearing surgical masks in adult clinical areas and has also introduced temporary visitor restrictions to further limit the risk of spreading infection.

Looking forward, the Trust continues to do all it can to respond to the current challenges and has invited the Emergency Care Intensive Support Team from NHS England to review its processes via an invited visit during January 2024. The Trust is also currently reframing its flow programme to focus on operational oversight. In addition, the Trust is rigorously eliminating all discharge delays within its control as well as continuing to work with community partners across health and social care to try and deal with the longer-term issues of capacity outside of the hospital.

According to 'Winter Watch' published by NHS Providers, an overview of the situation in NHS England, during the week commencing 8 January 2024:

- 93.3% of general and acute beds were occupied and 586 beds were closed due to diarrhoea and vomiting and norovirus.
- A total of 90,294 patients arrived by ambulance, an increase of 25% compared to the previous year.
- There was an average of 23,645 patients each day who no longer met the criteria to reside. Of these, over half (57.7%) remained in hospital.
- An average of 49,039 staff were absent each day.

National Audit Office qualification of DHSC accounts

The NAO has qualified DHSC accounts for financial year 2022/23 due to the way in which the elective recovery fund (ERF) was administered.

The Government established the ERF in 2022/23 to incentivise trusts to increase their activity after Covid-19. The money was paid to trusts and ICBs on the assumption targets would be met, but there were intended to be financial penalties if the activity goal (104% of 2019/20 baseline) was not met. However, the clawback mechanism was suspended over fears this would destabilise local systems, most of which were underperforming on their elective targets. As a result, local organisations were allowed to keep the funding, regardless of the number of patients they treated.

In their audit statement, NAO state "ERF was required to be 'earned' by integrated care systems hitting elective recovery targets. Where elective recovery targets were not met, the cash received by the department should have been returned to the consolidated fund."

NHSE's 2022/23 accounts state: "The lower levels of elective activity were due to ongoing Covid-19 pressures and longer lengths of stay, factors for which no additional funding had been provided. Therefore, we decided to allow providers to retain the elective funding to cover these costs, which the government has now deemed to be irregular."

UHS was one of only a handful of providers which achieved the ERF target of 104%; UHS achieved 108% whereas the average performance for the country was 97%. Of course, like all providers, UHS incurred the costs described in the NHS accounts for Covid-19 pressures and longer lengths of stay for which the ERF money was used to cover, but *also* incurred the costs of delivering additional elective activity which others did not. No income was received to cover the UHS cost of activity between 104% and the national average of 97%, whereas other providers were able to keep the money originally intended to fund the 104% target. We estimate the UHS cost of this 7% additional activity to be around £10m. The £10m cost of this activity has subsequently been 'baked' into the UHS baseline and is therefore a significant contributor to UHS's current financial challenge and a strong headwind affecting the Trust's ability to return to financial break-even.

External Recruitment Status

The Board is aware that following an update to the Trust's forecasted headcount for 31 March 2024, additional recruitment controls were introduced on 22 December 2023 which remain in place. The executive team has been working through the detail of how the controls operate effectively but also with due regard to clinical quality and safety. One of the major challenges has been the dissonance between how it feels on the ground (busier than ever) and the explicit financial direction received from the Centre. This has been a fast-moving and dynamic situation and we will update the Board during the Board meeting on how we are navigating that challenge and how we are ensuring that clinical safety and quality is protected.

South Hampshire College Group

During January 2024, the Chief People Officer and Head of Education met the senior leadership team from the newly formed South Hampshire College Group (SHCG). This new organisation is the result of a merger between Eastleigh, Southampton City, and Fareham colleges, bringing together over 3,000 students across the area. The Trust will be working to create an overarching partnership with the group focused on growing vocational and entry-level opportunities for students into roles at the Trust (health-related, estates, business administration and digital). This supports the Trust's People Strategy objectives of extending the diversity of our relationships with education providers to support a wider range of education to employment opportunities. It also supports the ambitions of the NHS long-term workforce plan, particularly around apprenticeship opportunities for non-graduate entry roles.

SHCG can play an important role in the career promotion of the Trust, including working in partnership on industry placements. Senior leads from SHCG and the Trust will be meeting again in the Spring to take these activities forward.

Department of Health and Social Care Consultation on New Nursing Spine Pay Points

In May 2023, the government agreed a deal for the Agenda for Change (AfC) workforce through the NHS Staff Council. During negotiations, concerns were raised about how the AfC pay structure is affecting the career progression and professional development of nurses, and the direct impact that this is having on recruitment and retention. The Royal College of Nursing (RCN)

suggested that a separate pay spine for nursing staff could address these concerns. At present the same pay scales are used for all roles covered by Agenda for Change with banding (pay grade) determined through job evaluation.

This call for evidence is being published to explore these specific concerns, to understand the benefits and challenges of a separate nursing pay spine, and to explore other potential approaches to addressing any issues identified. This exploration does not form part of the AfC deal that was agreed with the NHS Staff Council.

The consultation is public and can be responded to as an individual (within or outside healthcare) or as an NHS organisation. The Trust will be participating in the consultation through evidence sessions being organised by NHS Employers and through its own written response.

NHS Providers Governance Survey 2023

In September and October 2023, NHS Providers invited chairs, company secretaries and other corporate governance leads in NHS trusts and foundation trusts to complete a survey in relation to boards, their assurance committees and how trusts are developing in relation to the systems they are part of.

The results of the survey were published on 15 December 2023. In summary:

- 86% of respondents agreed or strongly agreed that the board has time to focus on key risks and issues, but the comments provided gave a clear sense that it can be challenging to prioritise and effectively cover everything.
- Almost all respondents (99%) agreed or strongly agreed that the way the committees report to the board can provide it with assurance.
- However, many respondents stated that space on agendas is under pressure, often attributing this to initiatives from the centre as well as new system and partnership-working related matters. This contributes to reduced bandwith for those producing and seeking to digest reporting and assurance information and putting pressure on the time available for effective discussion and scrutiny.
- The pressures on executive directors were highlighted and there were concerns about too much detail coming through to boards and committees.
- More than half of respondents (58%) said that their trust has associate non-executive directors, with the most common reason being developmental and to aid succession-planning.
- Trusts' experience in systems remains variable and whilst there has been some improvement, for the most part, the picture remains one of considerable variation. Of 36 comments in relation to this subject, 23 were critical of the way systems are working at present and a further eight said it was too soon to say.
- Improvements were reported in relation to trust boards' ability to influence the development of the systems they are part of, and in non-executive directors' perceived confidence about their role and responsibilities in systems.
- Only 20% of respondents expressed confidence about approaches to continuous improvement across systems and the lowest level of confidence was reported for how risk was managed across systems (12%, compared to 20% in the prior year).
- 42% of respondents have a board member who is also a trust partner member on an Integrated Care Board, and chairs and governance leads were positive about the influence and access they felt having a board member in this role gave them.

The full report can be read at: https://nhsproviders.org/resources/surveys/governance-survey-results-2023

Intensive Care Society's 2023 National Awards

The neuro-physiotherapy team, who work closely with the Trust's Neuro Intensive Care Unit, were awarded 'Team of the Year' at the Intensive Care Society's national awards. Footage of the award ceremony can be viewed at: https://www.youtube.com/watch?v=fHPem9G_JGo (watch from 9 minutes 35 seconds in). I would like to congratulate the team on this achievement.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2023-24 Month 9**			
Agenda item:	**6.6**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**30 January 2024**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • Regarding the successful implementation of our strategy • That the care we provide is safe, caring, effective, responsive, and well led			
Response to the issue:	The Performance KPI Report reflects the current operating environment and is aligned with our strategy.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust performance metrics. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

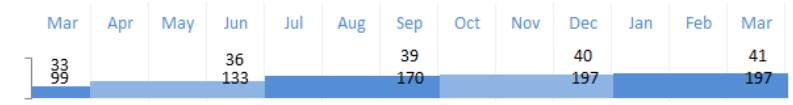
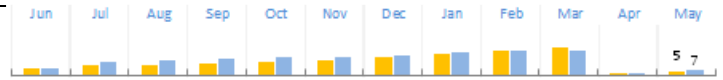
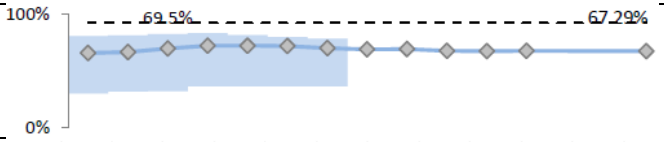
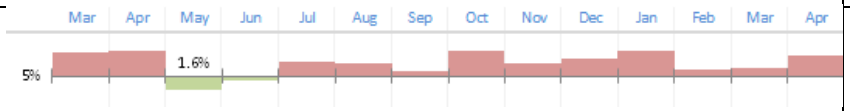
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
December 2023

Sponsor – David French, Chief Executive Officer
Author – Sam Dale, Associate Director of Data and Analytics

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 & bar Benchmarked		The line shows our performance, and the bar underneath represents the range of performance of benchmarked trusts (bottom = lowest performance, top = highest performance)
Control Chart		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 -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 is 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.

Introduction

The Performance KPI Report is presented to the Trust Board each month to provide assurance:

- regarding the successful implementation of our strategy; and
- that the care we provide is safe, caring, effective, responsive, and well led.

The content of the report includes the following:

- The 'Spotlight' section, to enable more detailed consideration of any topics that are of particular interest or concern. The selection of topics is informed by a rolling schedule, performance concerns, and requests from the Board.
- An 'NHS Constitution Standards' section, summarising the standards and performance in relation to service waiting times; and
- An 'Appendix,' with indicators presented monthly, aligned with the five themes within our strategy.

Due to the earlier timing of the December 2023 Board, at the time of publishing last months' report several of the validated IPR data points were not yet available but have now been updated within this report.

- **31** - Patients on an open 18 week pathway (within 18 weeks)
- **33** - Patients on an open 18 week pathway (within 52 weeks)
- **34** - Patients on an open 18 week pathway (within 65 weeks)
- **35** - Patients on an open 18 week pathway (within 78 weeks)
- **35a** - Patients on an open 18 week pathway (within 104 weeks)
- **32** - Total number of patients on a waiting list (18 week referral to treatment pathway)
- **36 -** Patients waiting for diagnostics
- **37** - % of patients waiting over 6 weeks for diagnostics

Other changes of note within the report include:

- **7** –MRSA bacteraemia: A correction in the November 2023 data, which was reported as 1 case, but on review has been changed to 2 cases.
- **13** – Serious Incidents Requiring Investigation: As part of the move to the new Patient Safety Incident Response Framework (PSIRF) from October 2023, the metrics have removed the reporting of SIRIs, although Patient Safety Incident Investigations (PSII) are still being reported in this measure.
- **38** – Cancer 2 Week Wait: In December 2023 NHS England stopped publishing 2 week wait data. Benchmark data is available for the period up until October 2023 for other hospitals. UHS will continue to publish our own performance against this metric.
- **41 / 42** – Cancer 31 Day Performance / Cancer 31 Day Subsequent Treatment performance: From December 2023, NHS England measurement methodology changed, and published data from October 2023 onwards for 31 Day Cancer Performance combines both First and Subsequent treatment performance. As a result, metric 42 (Cancer 31 Day Subsequent Treatment) has been removed.

Summary

This month's spotlight covers Cancer performance. It highlights how UHS has seen improving levels of performance against the three new national cancer metrics, and the interventions that have been made to improve performance despite the ongoing challenges of increased demand. Detail is also provided by tumour site, outlining the specific challenges and actions taken by Care Groups to address performance.

Areas of note in the appendix of performance metrics include: -

1. As outlined within the Cancer spotlight, our increased focus on Cancer performance has led to significant improvements in 2 Week Wait performance (increasing to 88.9% in November 2023), UHS being in the top three teaching hospitals for 62 Day performance, and being the top teaching hospital for 28 Day Faster Diagnosis for the last three months – with an improvement in performance to 85.4%.
2. The Emergency Department (ED) four hour performance saw a small improvement in performance in December 2023 to 58.0%, although this remains below our H2 recovery ambitions. The GP programme has also led to some diversions away from the department which might otherwise have further improved performance. However, ED performance continues as a national issue, as illustrated by UHS remaining within the top quartile of teaching hospitals.
3. We have seen a further increase in the number of patients not meeting the Criteria to Reside in hospital which remains extremely high at an average of 203 patients through December 2023 – even though we would normally see a reduction over the Christmas period.
4. A positive ongoing reduction in the proportion of patients being readmitted within 28 days of discharge continues, with this standing at 10.6%.
5. There was a second consecutive month in the reduction of the waiting list to just over 58,000 patients. However, this remains significantly higher than pre-COVID, and there is often a softening of demand over the Christmas period.
6. We have also seen a continued reduction in the Diagnostic waiting list, which now stands at under 8,000 patients. The size of this waiting list is now broadly in line with pre-COVID levels, although the proportion of patients breaching the six week diagnostic standard is still higher.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Coast Ambulance Service (SCAS). Due to the significant challenges within the ED department, and the wider challenge with flow experienced in the trust since the New Year, we have seen an increase in handover times. In the week commencing 15 January 2024, our average handover time was 22 minutes 38 seconds across 675 emergency handovers, and 32 minutes 26 seconds across 35 urgent handovers. There were 73 handovers over 30 minutes, and 44 handovers taking over 60 minutes within the unvalidated data.

Spotlight: Cancer performance

1. Introduction

Cancer is a large basket of disparate diseases across every organ and tissue type of the body, unified by its biology in which abnormal cells divide without control and can invade nearby tissues. Cancer cells can also spread (metastasise) to other parts of the body. These cancerous diseases have very different treatments and prognoses. The other uniting factor underlying this name is that for many patients the word cancer generates significant anxiety and fear and recognising this, UHS works hard to provide the most streamlined service that we can offer to patients referred to our service.

UHS is one of 12 regional cancer centres in the UK offering treatment for rare and complex cancers as well as children's cancer and brain cancer. We offer a wide range of treatments including novel therapies. UHS has historically benchmarked in the upper quartile, relative to our teaching hospital peers. We continue to perform well against the 28 day faster diagnosis and 62 day standards, but face challenges in meeting the 31 day standard. Recovery plans are in place focusing on the three key areas affecting this standard, radiotherapy, prostate surgery and skin (plastics). More detail follows below.

We continue to monitor cancer performance through regular performance meetings. However, there is an ongoing risk, with many tumour sites dependant on relatively few individuals to deliver, meaning that unexpected or unplanned absences can quickly affect performance.

2. Changes to Cancer Waiting Time Standards (CWT)

In August 2023, NHS England received government approval to implement changes to the cancer waiting times standards from 1 October 2023. These changes were the outcome of a long term consultation which had the full support of NHS staff, patient groups and cancer. The proposed standards are in line with recommendations made by the Independent Cancer Taskforce in 2015 and the subsequent clinical review which was started in 2018.

The three new standards (detailed below) are aligned to the requirements of modern cancer care, with a greater focus on outcomes and ensuring equitable access to care. The new treatment standards will measure waiting time for all patients regardless of their route into the system, rather than just those who were urgently referred by their GP.

1. **The 28-day faster diagnosis standard (FDS).** Patients with suspected cancer who are referred for urgent cancer checks from a GP, screening programme or other route should be diagnosed or have cancer ruled out within 28 days

2. **A 62-day referral to treatment standard**. Patients who have been referred for suspected cancer via any route and go on to receive a diagnosis should start treatment within 62 days of their referral.

3. **A 31-day decision to treat to treatment standard**. Patients, regardless of how they came to be diagnosed with cancer, should receive their treatment within a month of a decision to treat their cancer.

These changes will still set the same high-performance bar for the same groups of patients as were covered by the previous standards and will increase the number and proportion of patients covered by the standards. They are designed to focus on two clear goals: achieving the fastest possible diagnosis, and for those who are diagnosed and require treatment, ensuring they receive treatment as quickly as possible. The new standards will also put all patients on a level playing field, regardless of the origin of their referral.

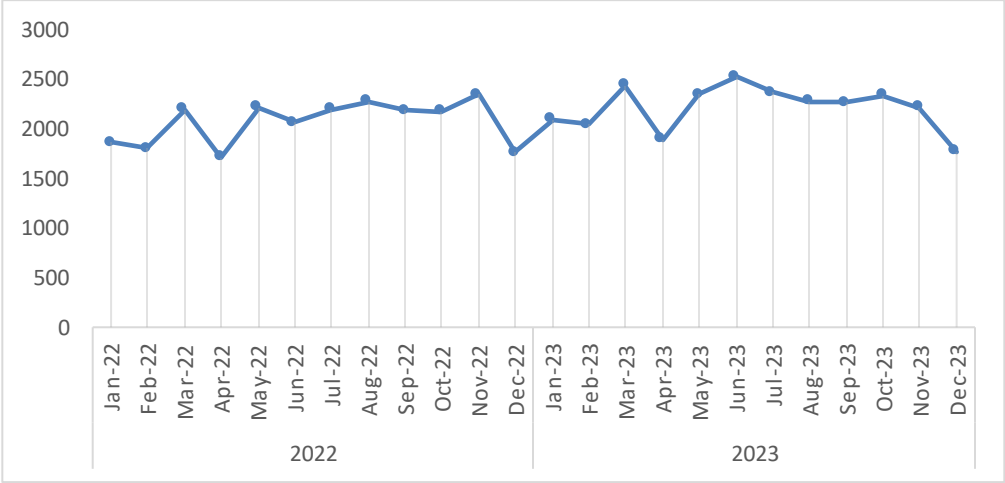
Trusts do not need to make significant changes in terms of their data submissions – the only change of note in terms of overall process will be their reporting of performance against the 62-day standard to include patients who've entered cancer pathways via screening or consultant upgrades as well as those who were referred by their GP.

In this paper, we explore early performance against the national targets in place for each of the new standards, UHS position compared to comparator Trusts and an exploration of the drivers and actions in place to improve performance for key tumour sites.

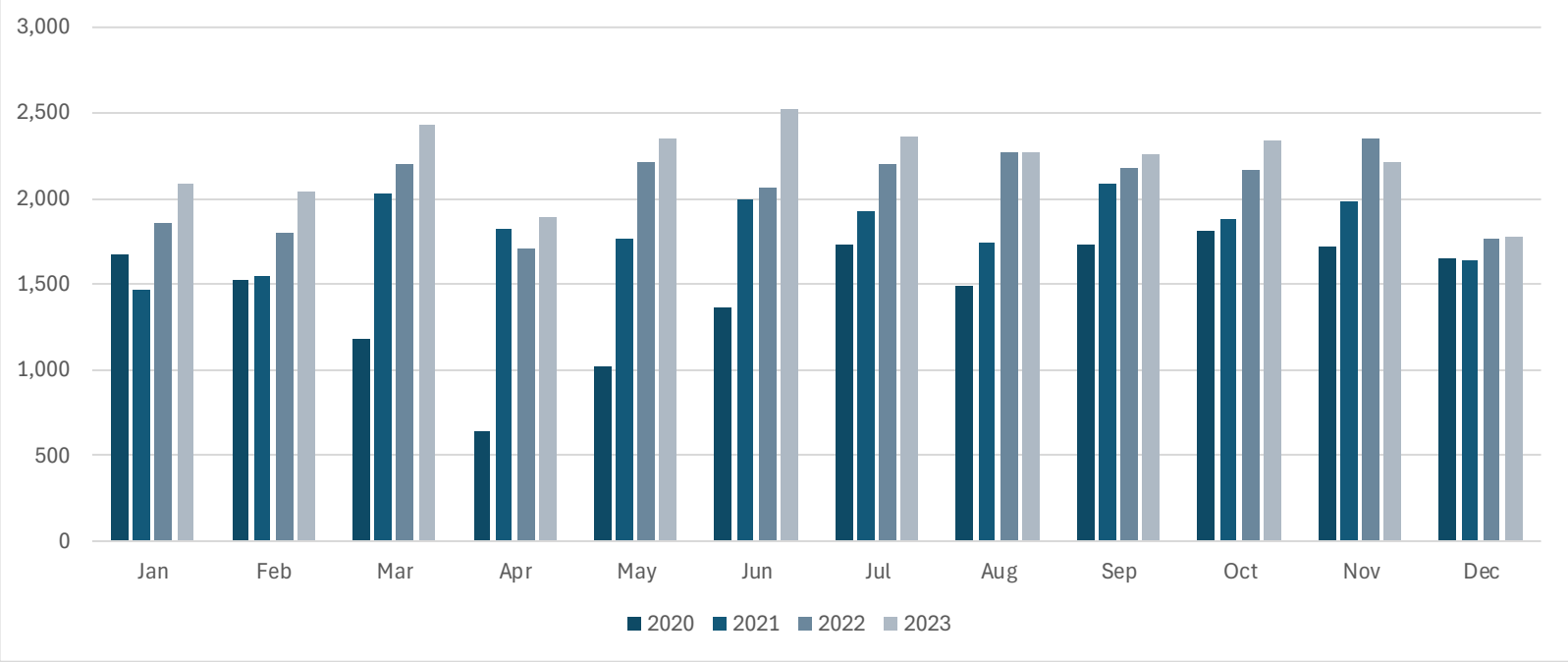
3. Cancer Referral Volumes

At the start of the 2023 calendar year, the Trust experienced a period of significant volatility on cancer referrals which reached a five year high when 2,524 referrals were received in June 2023.

This high volume of referrals has remained since, but with some stabilisation of the monthly variance seen in the first half of the year. As expected, the festive period sees a reduction with December 2023 at 1,774. Despite this levelling off in recent months, the referral volumes in 2023 averaged at 2,213 per month which overall is 7% higher than 2022 and 21% higher than the 2021 calendar year.



Graph 1: Cancer referral volumes by month



Graph 2: Cancer Referrals – historic monthly comparison

4. Overall cancer waiting list (PTL) and patients waiting over 62 days (backlog)

The overall waiting list size is heavily dependent on the number of two week wait referrals and the speed of seeing these patients, as the large majority of patients will leave the cancer waiting list at the point of being told that they don't have cancer. Throughout 2023 a series of actions plans were developed and agreed to support improvements across all tumour sites and cancer pathways. The success of these is reflected in the downward trend seen in the PTL since July 2023 (Graph 3) despite the consistently high volume of referrals previously referred to.

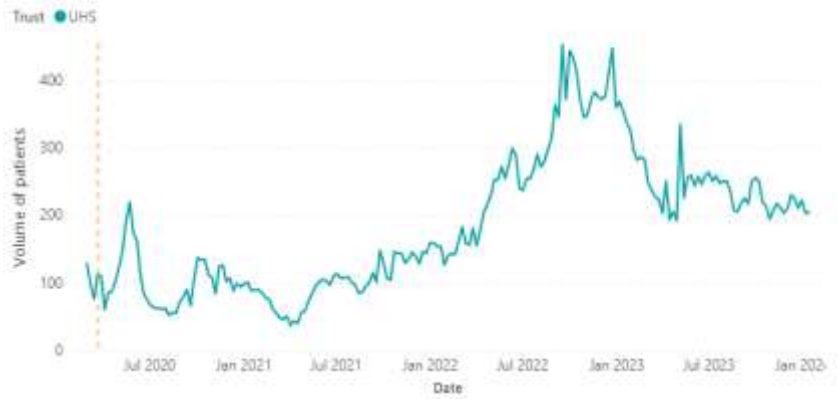
The trust has now demonstrated a month on month reduction to the cancer PTL which has remained at or below 2000 patients in recent weeks. Whilst recent numbers are always subject to additional validation, these volumes reflect a 32% reduction in the PTL since the peak seen in January 2023 and 25% reduction to the secondary peak of 2,708 seen in July 2023.

Graph 3: UHS overall PTL trend line

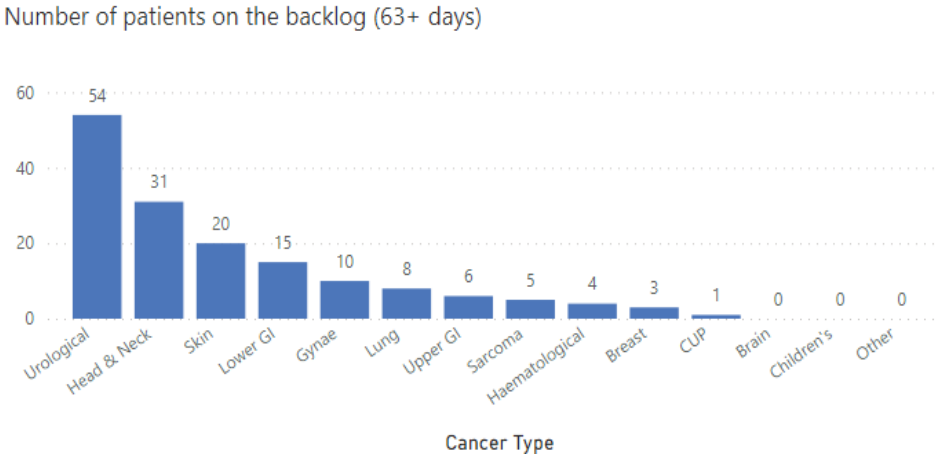
The number of patients waiting over 62 days from the date of receipt of referral is the subset of the PTL known as the backlog. The historic trend of the backlog is illustrated in Graph 4 alongside a breakdown of the tumour sites and their recent backlog volumes. The backlog has been as high as 350 but has come down significantly through 2023 as we have focussed on reviewing each of these patients and the barriers in their pathways. The composition of the backlog is mixed as it includes not only patients with cancer who are awaiting their first definitive treatment but also patients whose diagnostic pathway is complex and who may not have cancer.

It also includes patients who have had their first treatment already, but who are awaiting pathological confirmation that this is, or isn't cancer. Finally, it includes patients who have other comorbidities, and sometimes more than one primary cancer, where longer diagnostic pathways, and more inter-specialty discussion is essential as well as time for patients to understand and then contribute to decision making. As a specialist centre, our backlog position is also influenced by late referrals from other trusts.

Patients on the backlog are discussed on a weekly basis by the cancer centre and by the relevant care groups.



Graph 4: Trendline of Cancer Backlog



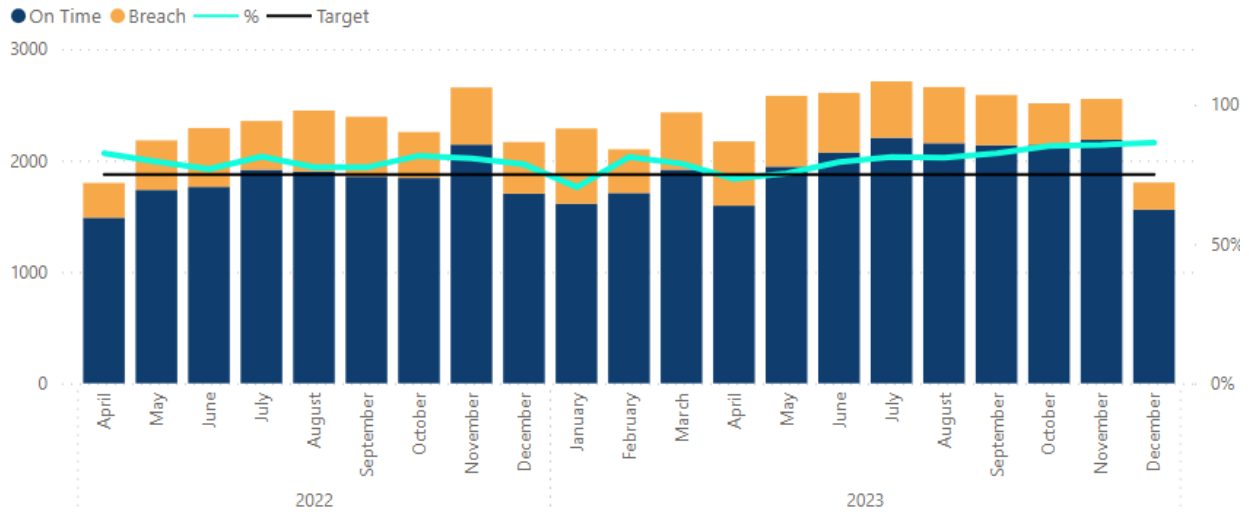
Graph 5: Breakdown of latest backlog by cancer/tumour type

5. Performance Overview

At the time of writing, the latest validated performance reports and comparators are available for November 2023.

28 day faster diagnosis performance remained strong, at 85% in both October and November against a national target of 75%. This performance is expected to continue once December position is finalised and validated. UHS has benchmarked as the top performing hospital against our peer group of teaching hospitals for the last three months.

Whilst we remain strong in our achievement of the 28 day target, it is very dependent on our high volume one stop services delivering on early first appointments. The December position is historically a challenge due to reduced clinic capacity around the bank holidays and this year has been further impacted by the strike action. We are however confident in the processes we have in place and have committed to maintain 85% compliance by March 2025.

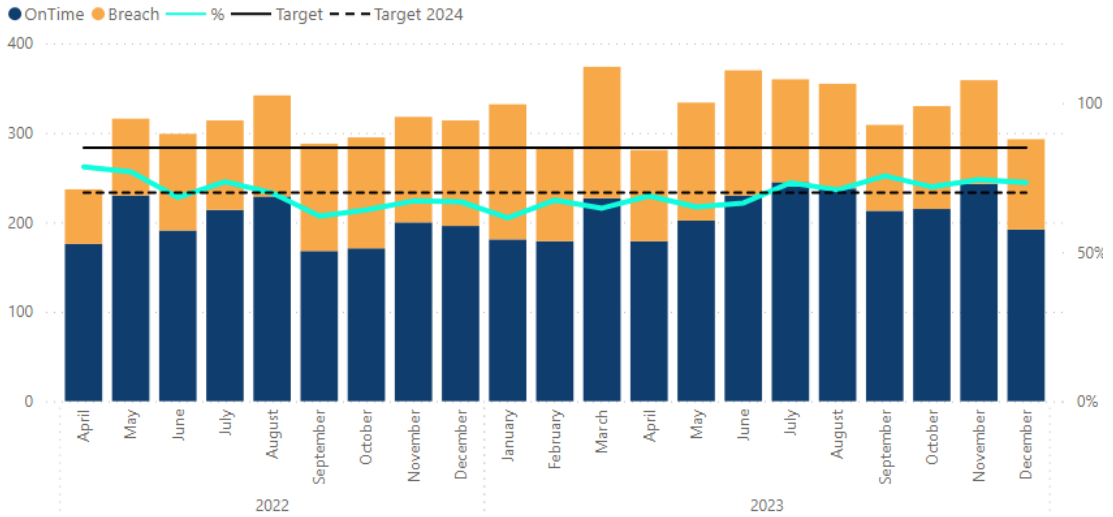


Graph 6: 28 day faster diagnosis performance trendline

The colorectal service has significant challenges to overcome to achieve the 28 day target primarily caused by the time to first appointment and earlier in the year by endoscopy waits. We are working with the cancer alliance to embed the transfer of FIT monitoring prior to referral in primary care from Jan 24 which we hope will reduce the referrals received and to engage GPs in completing a frailty assessment to ensure patients are directed into the appropriate appointments.

Sarcoma diagnosis is also difficult within the 28 day target and again we are looking at a complete pathway redesign with the assistance of the cancer alliance. Backlog position for urology remains a challenge due to the long waits for clinical oncology appointments and this affects the 62 day performance - waits for the Robot have been significantly reduced. An area of success has been the roll out of the teledermatology service although there are still PCN's who need to engage in the pathway and this need to be encouraged - early patient feedback is very positive for the service.

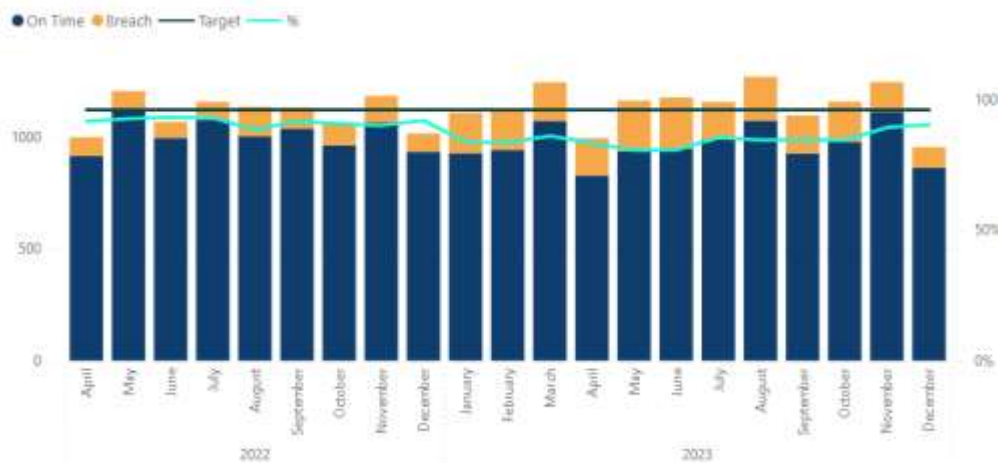
We also performed comparatively strongly against the 62 day standard, achieving 73.6% in November 2023. This places us as the 2nd best performing trust against a peer group of teaching hospitals. As part of the 2023-24 planning guidance there was an ask to reduce the backlog of patients breaching 62 days to a 'fair shares' allocation of 168. We continue to achieve at or around this, however, we are still falling short of the constitutional standard, which is 85%. The backlog position for urology remains a challenge due to the long waits for clinical oncology appointments and this significantly affects the 62 day performance however wait times for the robotic surgery have been significantly reduced.



Graph 7: 62 day standard performance trendline

Significant challenges remain around achieving the 31 day standard with the three key drivers being prostate surgery, skin surgery requiring plastic surgeon involvement and radiotherapy.

In October 2023 we achieved 80.3% benchmarking in the third quartile, however performance has improved in November moving us into the second quartile with 88.6%. Improvement plans for relevant tumour sites are under constant discussion and are outlined further below. The national target is 96%.



Graph 8: 31 day standard performance trendline

6. Tumour site focus areas

In this section we outline some of the key drivers impacting waiting times by service and the key actions being explored to improve the position.

6.1 Lung

Lung pathway is delayed by several constraints at the end of the pathway: theatre capacity, SABR and general Linac capacity, and the delays in receiving immunohistochemistry results from Birmingham prior to a medical oncology appointment. This is added to by the large number of diagnostic procedures performed and late referral from our tertiary centres.

The service continues to face pressures with theatre cancellations/reduction to operating lists due to industrial action, availability of robotic trained theatre staff and unplanned consultant absences all of which have a disproportionate impact in a relatively small consultant service (5 WTE). Work is underway to review the management of referrals to appropriately manage the waiting list, including a formal notification of acceptance criteria for referrals from our local referring centres.

Additional actions are the re-establishment of the weekly meeting with the thoracic nurse case managers to ensure actions are progressed in a timely manner as well as a review of coding to ensure reporting accuracy and scoping whether slots can be held in thoracic clinics to support a (partial) one-stop clinic.

The three care group managers across the lung pathway are meeting regularly to identify a range of other possible actions for consideration with clinicians across the pathway to inform and develop a shared action plan and redefine the patient pathway. A new Respiratory consultant started in December who will be joining the lung cancer team to provide additional clinic capacity to support with improving waiting times in the diagnostic part of the pathway.

6.2 Skin

Teledermatology for suspected skin cancer referrals started to pick up in September 2023, we are currently seeing around 40% of all referrals coming through via this route with approximately 20%-30% being managed via advice and guidance or direct to surgery pathways negating the need for a face to face clinic appointment. We are working with primary care and the Wessex Cancer Alliance to improve the quality of images that are being sent with referrals to further maximise the number of patients that can be expedited to surgery or managed by advice and guidance.

From a dermatology perspective the service is currently meeting the cancer performance metrics, largely down to using an insourcing provider that has been contracted since July 2022 (currently in contract until 31st March 2024), and additional waiting list initiative / locum surgical sessions. The insourcing service provides approximately 35% of all of our surgical capacity and a further 35% is delivered using waiting list initiative / locums. We are currently working on a workforce plan to plan to deliver this work with our own substantive workforce.

6.3 Urology

In the past 12 months the service has seen the highest number of patients (350 patients) being treated robotically for their prostate cancer. During this time we have also seen a reduction in the numbers of patients waiting for their operation. The prostate backlog hit a peak of 74 patients in May 2023, but reduced to 47 by December 2023. This reduction was due to additional capacity being put in place through two super weekends (late November / early December) where we treated 12 additional prostate cancer patients (each operation can take between four to six hours). Additional capacity was also created at the Spire Hospital with 45 additional robotic procedures commissioned (cost neutral to UHS) between November 23 and February 24.

At present there is no additional prostate operating capacity available within the SGH theatres. Robotic prostatectomies can only take place at SGH due to the robotic theatres being located in centre block theatres. Therefore, we will have to maintain access to the robot capacity (four cases per week) at the Spire at least until additional capacity can be created.

However, we are yet to make sufficient inroads into the total length of the prostate pathway. This will be the focus of Ms Alice O'Leary (prostate diagnostic consultant) who started with UHS in October 23. In the next six months the team plan to move to a one stop model (2ww Diagnostic/MRI and Biopsy of the prostate where required will be completed in one day for all patients who choose this pathway). This should help improve delivery of the 62 Day standard and sustain the 28 Day Faster Diagnosis standard.

The Wessex Cancer Alliance has also confirmed funding for an additional 0.75WTE Band 6 Surgical Pre-assessment Practitioner to support the trial of pre-assessing prostate cancer pts within the Urology Centre. This enables the urology team to pre assess and provide pre-habilitation support. It is hoped this will reduce the chances of patients being unfit on the day of surgery.

Whilst prostate cases form most of the urology cancer activity there are also kidney and bladder cancers that often are more time critical. Therefore additional urological operating cancer needs to wrap around this group of patients as a priority (alongside colorectal/melanoma and HPB). This is reflective of the divisions risk register around the need for more operating capacity.

6.4 Colorectal

Since January 2023 the team has been involved in the trial of triaging patients from their 2ww referral to stream patients according to their Faecal Immunochemical Test (FIT) results which could lead to fewer patients having an endoscopic procedure (a FIT test is recognised as diagnostic tool for ruling out cancer without a surgical intervention that can be undertaken in primary care). This trial has now finished with the agreement that from January 2024, 24 GPs will be managing patients with a FIT score of <10 in the community. UHS will no longer be expected to accept a 2ww referral without a FIT test score included in the referral. In turn this should reduce the volume of 2ww referrals. However, this does mean that the patients who are referred have the potential for a higher conversion to cancer which means that our staff can spend more time supporting patients/helping them navigate NHS services.

In October 2023 Mr Nigel D'Souza started as a new consultant surgeon which is in recognition of the demands on the current team. We also have Mr Andy King and Mr Paul Nichols, two consultant colorectal surgeons now trained in treating colorectal cancer patients using the CMR robot with Mr D'Souza trained on the Da Vinci robot. We also have plans for Mr Tom Dudding, consultant surgeon, to be trained to treat cancer patients robotically. This supports post operative length of stay reductions alongside the clear patient benefits of having a robotic procedure.

As a sub-specialty within colorectal, our pelvic exenteration patients have seen an increase in referrals whilst their operating capacity remains limited. Cases can often take over twelve hours with some rare cases taking place over two concurrent days. As a result we may have to take the difficult decision to reduce the volume of patients we accept for assessment and subsequent surgery due to the need to operate on these time critical cases. Often waiting 62days is too long and they may become inoperable. Work is ongoing at present to review the referral base for this exceptional team with a recommendation to go to our CMO before any further decisions are made.

6.5 Breast

The two week wait targets have and continue to fluctuate with demand. This remains a vulnerable part of the pathway due to the large reliance on additional overtime (an average of two sessions per month). The booking for these clinics rarely increases beyond 17 days and the 28D targets have consistently been above 90% due to the one stop service, sitting at 98% for December. We are currently booking to day 7.

Recruitment into a breast pathway navigator post (start October 2023) has vastly improved the care group oversight and validation of patients from first appointment to a decision to treat. This has enabled more appointments to be brought forward, slots converted to telephone where suitable to maximise face to face capacity, liaising between teams and attendance at MDTs to ensure no patients delayed or lost to follow up.

It was highlighted that a large proportion of our 62D breaches were patients who had required MRIs and/or a second look ultrasound. To address this the team have implemented a rapid access MRI plan with ringfenced capacity for this cohort of patients. Patients are seen in clinic following MDT, told they require MRI, and a rapid access MRI slot is requested. This is vetted, the patient attends, and the report is verified within a total of four days (reducing the wait from an average of eight days). This will have a positive impact on 62D targets and started in December 2023.

Breast continue to utilise both theatre estates and list utilisation well and this is reflected in the 31D targets surgical targets, which have averaged 98% since September, with 100% performance in December 2023.

6.6 Radiotherapy

Although the Radiotherapy treatment pathway is complex with many potential bottlenecks, the consistent capacity constraint affecting Cancer waiting times performance is Linac treatment capacity. An analysis of historical Linac Demand and Capacity in Feb 2023 estimated that an increase in 40 Linac Hours per week (approximately 18% increase in Linac capacity) would be required to ensure consistent performance against the 31 Day Cancer Standard. Projects were put in place to deliver this capacity increase by December 23.

It can be seen in Graph 9 that the estimated required capacity (yellow line) has been achieved (green line), primarily through increased Radiotherapy Radiographer staffing numbers. With HR recruitment support (and £80k external NHSE funding), a successful international recruitment campaign has been run. To provide increased capacity during recruitment and subsequent staff induction, Agency Radiographers have been utilised to support the substantive workforce.

Demand Increases:

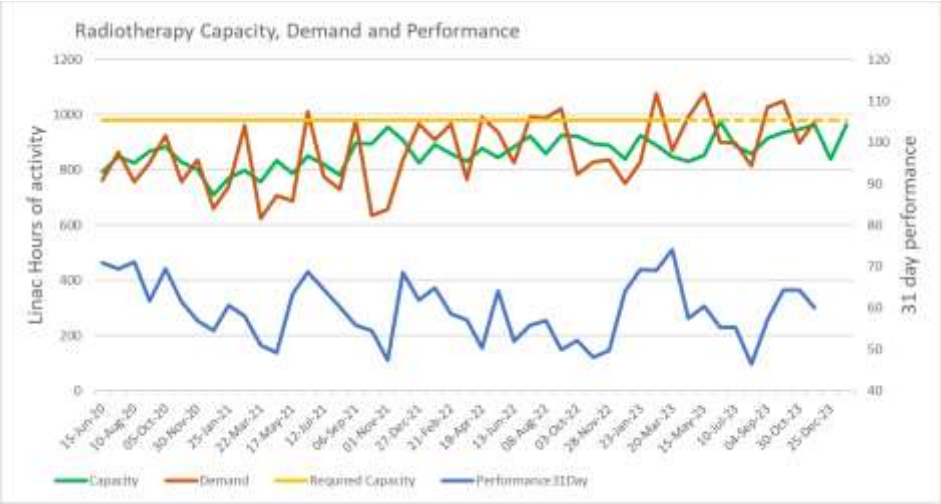
A stated risk of the recovery project was an unanticipated rise in demand, and in the second half of 2023, a rise in demand far more than previous demand variability was seen (brown line in Graph 9). The primary tumour sites of increased demand were Urology (Prostate) and Head and Neck.

It is worth noting that this increase in Prostate referrals reflects an increase in Prostate cancer diagnosis and is seen across both Surgery and Radiotherapy as seen in Graph 10.

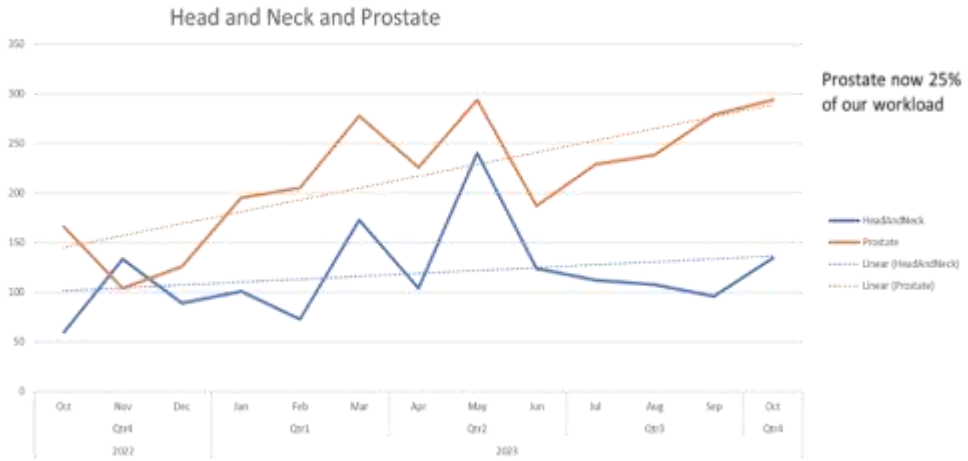
Reducing demand from Prostate patients:

Secondary to increasing Radiotherapy Radiographer staff numbers (to increase Linac capacity) the main recovery project for the service is the implementation of Prostate Hypofractionation. This will decrease the number of treatments for approximately half of all prostate patients from 20 treatments to 5.

This is projected to decrease overall demand for Radiotherapy by approximately 8%. The patient pathway requires an additional MRI scan, capacity for which is currently under discussion. This project is on track to deliver the reduced fractionation to the first patients in February 2024, and will be rolled out to the remaining patients as MRI capacity allows.



Graph 9 Radiotherapy Capacity, Demand, and Performance



Graph 10 Head and Neck, and Prostate, referrals

Best prediction of recovery:

Through a combination of increased Radiotherapy Radiographer staffing (delivering increased Linac capacity) together with some lowering of demand (back to the historical average) at the end of 2023, waiting times for Radiotherapy are significantly improving.

7. Conclusion

We continue to perform well against the 28 day standard, and comparatively well against the 62 day standard, although clearly more work is needed to achieve the constitutional standard. While not meeting the 31 day standard, there have been signs of improvement. There are plans to support these improvements in key tumour sites, and in radiotherapy, and these will be closely monitored via cancer performance meetings.

NHS Constitution - Standards for Access to services within waiting times

The NHS Constitution* and the Handbook to the NHS Constitution** together set out a range of rights to which people are entitled, and pledges that the NHS is committed to achieve, including:

The right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible

- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- Be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected

The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

The handbook lists eleven of the government pledges on waiting times that are relevant to UHS services, such pledges are monitored within the organisation and by NHS commissioners and regulators.

Performance against the NHS rights, and a range of the pledges, is summarised below. Further information is available within the Appendix to this report.

* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
** https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	75% 50%	64.0%													61.4%	≥92%	63.0%
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	100% 55%	75.1%													88.9%	≥93%	74.6%
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 40%	58.0%													73.6%	≥85%	65.2%
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	100% 25%	52.0%													58.0%	≥95%	61%
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	40% 0%	22.6%													16.8%	≤1%	20.1%

Outcomes		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
1	HSMR - **UHS** HSMR - **SGH**	90.63												86.3			≤100	89.8	≤100
		88.51												85.23					
		75																	
2	HSMR - Crude Mortality Rate	3.1%															<3%	2.7%	<3%
		2.9%												2.7%					
		2.5%																	
3	Percentage non-elective readmissions within 28 days of discharge from hospital	15%															-	12.1%	
		11.2%												10.6%					
		10%																	
		Q3 22-23			Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80															+1 Specialty per quarter		
		70	68			71			72			72			73				
		60																	
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100%	38			35			34			37			41				
		75%	79			81			82			75			67				
		50%	317			336			340			333			337				

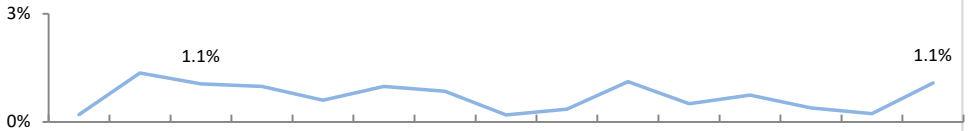
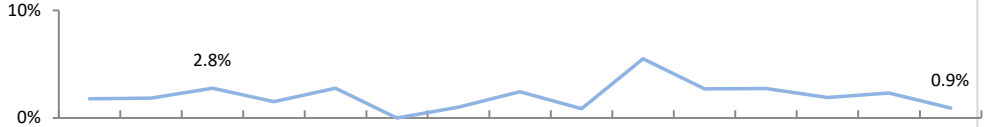
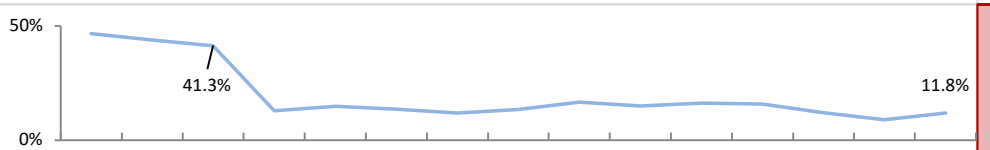
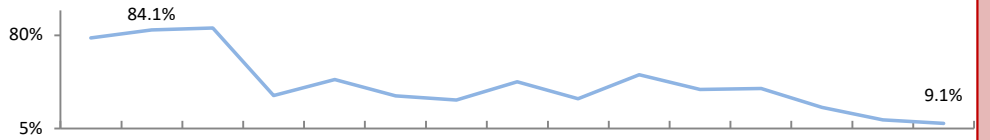
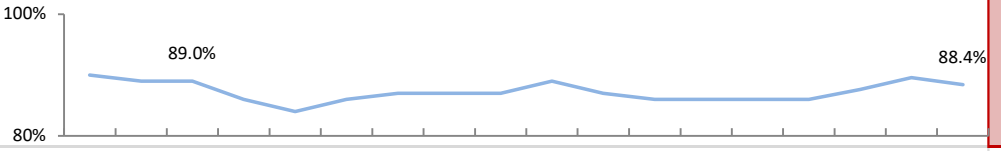
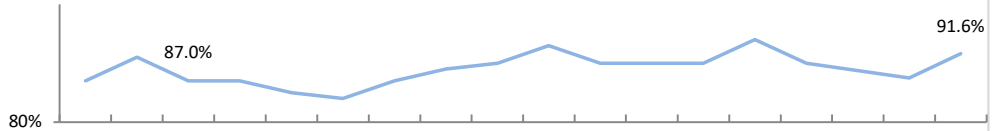
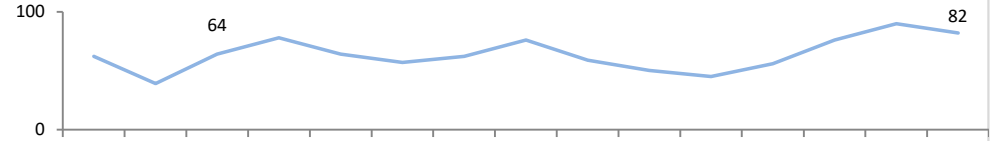
Red : below the national standard or 10% lower than the local target
Amber : below the national standard or 5% lower than the local target
Green : within the national standard or local target

Safety		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	64	73	71	77	74	84	9	4	11	12	18	27	24	35	28	49	35	60	47	66	55	72	65	81	≤5	81	≤45
7	MRSA bacteraemia	1	1	1	0	0	0	0	0	0	1	0	0	1	2	1	0	5	0
8	Gram negative bacteraemia	14	24	16	17	14	32	14	19	27	16	21	15	25	18	17	≤18	172	≤155
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
9	Pressure ulcers category 2 per 1000 bed days	0.24														0.29	<0.3	0.38	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.42														0.12	<0.3	0.39	<0.3
11	Medication Errors (severe/moderate)	3														5	≤3	21	27
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,331	2,857	2,634	2,734	2,634	24,717	23,072

12 - For 2022/23 and forward, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for “watch” and “reserve” agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions).

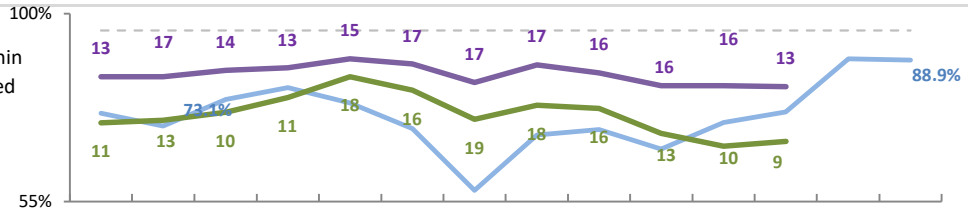
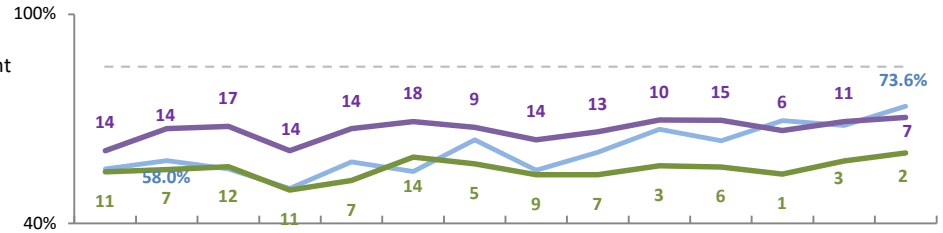
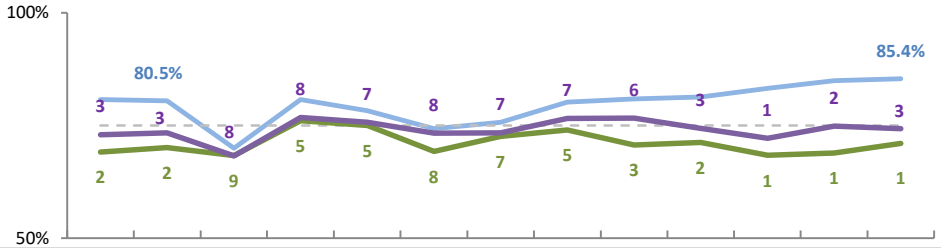
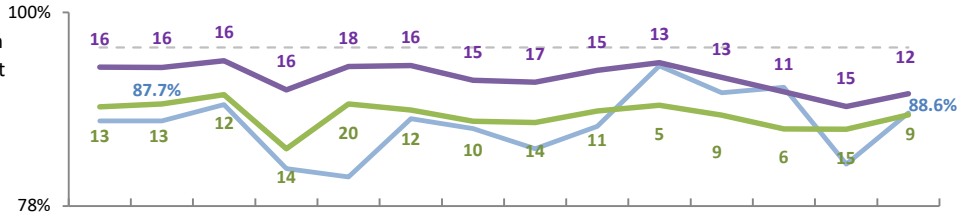
Safety		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)			4												1	-	27	-
13	From October 2023, as part of move to PSIRF, reporting of SIRIs was stopped. Patient Safety Incident Investigations (PSII) are reported going forward																		
14	Serious Incidents Requiring Investigation - Maternity			1												0	-	4	-
15	Number of falls investigated per 1000 bed days			0.13												0.14	-	0.09	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			93.8%												96.4%	≥90%	95%	≥90%
		676	669	711	1624	780	1600	844	871	788	806	798	772	770	894	879			
17	Red Flag staffing incidents			30												37	-	143	-

Maternity		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	463	412	440	436	383	387	416	402	418	417	400	400	467	409	428	-	-	-
		416	498	363	453	432	513	449	477	450	382	424	442	446	469	392			
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	3	1	5	1	0	2	1	1	4	6	1	3	3	1	4	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	36.9%	35.7%	37.5%	37.2%	36.0%	36.7%	40.6%	32.6%	43.3%	43.7%	44.8%	43.0%	43.5%	43.5%	38.6%	-	-	-
		47.1%	48.5%	48.2%	49.3%	54.8%	48.8%	46.9%	53.0%	43.3%	38.6%	44.8%	43.5%	44.3%	45.2%	49.3%			

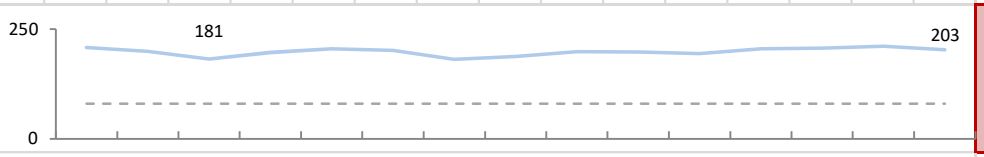
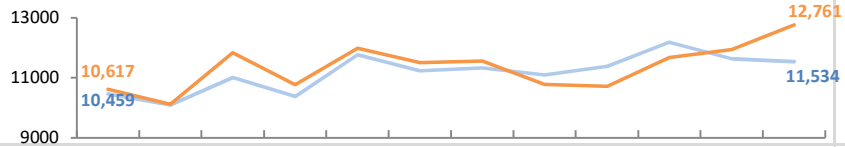
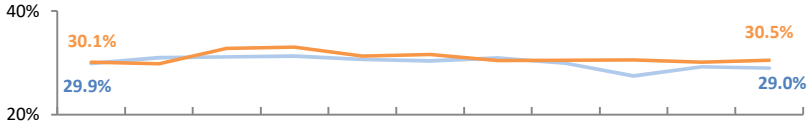
Patient Experience		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients																≤5%	0.6%	≤5%
22	FFT Negative Score - Maternity (postnatal ward)																≤5%	2.3%	≤5%
23	Total UHS women booked onto a continuity of carer pathway																≥35%	13.5%	≥35%
24	Total BAME women booked onto a continuity of carer pathway																≥51%	29.3%	≥51%
25	% Patients reporting being involved in decisions about care and treatment																≥90%	87.3%	≥90%
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)																≥90%	90.5%	≥90%
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)																-	596	-

Access Standards		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	7	6	52.8%	7	5	4	9	12	9	8	8	12	10	11	58.0%	≥95%	60.8%	≥95%
		4	4	4	3	3	3	5	7	5	5	5	7	7	7	5			
29	Average (Mean) time in Dept - non-admitted patients			03:49												03:47	≤04:00	03:33	≤04:00
30	Average (Mean) time in Dept - admitted patients			07:15												06:28	≤04:00	05:57	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	63.3%	5	5	4	4	4	4	5	4	4	4	4	61.4%	≥92%	63.0%	≥92%
		5	5	5	5	5	6	6	5	5	6	6	6	5	4				
32	Total number of patients on a waiting list (18 week referral to treatment pathway)			53,941												58,031	-	58,031	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	5	5	5	4	4	4	4	3	3	3	2	2		≤2,011	1,767	≤2011
		12	12	12	12	12	11	11	11	9	8	8	8	8	8	1,767			

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6	6	6	6	5	5	4	4	4	4	5	5	3	3		-	314	-
		950														314			
		13	13	12	13	12	12	11	11	10	9	9	9	8	8				
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	7	7	7	6	4	4	5	8	8	7	6	5	6		0	27	0
		327														27			
		15	15	15	15	15	12	10	11	12	11	10	9	9	9				
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	1	1	1	1	1	1	8	14	17	15	16	12	13		0	1	0
		1	0	0	0	0	0	0	1	4	5	2	2	1	1	1			
		10	1	1	1	1	1	1	13	13	17	13	14	10	11				
36	Patients waiting for diagnostics	11,429														7,924	-	7,924	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	11	11	12	12	12	12	11	11	8	7	9	7	7	6		≤1%	20.1%	≤1%
		8	8	10	7	8	8	7	7	11	10	10	8	7	7	16.8%			
		29.6%																	

38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**		≥93%	74.6%	≥93%
38	Beginning December 2023, NHSE published Cancer data no longer includes 2 week wait as a cancer standard for benchmarking. Data shown for October 2023 onwards will reflect internally reported UHS position for each month, but will not include Teaching Hospital/South East Hospital data				
		Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec	Monthly target	YTD	YTD target
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**		≥85%	65.2%	≥85%
39	From October 2023 data onwards, the 62 day standard metric published in NHS england data combines Urgent Suspected Cancer and Breast Symptomatic with previously excluded Screening and Upgrade routes.				
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**		≥75%	80.7%	≥75%
41	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**		≥96%	88.2%	≥96%
41	From October 2023 data onwards, the 31 day standard metric published in NHS england data combines First Treatment and Subsequent Treatment routes.				

R&D Performance		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	7	7	14	15	15	13	14	17	19	19	21	17	17	16	15	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	8	10	10	10	11	9	9	6	12	14	15	12	11	12	9	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection								25%	47%	59%	64%	46%	60%	67%	46%	88%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	23.5%	71.4%	76.2% 79.2%	166.3%	69.5%	35.6%	50.7%	65.2%	84.7%	104.1%	45.8%		133.3%	133.3%	84.7% 9.4%	≥5%	-	-

Local Integration		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	195	-
48	Emergency Department activity - type 1 This year vs. last year																-	102,504	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.3%	≥25%

Digital		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)	141,938														184,817	-	184,817	-
51	My Medical Record - UHS patient logins (number of logins made within each month)		24,714													31,153	-	31,894	-
52	Average age of IT estate Distribution of computers per age in years	0	0	16	39	81	132	330	840	1060	1160	2480	3080	1790	645		-	-	-
		14	13	12	11	10	9	8	7	6	5	4	3	2	1				
53	CHARTS system average load times - % of pages loaded under 5s							99.75%	99.72%	99.73%	99.81%	99.77%	99.82%	99.74%	99.79%	99.80%			
53	Data only available from April 2023 onwards																		
					Q3 22-23			Q4 22-23			Q1 23-24			Q2 23-24		Q3 23-24			
54	Cyber attacks / phishing / incidents blocked Average # Malware attempts blocked per month (10s) Average # Phishing emails blocked per month (100s) Average # Ransomware attempts blocked per month				1222	346	5	3673	262	38	1005	114	2	1005	61	3	2479	71	1	-	-	-
55	Inpatient noting progress Left axis: IP Noting data recorded (100s) IP Noting unique user views Right axis: IP pages scanned (1000s)	NEU go live	EYE go live	CV&T go live	T&O go live			Med go live		Sur go live			Can go live				-	-	-
55	IP Noting went live in Oct-22. CGs going live are marked on green line.																		

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors

Title:	**Finance Report 2023-24 Month 9**			
Agenda item:	**6.7**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**30 January 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			

Response to the issue:

M9 Financial Position

UHS is reporting a financial position as outlined in the table below:

UHS M9	In Month			Year to Date		
	Original Plan	Recovery Plan	Actual	Original Plan	Recovery Plan	Actual
Financial Position	(1.3)	(2.9)	(4.1)	(24.0)	(21.7)	(23.0)

The in-month position does however include £1.2m of non-recurrent industrial action (IA) pressures, which trusts nationally have been permitted to report as a variance. The balance of the in-month deficit (excluding IA pressures) is in line with revised forecast trajectory figure for December of £2.9m, although does include one off benefits of c£2m.

Estimated Impact of Industrial Action (IA)

The estimated impact of industrial action for December 2023 and January 2024 is shown in the table below.

IA Impact	M9	M10	Total
Cost of Cover	(0.2)	(0.4)	(0.6)
Impact of reduction on ERF & lost efficiency opportunity	(1.0)	(2.1)	(3.1)
Total	**(1.2)**	**(2.5)**	**(3.7)**

Forecast

If costs and lost income materialise to this level in January, then UHS will be forecasting an adjusted deficit of £29.7m (£26m + £3.7m IA impact from Dec 23/Jan24).

UHS M9	Forecast		
	Original Plan	Recovery Plan	Potential Forecast
Financial Position	(26.0)	(26.0)	(29.7)

In line with South East Region reporting guidelines, we expect to formally changing our forecast to NHSE in our M10 reporting.

Revised Plan Trajectory

A reminder of the recovery plan trajectory is shown in the table below. This targeted financial improvement over the last 5 months of the financial year in order to deliver the required planned deficit of £26m. This included stretch improvement of c£5.5m to be achieved predominantly in Q4.

Period	Apr-Oct	Nov	Dec	Jan	Feb	Mar	Total
Surplus / (Deficit)	(25.0)	6.2	(2.9)	(2.2)	(1.4)	(0.7)	(26.0)

A reported YTD position of £23m deficit means there is therefore headroom for £6.7m of deficit to be reported in Q4 (including the impact of IA).

A continued underlying run rate challenge makes this extremely challenging and requires financial recovery actions to deliver at pace. December has shown encouraging signs with regards to pay expenditure reductions, but income and non-pay levels remain off trajectory.

ERF

In month ERF performance was above target at 112%. The revised target is now 109% after a further 2% reduction has now been applied (so 4% reduction applied in year). This overperformance has generated c£0.5m of additional ERF income in month with overperformance now £11.5m YTD.

Industrial action in the month of December has reduced activity and the scale of overperformance was c£1.5m lower than had been anticipated as part of financial recovery. In addition to IA pressures, significant non elective pressures continue to cause strain on elective delivery. These are known to be continuing into January.

Further industrial action is scheduled in January representing future risk to the delivery of ERF overperformance achievement with a run rate of £2m per month overperformance targeted.

Underlying Position

The underlying position for December deteriorated when compared to average levels for the year to £4.9m. The primary drivers of the increase in month related to:

- Reduced ERF activity was behind the run rate level of overperformance – this is related to Industrial action challenges and significant non elective pressures incurred in December.
- Non pay costs increased by c£0.5m with no offsetting income. Some level of volatility does exist within non pay however due to this scale this is being investigated further.

Continuation of these pressures would be of concern given the requirement to drive financial improvement at pace.

The previous monthly average underlying deficit had been c£4.5m per month once the impact of industrial action and other one offs are removed. This includes ERF of c£1.5m per month overperformance. The target exit run rate for 2023/24 is a deficit of no worse than £4m per month, which could reasonably be delivered by improved ERF performance.

Pay costs have reduced in December by £0.5m. Temporary staffing costs have dropped by £0.9m in month across bank and agency. Substantive staffing increased by £0.4m but this was as a result of bank holiday enhancements paid in month. Substantive WTE remained relatively flat,

increasing by 12 WTE despite an overall reduction in WTE of 120 in the period.

In month, some reduction on HCA agency and bank has been achieved following targeted efforts on the criteria of requests for mental health support staff and additional workforce controls coming in across the organisation.

Deficit Drivers

The underlying deficit continues to be driven by a number of underlying system pressures seen in 22/23, for which we have not been able to recover to date:

- Non-pay inflation beyond funded levels
- Impact of energy prices (with gas prices impacting UHS particularly hard)
- High-cost drugs spend (previously pass-through)
- Number of patients not meeting criteria to reside, impacting capacity (opening expensive "surge" capacity / bed capacity restricting elective activity)

In 23/24, we are now seeing further pressures, notably:

- Unfunded elements of pay awards - £0.4m per month.
- Workforce pressures as substantive recruitment is not offset with temporary staffing reductions - £0.7m per month (prior to M9).
- Covid testing funding reductions not immediately offset with cost reductions - £0.2m per month.
- Mental health nursing pressures - £0.2m per month.
- Tariff efficiency reductions not offset by recurrent CIP delivery - £0.7m per month.
- Further growth in the number of patients not meeting the criteria to reside. These have been consistently at 200 with some weeks peaking at over 250.

Unfunded additional activity is a further pressure for UHS where we are YTD providing activity above block funded level for free in the following areas:

- £8.6m of outpatient follow up appointments
- £8.9m of non-elective
- £3.2m of other treatments

This is likely to be between £25m and £30m across 2023/24 and remains a key component of the Trust's deficit. This will form a key part of contracting discussions for 2024/25 as this is clearly unsustainable in the medium to long term with focused efforts required either to reduce demand or acknowledge costs that require mitigation via other means.

Cost Improvement Plans

The most-likely risk assessed position of cost improvement delivery sits at £65m. This includes the £5.5m targeted improvement within the financial recovery plan. Whilst we have made good progress with CIP performance, it is heavily supported by non-recurrent delivery that cannot be relied upon for underlying financial improvement. The aim is now to shift this into recurrent delivery.

Capital

The 2023/24 capital programme is currently £9.3m behind plan YTD (spend of £28.6m compared to planned delivery of £37.9m).

Currently there is confidence in forecast delivery of the planned level of expenditure, which totals nearly £60m including externally funded schemes for 2023/24. This does however require spend of over £30m in the remaining three months of the year. A month-on-month trajectory is being

developed so that this can be tracked in detail and risks understood at the earliest opportunity.

Prioritisation for 2024/25 has been discussed at Trust Investment Group in January and is supported for onward approval. Plans for 2025/26 are being reviewed in February by the Trust Investment Group. A two-year plan will then be submitted to Trust Board Study Session for discussion.

We have delivered some significant achievements in month, notably:

- **£10.3m additional cash** PDC to be received for the Neonates build to support the national redesignation programme. UHS were originally awarded CDEL-only. This has been a significant challenge to deliver.
- **£0.8m** cash and CDEL to support carbon efficiencies by changing lighting to LED in PAH. This is expected to deliver a revenue saving of £0.95m per year.
- **£0.4m** cash and CDEL for new equipment.
- Additional funding for LIMS and CDC projects has been confirmed as expected.

Cash

A spotlight report on cash was considered by Finance & Investment Committee. The Trust's cash balance has been reducing over time due to the monthly underlying I&E deficit. At the end of December, the Trust is holding cash totalling £35.5m which is a £10.5m decrease since November close (£46.0m). £112.0m of cash receipts against £124.1m of payments were made in the month.

The underlying trend remains as per previous months with reduction driven primarily by the underlying deficit. Cash fluctuations in the year are noted as a result of the phasing of the Education income and one-off funding received. Capital draw downs for externally funded projects are also likely to be made which may artificially inflate cash in the short term before capital suppliers are paid in Q1 2023/24.

The graph below shows the cash forecast for the remainder of 2023/24 assuming there is no underlying improvement in the financial position. Clearly it is intended that recovery actions will therefore see this position improve. It should be noted that the trusts minimum holding of £30m is therefore close to being breached with in month ebbs and flows seeing the balance reduce to below this level.

Significant one-off cash income receipts anticipated for the remainder of the year are anticipated, including for the Neonates programme as outlined above, which has increased our year-end forecast position to £40m. This is equivalent to 12 days of Operating Expenditure. Further cash is anticipated for industrial action and ERF performance, for which no cash has been transacted up to M9.

Cash support is likely to be required in Q1-Q2 of 2024/25. This will be considered as part of our Plan.

Implications:	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties.
Risks: (Top 3) of carrying out the change / or not:	• Financial risk relating to the underlying run rate and projected potential deficit if the run rate continues. • Cash risk linked to volatility above • Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2024/25 due to the forecast deficit for 2023/24.
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Note the finance position.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2023-24 Month 9**			
Agenda item:	**6.8**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**30 January 2024**			
Purpose:	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The UHS People Strategy (World Class People) sets out our goals to support the delivery of the Trust's Corporate Strategy. The 5-year Strategy, based on the insights from our UHS family, was approved by Trust Board in March 2022. Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS. The monthly people report summarises progress against the delivery of the critical metrics in the strategy. It is provided monthly to Trust Executive Committee and People and OD Committee. The information is based on December (M9).			
Response to the issue:	**Progress against pillars of the UHS People Strategy:** THRIVE (Workforce Capacity) • Total workforce (Substantive, Bank, Agency) reduced by **120 WTE in month**. There was a significant reduction in temporary workforce in December which is a normal seasonal trend due to Christmas rostering and the availability of temporary staff. • Substantive workforce only grew by 12 WTE driven by reduced starters through the Christmas period. • Total workforce variation to NHSE plan is now **293 WTE**. • A recruitment pause was initiated on 22 December to slow substantive growth to the end of 23/24. New starters are being phased through the remainder of Q4. • A senior clinical panel is prioritising roles currently in conditional offer to manage the appropriate balance of clinical risk and safety. • Further **additional temporary workforce controls** have been implemented for nurse bank authorisation (a duel sign off at senior level for all new shifts) • **Turnover** continues to be lower during 23/24 at 11.5%, below the UHS target of 13.9%.			

	• **Sickness continues** to be below the Trust target of a rolling average at 3.7% (Target 3.9%). In month absence in December of 4.1% driven by seasonal absence reasons (Cold, Flu, Covid) Excel (Capability, Reward, Wellbeing) • **Appraisal rates** remained below target at 85% driven by a combination of winter operational pressures and industrial action. Teams are still being encouraged to report all appraisals on ESR in a timely manner to ensure the data is up to date. • Recognising the significant continued pressure on our People, our comprehensive **UHS well-being offer** has been recirculated through leaders across the Trust and through the monthly UHS Spotlight meeting**.**
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and providing safe clinical and organisational delivery.
Risks: (Top 3) of carrying out the change / or not:	We need to meet our strategic objectives as set out in the business assurance framework for UHS. Specifically: a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. b) We fail to develop a diverse, compassionate, and inclusive workforce providing a more positive staff experience for all staff c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs to be identified in the Trust's longer-term workforce plan.
Summary: Conclusion and/or recommendation	Trust Board is required to: • Note the feedback from the Chief People Officer and the People Report

UHS People Report

WORLD CLASS PEOPLE

December 2023

THRIVE EXCEL BELONG

Workforce Grip and Control

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Substantive WTE between November and December increased by **12 WTE**. The overall **total workforce** reduced by **120 WTE,** largely driven by a reduction in bank and agency staff

The decelerated substantive workforce growth was due to 100 WTE leavers in December (it was previously 70 WTE in November) and the lowest number of starters seen this year (128 WTE)

The staffing group with the largest net growth was Nursing and Midwifery (14 WTE)

Category	WTE	Comments
Newly Qualified Nurses	1.6	Staff start as supernumerary. Should reduce future bank usage
Overseas Recruited Nurses	36	Planned recruitment. Should reduce future bank usage
Domestic nursing recruitment	37	Reducing nursing vacancies
Admin and clerical recruitment	32.4	Reduced vacancies across the trust
All other substantive recruitment	20.6	Reduced vacancies across the trust
Increase in WTE due to contract changes	3	3 WTE net increase in contract changes from Nov to Dec
Leavers	(119.1)	Includes junior doctor leavers
Reduction in bank usage	(114)	Heightened controls on bank usage, reduced bank WTE in December
Reduction in agency usage	(17)	Heightened controls on agency usage
Total	**(120)**	

Bank usage **decreased** from November to December by 15% (788 to 674 WTE)

Agency usage **decreased** from November to December by 12% (137 to 120 WTE)

Workforce Grip and Control

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Growth versus plan since April:

Additional Clinical Services (HCAs) continued recruitment to vacancies and reduced turnover

Allied Health Professionals growth due to filling vacancies in Occupational Therapy (OT), ODPs and radiographer staffing groups

Medical growth in junior doctors and additional externally hosted posts

Continued pressure in Emergency Medicine (Div B) due to mental health and enhanced care requirements

New cohorts of internationally educated nurses joined the trust between Nov and Dec

Division	Plan WTE	Actual WTE	Variance WTE	Variance %
Division A	2552	2547	(5)	-0.2%
Division B	3493	3655	162	5%
Division C	2785	2904	119	4%
Division D	2456	2489	32	1%
THQ (inc EFCD and R&D)	1872	1874	3	0%
Other	73	55	(18)	-24%
Total	13232	13524	293	2%

Staff Group	Plan WTE	Actual WTE	Variance WTE	Variance %
Add Prof Scientific and Technic	407	403	(4)	-1%
Additional Clinical Services	2497	2526	29	1%
Administrative and Clerical	2363	2391	28	1%
Allied Health Professionals	672	728	56	8%
Estates and Ancillary	406	388	(19)	-5%
Healthcare Scientists	482	502	20	4%
Medical and Dental	2099	2187	87	4%
Nursing and Midwifery Registered	4305	4399	94	2%
Total	13232	13524	293	2%

Variance is against internal UHS trajectory since April 2023; data is for total workforce (substantive, bank, agency) as of December 2023
'Other' category refers staff in 'CLRN' and 'THQ other services'

Workforce Grip and Control

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Area	Action taken forward
New substantive recruitment Controls	• A recruitment pause was initiated on 22 December to slow substantive growth to the end of 23/24. Unconditional offers planned to start as committed during the remainder of Q4. • Senior clinical oversight panel established to prioritise conditional offers in pipeline and identify critical posts that require start dates sooner. This is supported by risk-based assessments on impact. • Additional controls on fixed-term contract extensions, hours changes, and internal recruitment requests
Forecasting	• Detailed staff group and care group forecasting analysis for the substantive workforce to March 2024 has been undertaken and shared with divisions. This is based on known starters and predicted turnover. • This will be used to forecast for 24/25 and to support continued decisions relating to recruitment controls • Forecasting has also been shared with People and OD committee Non-Executive Directors
Temporary Staffing Controls	• The CNO is leading a specific nursing group focused on bank demand supported by Finance and Workforce. • Dual approval for nursing NHSP shifts enacted on 3 January 2024 • Nursing rosters on wards have been reviewed to ensure maximum deployment of staff • The Deputy CNO is continues to review the use of mental health nursing agency, including reviewing opportunities for safe reduction. This work has shown positive benefits already. • Role by role review of all A&C bank and agency by executive directors with assignments agreed to end where feasible. Executive sign-off for all new A&C bank and agency
Reporting	• Continued weekly reporting on WF (substantive, bank, agency) internally and to the ICB, including quantification of mental health pressure. Weekly reporting updated to include variation to forecast in addition to plan • Divisional WF trajectories completed for all divisions and THQ included in the People Report to TEC

Workforce Grip and Control

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Spotlight on Nursing Workforce

The Nursing workforce group meets biweekly with a focus on controls to reduce demand for bank and agency whilst maintaining patient safety and quality. The following initiatives are being implemented and in the process of being quantified for ongoing monitoring.

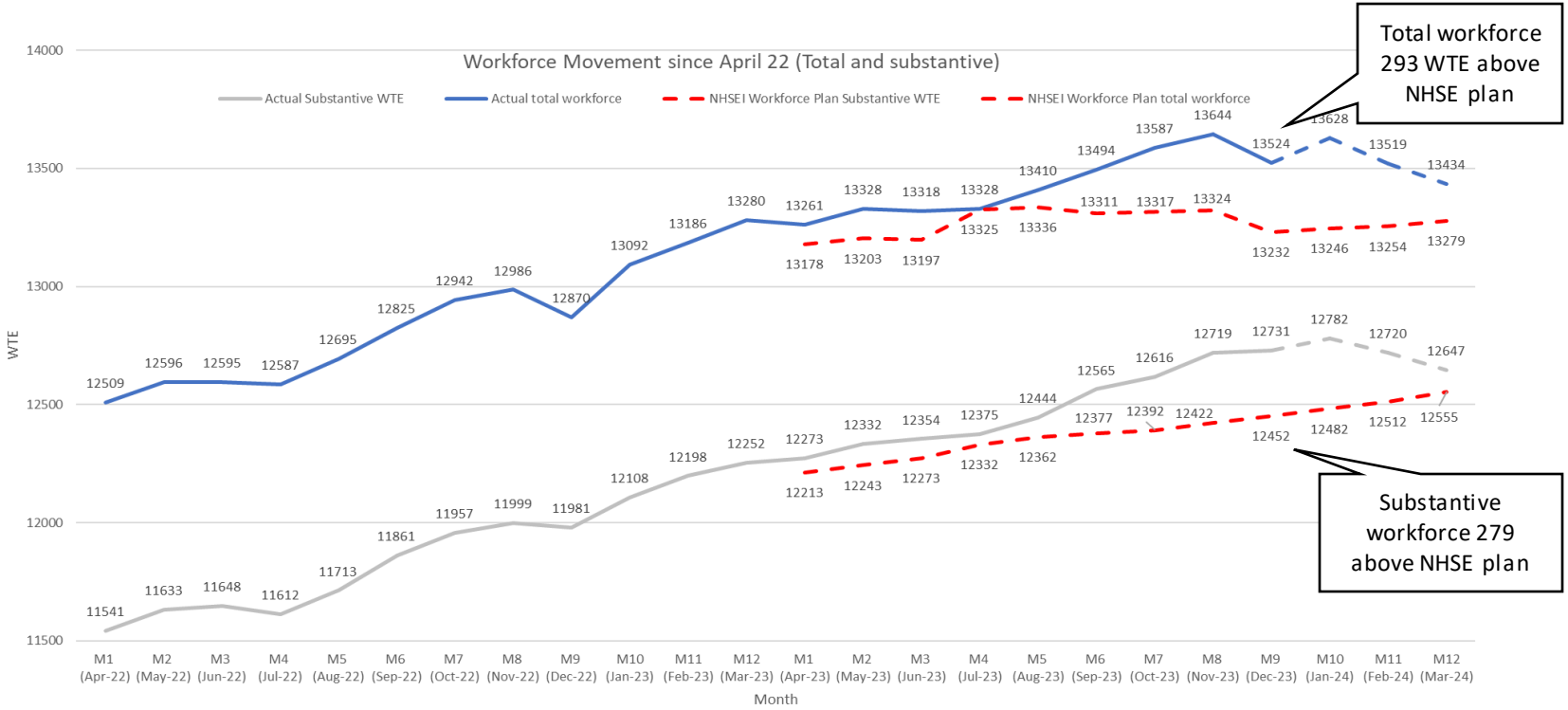
- Second level approval implemented on Nursing rosters from January
- Mental Health Care Support Worker (CSW03) now require 'golden key' approval from matron / DHN
- Matrons reviewing all bank requests to ensure appropriateness offering additional oversight and challenge
- A "guide to manage bank requests" has been launched for bleep holders including a flowchart for managing short term absence
- Bank shift times have been amended for early and late shifts to ensure cover is only for key hours (i.e. early shift to finish at 1300 rather than 1500)
- Weekly review meetings are in the process of being launched which will review staffing levels and compliance to budget. These will have Divisional Head of Nursing oversight. Budget surgeries also continue to take place monthly.
- Housekeeping process to be completed for supernumerary periods to ensure they are compliant with the agreed timescales.

Nursing workforce overview:

- Nursing vacancies have reduced from 17% in 2018 to 5% in Dec 2023
- Over half (52%) of nurses are aged 35 or under. Over half (54%) of nurses are Band 5, a quarter of nurses (26%) are Band 6, and a further 16% are Band 7. The remaining 4% are Bands 8a and above
- Over half (53%) of nurses have between 1-5 years of service. Approximately 5% of nurses at UHS have 15 years of services or longer

Workforce Grip and Control

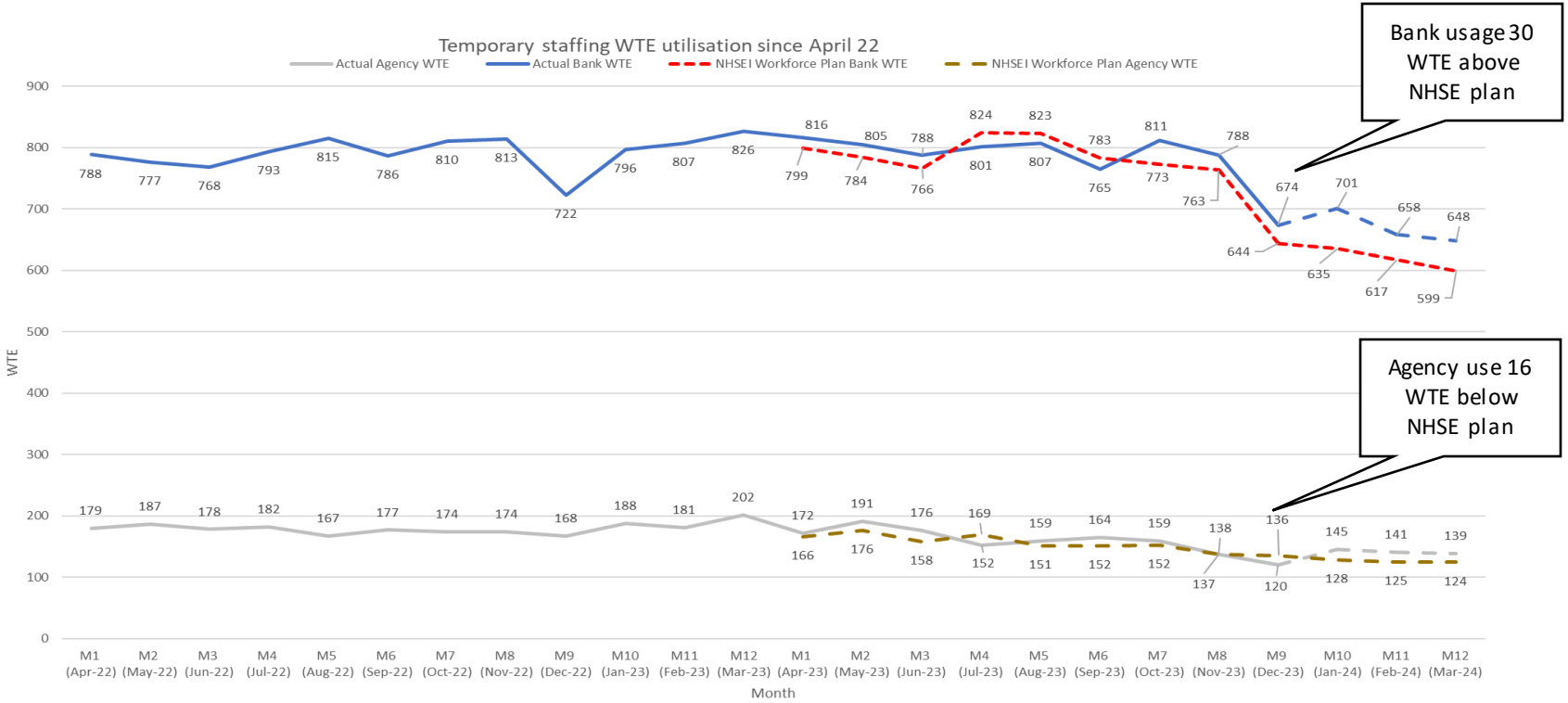
NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of 31 December 2023

Workforce Grip and Control

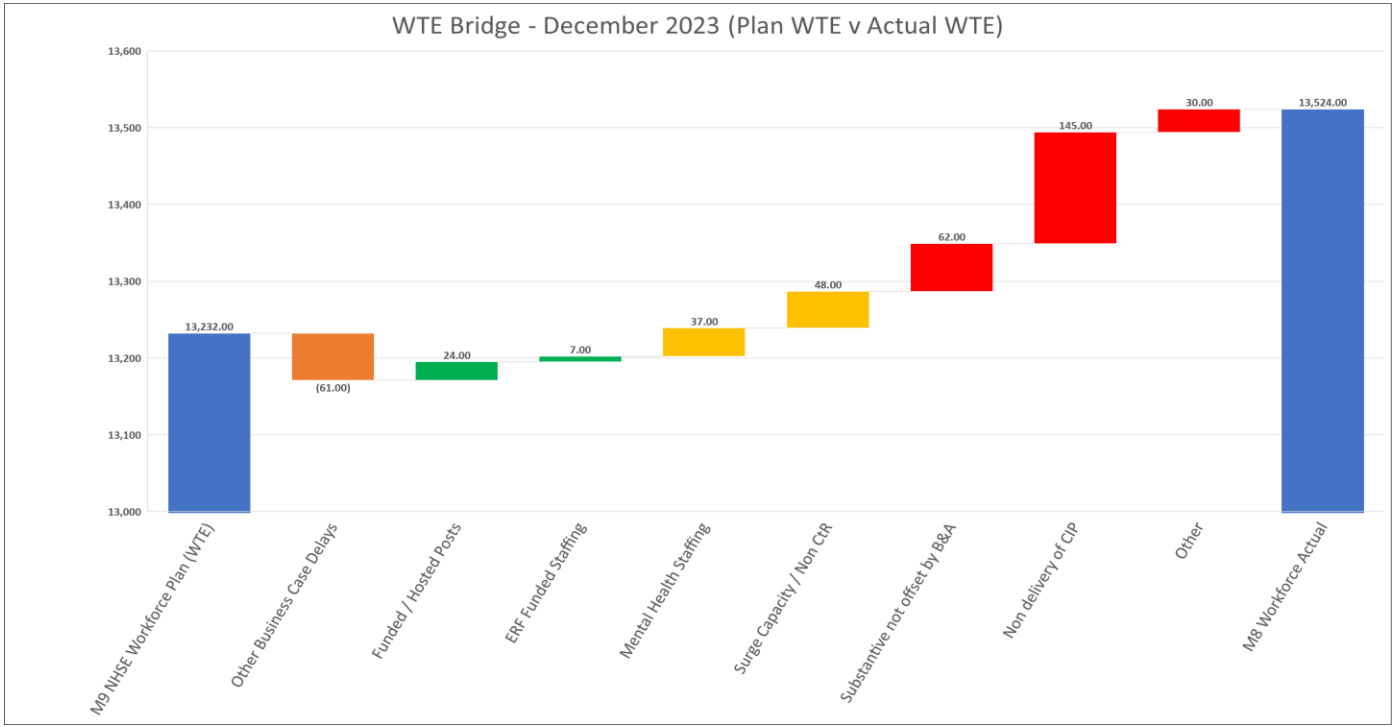
NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of 31 December 2023

Workforce Grip and Control

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



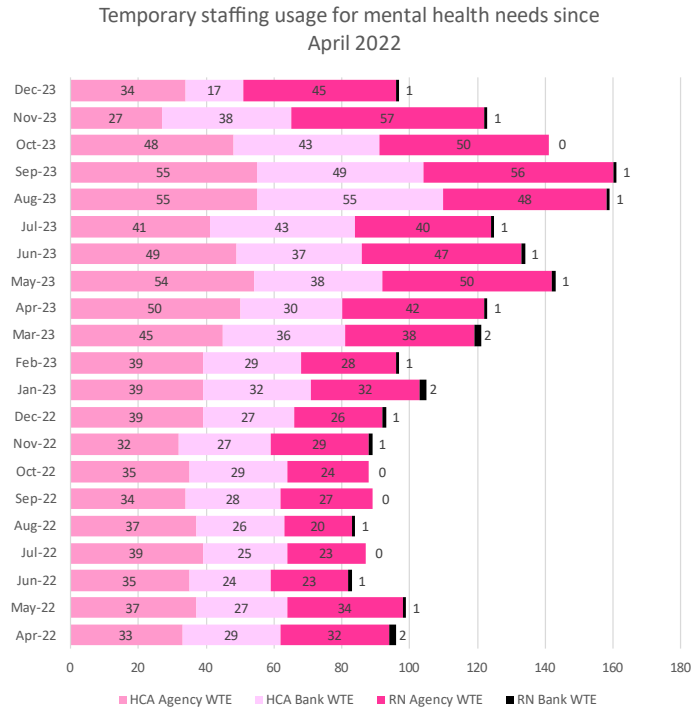
NB: Industrial Action impact is within WLI/Overtime/Excess Hours which is excluded from the above

Workforce Grip and Control

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Mental Health narrative:

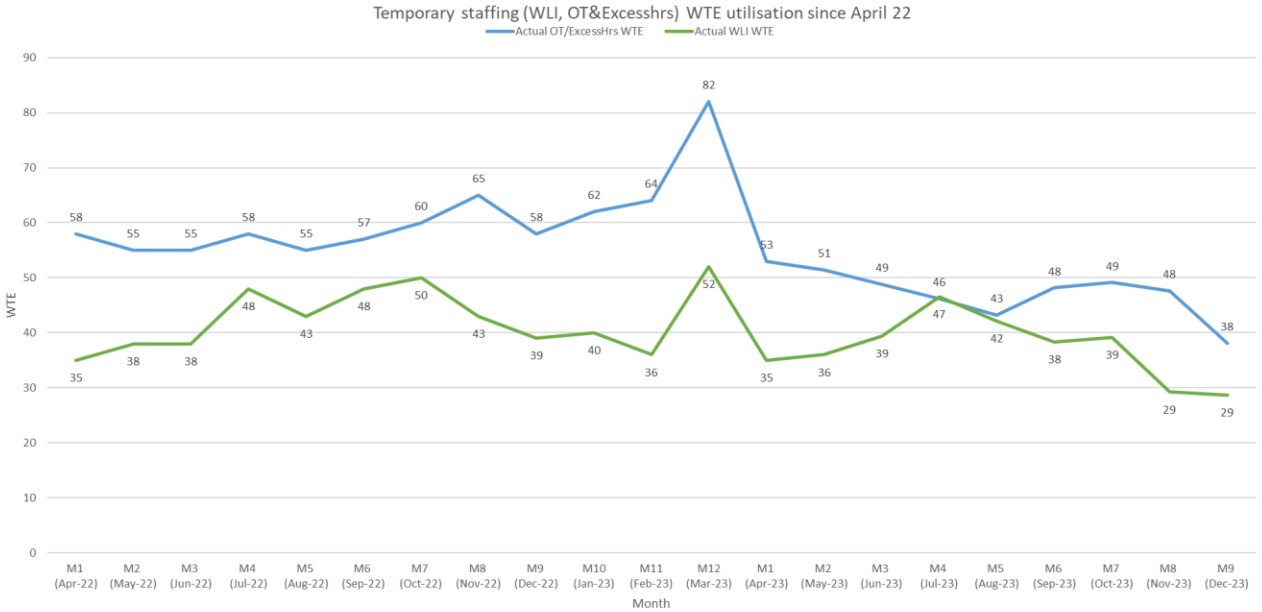
- Mental Health (December 2023):
  - Total of 97 WTE of temporary staffing needed for MH needs (nursing and HCAs)
  - 46 WTE of whom are MH Nursing, 45 WTE of whom were agency
  - 51 WTE HCAs (34 agency & 17 bank)
- The continued mental health pressures present a safety, quality, and financial challenge to the Trust. UHS continues to escalate to the ICB and press for more comprehensive system solutions to this issue.
- All agency Mental Health HCA was centralised in a hub from 11 Dec



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

	M11 – M12	M12 – M1	M1 – M2	M2 – M3	M3 - M4	M4 – M5	M5 – M6	M6 – M7	M7 – M8	M8- M9	M11 – M9 Total
WLI Movement	16	-17	1	3	8	-5	-4	1	-10	0	-7



OT and Excess hours peaked in March 2023 and saw a steady decline to a low of 43 WTE in August 2023. This increased by 5 WTE in September and has remained relatively consistent until December with a decrease of 10 WTE

Whilst WLI also peaked in March 2023, numbers have been more balanced until a decrease of -10 in November 2023 to a low of 29 WTE and stayed the low usage in December

Source: HealthRoster as of December 2023; retrospective WLI figures have been updated from April 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

Substantive Monthly Staff in Post (WTE) for 2023/24

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	379	383	381	380	386	393	402	404	403				26	
Additional Clinical Services	2106	2113	2118	2129	2124	2153	2143	2143	2146				51	
Administrative and Clerical	2256	2271	2284	2287	2282	2295	2298	2321	2328				76	
Allied Health Professionals	682	673	681	690	691	699	703	702	698				27	
Estates and Ancillary	383	381	385	386	380	380	382	382	385				2	
Healthcare Scientists	486	484	486	491	494	493	490	496	493				7	
Medical and Dental	2087	2074	2065	2061	2109	2120	2134	2145	2137				57	
Nursing and Midwifery Registered	3850	3910	3912	3908	3935	3987	4009	4072	4086				221	
Students (Apprentices)	43	43	43	43	43	43	54	53	53				10	
Grand Total	**12273**	**12332**	**12354**	**12375**	**12444**	**12565**	**12616**	**12719**	**12731**				478	

Substantive increase is due to improved vacancy fill and new approved business cases. Students increase is due to new courses starting.

Source: ESR substantive staff as of 31 December 2023; includes consultant APAs and junior doctors' extra rostered hours, excludes Wessex AHSN, UEL and WPL. Numbers relate to WTE, not headcount.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE TURNOVER (December 2023)

Staffing group	Leavers (WTE) in month	Turnover 12m rolling %
Add Prof Scientific and Technic	3.7	9.5%
Additional Clinical Services	28.1	16.8%
Administrative and Clerical	28.3	13.6%
Allied Health Professionals	4.5	11.7%
Estates and Ancillary	1.6	12.5%
Healthcare Scientists	5.3	11.1%
Medical and Dental	2.0	5.1%
Nursing and Midwifery Registered	25.9	8.9%
UHS total	**99.5**	**11.5%**

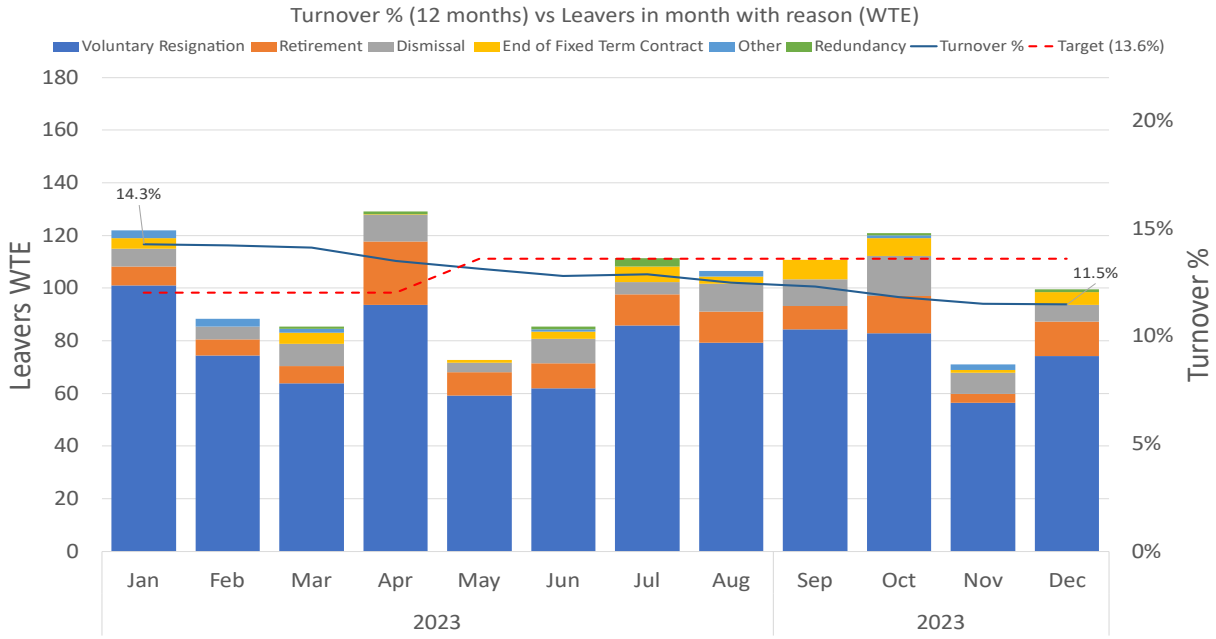
Source: ESR leavers December 2023 (excludes junior doctors)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY LEAVING REASON

In December 2023, a total of 99.5 WTE employees left the organisation. Most of the leavers were voluntary resignations, accou nting for 74.1 WTE (74%) of all leavers. Retirement accounted for 13 WTE (13%), while dismissal and end of a fixed term accounted for 6.4 (6%) and 4.8 WTE (5%) respectively.



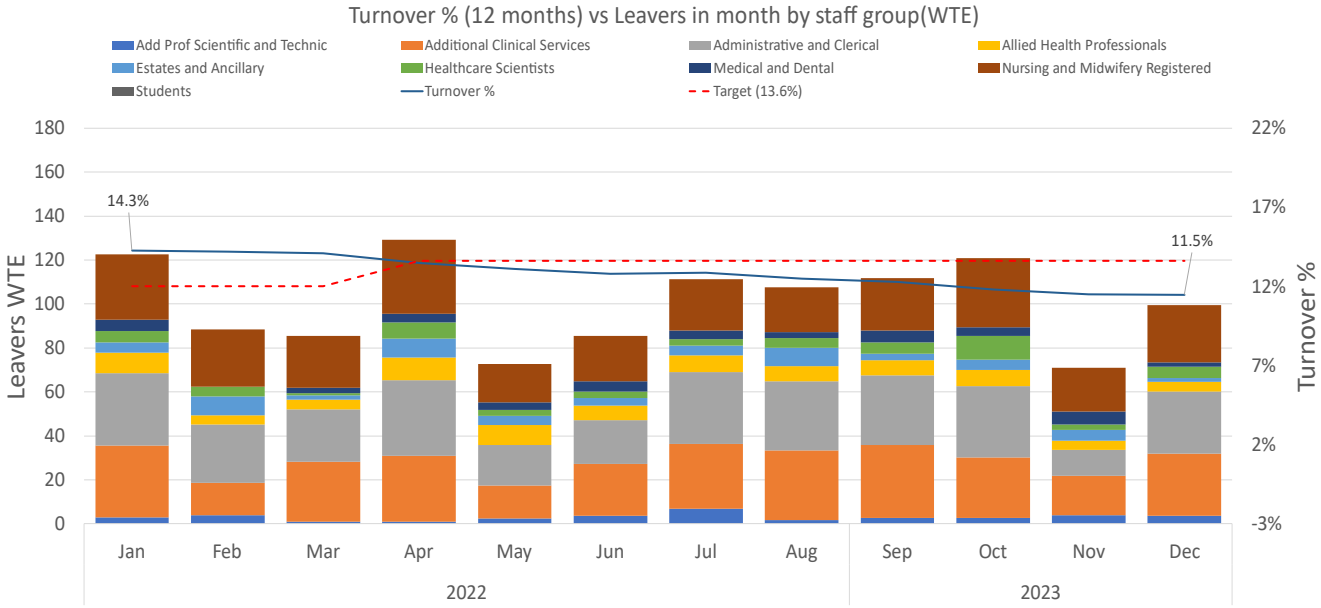
Source: ESR Leavers Report

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY STAFF GROUP

. Turnover (12 month rolling average) has been on a downtrend since January 2023, and is currently at 11.5% keeping the Trusts turnover below the 23/24 target of <13.6%; in December 2023 there were 99.5 WTE leavers, which is 28.5 WTE higher than November 2023. It is important to note that the Trusts Turnover has reduced by -2.8% from January 2023 figures of 14.3%.



Top reasons for leaving by staff group	
Add Prof Scientific & Technic	Excessive workload or pressure
Additional Clinical Services	Further education/training; Relocation within the UK
Admin & Clerical	Not feeling valued/recognised; Retirement
Allied Health Professionals	Relocation within the UK
Estates & Ancillary	Bullying, harassment or discrimination; Lack of job satisfaction; Pay, Senior leadership; Promotion; Relationship with line manager
Healthcare scientists	Relocation within the UK
Medical & Dental	Further education/training
Nursing & Midwifery	Excessive workload or pressure

- This data is from respondents to the exit survey (now via Microsoft Forms)
- The data above is for quarter 2 (July, August, September 2023).
- During the quarter 1,067 exit survey invites were sent out, 106 leavers completed the survey (and informed the below table).
- The exit survey is also sent to internal movers (so it is not as simple as 106/1067 is the response rate %, as some of those are internal movers not leavers).
- The table above covers those that left UHS only (leavers).

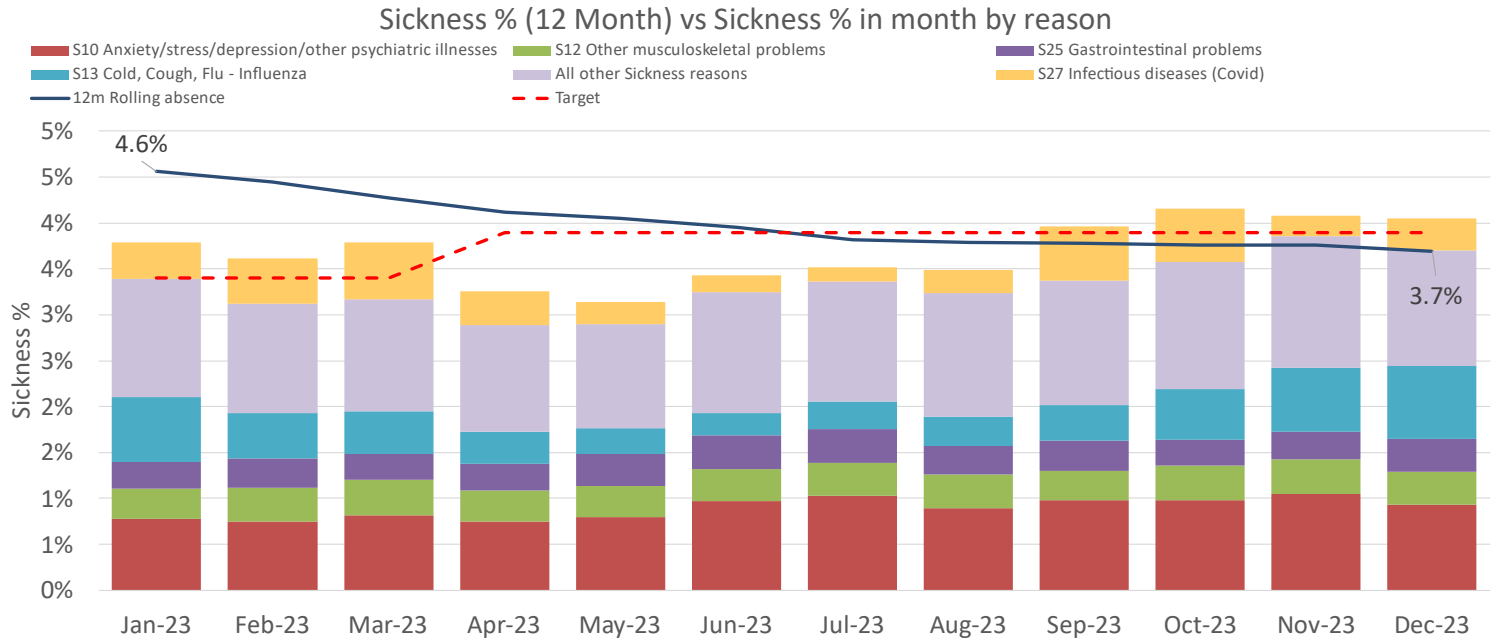
Source: ESR – Leavers Turnover WTE, HRBPs

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The current rolling sickness rate as of December 2023 is 3.7%, lower than January 2023 figure (4.6%) which is a continued downtrend from January 2023. The sickness target for 23/24 is <3.9%.Covid prevalence has decreased over the last 12 months. However, Covid increased by 0.2% in December 2023.



Source: ESR – Sickness data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

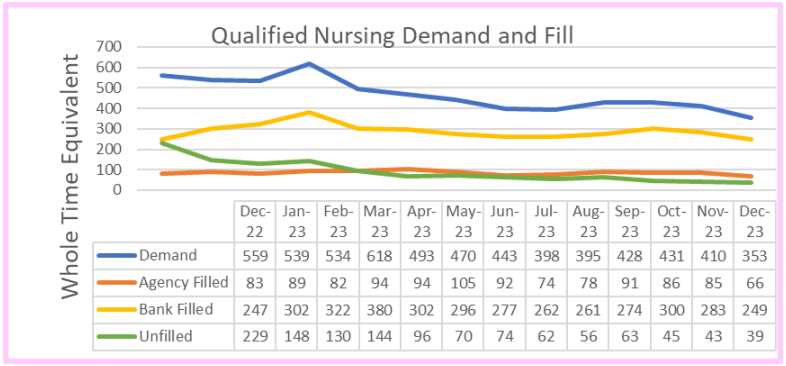
TEMPORARY RESOURCING

Status

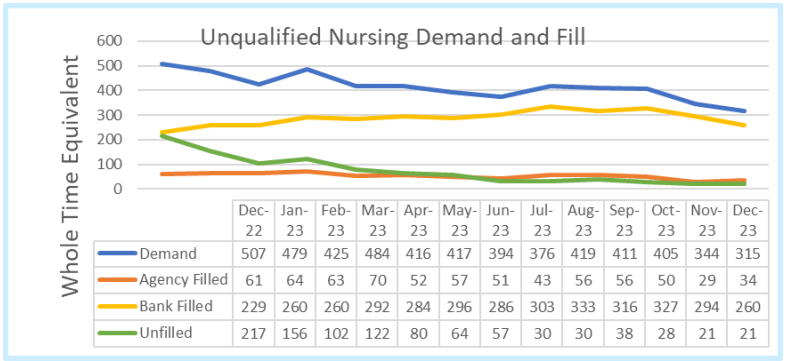
- Qualified nursing demand/fill (WTE): Demand decreased from 410 in November to 353 in December, of which, bank filled 249 (34 down on last month), agency filled 66 and 39 remained unfilled.
- Bank fill for qualified nursing decreased slightly from 68.8% in November to 70.4%.
- Demand for December 2023 is 206 WTE lower than December 2022.
- HCA demand/fill (WTE): Demand decrease from 344 in November to 315 in December, of which, bank filled 260, agency filled 34 WTE (34 WTE were MH HCA's) and 21 remained unfilled.
- Bank fill for HCA decreased from 85.5% in November to 82.4%.
- Demand for HCA's is 192 WTE lower than in December 2022

Actions

- 2nd level approval for all bank shifts to be released implemented on all Nursing rosters from January 4th
- All mental health shifts are now centralised in the staffing hub.
- Removal of agency for all band 5 general Nursing shifts
- Additional warning and violations to be considered in Healthroster
- Monitoring the demand for HCAs is in line with substantive recruitment numbers.
- Mental Health demand being closely monitored and working with specialised teams.



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Demand	559	539	534	618	493	470	443	398	395	428	431	410	353
Agency Filled	83	89	82	94	94	105	92	74	78	91	86	85	66
Bank Filled	247	302	322	380	302	296	277	262	261	274	300	283	249
Unfilled	229	148	130	144	96	70	74	62	56	63	45	43	39

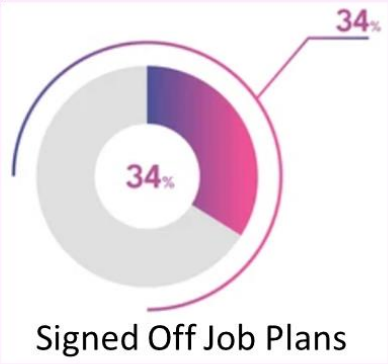


	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Demand	507	479	425	484	416	417	394	376	419	411	405	344	315
Agency Filled	61	64	63	70	52	57	51	43	56	56	50	29	34
Bank Filled	229	260	260	292	284	296	286	303	333	316	327	294	260
Unfilled	217	156	102	122	80	64	57	30	30	38	28	21	21

Source: NHSP December 2023

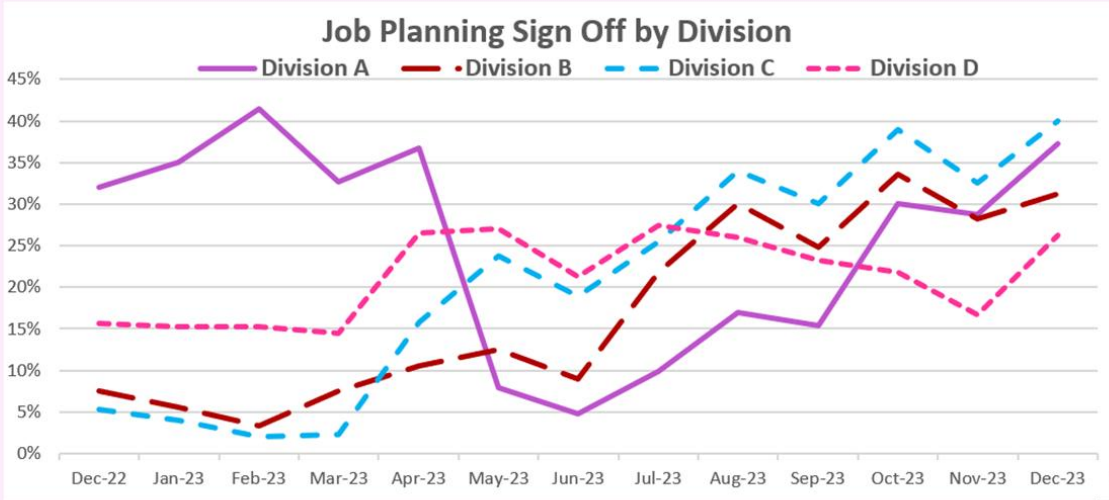
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY



Job Planning – December 2023

- Job planning sign off levels have increased from 27% in November to 34% at the end of December.
- Active Job Plans increased 1.1% to 89.3% in December.
- Consistency Committee Report for Division D
- 30 Seconds of Job Planning News – Variations to PAs – Change to Contract Form

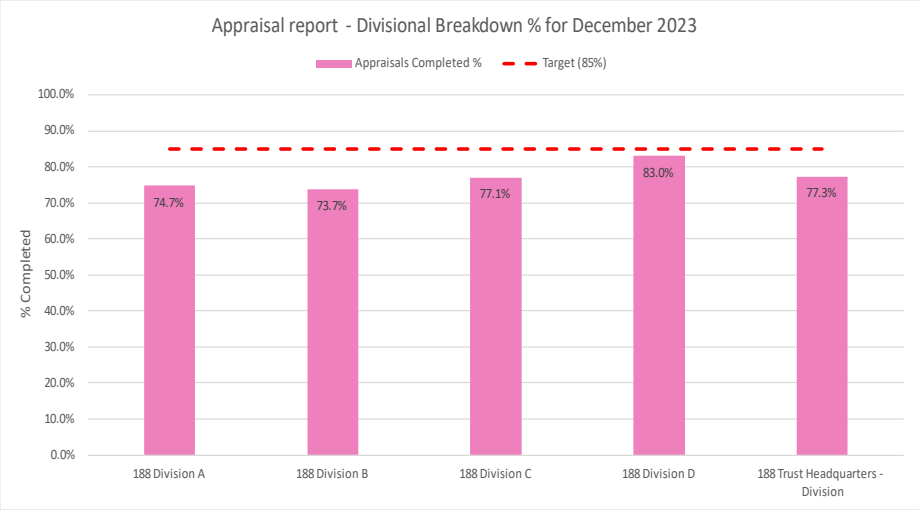


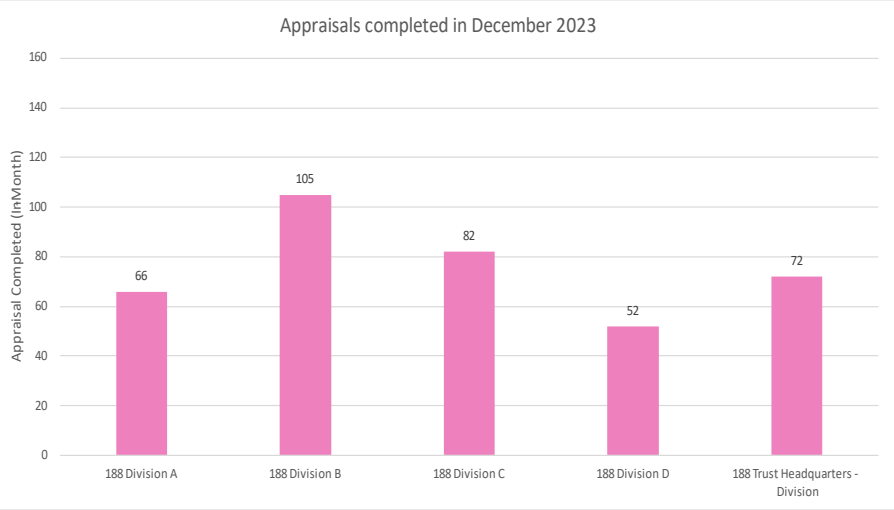
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

A total of **377** appraisals **(76.9%)** were completed in M9 (December 2023). Appraisal completion has been affected by a combination of factors including annual leave, sickness absence, Industrial Action, and the use of ESR.





Source: ESR – Appraisal data for Divisions A, B, C, D and THQ only

People Report

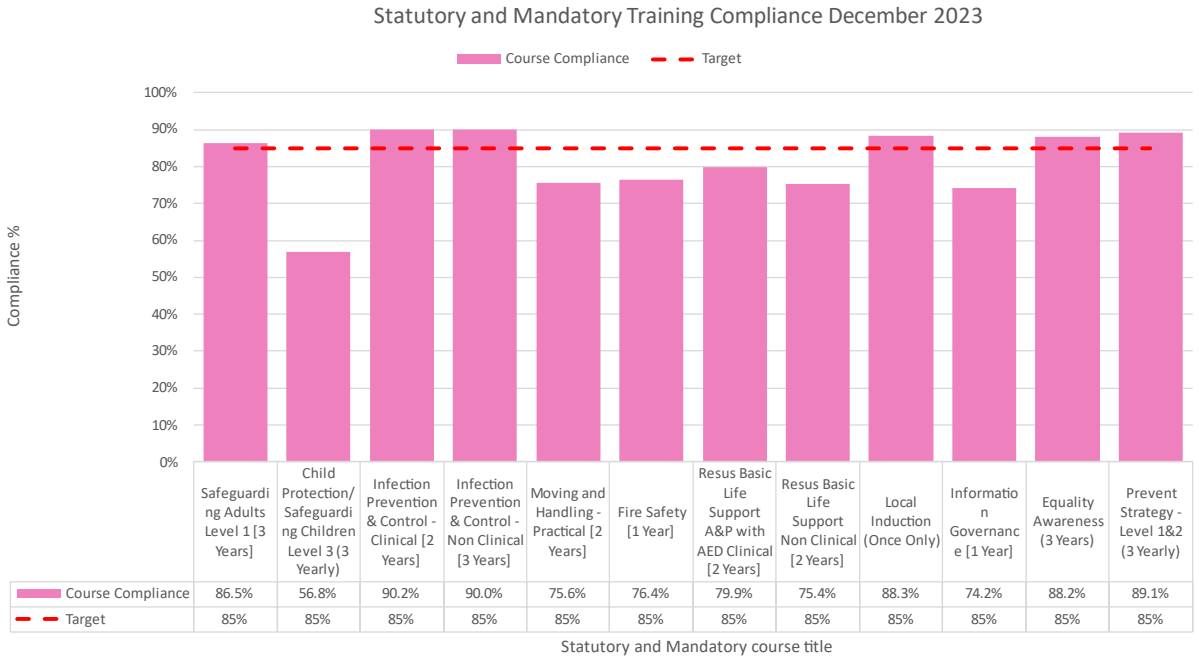
THRIVE | EXCEL | BELONG | PATIENT SAFETY

Statutory and Mandatory Training

Revised VLE launched on 27th Nov 2023. Work will be continued on the platform as feedback is received.

Recommendations were accepted to change Stat & Mand matrix to just be statutory (legal) and mandatory (core skills training).

Work is being undertaken to review how we capture compliance data and where we escalate.



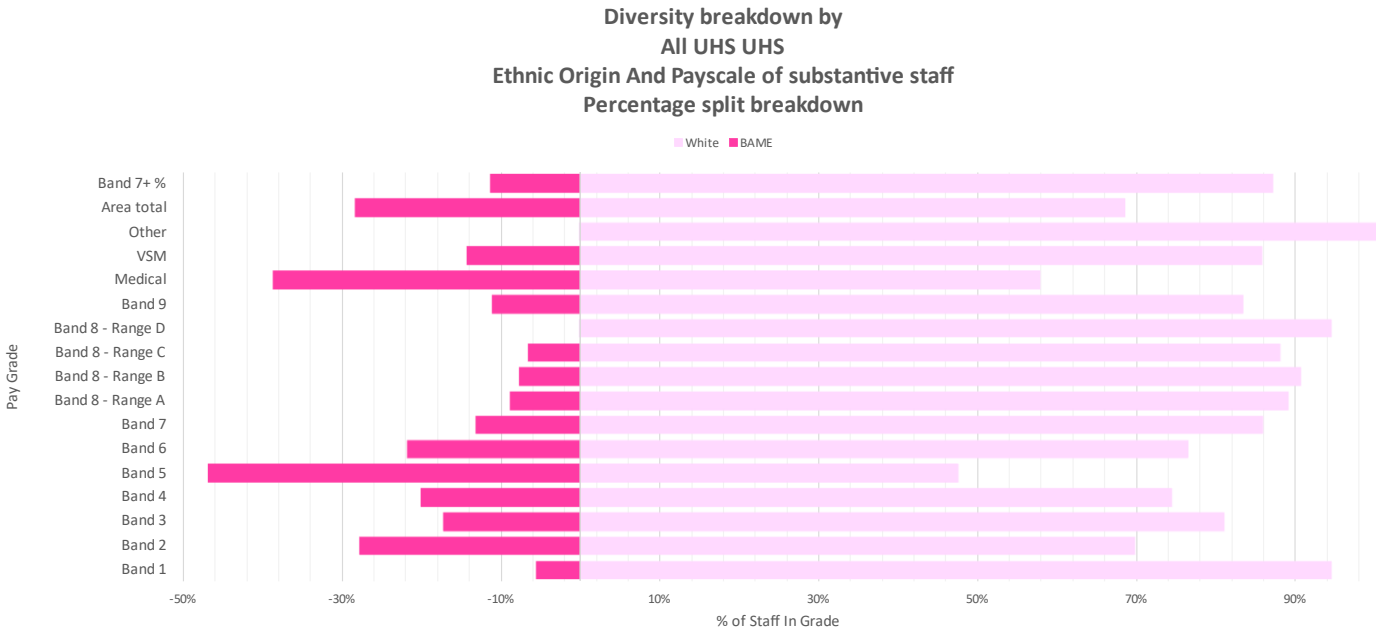
	Safeguarding Adults Level 1 [3 Years]	Child Protection/ Safeguarding Children Level 3 (3 Yearly)	Infection Prevention & Control - Clinical [2 Years]	Infection Prevention & Control - Non Clinical [3 Years]	Moving and Handling - Practical [2 Years]	Fire Safety [1 Year]	Resus Basic Life Support A&P with AED Clinical [2 Years]	Resus Basic Life Support Non Clinical [2 Years]	Local Induction (Once Only)	Information Governance [1 Year]	Equality Awareness (3 Years)	Prevent Strategy - Level 1&2 (3 Yearly)
Course Compliance	86.5%	56.8%	90.2%	90.0%	75.6%	76.4%	79.9%	75.4%	88.3%	74.2%	88.2%	89.1%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: Virtual Learning Environment (VLE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – ETHNICITY

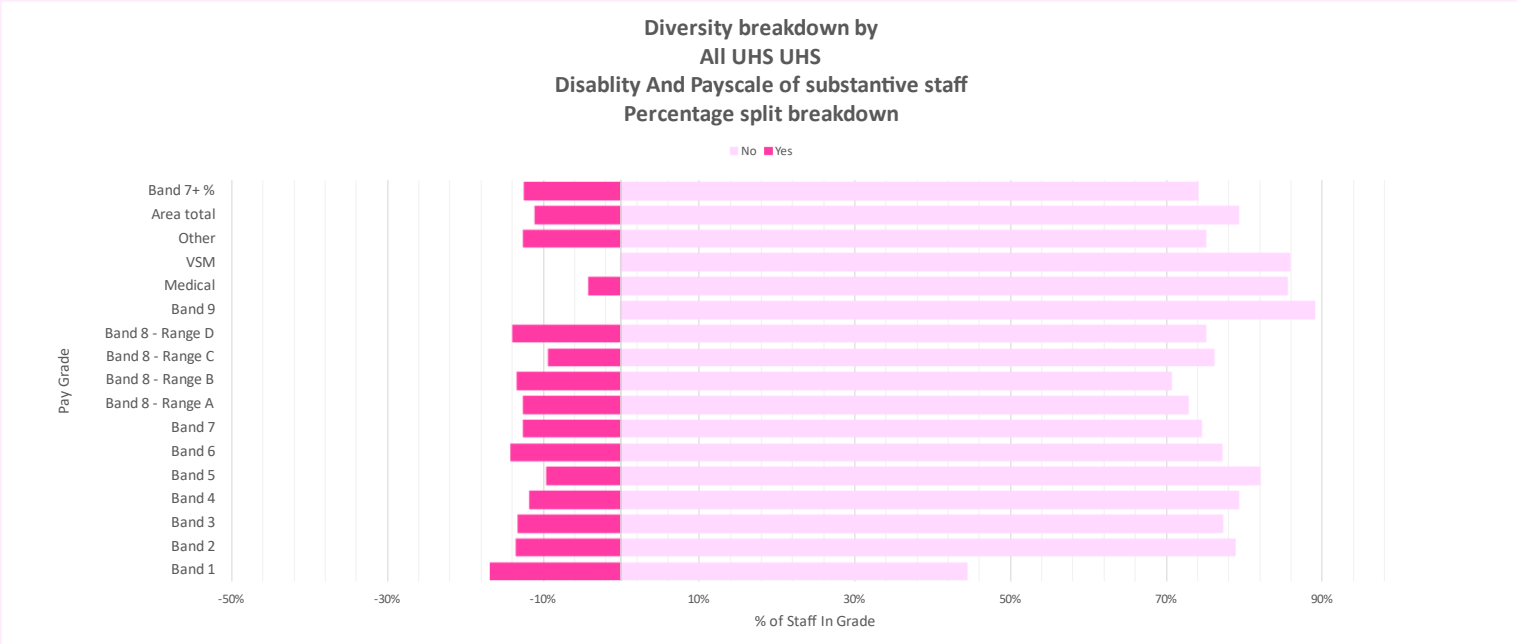


Source: ESR – December 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

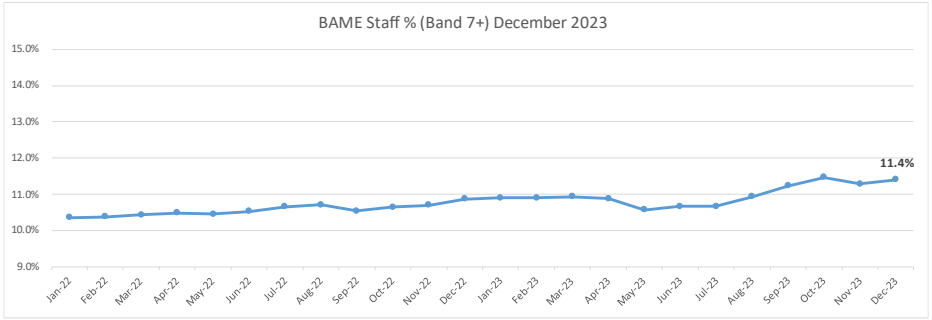
STAFF IN POST – DISABILITY STATUS

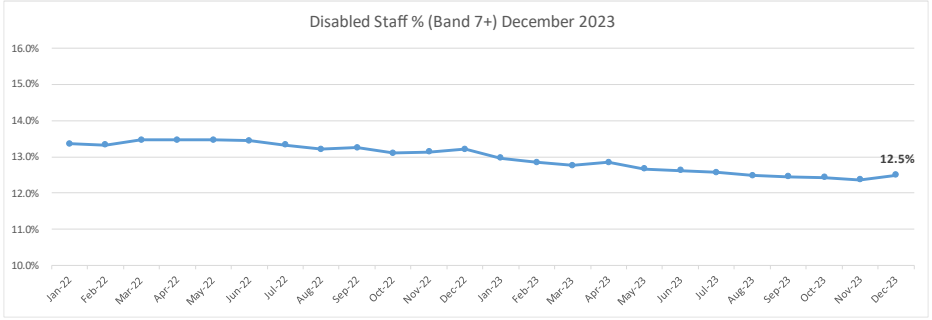


Source: ESR - December 2023

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY





STAFF IN POST – ETHNICITY and DISABILITY

- Nursing Positive Action Programme with Florence Nightingale Foundation has completed, with the final presentations and celebration on 5th December. Twenty three people completed the programme and are now moving onto the career support phase.
- Following the results of the 2023 Workforce Disability Equality Standard (WDES) at UHS which showed that disparity levels between those with disability and those without at UHS have increased, an action plan has been agreed to specifically focus on improving experiences of disabled colleagues. Focus is on how the sickness absence policy is applied, ensuring workplace adjustments are appropriate and timely and support is available for managers to implement them, and culturally in relation to reducing bias and changing perceptions about capabilities of people with disabilities.
- 0.1% increase for B7+ BAME staff from M8 to M9 equates to 3 employees.
- 0.1% increase for B7+ Disabled staff from M8 to M9 equates to 4 employees.

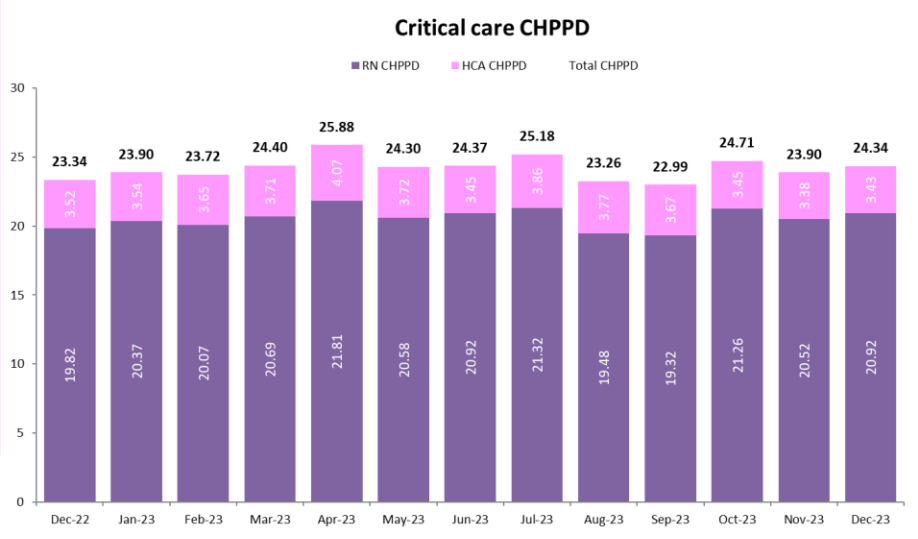
Source: ESR

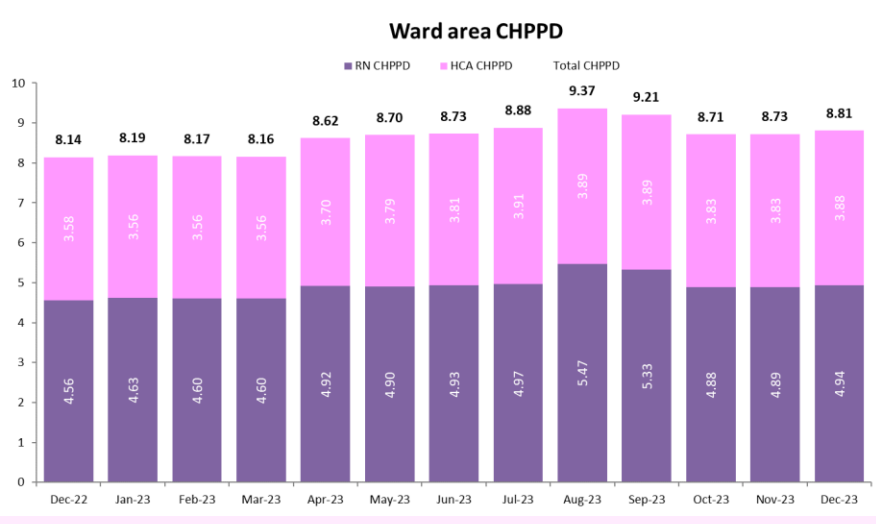
People Report

THRIVE | **EXCEL** | BELONG | PATIENT SAFETY

CARE HOURS PER PATIENT DAY
December 2023

The Ward areas CHPPD rate in the Trust increased marginally by 0.01 from last month to RN 4.9 (previously 4.89), HCA increased from 3.8 to 3.9.





The CHPPD rate in Critical care increased overall from last month. RN 20.9 (previously 20.5), HCA remained in the 3.4 region and overall, 24.3 (previously 23.9). 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.

Source: HealthRoster & eCamis

Appendices

Data Sources

Metric	Data Source	Scope
Industrial Action	HealthRoster	All staff rostered for strike action during IA periods
Substantive Staff in Post (WTE)	ESR (Month-end contracted staff in post; consultant APAs; junior doctors' extra rostered hours)	Exclusions: Honorary contracts; Career breaks; Secondments; UPL; UEL; WPL; Wessex AHSN
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	Exclusions: UPL; UEL; WPL; Wessex AHSN
Temporary Staffing (WTE)	Bank: NHSP; MedicOnline Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies	Exclusions: Vaccination activity
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/junior Doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	ESR (Appraisals completed in-month and last 12 months)	AfC staff only
Statutory & Mandatory Training	VLE	No exclusions
Staff in Post (Ethnicity & Disability)	ESR	No exclusions
Pulse Survey	Picker (Qualtrics)	No exclusions
Care Hours PER Patient Day (CHPPD)	HealthRoster (In-month shifts) eCamis (In-month daily patient numbers)	Clinical inpatient wards, Critical Wards, and ED only

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Maternity Safety Report 2023-4 Quarter 3 Report**			
Agenda item:	**6.10**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Emma Northover, Director of Midwifery and Professional Lead for Neonatal Services** **Marie Cann – Maternity & Neonatal Safety Lead**			
Date:	**30 January 2024**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This report constitutes the agreed Maternity & Neonatal (MatNeo) Services safety report for Board members. The report is intended to provide a key overview of our services providing assurance to the members for the following: **1.** Perinatal Quality Surveillance – please see the Qtr. 3 Maternity Dashboard (Appendix 1) **2.** CQC Update on Improvements **3.** Update NHSR Year 5 **4.** New Safety Improvement Work Streams for MatNeo Services **5.** Maternity & Neonatal Safety Investigation (MNSI) Feedback **6.** Serious Incidents (Appendix 2, 3, 4, 5) **7.** Avoiding Term Admissions to the Neonatal Unit (ATAIN) (Appendix 6) **8.** Perinatal Mortality Review Tool (PMRT) – A summary **9.** Quality and Safety Shared Learning (Appendix 7)			
Response to the issue:	**1. Perinatal Quality Surveillance – Maternity Dashboard** The Maternity Dashboard provides a perinatal quality surveillance overview of our Qtr.3 indicators for both maternity and neonatal services. Outcome indicators continue to be added and adjusted with highlights being: • **% Bookings ≤ 9+6 weeks.** Current compliance 6.6% achievable compliance 75%. Digital innovations within the Self-Referral Team are being undertaken and should result in improved compliance but monitoring will continue until compliance is achieved. This outcome is closely related to both % Bookings ≤ 10+6 weeks and timeliness of testing KPI for Sickle cell and Thalassemia screening. • **Scheduled Caesarean Section capacity** for Qtr.3 was 225 (Qtr.2 225). Elective caesarean section capacity continues to be well monitored and oversight provided by the senior team. • **Term Admission to NNU**. Current compliance 5.7% benchmark compliance 4.9%. Term admissions to the NNU is reviewed by a multidisciplinary group and information of this process is available in section 7 of this report. • **Booked Continuity of Carer.** Our current compliance is less than expected and is a consequence of the recent operational pressures within the service. A decision has been made to remove the CoC team out of our contingency measures. With challenges in recruiting and all too frequent use of this limited resource during periods of high activity, the team have now been ringfenced to allow them to focus on their core roles and responsibilities. This will result in greater support for vulnerable families and improve compliance.			

2. Care Quality Commission (CQC) Update on Improvements

The CQC announced inspection of our service in May 2023, which resulted in the following improvement activity:

- **Medical staff are up to date with all training, including mandatory training modules.** We can confirm that an improvement plan is in place which has been made available to the CQC demonstrating plans to achieve compliance by January 2024 which we intend to achieve by the end of the month.

- **Ensure the security of the unit at all times.** The Estates Team have installed temporary measures (such as cameras behind reception) to secure the environments with ongoing monitoring and are exploring permanent solutions.

- **Ensure staff complete daily checks of emergency equipment.** Quality improvement project in place which provides oversight and monitoring of equipment checks. Compliance is currently around 90 - 100% across all areas.

- **Continue to monitor and review infection control practices.** Infection prevention monitoring continues with no further reported cases of poor practice.

- **Consider investment in the estate.** The Estates Team continue to provide oversight and improvements for the environment including the planned works for the induction of labour area.

- **Consider review of training for medical staff for level 3 safeguarding training in line with current guidance**. We can confirm that there is an improvement plan in place which has been made available to the CQC demonstrating plans to achieve compliance by January 2024, we are on track to meet this target.

3. NHSR Year 5 Update

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) is due for submission in February 2024. Our compliance and associated mitigations have been shared and discussed with Trust Board in December 2023, with the respective Board members providing approval for full sign off. We can confirm that our evidence has been externally reviewed by the LMNS & ICB who have reported that they are satisfied with the evidence provided. The final declaration will require external sign off by the Accountable Officer (AO) with final submission to NHSR before 1st February 2024.

4. MatNeo Improvement Programmes

The members should note that there continues to be increasing focus on safety and quality improvements within maternity and neonatal services including the launch of the following programmes.

4.1 Perinatal Culture and Leadership Development Programme

The MatNeo Three Year Delivery Plan requires the development and sustainability of a culture of safety, learning and support, within a MatNeo leadership quadrumvirate (Quads). All Quads will complete the perinatal culture and leadership programme and as well as being culture leads. A SCORE survey will be undertaken to better understand the local culture and provide practical support to nurture culture and leadership. To further support the Quad Team and the Director of Midwifery in the culture and safety work streams it is recommended that the Executive Safety Champions attend some meetings across the next year so we will plan for this as we move forward.

Our Quad members currently include a Maternal Fetal Medicine Consultant; Care Group Manager; Consultant Neonatologist and the MatNeo Safety Lead.

4.2 Patient Safety Training Syllabus for MatNeo Safety Champions

NHSE have fully funded a Patient Safety Specialist Training Programme for MatNeo Safety Champions nationally. The programme covers all the content of the NHS Patient Safety Syllabus Levels, including unpacking the systems issues; managing patient safety risks; understanding the cultural, legal, and regulatory factors; Involving those affected and designing solutions.

5. Feedback from Maternity & Neonatal Safety Investigations Team (MNSI)

The MNSI team visited our service in October 2023 and highlighted some key findings which we have reviewed and provided assurance around ongoing monitoring:

- **Escalation in an emergency**
  We have reviewed our process around escalation in an emergency. All critical incidents that are investigated at clinical events are reviewed to ensure appropriate escalation has happened. All staff groups attend PROMPT training, which covers the importance of how and who to call for help and escalate in an emergency. Audits found 100% compliance with appropriate escalation when a bradycardia was identified, leading to appropriate escalation.

- **Oversight of labour ward**
  As per Ockenden requirements, our Labour Ward co-ordinator and operational co-ordinator are supernumerary to the workforce ensuring they maintain a helicopter view of their areas. We have a staffing escalation pathway that triggers when there is a peak in activity to ensure the oversight of Labour Ward is maintained.

- **Management of blood loss**
  We have reviewed our processes around the management of blood loss and ongoing improvement work has recently seen the introduction of whiteboards in the clinical areas to improve the recording of blood loss, portable scales on the PPH emergency trolley and digitalisation of the equipment checks, including PPH trolley and emergency drugs.

- **Placenta previous no histology**
  Ongoing improvement project with the Consultant Midwifery Team and pathology team to improve the processes around sending placenta for histology. It is worth noting that nationally there is a delay in receiving histology results.

- **An update on the emergency bell**
  Clinical events reviews have identified that the emergency bell is used appropriately when emergency help is required. PROMPT emergencies training includes the process of calling for help and timely use of the emergency call bell. We have an audit in place, looking at obstetric emergencies and the correct identification, appropriate escalation, and the identification of any thematic learning which is then communicated with the workforce.

6. Serious Incidents (SI)

Appendix 2 provides assurance to the members that the appropriate reporting has taken place for Qtr.3 including all new MNSI and SI cases for the quarter and provides an update on all cases closed within the same timeframe, together with any learning identified. Information will also be included which relates to new and closed perinatal mortality cases even where there are no patient safety care concerns in order for the service to continue to be transparent.

	6.1 Lesson learnt information for closed cases • Appendix 3 – Case 9942907 • Appendix 4 – Case 9946367 • Appendix 5 – Case 9944553 **7. Avoiding Term Admissions in the Neonatal Unit (ATAIN)** Qtr.3 resulted in a total term admission rate to the Neonatal Unit (NNU) of 75 babies of which 38 babies were unexpected admissions. Following analysis of these unexpected admissions and exclusion of congenital cases there remains an avoidable admission rate that the service continues to complete deep dives into the data to identify further learning and focus for improvement work, Appendix 6. **8. Perinatal Mortality Review Tool Report (PMRT)** In Quarter 3, a total of 7 perinatal deaths were reported to MBRRACE-UK during the reporting period. **8.1 Summary of PMRT Reviews – Stillbirths** Of the 7 babies in this reporting period: • 3 babies were not supported as fell outside the PMRT criteria • 1 baby has not had a full review completed • 2 babies are in the review process • Of the 2 babies reviewed the group concluded that there were no issues with care identified and that the incidental care issues that were noted would have made no difference to the outcome. Therefore, no key theme(s) identified. **9. Quality and Safety Shared Learning** Appendix 7 provides members with an overview of the key learning for Qtr.3.
Implications: (Clinical, Organisational, Governance, Legal?)	The risk implications for the UHS Trust and Maternity Services sit within several frameworks including: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services which they believe have safety concerns. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten safety actions remains to be an expectation for maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing.
Risks: (Top 3) of carrying out the change / or not:	The risk implications for the Trust and the MatNeo service sit within several assurance frameworks including: • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on the women and their families leading to increased poor outcomes and staff wellbeing. • **Governance** – Governance abd safety concerns can be escalated to the Care Quality Commission for their consideration, and to NHS England, the NHS Improvement Regional Director, the Chief Midwifery Officer, and the Regional Chief Midwife. • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten is an expectation for many maternity safety requirements.

Summary: Conclusion and/or recommendation	This safety report provides an overview of key safety workstreams within our MatNeo Services and will continue to adapt and respond to all the safety improvements impacting our families, services, and staff. Our Maternity Dashboard provides Perinatal Quality Surveillance information to the members as required will be continually refined and modified to provide a platform for clear oversight of key outcomes. The information provided is for assurance and reassurance and highlights the safety improvement projects and learning from all aspects of the services including serious incident and MNSI cases. We ask members to continue to support the MatNeo Services and provide monitoring and scrutiny as required.

Appendix 1 – Maternity Dashboard

University Hospital Southampton
NHS Foundation Trust

UHS Maternity Dashboard

Q1 = April - June Q2 = July - September Q3 = October - December Q4 = January - March

Antenatal Booking	Q2 23/24	Q3 23/24				2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
		October	November	December	Q3 total					
Total number of women/clients booked	1248	446	469	392	1307	5475	5336	No performance threshold		Total number of clients booked during **2023 - 5336**
Timeliness of testing KPI for Sickle cell and Thalassemia screening	9.10%	9.0%	9.00%	Provisional data 15.6%	11.2%	5.8%	17.5%	Performance threshold of testing Acceptable level >50% Achievable level >75%		The proportion of pregnant women/clients having antenatal sickle cell and thalassemia screening for whom a screening result is available ≤10 weeks + 0 days gestation. **Note - December and final Q3 compliance is provisional only as of 08/01/2024. Data is currently being finalised by the Screening Team.**
First point of contact with a midwife ≤ 9+6 weeks	12.80%	17.50%	20.5%%	70.5%	44.00%	13.17% (April - Dec)	34.40%	Acceptable level >50% Achievable level >75%		NICE recommends that Maternity Service's should ***"offer a first antenatal (booking) appointment with a midwife to take place by 10+0 weeks of pregnancy"***. UHS have a stepped approach to achieving this recommendation, which includes a First Point of Contact with a midwife and an appointment with an MSW for blood tests by 9+6 weeks. Women/clients are risk assessed at the First Point of Contact and appropriate care pathways are started (e.g. risk assessment for aspirin, smoking referral, consultant referrals) FPOC and booking data is shared with the senior team monthly, high levels of sickness combined with summer annual leave within the Self Referral Team is impacting compliance levels. Robust systems are in place to identify the most vulnerable women/clients.
% Bookings ≤ 9+6 weeks (NICE recommendation)	7.4%	4.7%	7.5%	7.7%	6.63%	6.30%	9.90%			
% Bookings ≤ 10+6 weeks	24.0%	26.5%	20.3%	29.9%	25.52%	13.10%	28.94%			

Birth Outcomes - mothers	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
Total number of Births (women/people)	1217	467	409	428	1304	5094	4963	1375 or fewer a quarter	More than 1375 a quarter	Total number of births for **2023 - 4963**
Predicted birth rate	1219	418	429	383	1230	4897	4808	1375 or fewer a quarter	More than 1375 a quarter	The final predicted birth numbers for Quarter 3 2023/24 was 1230, we had 1304 births. Predictions as of 04/01/2024 - Q4 - 1242 Q1 - 1189
Sets of Multiples	22	7	5	2	14	74	79	20 a quarter	21+ a quarter	Office for National Statistics 2020 data - National rate 14.4 per 1,000 women/birthing people. UHS multiple rate per 1000 births 2022 - 14.5 UHS Total number of multiple births - 2022 - 74 (73 x twins, 1 x triplets). 2023 - 78 sets of twins and 1 set of triplets
Home birth rate	0.53%	0.63%	0.70%	0.50%	0.61%	0.56%	0.63%	No performance threshold		ONS 2021 - 2.5% of maternities delivered at home UHS births - 2022 -29 homebirths 2023 - 32 homebirths
IOL rate	31.8%	32.10%	32.00%	33.90%	32.67%	30.23%	32.46%	Less than 33%	More than 33%	Total number of inductions 2022 - 1540. 2023 - 1611
Scheduled Caesarean Section capacity	225	83	72	70	225	689	814	157 or Less a QTR. 52 or less a Month	Greater than 157 a QTR. Or 52 a month	The Maternity services have calculated the number of elective caesarean sections capacity as 157 slots per quarter, equalling 627 a year.
Number of scheduled CS slots blocked due to complexity of cases on the list	27	5	6	7	18	New measure 2023	77	No performance threshold		New measure added to show the number of elective slots blocked out due to complexity of the cases on the lists
PPH 500ml or more - NMPA	36.4%	34.1%	38.7%	37.3%	36.7%	35.6%	35.7%	34.0% or less	Over 34.1%	% of term, singleton births with an obstetric haemorrhage more than or equal to 500ml. Source NMPA 2016/17 - UHS 34.5%(unadjusted) & 34.3% (adjusted) - National Mean 34.1%
PPH 1500ml or more - NMPA	3.2%	3.3%	5.1%	4.0%	4.1%	3.4%	3.8%	2.8% or Less	Over 2.9	% of term, singleton births with an obstetric haemorrhage more than or equal to 1500ml. Source NMPA 2016/17 - UHS 3.4%(unadjusted) & 3.3% (adjusted) - National Mean 2.9%. **Audit monitoring in place to understand any safety concerns. We have reviewed our processes around the management of blood loss and ongoing improvement work has recently seen the introduction of whiteboards in the clinical areas to improve the recording of blood loss, portable scales on the PPH emergency trolley and digitalisation of the equipment checks, including PPH trolley and emergency drugs.**
Episiotomy rate	29.1%	24.2%	25.90%	26.60%	25.6%	25.5%	26.8%	24.6% or less	Over 24.6%	NMPA 2018/19 total episiotomy rate 24.6% Reported figure related to all births, not NMPA specification
3rd/4th degree tears - NMPA	3.0%	3.2%	7.2%	4.6%	5.0%	3.0%	3.9%	3.1% or Less	Over 3.1%	% of term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear. Source NMPA 2018/19 - UHS 3.5%(adjusted) - National Mean 3.1% - Local indicators updated Q1 2022/23 - 3.1% **November/December 2023 - local audit to understand increase in cases**
ITU Transfers	0	0	1	1	2	8	9	1	2 or more	ITU data obtained via Trust BI team from Camis data. All cases shared with Maternity Risk Team and Maternity Audit Midwife for review

Birth Outcomes - Babies	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
Total babies born	1240	474	414	430	1318	5169	5043	1375 or fewer	More than 1375	Total number of babies born during - 2022 - 5169 2023 - 5043
Total number of registerable babies	1234	473	412	428	1313	5149	5012	No performance threshold		All liveborn babies plus stillborn babies born from 24 weeks gestation
Normal Birth Rate (babies)	41.4%	43.70%	44.20%	48.60%	45.50%	48.79%	45.91%	No performance threshold		All babies born via normal vaginal delivery
Apgar's <7 at 5 minutes - NMPA	3.0%	2.6%	2.5%	2.7%	2.6%	2.1%	2.6%	1.1% or Less	Over 1.1%	% of liveborn, singleton, term babies with an Apgar score of less than 7 at 5 minutes (BBAs excluded). Source NMPA 2018/19 - UHS 2.3%(adjusted)) - National Mean 1.1% - Local indicators updated Q1 2022/23 - 1.1%
Pre-term birth rate (registerable babies)	9.1%	9.7%	8.0%	8.4%	8.7%	8.7%	9.7%	No performance threshold		ONS 2021 - 7.6% of liveborn babies were pre-term Pre-term birth rate ambition announced in the NHS Long term Plan aims to achieve a 25% reduction in pre-term births by 2025 by reducing from 8% to 6%. Supportive improvement programme within our service include SBLs, specialist pre-term birth clinics, implementation of MCoC model of care. The recent improvements lead by MatNeoSIP include peri and post-partum optimisation of a very preterm infant additionally contribute to improving outcomes.

Neonatal outcomes	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
Encephalopathy >34 weeks (inborn babies, graded moderate and above)	1	0	0	0	0	4	7	No performance threshold		Awaiting further clarification from the LMNS on this outcome measure
Term Admission to NNU -All babies	5.4%	5.7%	5.60%	4.40%	5.7%	4.8%	5.7%	Less than 5%	More than 5%	2020/21 comparison 4.9% Data source - Neonatal Network.
Avoidable Term Admission to NNU - Excluding surgical/cardiac/congenital babies	3.6%	4.9%	3.20%	2.50%	4.9%	3.3%	3.9%	Less than 5%	More than 5%	2020/21 comparison 3.7% Data source - Neonatal Network and excludes babies coded under the surgical and cardiac categories -
Appropriate place of birth	100%	100%	100%	100%	100%	100%	100%	100%		Ensuring births occur in an appropriate place for the gestation of delivery is a measure reported upon by the National Neonatal Audit Programme and also falls part of Safety Action 6 (Saving Babies Lives) in the Trust's yearly submission of evidence to NHSR
Number of neonatal deaths	6	0	0	2	2	23	18	No performance threshold		Safer Maternity Care Progress Report published in 2021 removes the performance threshold for Neonatal Deaths occurring at any gestation. Moving forward the measure have changed to reflect liveborn from 24+0 weeks gestation who sadly die. Dashboard measure to be adjusted going forward
Neonatal deaths per 1000 live births	4.88	0.00	0.00	4.69	1.53	4.50	3.60	No performance threshold		

Public Health Outcomes	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
Infant feeding - Breast Feeding Initiation (mothers)	77.1%	81.1%	80.2%	76.9%	79.4%	75.3%	77.1%	More than 75.0%	Less than 75.0%	Source - NHS Digital 2018/19 - 75% Q2 2021/22 - Data taken from the BadgerNet feeding summary report - On BadgerNet Breastfeeding initiation is defined as "The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast (including familiarization) or the baby is given any of the mothers breast milk". We were unable to provide this level of detail from HICSS Maternity
Infant feeding - Breast Feeding at Discharge to community (babies)	53.9%	71.6%	72.6%	70.5%	71.6%	67.7%	64.7%	More than 70.6%	Less than 70.6%	Source NMPA 2016/17 - UHS 70.5% - National Mean 70.6% Q2/Q3 - it's worth noting there has been an increase in the number of records with missing data, this has been highlighted to the Digital Midwives and Infant Feeding Lead
Smokers at booking	9.1%	9.2%	6.6%	6.9%	7.6%	11.1%	11.3%	No performance threshold		Percentage of women who declare a smoking status at booking. In response to the National Tobacco Dependency Long Term Plan, UHS Maternity have trained nearly all community midwives as Tobacco Advisors who will be offering support to women who wish to undertake a supported quit attempt. And the inpatient pathway has been implemented.
Smoking at Delivery	7.0%	9.4%	7.6%	8.6%	8.5%	9.8%	8.2%	Less than 6.0%	More than 6.0%	The smoking at the time of delivery data is used to monitor the national ambition to reduce smoking in pregnancy to 6% by the end of 2022. Dashboard target changed from 11% to 6% December 2019
% of delivered women who quit during pregnancy	24.1%	25.5%	27.0%	40.0%	30.9%	26.8%	29.1%	No performance threshold		New measure. This figure is our quit rate comparing the smoking status declared at booking and whether the women is a smoker or non-smoker at time of delivery
Southampton City Smoke Free Pregnancy Monitoring	27.1%%	Quarterly reporting due next quarter				24.0%	Reportable next quarter	Greater than 35%	Less than 35%	% of Southampton locality women / pregnant people who successfully quit smoking during pregnancy

Booked Continuity of Carer	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
Booked - total women/pregnancy people booked onto a CoC pathway	15.7%	12.0%	8.9%	11.8%	10.9%	12.4%	13.1%	Greater than 35%	Less than 35%	Maternity continuity of care model is a key workforce model for our service ensuring all families, particularly those most vulnerable, have safer and improved pregnancy and birth outcomes. During COVID, and in response to the Final Ockenden Report, we were asked to consider suspending the MCoC model, so as to preserve our staffing resources and provide a safer workforce overall. After careful consideration, we decided that it would be safe for us to continue providing care within a continuity framework to our vulnerable families, but would not expand the model further, hence the work around the two pilot sites was paused. The current reduction in compliance reflects these changes. It is important that we know that the most vulnerable families are still supported by our Needing Extra Support teams (NEST) and as we progress workstreams around future workforce plans it will be likely that new and more sustainable MCoC models of care may be successfully implemented which in turn will see an increase in compliance levels. **Update - October 2023 - The current CoC provision has been further affected by staffing and operational pressures over the summer. The majority of this has affected continuity around intrapartum care. The maternity service is trialling a different way to recruit into these teams by offering more flexible options for midwives to seek to increase recruitment into these rewarding but very challenging roles. To give assurance the maternity services monitors and audits outcomes to ensure that groups most likely to be offered a CoC model are not showing as exceptions in our data or when clinically reviewing adverse outcomes.**
Booked - total BAME women / pregnant people booked onto a CoC pathway	40.6%	21.7%	11.8%	9.1%	14.2%	71.8%	18.6%	Greater than 51%	Less than 51%	
Booked - total women living within an IMD-1 area booked onto a CoC pathway	29.4%	34.2%	37.5%	54.2%	42.0%	75.1%	31.7%	Greater than 51%	Less than 51%	

Ockenden review	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
% Risk assessments undertaken at each AN contact	58.3%	53.4%	57.3%	54.9%	55.2%	46.9%	59.7%	Acceptable level ≥ 80% Achievable ≥ 90%		New dashboard measure. Data for these performance indicators is currently under review by the Quality/Digital Team. Risk assessment at each antenatal contact and place of birth continue to be monitored via local audits where compliance is greater. Compliance via BadgerNet is reliant on the authorisation of each note on Badgernet therefore there is some data quality work to be undertaken.
% Place of birth risk assessments undertaken at each AN contact	75.2%	74.3%	24.7%	77.2%	58.7%	68.9%	75.3%			
% High Risk women allocated a named consultant at any point during pregnancy	100.0%	100.0%	99.46%	99.6%	99.7%	94.0%	97.3%			

Saving Babies Lives v3	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
% Precept Mag Sulphate Criteria (<30 weeks)	73%	100%	100%	100%	100%	100%	85%	Greater than 80%	Less than 80%	% of singleton live births <30 weeks receiving Magnesium Sulphate within 24 hours prior to birth
Number of Stillbirths	4	1	2	2	5	17	15	5 or less	6 or above	Actual number of Stillbirths each quarter
Stillbirth rate per 1000 births	3.40	2.10	4.85	4.67	3.81	3.30	2.99	4.1 or less	4.2 or above	National rate 2021 4.2 per 1000 births
% <3rd centile >37+6 weeks	63.17%	63.60%	50.00%	40.00%	51.20%	New measure 2023	57.7%	To be defined		Numerator - number of babies born greater than 37+6. Denominator - total babies born less than the 3rd centile
Low Birth Weight at Term (<2500g)	2.6%	2.1%	2.1%	2.8%	2.3%	2.5%	2.2%	Less than 2.8%	More than 2.8%	Source Public Health England 2017 National average 2.82% of live term births.

Risk and Patient Safety cases	Q2 Total	October	November	December	Q3 total	2022 Totals (calendar year)	2023 Totals (calendar year)	Green	Red	Comments
Total number of cases UHS have reported to HSIB	1	0	0	0	0	6	5	n/a	n/a	December 2023 - no new cases. Four cases remain open - MI-023716/MI-026554/MI-0129127/MI-031668
Total number of UHS cases accepted for review by HSIB	1	0	0	0	0	6	5	n/a	n/a	
Term Intrapartum Stillbirths	0	0	0	0	0	0	0	n/a	n/a	
Early neonatal death	0	0	0	0	0	1	1	n/a	n/a	
Severe brain injury	1	0	0	0	0	4	1	n/a	n/a	
Maternal death	0	0	0	0	0	3	0	n/a	n/a	

The number of incidents logged graded as moderate or above and what actions are being taken	7	2	1	4	7	48	30	n/a	n/a	Moderate incidents are reported to the Board Level Maternity Safety Champions and the LMNS on a monthly basis. These figures now include moderate neonatal incidents but do not include HSIB reportable incidents which are reported separately. December 2023. 9963797 - ruptured ectopic pregnancy, case reviewed and felt to be well managed. Closed no further actions 9964396 - Suspected birth injury, baby reviewed and referrals made. 9964824 - delay in baby receiving IV antibiotics. Case closed with learning shared 9965240 - skin to skin in theatre, case with LW matron for learning
Number of SIs reported and under investigation	0	0	0	0	0	11	6	n/a	n/a	New figure reporting to provide clarity around SIs reported and under investigation per quarter. Only incidents reported as a SIRI (i.e. on STEIS) have been included. These may not include cases under HSIB investigation. 3 Current HSIB cases are still being investigated (which are STEIS reportable)
Number of major complaints received for Maternity Services	3	0	0	0	0	10	3	n/a	n/a	No Major complaints in Q3 Total maternity complaints received: Oct 1 Nov 1 Dec 3

Education and training	**Q2 Total**	**October**	**November**	**December**	**Q3 total**	**2022 Totals (calendar year)**	**2023 Totals (calendar year)**	**Green**	**Red**	**Comments**
Provider Board Level Measure - Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training										UHS Maternity service has a dedicated lead midwife and lead obstetric consultant with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring. Q1 2021/22 onwards, these percentages relate to Fetal Monitoring training provided via the Fetal Surveillance study day (previously included as part of PROMPT). June 2023 - all non-compliant obstetric trainees are rostered to attend PROMPT during July and August. July 2023 - details sent to all area leads August 2023 - 1 consultant to complete assessment and 2 booked on for September. Trainee compliance should be green by September as outstanding trainees booked
Fetal Monitoring Training (SBL2 & NHSR)	92.3%	94.4%	86.4%	87.8%	89.5%			Midwives	90% compliance target	
	84.7%	100.0%	100.0%	73.7%	91.2%			Consultant Obstetricians		
	82.0%	97.0%	94.0%	89.3%	93.4%			Obstetric trainees		

Friends and Family Test	**Q2 Total**	**October**	**November**	**December**	**Q3 total**	**2022 Totals (calendar year)**	**2023 Totals (calendar year)**	**Green**	**Red**	**Comments**
Responders as % of eligible populations	27.0%	22.6%	32.8%	25.3%	26.9%	24.2%	28.2%	20% or more	Less than 20%	Our rates have been consistently above the 20% Trust target since the introduction of sending a text to all families on Day 7 postnatal with the reminder and link to the 'Gather Survey' which commenced in April 2022. Ongoing work continues in all areas to help improve our services to reduce the percentage of families who would not recommend our service.
Recommenders as % of responders	84.7%	81.5%	83.3%	83.2%	82.7%	86.4%	85.7%	90% or more	Less than 90%	
NOT recommending as % of responders	4.6%	4.1%	4.8%	4.5%	4.5%	3.9%	3.9%	Less than 5%	5% or more	

Service monitoring	**Q2 Total**	**October**	**November**	**December**	**Q3 total**	**2022 Totals (calendar year)**	**2023 Totals (calendar year)**	**Green**	**Red**	**Comments**
Black Alerts / OPEL 4	10	3	1	4	8	31	27	0	1 or more a month	2020/21 - Average 0.75 a quarter 2021/22 - Average 7.5 a quarter .
Concerns raised	2	0	0	0	0	New reporting measure June 2023	4	0	1 or more a month	Qtr3 - No concerns raised to the Safety Champions. Intentional rounding taking place daily in all areas across the MatNeo service.

Appendix 2 – Serious Incident Overview

Qtr.3 New cases

Case type	ID	Log Date	Incident Trigger	Summary of incident	Outcome of incident
PMRT	89677	02/10/2023	Antepartum stillbirth	SOL at 20 weeks- Extreme prematurity- NND Presented to ED at 19+6 with back pain, discharged home. Represented to ED the next day (20/40) in labour, baby born with signs of life, survived for 1 hour. Complaint received from the patient which led to a scoping request.	Reported to PMRT PMRT completed, grading A/A/A Case heard at Clinical event review, no significant learning identified, bereavement team to ensure lead consultants informed of the stillbirth. Also, PST Scoping which deemed not for a PSII as no learning identified. To remain with complaints.
PMRT	89759	09/10/2023	Antepartum stillbirth	RFM at 41+ weeks Attended MDAU however no FH seen Routine IOL -No complications	Reported to PMRT PMRT completed, grading A/B. Case heard at Clinical event review, no significant learning identified, bereavement team to ensure lead consultants informed of the stillbirth.
PMRT	89745	06/10/2023	Neonatal death	Transfer from HHFT with extreme prematurity and NEC. Gestational age: 23+0 Baby RIP at 59 days of age	Reported to PMRT PMRT ongoing within timeframe. Case heard at CDRM – only action is to provide a soundproof room which is in the NNU expansion plan. Graded A/B/B
PMRT	90303	10/11/2023	Antepartum stillbirth	Low risk Pregnancy Attended MDAU with 1st episode of RFM, IUD diagnosed. Gestational age: 33+1	Reported to PMRT PMRT completed, grading A/A No care concerns nor learning.
PMRT (led by the Children's hospital)	90961	19/12/2023	Neonatal death	Antenatal diagnosis of HLHLS, ELLSCS at 39+2 Started on Prostin post birth. Soft dysmorphic features noted, genetics sent Anatomy not suitable for Norwood/Sano. No palliative options. Treatment withdrawn with agreement of parents. Baby RIP at 10 days of age	Reported to PMRT CDRM review scheduled in Jan 24 PMRT ongoing

Qtr.3 Closed cases (to note some PMRT cases were opened and closed within the quarter and are included in the open cases section)

Case type	Incident form	MNSI /PMRT	Closure Date	Incident Trigger	Summary of incident	Outcome of incident
HSIB SIRI	9942907	MI-021603	07/12/23	Therapeutic cooling	Low risk pregnancy. Laboured in alongside birth centre using birthing pool. Fetal bradycardia heard on IA, transfer to labour ward. Emergency instrumental birth at 39+1 weeks, baby born in poor condition and therapeutically cooled. Abnormal MRI.	HSIB report completed. Local action plan written. Closed at PSIIOG on 21/11/2023. **Appendix 3 - below**
HSIB SIRI	9946367	MI-024705	25/03/23	Therapeutic Cooling	Low risk pregnancy Attended MDAU for reduced fetal movements - Suspicious CTG Had ARM then CTG deteriorated therefore transferred to theatre for Cat 1 LSCS. Baby born in poor condition and transferred to NNU for cooling.	HSIB report completed. Local action plan written. Closed at PSIIOG on 21/11/2023. **Appendix 4 - below**
SEC	9944553		07/12/23	Myxoedema crisis	Patient transferred to ITU from Lyndhurst Ward as found extremely unwell on ward, working diagnosis myxoedema crisis. Patient had a significant social history with possible alcoholism/ drug use. Midwifery team earlier in the week assumed patient had been withdrawing on ward as behaving unusually. Baby had been found neglected overnight - drenched in faeces and urine, not fed regularly. Multiple learning opportunities in relation to deterioration, emphasis on substance withdrawal and communication regarding safeguarding.	RCA completed. Closed at PSIIOG on 07/12/2023. **Appendix 5 - below**
SIRI	9949437		05/10/23	Impact on service	NNU on OPEL 4 ALERT for just over 24hrs	RCA completed. Closed at PSIIOG on 05/10/2023. All actions completed, no new learning
PMRT	N/A	89652	15/11/2023	Neonatal death	Born at 32 weeks with a CHD/AVSD/hypoplastic Aortic Arch Was discharged home for palliative care and died one week post discharge.	PMRT completed, graded B/A/B

Qtr.3 Moderate incidents

Incident Date / Number	Type of incident	Summary of incident	Outcome of incident Key Learning and Recommendations
26/10/2023 9960693	Moderate incident	A pregnant patient had her ferritin level checked in August (was low) although this was not actioned (treatment not initiated at the time i.e., iron transfusion). Patient reports went away on holiday for a month during which she did not take her iron tablets. She presented for preassessment on the 25/10/23 was 78 and she received 2 units of PRC on the 25/10/23 before elective section. In summary, a transfusion could have been avoided if iron transfusion was given in a timely manner and low ferritin actioned.	Downgraded to Low minor as there was no harm caused Delayed care due to patient having informed the midwife that she was moving out of area. The midwife advised that she contact her new midwife as a matter of urgency to access the ferritin infusion care
13/11/2023 9962567	Moderate incident	Issues with UHS midwife access to Badgernet and account being merged with a Student midwife in Nottingham.	Downgraded incident to Low/ minor as no harm by Digital team, who have investigated the incident.
13/12/2023 9963797	Moderate incident	Patient attended for Flu jab however felt unwell and was advised to attend ED. Patient collapsed at ED. This lady underwent emergency surgery for a ruptured ectopic pregnancy and has now been discharged home.	Scoping meeting was held on 2/1/2024 and no further action is required as this case was deemed to be well managed in the circumstances.
15/12/2023 9964396	Moderate incident	Baby born by ventouse in labour room. Subsequently broken nose and septum identified and shoulder/clavicle fracture currently being investigated. Further investigation showed that there were no fractures and that these had initially been identified due to structural differences. Issue with nose appropriately identified at birth and noted for review at NIPE, Review and referrals to ENT and NNU made. Reviews completed and pain relief prescribed.	Case discussed at CER on 02/01/2024 -Downgraded to low harm as no Nose fracture identified, structural differences noted, which baby is being followed up for. No other fractures however baby has an Erb's palsy for which she is undergoing Physio for.
21/12/2023 9964824	Moderate incident	Baby had a delay in receiving IV Antibiotics	Case closed with local learning for staff DOC being undertaken.
29/12/2023 965240	Moderate incident	Baby was put skin to skin during ELLSCS however this was felt to be inappropriate by the Anaesthetic team as baby was not in good condition.	AER with LW Matron to close with local learning to be disseminated. For clinical event review, likely to be downgraded

Appendix 3

Sharing the Learning

Incident AER - 9942907

Summary of incident:

A 25-year-old, White British mother was booked for maternity care at 8 weeks and 5 days' gestation (8+5 weeks) in her first pregnancy. The Mother's plan was to give birth in an alongside birth centre. At 39+1 weeks, the Mother contacted the maternity triage telephone service on three occasions for advice as she was having contractions. On the third occasion, having also reported vaginal bleeding, the Mother attended MDAU. The Mother was found to be in labour, and the vaginal bleeding was considered to be a heavy show. The Mother was transferred to the alongside birth centre for midwifery led care in labour. During intermittent auscultation of the Baby's heart rate a slowing of the heart rate was heard (a bradycardia) and the Mother was transferred to the labour ward for ongoing care. The Baby's birth was assisted shortly afterwards using a ventouse cup.

Outcome:

The Baby, who weighed 2,950g at birth (on the 15.7th growth centile and within the expected range), was born requiring resuscitation. The Baby met the criteria for therapeutic cooling. An MRI was performed at six days of age, this found 'restricted diffusion within the posterior lentiform nuclei bilaterally in keeping with HIE [hypoxic ischaemic encephalopathy]'.

Contributory factors:

- Lack of appropriate risk assessment for place of birth

Areas for improvement:

- Staff to ensure that Baby's temperature is monitored in line with national guidance when cooling is commenced (as this resulted in a risk of over cooling the Baby)
- Staff to be made more aware of local guidance when a mother's PAPP-A result is found to be beneath the expected range

Learning points for sharing:

The Trust to ensure that all mothers planning birth on a midwifery-led unit who are admitted with new risk factors have a holistic obstetric review in person to plan ongoing care in labour.
Staff to escalate to the shift lead/Operational Co-ordinator if they are unable to follow guidance regarding Intermittent Auscultation (IA)

Appendix 4

Sharing the Learning

Incident AER - 9946367

Summary of incident:

A 22-year-old white British mother was booked for maternity care at 11 weeks and 6 days' gestation (11+6 weeks) in her first pregnancy The Mother followed a low-risk antenatal care pathway. At 39+3 weeks, the mother attended the maternity day assessment unit reporting back pain and no fetal (Baby) movements for approximately five hours. Following assessment, a cardiotocograph (CTG) was commenced which showed an abnormal antenatal CTG trace.The Mother was transferred to the labour ward, where the CTG became pathological, and a plan was made for a category 2 emergency caesarean section. After the CTG trace deteriorated further showing a bradycardia (slow heart rate), the caesarean section was upgraded to a category 1 emergency caesarean section. The Baby was born in poor condition, weighing 3,080g, on the 28.5th centile (within the expected range), making no respiratory (breathing) effort and required full resuscitation. The Baby was admitted to the onsite neonatal intensive care unit (NICU) where active therapeutic cooling commenced and continued for 72 hours.

Outcome:

- An MRI of the Baby's head was performed at 6 days of age and stated 'the appearances are those of mild ischaemic damage involving basal ganglia.

Contributory factors:

Delay in handing over care to the Night team.
Delay in transferring mother to Labour Ward

Areas for improvement:

Review of handover processes from MDAU to incorporate shift change time.
Review delays in LSCS

Learning points for sharing:

The Trust to ensure that all cardiotocographs that are undertaken are systematically categorised, and if an antenatal cardiotocographs is found to be abnormal, a plan of care with a timeframe to expedite birth is documented

Staff to receive an update on placing 2222 emergency calls

Appendix 5

Sharing the Learning

Incident AER - 9944553

Summary of incident:

A 41-year-old white British mother was booked for maternity care by the NEST team at 9 weeks gestation (9+0 weeks) in her sixth pregnancy. She had a history of hypothyroidism and cannabis usage. there were missed opportunities to take bloods to monitor and manage her thyroid function in the first and second trimesters. The thyroid function tests taken at 34+6 weeks gestation were highly abnormal, and whilst this had been noted by maternity services, it was assumed that follow up and medication adjustment would be undertaken by primary care in coordination with the midwife. The woman had an unplanned home birth and was admitted to PAH for postnatal care. She On admission it was noted that she was very tired. This presentation continued over the next 36 hours, but because she had a significant social history with possible alcoholism/ drug use, the team assumed that she was exhibiting withdrawal symptoms. The following morning, Ms VW was found to be semi unresponsive, difficult to rouse and complaining of feeling very unwell. She was quickly escalated to the on call consultant who immediately reviewed VW. She was escalated to the medical outreach team with a working diagnosis of myxoedema crisis.

Outcome:

No long term harm to baby nor mother

Contributory factors:

There was an assumption, likely with an element of confirmation bias, by the midwifery and medical staff that VW's drowsiness was linked to her past history of drug and alcohol abuse, coupled with the fact that she had just given birth.

Myxoedema crisis is a rare complication, which is infrequently seen. None of the attending staff considered this as a reason for the symptoms that VW was exhibiting.

There were missed opportunities for the GP and the midwifery/obstetric team to monitor and manage the Thyroid function tests (TFT) levels.

It is believed that there was poor patient compliance with blood tests/taking medication. Capacity was not formally assessed as there was not an indication to do so. The GP noted that VW was able to understand and retain the information, balance the information and communicate her decisions

Areas for improvement:

TFT's to be taken with booking bloods as a baseline if the patient has hypothyroidism and these should then be repeated each trimester as per University Hospital Southampton (UHS) guideline.

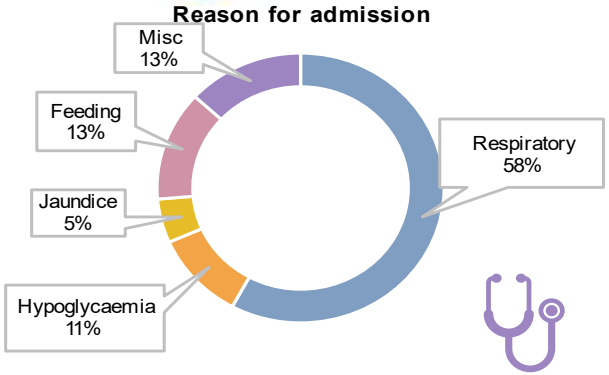
Learning points for sharing:

- Training to be provided to the maternity/obstetric teams about situational awareness
- TFT to be taken at booking and in each trimester as a minimum
- Improved working between primary and secondary care

Appendix 6 – ATAIN Deep Dive

ATAIN

Reason for admission



Respiratory – 22 cases reviewed

Ethnicity
68% White British
18% Black African
9% White Other
5% Pakistani

Deprivation decile
23% IMD 1&2
27% IMD 3&4
23% IMD 5&6
23% IMD 7,8,9,10
5% IMD Unknown

Type of delivery
27% NVD
27% Cat 1 & Cat 2 CS
18% Cat 3 CS
18% ELCS
9% Forceps

Qtr. 3 2023– 38 unexpected term admissions

Current and Ongoing Quality Improvements

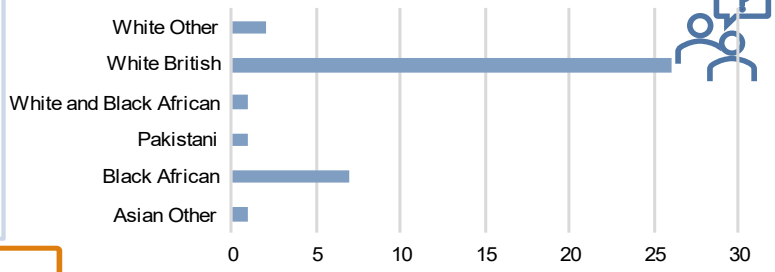
- Management of hypoglycaemia processes and pathways
- Management of thermoregulation processes and pathways
- Implementation of Infant Feeding Initiative

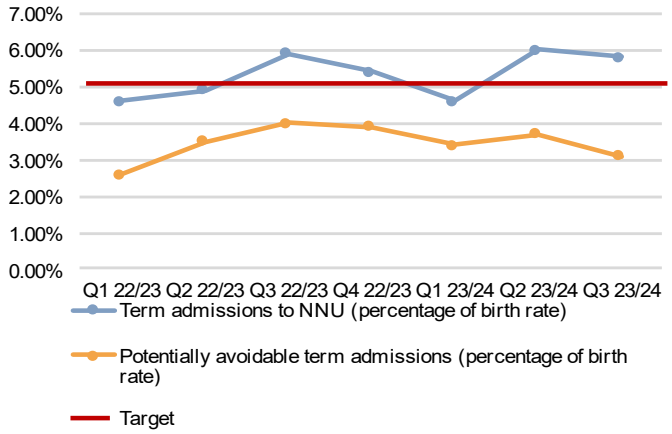
New 2023 Quality Improvements

- Management of jaundice increasing use of bilirubinometers
- Implementation of NEWTT/NEWS – Upcoming regional implementation in 2023/4
- Pilot of in-reach neonatal nurse in Q3 to support babies after delivery to remain with their mothers

Admission from:
- Home x 2
- Delivery Suite x 15
- PN ward X 7
- Theatre x 8
- Unrecorded x 6

Ethnicity of delivered women/birthing person





Appendix 7 – Shared Learning

Quarter 3 2023
Learning from Maternity Clinical Event Reviews

MatNeo Clinical Events Reviews
MDT reviews of any adverse incidents, critical incidents or concerns raised via an AER.
ATAIN – Avoidable term admissions of the infant

Aim: Promoting a patient safety culture and a patient safety system, including a 'systems' approach to error considering all relevant factors and means the pursuit of safety focuses on strategies that maximize the frequency of things going right.

Tools & Technology

- IT Systems & lack of resources.
- Utilising the Badgernet management plans and ensuring this builds the clinical picture.
- NN Call Bell System is currently down new bleep process in place to summon emergency support

Internal environment

- When delaying elective work due to capacity ensure clear plan documented.
- When environment is busy and capacity high, documentation via Badgernet can be impacted.

External environment

- Decisions made around care planning influence by split site working.

Tasks

- 2222 for ALL emergencies (even in theatre or on LW).
- At each Antenatal contact/review for any recent appointments/USS.
- Always check Badger for critical alerts, and add if required i.e. GBS, Antibodies.

Person

- When reviewing a CTG, as part of the review, look back at previous CTG's to help with ongoing plan of care.
- Senior/Obstetric review must be sought when patients deemed to be HIGH risk present to the MDAU.
- PROMPT MDT training focuses on working together at managing emergencies.

Organisation

- Creating a culture that promotes patient safety.
- MDT approach to High-risk patients for ongoing care plans.
- .

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Corporate Objectives 2023/24 – Quarter 3 review**			
Agenda item:	**7.1**			
Sponsor:	**David French, Chief Executive Officer**			
Author:	**Kelly Kent, Head of Strategy and Partnerships**			
Date:	**30 January 2024**			
Purpose	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information**

Issue to be addressed:

The 2023/24 Corporate Objectives were approved by the UHS Board in May 2023 and were noted by the Board to be deliberately stretching but highly focused to bring the trust back to equilibrium with capacity and demand and within the confines of the overall financial position.

Response to the issue:

This paper provides an update regarding achievements of Quarter 3 for 2023-24.

During Q3, there has been a positive increase to 60% of the Q3 objectives which were noted as on track to be delivered in full.

The agreed objectives have been RAG rated:
Green = On track to be delivered in full
Amber = Minor delays/or shortfall in target
Red = Significant delays/or shortfall in target

Ref	Corporate ambition	Leads	Number of Objectives for 2023/24	Q3 Green	Q3 Amber	Q3 Red
1	Outstanding patient outcomes, safety and experience	COO/CMO/CNO	5	4	1	0
2	Pioneering research and innovation	CMO	5	4	1	0
3	World class people	CPO	5	2	2	1
4	Integrated networks and collaboration	CEO/CMO	5	3	1	1
5	Foundations for the future	CFO/COO/CNO	5	2	2	1
Totals			25	15	7	3
			% against 25 Objectives	60%	28%	12%

The areas with the highest on track objectives are: -

Outstanding patient outcomes, safety, and experience with 4 objectives on track; seeing continued increase on shared decision-making questionnaires completed. Also, successful roll out of PSIRF and next steps of reviewing the plan and policy for April 2024 and continued training with specialists now undertaking level 3 of the patient safety syllabus. There is also much work continuing with fundamentals of care and the annual review has taken place for QPSPS to establish what is working well and what can be learnt/improved upon.

Lastly despite repeated strike action UHS has remained close to our glide path for seeing patients no more than 65 weeks for treatment with the only exception being ophthalmology where the treatment of long waiting corneal transplant patients has been impacted by national tissue supply issues.

Pioneering research and innovation also have 4 objectives on track, seeing an 8% improvement against the national metrics for site set-up and time to target for clinical research studies. The 3rd year of the research and innovation investment plan continues to deliver as planned. Year 1 of the R&D strategy implementation plan for research impact has seen alignment with annual plan and is under regular review.

	Strengthening and broadening of the UHS/UoS partnership for research also continues- a paper was taken to Joint Strategy Board for approval on 16/01/2024 and will now go to the Joint Senior Operational Group before submission at UoS council and UHS board meeting. The areas with the highest number of objectives outstanding or greatest risks are: • World Class People • Integrated Networks and Collaboration • Foundations of the future The *World Class People* objectives at greatest risk relate to the workforce plan- During Q3 our nursing vacancy position further reduced due to our newly qualified nursing intake and also a further intake of overseas nursing. At 31 December our registered nurse vacancy rate stands at 5%. This is the lowest it has been in over 10 years. To date, whilst the substantive workforce has increased, the required sustained reductions in the banks have not come to fruition. In addition, planned cost improvements in WTE have not been fully delivered. As a result, UHS is UHS is 293 WTE above the NHSE plan as of the end of December 2023. To slow substantive growth a recruitment pause has been initiated in Q4. Substantive recruitment prioritisation is being determined by a senior clinical panel. Further controls on bank authorisation have been introduced. A projection of the workforce to the end of Q4 has been produced for 2023/24 based on known committed starters. The projection also demonstrates the level of bank and agency reduction required to meet our financial recovery plan. *Integrated networks and collaboration:* the ambition with greatest risk of non-achievement is the aim to halve the number of patients without criteria to reside in UHS. *Foundations of the Future:* The NHS/Trust financial position presents the greatest challenge within this strategic ambition: Financial Recovery actions are underway to deliver back to £26m plan for 23/24, but there is significant risk to achieving a break-even run rate by April 2024.
Implications: (Clinical, Organisational, Governance, Legal?)	Achieving appropriate corporate objectives which are aligned to our Values, Strategic Ambitions, Legal and Regulatory requirements will have positive impacts.
Risks: (Top 3) of carrying out the change / or not:	In the absence of this process, we would risk: • failing to take the right steps, over the next year, in order to support achievement our longer-term strategic ambitions. • not being able to appropriately monitor progress and make corrective adjustments when required
Summary: Conclusion and/or recommendation	The Board is asked to note the progress made delivering the corporate objectives in the context of the agreed objectives being deliberately stretching.

Appendix 1 – Corporate Objectives and Quarter 3 updates in full

Strategic Theme One - Outstanding Patient Outcomes, Safety and Experience

Objective	Q2 Update	Q3 Update
Increase the number of reported Shared Decision-Making conversations as evidenced by SDMQ9 questionnaires to >500.	On track. - 210 SDMQ9 questionnaires have been collected in Q1 and 2, which is slightly behind target (500 full year). Volunteers are supporting key CQUIN areas with increasing data collection. New specialties have requested SDMQ9 templates to be set up following the consultant meeting roadshow. - NHSE/ HIOW workshop on SDM in MSK pathways is due to take place 2nd November. - We are UHS presentation on Shared decision making planned to engage more teams.	On track: Over 301 questionnaires captured in Q1-3 - NHSE/ HIOW workshop on SDM in MSK pathways took place 2nd November. Follow up booked for 29th Jan. - CQUIN continues within adult and paediatric congenital heart and head and neck and is on track.
Objective	Q2 Update	Q3 Update
Increase number of specialties reporting outcomes that matter to patients to >90%.	Partially achieved- new format started with specialist medicine. New templates delivered a refreshed focus on areas to be celebrated, in need of improvement and action plans. The number of specialties reporting remains at 82%. Areas who have not presented in previous years have not brought outcomes to the past 2 meetings. We are developing support and follow up framework for these specialties to improve the ability to contribute going forward. We are developing support and follow up framework alongside care group leadership teams for these specialities to improve their ability to contribute moving forward.	Partially achieved at 82%. Although the percentage remains stable, the quality of outcomes being reported has improved. There has also been a divisional structure set up to enable more closely working with specialites, particularly with those who are not currently reporting.

Objective	Q2 Update	Q3 Update
Roll out PSIRF across the trust by March 2024.	ON track. The PSIRF plan and policy has been agreed with the trust board and ICB and we have switched away from the SI framework to PSIRF on the 2nd October. As part of the move to PSIRF we have introduced a new cases review meeting and a Patient safety Incident Investigation Oversight Group. Each division has at least 2 patient safety/governance team members who have done the HSIB level 2 investigator training. Over 140 have completed the introduction to PSIRF training, although 1200 staff have completed the level 1 patient safety syllabus this remains a focus. We are providing PSIRF oversight training to senior leaders across the organisation during October to December.	On Track: UHS transitioned to PSIRF on 2nd October 2023. The plan and policy will be reviewed at the end of April 2024. PSIRF oversight training was provided to the Trust Board in December. The patient safety specialists are currently undertaking the level 3 patient safety syllabus education. The new cases review group continue to evolve to ensure that the proposed investigation plan is in line with the PSIRF plan and identifies system based learning. The assurance around local learning reviews and their consistency across the divisions is requiring ongoing work, as is the robust monitoring of actions for all patient safety investigations to ensure corporate oversight of learning and actions. After action review (AAR) training has been established in line with HSSIB training. The process for pressure ulcer AAR's is currently under review to ensure it is the appropriate tool to be used. The education of staff continue to slowly increase with over 1600 having completed level 1 of the patient safety syllabus and 174 trained on the introduction to patient safety incident investigations.

Objective	Q2 Update	Q3 Update
Work with patients as partners to improve patient satisfaction in 5 targeted areas: wayfinding, PSIRF rollout, fundamentals of care, activities, and carer involvement.	On Track - QPSP'S: This quarter saw one of our QPSP's withdraw due to personal reasons. The remaining 5 continue to be active and support a number of projects. The wayfinding project has yet to commence. The 'Brain Gym' project was undertaken across four wards with one of our QPSPs taking the lead supported by therapies. Both quantitative and qualitive feedback was recorded and demonstrated a significant improvement of patients feeling mentally stimulated. This project is being presented at We are UHS week. Our QPSPs continue to be core members of the PSIRF operational and oversight groups, Patient safety steering group and Serious incident scrutiny group (This has now become the patient safety incident investigation oversight group). Other projects include supporting the fundamentals of care, call for concern, NATSSIPs and a trial of being linked with one divisions QI team. Our QPSP's have now been in post for 1 year and we have been reviewing our year and the learning and challenges will be summarised in an annual review for Trust Board. Each QPSP has been offered an annual review with their Mentor and Buddy. QPSP recruitment has been supported by the group attending a number of diverse events including radio Aswad, Freshers Week and Southampton Pride. We have received 6 applicants with some diversity, informal conversations have been held and those successful will start their training in October. With more QPSPs becoming available we are setting up a process for oversight of the project requests to ensure that they are suitable and that we are not overloading anyone QPSP. The QPSP's have been made a significant contribution to the FOC work to date, providing a patient centric view on all the core standards that have been developed. The working group are keen to ensure that patient stories are the focus in the roll out across the Trust and will be working with patients and their families to make this happen. The Carer's Lead continues to work closely with carers to hear their experiences by facilitating "drop in" clinics within ward areas and undertaking ward rounds. We are part of ICS discussion and planning for carer passports and referral pathways for the support of carers across the area. Obtaining a higher depth of carer feedback is now being prioritised to enhance the carer voice within development and planning of services within the Trust."	The QPSPs continue to be active participants at the Patient Safety New Cases Group (PSNCG), Patient Safety Inicident Investigation Oversight Group (PSIIOG), PSIRF Oversight Group and Patient Safety Steering Group (PSSG). The annual review for the QPSPS has taken place to identify what is working well and what has worked less well which will be summarised in an annual review for Trust Board. Process and clarity on the roles and responsibilities is being developed to ensure all have oversight of this. Each QPSP have had a personal annual review with their buddy and mentor. Six new QPSPs have commenced in this quarter and are part way through their training. The Call For Concern which is linked to the national Martha's rule (national legal requirement) has been rolled out across medicine, with oncology and medicine for older person by end of January and subsequent areas following this. There have only been two calls for concern in four months, ongoing communciation will be dsitrubuted to promote this service. The Fundamentals of Care workstreams continue and have active enagagement from clinical staff and QPSPs, providing patient centric focus. Wayfinding project on hold due to financial constraints. Due to be reviewed in 2024/25.

Objective	Q2 Update	Q3 Update
Treat patients according to need but aim for no patient to wait, other than through patient choice, more than 65 weeks for treatment by March 2024.	On Track - despite industrial action, we have remained close to our glide path. We have reiterated our commitment to the ICB and NHSE that based on the current operational situation at UHS, we will achieve this target for all specialties with the exception of Ophthalmology where the treatment of long waiting corneal transplant patients has been impacted by national tissue supply issues.	On Track - despite industrial action, we have remained close to our glide path. We have reiterated our commitment to the ICB and NHSE that based on the current operational situation at UHS, we will achieve this target for all specialties with the exception of Ophthalmology where the treatment of long waiting corneal transplant patients has been impacted by national tissue supply issues.

Strategic Theme Two - Pioneering Research and Innovation

Ref	Lead	Objective	Q2 Update	Q3 Update
2(a)	CMO	**Deliver national metrics for site set-up and time to target for clinical research studies (80%).**	Reduction in meeting 80% over the summer due to staff leave and vacancies. Currently addressing and expect to see improvement again in Q3.	On track. At the end of Q3 this KPI had been achieved and exceeded (88%). There may be slippage in Q4 due to changes in Trust HR recruitment processes at the end of Q3.

Ref	Lead	Objective	Q2 Update	Q3 Update
2(b)	CMO	**Improve Trust position against peers to secure Top 5 ranking for CRN portfolio weighted recruitment, and Top 10 ranking for absolute recruitment.**	Large study opened in September which has had an impact on ranking already (moving from ranking from 21 to 17 for absolute recruitment and 14 to 12 for weighted recruitment). Should continue to see improvement in ranking as we go forward as recruitment to this study is going well. Ongoing work on action plan will also impact in longer term.	There has been a slight improvement in the ranking (moving from 17 to 15 for absolute recruitment and from 12 to 10 for weighted recruitment).Another large study is due to commence recruitment in Feb 24 which will further help with achieving this. The portfolio balance required to enable objectives to be met has been reviewed and is being regularly communicated to research leads. Work is ongoing with action plan which will also impact in the longer term.

Ref	Lead	Objective	Q2 Update	Q3 Update
2(c)	CMO	**Deliver year 3 of the research and innovation investment plan including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure.**	On track	On track

Ref	Lead	Objective	Q2 Update	Q3 Update
2(d)	CMO	**Develop the five-year R&D strategy implementation plan for Research for Impact and deliver year 1.**	On track. Implementation plan has been developed and due to be shared with action owners in Q3. Progress with the implementation plan is aligned with the R&D annual plan.	On track. Alignment of developed implementation plan with R&D annual plan enables regular review.

Ref	Lead	Objective	Q2 Update	Q3 Update
2(e)	CMO	**Strengthen and broaden the UHS-UoS partnership through mapping alignment and characterising our Research Centres of Excellence.**	On track. Joint strategic vision drafted and currently out for review. Will be taken to Joint Strategy Board for approval before being taken to Senior Operational Group in Q3 and then onto UoS Council and UHS Board meeting.	In progress. Will be taken to Joint Strategy Board for approval on 16/01/24 before being taken to Senior Operational Group in Q4 and then onto UoS Council and UHS Board meeting. JSRB will be asked to identify potential new centres of research excellence.

Strategic Theme Three - World Class People

Ref	Lead	Objective	Q2 Update	Q3 Update
3(a)	CPO	**Support the delivery of our workforce plan for 23/24 through recruitment to key vacancies, reductions in temporary staffing, and targeted CIP.**	UHS is 183WTE over the NHSE plan at the end of September, with increases in substantive WTE through NQN and overseas recruitment and challenges in significantly reducing temporary staffing. Constructive executive-led workforce meetings were held in September with every division and THQ function. These focused on reviewing headcount, CIP plans, and overall workforce usage. The workforce plan has been broken down to the divisional level with regular reporting. There continues to be a strong focus on oversight and control of temporary staffing spend. A programme of training for budget holders focusing on budget management, rostering and best practice temporary staffing management has been rolled out. We continue to implement grip and control through corporate sign-off of vacancies through our senior weekly recruitment control process. The Chief Nurse is also leading work with divisional nursing leads, workforce and finance to focus on bank expenditure. The Deputy Chief Nurse is also leading work on our usage of mental health registered nursing and HCAs to try to reduce where possible safely. Weekly reporting internally and to the ICB continues"	During Q3 our nursing vacancy position further reduced due to our newly qualified nursing intake and also a further intake of overseas nursing. At 31 December our registered nurse vacancy rate stands at 5%. This is the lowest it has been in over 10 years. To date, whilst the substantive workforce has increased, the required sustained reductions in the banks have not come to fruition. In addition, planned cost improvements in WTE have not been fully delivered. As a result UHS is UHS is 293 WTE above the NHSE plan as of the end of December 2023. To slow substantive growth a recruitment pause has been initiated in Q4. Substantive recruitment prioritisation is being determined by a senior clinical panel. Further controls on bank authorisation have been introduced. A projection of the workforce to the end of Q4 has been produced for 2023/24 based on known committed starters. The projection also demonstrates the level of bank and agency reduction required to meet our financial recovery plan

Ref	Lead	Objective	Q2 Update	Q3 Update
3(b)	CPO	**Reduce turnover to below 13.6% and sickness absence to 3.9% by March 2024.**	On track - in month sickness for September was 3.8%, slightly higher than the previous month due to increases in Covid, and the same as the annual rolling sickness value. Rolling turnover for September was 12.1%, lower than target.	Sickness and turnover both continue to be on track in Q3. In-month sickness for December is 4.1% and 3.7% rolling 12 month average, which is within the <3.9% threshold and local standard. Covid sickness absence has reduced in November and December. The turnover target is <13.6% and as of December, the rolling turnover is 11.5%.

Ref	Lead	Objective	Q2 Update	Q3 Update
3(c)	CPO	**Increase overall participation in the NHS staff survey and maintain our overall staff engagement score and recommendation of place to work in line with comparator organisations (Feb 2024).**	The Staff Survey for 2023 is now open and runs until 24 November. There is an action plan in place to support departments with traditionally low uptake to maximise response levels. UHS Champions Awards and 'We Are UHS week' ran in mid-October and both were exceptionally well received. The CEO and CPO have met with every division to review staff survey actions taking place. There has also been a campaign of publishing how the Trust has responded to the key challenges our people are facing, including a letter from the CEO and CPO to all staff. Despite significant ongoing action on staff experience at a corporate and local level, we remain concerned about a likely reduction in staff engagement scores in the 2023 survey. The scores at UHS are likely to be impacted due to ongoing intense service pressure, industrial action, financial pressures, and the general macro environment of the NHS. This is reflected in the amber RAG rating for this objective.	The 2023 Staff Survey results have started to come in via Picker, our survey provider. These results are embargoed until March when results are nationally released. Reports show our participation rate fell by 14% on last year, 5639 people (41% of those eligible). This is a disappointing result, despite significant support offered to enable people to complete via drop in sessions, taking laptops to clinical areas, lack of capacity significantly impacted on participation. We did not offer incentive vouchers for hot drinks this year which may have impacted on participation. A plan to release data into the organisation via a Power BI dashboard will commence at the end of January for managers to take a first look at their results and start to consider action. Reporting on 2023 results will take place through usual governance and to Trust Board in March when the embargo is lifted. Teams will be supported to action plan on their results as per the usual process in Q4.

Ref	Lead	Objective	Q2 Update	Q3 Update
3(d)	CPO	**Increase the proportion of appraisals completed and recording to 85%, and increase staff quality perception of appraisal, by March 2024.**	Rolling appraisal performance was 76.7% in September, against a target of 85%. Strike disruption and hospital capacity challenges are impacting upon ability to achieve target. There continues to be a focus on delivering timely, effective appraisals across all areas of the organisation.	The rolling appraisal performance in December was 76.9%; an improvement from Q2 but not meeting the 85% target. Appraisal completion has been affected by a combination of factors, including overall service demands, higher levels of absence, and continued industrial action disruptions. In Q4 planned work will commence to offer a digital appraisal via the refreshed VLE, which will enable functionality for talent management, also in response to the staff survey results teams with lower results and lower appraisal compliance will be asked to participate in a "proof of concept" pilot on a simplified appraisal with in built impact measures.

Ref	Lead	Objective	Q2 Update	Q3 Update
3(e)	CPO	**Deliver year 1 objectives of the Inclusion and Belonging strategy by March 2024.**	Progress is being made with all streams of the Inclusion and Belonging Strategy, with key working groups focused on each element. The Actionable Allyship training programme continues, at the end of September **51.2%** of UHS staff had participated against a target of 50% at end of 2023, and a stretch target of 80% by end of 2024. Following on from recent bullying and harassment experiences shared on social media, F2SU listening events hosted by Execs and Senior leaders have commenced and will continue into October and November to enable people to speak up and be heard, and actions to be taken. An independent review of the People Policies, specifically grievance and disciplinary processes has commenced. Full quarterly updates against each strategy theme of the Inclusion and Belonging Strategy are reported to the EDI Committee, and to People and OD Committee	Progress continues against plan. At 1st January 2024 the participation in the Actionable Allyship was 60%. There has been a slow down of participation over the final month in Q3, although we have exceeded our target of 50% participation at this point against a stretch target of 80% by the end of 2024. Q3 saw the completion of two Positive Action Leadership Programmes, one focused on our Nursing and Midwifery workforce facilitated by the Florence Nightingale Foundation, and the other for all other staff facilitated by the Mahaa People. Both programmes were highly evaluated and participants are now taking part in reciprocal mentoring, career development, and in Q4 will be offered the chance to take part in a simulation recruitment centre to gain confidence in future interviews and assessments. Mobility of the participants is tracked at regular intervals to capture the success of programme in terms if our target of increasing our representation at senior levels. Our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results were reported in Q3. These showed a continued improvement in our WDES and experiences related to race and ethnicity. However the experiences of colleagues with disabilities has continued to decline. An action plan has been agreed to focus on improvements which will be monitored by People Board and the EDI committee.

Strategic Theme Four - Integrated Networks and Collaboration

Ref	Lead	Objective	Q2 Update	Q3 Update
4(a)	CMO	**Work in partnership with acute trusts to agree and implement the acute services (and planned care) strategy.**	Partially achieved - ICS medical directors group taking forward discussions on clinical networks strategy and focus. - Progress continues to be monitored and supported in specialty networks. - Minor delays to pursuing plans while ensuring alignment to ICB's vision.	Partially achieved - ICS work ongoing, but progressing and focussed on single point of access for dermatology and ophthalmology. UHS meetings planned with UHD and SFT to discuss specific network opportunities.

Ref	Lead	Objective	Q2 Update	Q3 Update
4(b)	CMO	**Produce and embed an internal framework for network development to drive delivery in critical/ prioritised networks, demonstrated by progress against the UHS networks maturity matrix.**	On track - INC board have approved renewed governance approach with greater oversight of annual plans. - Continuing to measure improvement against objectives - regular review of all prioritised specialties enabled through INC Board - Delay to progress in some specialties due to time and resource internally and externally.	On track

Ref	Lead	Objective	Q2 Update	Q3 Update
4(c)	CMO/ COO	**Work with the Local Delivery System on vertical integration with ambition to halve number of patients without criteria to reside in UHS.**	The number of patients not meeting the criteria to reside remains significantly above both historic levels and plans, consistently over 210 and up to almost 250. The removal of Hospital Discharge Programme (HDP) funding by the ICB represents a further risk, meaning that we are likely to see a deterioration rather than improvement in the position. To try to mitigate this UHS has agreed to contribute to a ICB wide scheme to keep some short term services beds in Hampshire open, that would otherwise have shut with the removal of HDP funding. We also continue to work with the Local Delivery System to support their improvement plans. However, we have no assurance that the number of patients not meeting the criteria to reside will reduce over the rest of this year.	Numbers of patients not meeting criteria to reside continues to increase for UHS. ICS and council budgets challenged leading to lack of viable plans externally. UHS continues to focus internally on discharge processes as part of the Flow transformation programme, and also working with external partners on improvement work.

Ref	Lead	Objective	Q2 Update	Q3 Update
4(d)	CMO	**Work with system partners to open the surgical elective hub in Autumn 2024.**	On Track: Clinical workshops are in progress to design clinical, financial and operational pathways. The Elective hub is expected to be open early 2025.	On Track: UHS plans for elective hub use agreed in principle. HHFT are waiting on updated pricing and building clearance to confirm being able to meet current timeline of Feb 2025 for build.

Ref	Lead	Objective	Q2 Update	Q3 Update
4(e)	CEO	**UHS to be seen as an anchor institution in the local area and have developed projects with partners e.g. University Technical College (business case approval) and Southampton Renaissance Board (city masterplan).**	On Track: UTC opening approved (only new school in south of England). Education team working with UTC leadership to develop and influence curriculum in line with our needs. Renaissance Board established and estate masterplan nearing completion. A health inequalities steering group has been established to agree priorities and plans for the UHS Inequalities Board which will be operational for April 2024.	On Track: Ongoing involvement in UTC curriculum development. UHS invited to join UTC management board. Renaissance Board completed city estate masterplan and city branding refresh for marketing materials. City-wide energy strategy development underway to address shortfall between power demand and existing / forecast capacity. Emerging strategic partnership with Southern College Group following the amalgamation of local FE colleges

Strategic Theme Five - Foundations of the Future

Ref	Lead	Objective	Q2 Update	Q3 Update
5(a)	CFO	**Deliver the UHS financial plan for 23/24, achieving a run-rate breakeven position by April 24. This will be supported by delivery of the CIP plan and improvements in productivity across all Divisions/Departments.**	Excluding the impact of unfunded pay-award and industrial action, the Trust would be on-plan YTD, and close to delivering an on-plan position for the year. However, the underlying run-rate remains a concern and break-even by April 24 is unlikely to be achieved. CIP performance YTD is positive but again too reliant on non-recurrent scheme delivery.	Financial Recovery actions underway to deliver back to £26m plan for 23/24, with some risk to delivery. Impact of most recent industrial impact is likely to challenge delivery. Underlying run-rate of break-even will not be achieved by April 24.

Ref	Lead	Objective	Q2 Update	Q3 Update
5(b)	CEO/ CMO	**Engage the organisation in the challenge to manage demand so that capacity and demand are in equilibrium.**	We continue to work to try to ensure capacity and demand in equilibrium. Steps to increase capacity have taken place including opening one additional ward (with another due to open in December) and approving the business case to build new theatres. Detailed work with the Care Groups to support outpatient transformation is ongoing, with some signs of change, including follow ups being 4% lower than last year. However, there remains a mismatch between capacity and demand	Partially achieving: Remains the focus of transformation for 2024. PTL growth has slowed in Q3 and rejection of referral numbers have increased. Further work needed to balance demand and will form basis for outpatient transformation for 2024-25.

Ref	Lead	Objective	Q2 Update	Q3 Update
5(c)	CFO/ CNO/ COO	**Delivery of the Always Improving strategy priorities, including transformation on out-patients, in-patient flow, optimising operating services and organisational culture.**	Partially achieving There are some positive signs of change in both the outpatient and inpatient flow programmes. Length of stay across key care groups has started to show a downward trajectory, as has outpatient follow up activity. There continues to be strong engagement between the clinical divisions and transformation team. A longer term plan for continuous improvement will be brought forwards in Q3. New Heads of Transformation are now in post to lead the Outpatients and Operating Services programmes forwards	Partially achieving Strong positive feedback from Divisions and Care groups on the Divisional alignment of the Transformation team to support them with the priorities. NHS Impact self-assessment ratified by the board and agreement of continuous improvement priorities on patient involvement and staff capability building. Across the Outpatient, Inpatient and Operating Services programmes there is partial achievement of the 3 core aims of each programme. The programmes are contributing to the halving of waiting list growth (1,000 to 500) per month and the associated productivity gains amount to £8.1m of identified CIP.

Ref	Lead	Objective	Q2 Update	Q3 Update
5(d)	CFO	**Deliver our capital programme in full, including new wards, theatres and neonatal unit redevelopment.**	Spend to date has been lower than anticipated. A capital reforecast exercise has been undertaken and we have brought forward schemes from 24/25 to offset the risk of slippage in 23/24. 1 new ward open, 2nd opening in December. Neonates programme on-track.	Whilst there remains significant expenditure required in Q4 to deliver to plan, plans are in place to ensure full expenditure and mitigate slippage risks.

Ref	Lead	Objective	Q2 Update	Q3 Update
5(e)	CFO/ CMO	**Enter into a new Energy Performance Contract and deliver year 1 of the Public Sector Decarbonisation Scheme.**	On track with Energy Performance Contract.	On track with Energy Performance Contract.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda item:	**7.2**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Lauren Anderson, Corporate Governance & Risk Manager** **Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 January 2024**			
Purpose:	**Assurance or reassurance** ✔	**Approval**	**Ratification**	**Information** ✔
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. The report has been updated following discussions with the relevant executives and their teams.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is fundamental to the delivery of the Trust's strategic objectives and is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be aware of key risks, or may not understand failures in the control environment and actions planned to address these failures.			
Summary: Conclusion and/or recommendation	The Board is asked to note the updated Board Assurance Framework and information contained within this report.			

1. Purpose

1.1. The University Hospital Southampton Board Assurance Framework (BAF) identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. The full BAF is provided as appendix 1.

1.2. This document seeks to provide assurance to the Board that the Trust is appropriately sighted on, and working to mitigate, key strategic risks through an appropriate governance structure. Each risk detailed within the BAF is overseen by a sub committee of board.

1.3. When reviewing the BAF the Board are asked to consider:

- the level of assurance provided by the BAF and those areas or actions around which further assurance may be required;
- the appropriateness and timeliness of key actions to develop either the control or assurance framework for these strategic risks, and
- any risks to the delivery of our strategic objectives that are not currently included in the Board Assurance Framework, or key operational risks not identified.

2. Key updates

2.1. The board last received the BAF in November 2023. Since then all risks have been reviewed by the responsible executive(s) and updated where appropriate.

2.2. Key changes are:

- **1a:** An interim target risk rating of 4 x 4 = 16 by April 2024 has been added to provide a milestone target between now and the existing target of 4 x 3 = 12 by April 2025.

  The action plan has been updated to reflect two new wards which opened in 2023. It also reflects ongoing and planned actions focussed on engagement with national and ICB support (including utilisation of GPs within SDEC), and pathways and flow within the ED and wider organisation.

- **1b:** The current risk rating has been reduced from 3 x 4 = 12 to 3 x 3 = 9.

  The assurances and actions have been updated to reflect ongoing work around patient experience to gather and utilise feedback including methods such as SMS and listening events.

- **1c:** The gaps in assurance have been updated to reflect the increased C.Diff and MRSA infections (including a small number of MRSA blood stream infections).

- **3a:** The controls and assurances have been updated to reflect the risk based approach and prioritisation panel implemented in response to the current recruitment pause.

- **4a:** The actions have been updated to reflect that resource both within and external to UHS is challenging. The risk rating remains under review in light of this.

- **5a:** The current risk rating has been reduced from 4 x 5 = 20 to 3 x 5 = 15 to reflect the level of impact within the current residual risk following implementation of controls. The target risk ratings have been re-assessed in line with this with an interim target of 3 x 4 = 12 by April 2024, and 3 x 3 = 9 by April 2025.

3. Ongoing review of risk management

3.1. In efforts to continuously improve risk management within the organisation and ensure that risk management supports informed decision making and strategic planning, development work is ongoing.

3.2. Since the board last received this report in November 2023;

- A risk appetite workshop was held in a Trust Board Study Session. The risk appetite statement has been updated and is out for consultation.
- The BAF template has been updated to incorporate the risk appetite and support greater use of the document to inform risk-based discussions at board and sub committees. The content of the BAF is currently being transferred across.
- Changes have been approved within the Ulysses system which will allow operational risks to be linked to strategic BAF risks, improving the relevance and accuracy of operational risks highlighted to each of the Board's sub committees.
- Engagement with the training and education team has commenced to develop a risk management education framework with a three tiered approach ensuring that all staff can access a basic level of training, with more detailed training available to those directly involved in risk management, as well as specialised board level training.

Appendix 1 – Board Assurance Framework

The risks are grouped according to the Trust's key strategic themes:

1: **Outstanding patient outcomes, safety and experience**

- 1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.
- 1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.
- 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.

2: **Pioneering research and innovation**

- 2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.

3: **World class people**

- 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
- 3b: We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff.
- 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

4: **Integrated networks and collaboration**

- 4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.

5: **Foundations for the future**

- 5a: We are unable to deliver a financial breakeven position, resulting in: Moving into NHS Outcomes Framework segment 4, which leads to entering into the Recovery Support Programme and additional controls / undertakings; A reducing cash balance, impacting both The Trust's ability to invest in line with its capital plan and estates / digital strategies, and the Trust's ability to invest in transformation initiatives.
- 5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.
- 5c: We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy.
- 5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.

Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO

1a) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Use of independent sector to increase capacity. Triage of patient lists based on risk of harm. Consultant-led flagging of patients of concern. Clinical Prioritisation Framework. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. Outpatient transformation programme focused on reducing follow up demand. Theatre transformation programme to improve theatre utilisation / treat more patients. Urgent and Emergency Care Board established to drive improvements across UEC pathways. Weekly divisional performance meetings with a particular focus	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures.	4 x 5 20	Clinical Assurance Framework, reported quarterly to executive. Reported bi-weekly by CPRP. Live monitoring of bed occupancy and capacity data. Weekly performance meetings to monitor key access targets. Rapid Improvement Plans to support improvements across cancer pathways. UEC recovery plan to support improvements across UEC pathways. Monitoring and reporting of waiting times. Harm reviews identifying cases where delays have caused harm.	Limited capacity within the Local Authority to support for patients without a criteria to reside. Lack of granular plans at specialty level to support reduction in outpatient follow ups. Ongoing industrial action through 22-23 and into 23-24 presents significant risk to the Trust's ability to meet ongoing demand on our services.	Outpatient, theatres and inpatient flow transformation programmes. Self-assessment against NHS Impact with a strategic plan generated regarding leadership, quality improvement and organisational development. Review of ED workforce model against national workforce tool has been completed resulting in an uplift to nursing staff Review of local delivery system plan for reducing delays throughout the hospital. Deliver target of 113% of 19/20 baseline activity to secure additional funding and address waiting lists. Deliver plans to hit the trajectory of no patients waiting over 65 weeks by March 2024. Open additional wards (Cancer Care D12 opened in August 2023 and a medical ward E12 opened December 2023) Community Diagnostic Hub opening in Q4 2024/5 to provide additional diagnostic capacity.	Interim target 4 x 4 16 Apr 24 Long term target 4 x 3 12 Apr-25

Outstanding patient outcomes, safety and experience				Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO		
1a) Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.						
on cancer and long waiting patients.	Challenges in staffing ED department during periods of extreme pressure.				Previously scheduled for 2023/4 however this has been delayed following redesign. Engagement in the NHSE Further Faster programme for elective care. Improvement work on flow focussing on 3 key areas: home before lunch, clinical standards, and Urgent & Elective Care (UEC). New appointments to the leadership team (TS as Clinical Director of the UEC and JP as Operational Manager). Implementation of cardiology pathway within ED although currently delayed due to inability to fulfil the rota. Use of SDEC to deliver appropriate care based on acuity and support flow within ED. Supported by GPs at the front door between January and March 2024, and on strike days, as funded by the ICB.	

Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO

1b) Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Trust Patient Safety Strategy and Experience of care strategy. Organisational learning embedded into incident management, complaints and claims. Learning from deaths and mortality reviews. Mandatory, high-quality training. Health and safety framework. Robust safety alert, NICE and faculty guidance processes. Integrated Governance Framework. Trust policies, procedures, pathways and guidance. Recruitment processes and regular bank staff cohort. Culture of safety, honesty and candour. Clear and supportive clinical leadership. Delivery of 23/24 Always Improving Programme aims.	No agreed funding for the quality of outcomes programme to go forward beyond this year. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. Reduction in SDM delivery team due to financial challenges.	3 x 3 9	Monitoring of patient outcomes. CQC inspection reporting: Good overall. Feedback from Royal College visits. Getting it right first time (GIRFT) reporting to Quality Committee. External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards. Clinical accreditation scheme (with patient involvement). Internal reviews into specialties, based on CQC inspection criteria. Current and previous	Negative outlier on follow-ups for outpatients. Ongoing industrial action through 22-23 and into 23-24 presents significant risk to the Trust's ability to meet ongoing demand on our services	**Introducing a robust and proactive safety culture:** Implement plan to enable launch of PSIRF in Q3 2023/24. Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy. Introduce thematic reviews for VTE. Implement the second round of Ockenden recommendations – completed. **Empowering and developing staff to improve services for patients** Ongoing completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. Engagement and rollout within adult congenital heart disease, head and neck cancer, and also orthopaedics across the ICS. To embed as business as usual from April 2024. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year.	3 x 2 6 Mar-24

Outstanding patient outcomes, safety and experience			Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO			
1b) Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.						
Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable.			performance against NHS Constitution and other standards. Matron walkabouts and executive led back to the floor. Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits. Performance reporting. Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance		**Always Improving programme** Delivery of 23/24 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. Outpatient follow-up reduction). Further development of our continuous improvement culture to ensure a sustained focus on quality and outcomes. Increase specialties contributing to CAMEO. We are developing a new strategy linking outcomes, transformation, and safety. Actively managing waiting list through points of contact, escalating patients where changes are identified. Ongoing harm reviews for p2s and recurring contact for p3 and p4 patients. Always Improving self assessment against NHSE guidance to be taken to Trust Board in December. Fundamentals of care programme roll out across all wards. **Patient experience initiatives** Roll out of SMS and other feedback mechanisms, offering clinical teams targeted response surveys to ensure	

Outstanding patient outcomes, safety and experience					Monitoring Committee: Quality Committee Executive Leads: COO, CMO, CNO	
1b) Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.						
			Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice		specific care needs are not only identified they are also addressed. Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesign and patient experience. We are Listening events – held in local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust.	

Outstanding patient outcomes, safety and experience	Monitoring Committee: Quality Committee Executive Leads: CNO, COO

1c) We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention agenda. Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Assurance Framework. COVID ZERO and #Don'tGoViral campaigns. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify HCAIs. Risk assessments in place for individual areas for ventilation, bathroom	Transmissibility of Covid and other infections such as norovirus, RSV and influenza. Non-compliant patients and lower uptake of vaccinations due to 'vaccine fatigue'. Refamiliarisation with response to resurgence of other common infections such as norovirus. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced.	3 x 3 9	Gold command infection control. Hand hygiene and cleanliness audits. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection assurance framework compliance reporting to executive, Quality Committee and Board. Clinical audit reporting. Internal audit annual plan and reports. Finance and Investment Committee oversight of estates and digital capital programme delivery. Digital programme delivery group meets each month to review progress of MMR. Quarterly executive monitoring of Estates KPIs (maintenance,	Ward and bay closures due to norovirus outbreaks. Increased in C.Diff and MRSA including a small number of MRSA BSIs (blood stream infections).	Ongoing campaigns to include all viruses supported by internal and external communications plan. Review infection prevention measures in response to changes in guidance and move to 'living with COVID'. Completed work to decentralise COVID pathways, with COVID positive patients to be cared for in the appropriate specialist areas. Review of infection prevention methods for C-diff following missing trajectory. Focussed education on catheter associated urinary tract infection (CAUTI) prevention through Trust wide newsletter August 2023	2 x 3 6 Apr-24

access, etc. to ensure patient safety.			cleanliness, fire safety, medical devices, etc.).			

Pioneering research and innovation					Monitoring Committee: Trust Board Executive Lead: Chief Medical Officer	
2a) We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.						
Key Controls	**Gaps in Controls**	**Current Risk Score (I x L)**	**Key Assurances**	**Gaps in Assurance**	**Key Actions**	**Target Risk Score* (I x L)**
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology. Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. No overarching strategy to support innovation.	3 x 3 9	Governance structure surrounding University partnership. Board to Council meetings. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint executive group for innovation. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation.	Limited corporate approach to supporting innovation across the Trust. National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway.	Staff survey to test staff engagement and understanding of innovation at UHS. Deliver R&I Investment Case. Ongoing work to review investment and return. International Development Centre, attracting external funding to support staff in pursuing innovation. Execute an agreed joint programme of work with partners through establishing executive group for education. Maximise the benefits of the newly established Wessex Health Partnership as a founding member. Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Review the Trust's approach to corporate-wide innovation.	3 x 2 6 Jan-25

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
New 5-year People Strategy and clear objectives for Year2 monitored through POD. Recruitment and resourcing processes. Workforce plan and overseas recruitment plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Overseas recruitment including a reduced level of nurse vacancies. Recruitment campaign. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific	Ability to fully manage demand on workforce requirements due to external factors such as patient needs, criteria to reside, industrial action. Complete data reviews to ensure alignment of HR and Finance information. Completion of divisional workforce plans to ensure local ability to track progress. Differential pay grading across the ICS leading to retention difficulties. Full workforce CIP identification for 2023/24.	4 x 5 20	Fill rates, vacancies, sickness, turnover and rota compliance . NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Joint finance and Workforce working group on data assurance. Temporary staffing collaborative	Improving forecasting of WF position at year end. Universal rostering roll out including all medical staff. Full review of new national workforce plan(published July) for impacts at UHS.	Approval of Year 2 objectives supporting delivery of the Trust's People Strategy. Deliver workforce plan for 22/23 including increasing substantive staff in targeted areas offset by reducing temporary agency spend. To develop and implement Divisional Workforce Plans. To deliver specific plans to reduce reliance on temporary workforce. To focus on delivery of workforce CIP in partnership with finance and the Divisional teams. To improve data reporting on workforce to support decision making, and alignment with finance reporting. To improve workforce prediction and forecasting. To implement a range of programmes to reduce turnover to 13.6%. To implement a range of measures to reduce our staff absence to 3.9%. To implement a range of measures to improve medical deployment. Ensure	4 x 3 12 Mar-25

World class people					Monitoring Committee: People and Organisational Development Committee	
					Executive Lead: CPO	
3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.						
recruitment and retention issues (e.g. the ACP review). Recruitment Pause initiated in December 2023 to slow substantive workforce growth and phase new starters. Phasing of new starters based on prioritisation from a senior clinical review panel. New forecasting model to support planning of future recruitment pipelines at Division, Care Group and Staff level			diagnostic analysis on effectiveness. Additional metrics on quality being reviewed by the Chief Information Officer and Deputy Chief Nurse to track recruitment impacts on quality.		accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups. Continued management of industrial action to mitigate patient impact, and continue to support staff motivation, morale and wellbeing.	

World class people	Monitoring Committee: People and Organisational Development Committee
	Executive Lead: CPO

3b) We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans.	To recruit to the new network leads for the Trust and re-energise the network capacity and capability. Coverage of allyship training. Embedded responsibility for all leaders on inclusion.	4 x 3 12	**Great place to work including focus on wellbeing** Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity.	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation	**Building an inclusive and compassionate culture** Deliver year 1 objectives of the new Inclusion and Belonging strategy by March 2024: This includes • 50% of UHS staff to have participated in Allyship training by 31 March 2024 • Completing the inclusive recruitment review • Strengthening the role of the staff networks • Embed the belonging blue print • Deliver another cohort of positive action programmes • To improve the quality and dept of EDI data to support decision making, • Ensuring all Board members objectives include a focus on EDI.	4 x 2 8 Mar 25

Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed. Nurse specific positive action programme also launched.			Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.		To deliver an enhanced staff recognition and reward programme including: • Delivery of the new We are UHS Awards • Deliver We are UHS week in September 2023 • New in-person monthly staff spotlight meetings • Refreshed weekly news to keep staff up to date • Peer to peer thankyous which are easy to enact efresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.	

World class people	Monitoring Committee: People and Organisational Development
	Executive Lead: CPO

3c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Education Policy New leadership development framework, apprenticeships, secondments In-house, accredited training programmes Provision of high quality clinical supervision and education Access to apprenticeship levy for funding Access to CPD funding from HEE and other sources Leadership development talent plan 2023-2024 Executive succession planning	Quality of appraisals Limitations of the current estate and access to offsite provision Access to high-quality education technology Estate provision for simulation training Staff providing education being released to deliver education, and undertake own development Releasing staff to attend core training, due to capacity and demand Releasing staff to engage in personal development and training opportunities Limited succession planning framework, consistently applied across the Trust. Areas of concern in the GMC training survey	4 x 3 12	Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme Full review of new national workforce plan(published July) for impacts at UHS.	To increase the proportion of appraisals completed and recorded to 85%, and increase staff quality perceptions on appraisal by March 2024. Take specific targeted action to improve areas of low satisfaction in the GMC survey. Building strategic partnerships with new Southampton UTC and the new FE colleges alliance, increasing our overall usage of the apprentice levy (March 2024) Relaunch/refresh of the VLE need to be put down as a key action in terms of supporting people to access more self directed learning opportunities? Implement the leadership development and talent plan throughout 2023 and 2024 Strategic leadership programme and positive action programmes	3 x 2 6 Mar-25

Integrated networks and collaboration	Monitoring Committee: Quality Committee
	Executive Leads: CEO, CMO, Director of Networks & Strategy

4a) We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Key leadership role within local ICS Key leadership role within local networked care and wider Wessex partnership UHS strategic goals and vision Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) Establishment of UHS Integrated Networks and Collaboration Board focussing on delivery of the four network types, (Integrated community, Hospital networks, Specialised services and Diagnostic networks)	Potential for diluted influence at key discussions Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local Form and scope of role for HIoW APC in relation to ICS and other acute provider collaboratives Work to develop a shared pharmacy model with Portsmouth has been delayed, and the Trust is looking at alternative options. The costs associated with the Elective Hub in Winchester may have been underestimated. Additional funding sources may need identifying. Vacancies and movement within the	3 x 3 9	CQC and NHSE/I assessments of leadership CQC assessment of patient outcomes and experience National patient surveys Friends and Family Test Outcomes and waiting times reporting Integrated networks and collaborations Board set up for regular meetings at executive level	Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. Specialised Commissioning budget delegation deferred until April 2024. Ability to network is difficult and manifests in capacity challenges.	**ICS and PCNs** Priority networks reviewed and updated against UHS network maturity framework; and agreed by trust board for 2023/24. **Integrated Networks and Collaboration** Urology Area Network plan agreed. Progress stalled due to lack of programme management resource and clinical lead stepping down. Clinical leadership Support for networks from clinical programme team continues. This is challenging due to lack of resources from other organisations and constrained resource within the UHS team. Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in Q1 of 2024/25. Business case development for aseptic services and elective hub by HIoW APC has been approved and is moving into the implementation phase. Further development of HIoW APC to drive improvements in outcomes Development of proposals for next phase for Community Diagnostics Centres.	3 x 2 6 April-24

Integrated networks and collaboration	Monitoring Committee: Quality Committee
	Executive Leads: CEO, CMO, Director of Networks & Strategy

4a) We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
	senior leadership team has slowed pace.				Integrated networks and collaboration project management post recruited to. Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward. NHSE has approved the business case for the Elective hub, this is a significant step forward and now moving ahead. Tim Briggs, National Director of Clinical Improvement, and team engaged to support HIOW on 'Further Faster' programme. ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor. Funding for dermatology AI pathway secured.	

Foundations for the future	Monitoring Committee: Finance and Investment Committee Executive Lead: CFO

5a) We are unable to deliver a financial breakeven position, resulting in:

- Moving into NHS Outcomes Framework segment 4, which leads to entering into the Recovery Support Programme and additional controls / undertakings
- A reducing cash balance, impacting both The Trust's ability to invest in line with its capital plan and estates / digital strategies, and the Trust's ability to invest in transformation initiatives

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Internal Financial strategy and Board approved financial plan. Trust Savings Group (TSG) oversight of CIP programme (£69m). Transformation Oversight Group (TOG) overseeing delivery of 23/24 transformation programmes including financial benefits Tightened 2023/24 business rules Robust controls over recruitment via the Recruitment Control Panel Enhanced workforce controls including workforce review meetings Weekly executive oversight of workforce numbers Robust business planning and bidding processes Engagement in revised ICB financial architecture	**Internal** Remaining unidentified and high-risk schemes within CIP programme Ability to control and reduce temporary staffing levels **System wide/external** Elements of activity growth unfunded via block contracts Grip of system wide initiatives and assurance	3 x 5 = 15	Regular finance reports to Trust Board & F&IC Divisional performance on cost improvement reviewed by senior leaders – quarterly. Trust Savings Group oversight of financial recovery plan and CIP programme actions F&IC visibility and regular monitoring of detailed savings plans Transformation Oversight Group (TOG) Operating plan based on cash modelling to ensure affordability of capital programme	Current short-term nature of operational planning Lack of confidence in system-wide initiatives – for example impact of reduced Hospital Discharge Programme funding on Non-Criteria to Reside patients in UHS.	Deliver the planned financial deficit. Improve the underlying financial run-rate back to break-even by April 2024 *(to be reviewed in planning for 24/25)* Improve identification of CIP and reduce value of high-risk schemes Work across health system partners to deliver system initiatives (e.g., planned care, urgent care, criteria to reside etc.) Support the organisation to understand the current financial environment, whilst balancing performance, quality and staff morale Full engagement in Recovery Support Programme, including supporting	Interim target: 3 x 4 12 Apr-24 Longer term target: 3 x 3 9 Apr-25

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: CFO

5a) We are unable to deliver a financial breakeven position, resulting in:

- Moving into NHS Outcomes Framework segment 4, which leads to entering into the Recovery Support Programme and additional controls / undertakings
- A reducing cash balance, impacting both The Trust's ability to invest in line with its capital plan and estates / digital strategies, and the Trust's ability to invest in transformation initiatives

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Robust controls over investment decisions via the Trust Investment Group and associated policies and processes Monthly reporting processes from Care Groups to Trust Board level. Monthly VFM meetings with each CG **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local / Primary Care • Staffing Improved "grip and control" measures with consistent application across all organisations.	of delivery e.g., Criteria to Reside Shortfall in funding from the pay award		Involvement in development of ICS Recovery Plan		development of the ICS Recovery Plan. Quantify and monitor delivery of financial productivity benefits from 23/24Transformation programme Deliver financial turnaround programme to deliver financial plan and 2024/25 run rate improvement.	Apr-24

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: COO

5b) We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Multi-year estates planning, informed by clinical priorities and risk analysis Up-to-date computer aided facility management (CAFM) system Asset register Maintenance schedules Trained, accredited experts and technicians Replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Estates masterplan 22-32 approved. Clear line of sight to Trust Board for all risks identified	Missing funding solution to address identified gaps in the critical infrastructure Timescales to address risks, after funding approval Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment	4 x 4 16	Compliance with HTM / HBN monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Funding streams to be identified to fully deliver capacity and infrastructure improvements	Continue work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions Identify future funding options for additional capacity in line with the site development plan Delivery of 2023/24 capital plan Implement the HOIW elective hub. Deliver £5m of critical infrastructure backlog maintenance Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital. CAFM System to be presented to November 2023 Trust Investment Group Estates Strategy currently being developed alongside the ICB Infrastructure Plan	3 x 4 12 Apr-25

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: COO

5c) We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Digital prioritisation programme, informed by clinical priorities, supported by chief clinical information officers and chief nursing information officers, and safeguarded by clinical safety officers Digital strategy incorporating: • technology programme • clinical digital systems programme • data insight programme	Hampshire and Isle of Wight ICS digital strategy yet to be fully finalised, including digital convergence, and alignment with wider expectations. Funding to technically refresh and for digital development, including the impact of proposals for 'levelling up' as part of funding distribution decisions for the funding available. Ability to implement workforce plan to retain staff needed to underpin strategy Cyber security and recovery capability requires investment and development Development of a non-clinical/business systems strategy	3 x 4 12	Monthly executive-led digital programme delivery group meeting Finance oversight provided by the Finance and Investment Committee Quarterly Digital Board meeting, chaired by the CEO	Funding to cover the development programme, improvements, and clinical priorities Difficulties in understanding benefits realisation of digital investment. ICB outline business case funding for EPR	Ongoing recruitment of key Digital resource to mitigate operational risk. Cyber security and leadership roles have been recruited to. Achieve 200,000 My Medical Record (MMR) accounts and 30% paper switch-off Inpatient noting for nursing has been rolled out to all appropriate wards Digital ophthalmology system project 'open eyes' to be implemented Identify opportunities for funding for digital transformation and programmes. Robust programme prioritisation in line with available funding. Develop benefits realisation calculations across whole digital programme, linked to other Trust transformation programmes Develop digital literacy across trust to support rollout of new products Explore commercial partnership options to mitigate lack of UHS workforce to deliver strategy.	3 x 3 9 Mar-24

Foundations for the future	Monitoring Committee: Finance and Investment Committee
	Executive Lead: COO

5c) We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
					Implementation of new Emergency Department patient flow and vital signs systems via Alcidion. Joint delivery of Outpatient, Inpatient and Operating Efficiency programmes with Transformation team through single programme governance	

Foundations for the future	Monitoring Committee: Trust Executive Committee
	Executive Lead: CMO

5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.

Key Controls	Gaps in Controls	Current Risk Score (I x L)	Key Assurances	Gaps in Assurance	Key Actions	Target Risk Score* (I x L)
Governance structure including Sustainability Board (with patient representation), Sustainability Delivery Group and Clinical Sustainability Group Appointment of Executive Lead for Sustainability Green Plan	Clinical Sustainability Plan/Strategy (CSP) Sustainable Development Management Plan (SDMP) Long-term energy/decarbonisation strategy Communications plan	2 x 3 6	Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 Quarterly reporting to NHS England and NHS Improvement on sustainability indicators Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones	Agree funding requirements to commence the delivery of the strategies Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. Develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies. Review green energy ambitions following extreme rises in electricity costs. Forward plans to review energy contract.	2 x 2 4 Dec-24

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**8.1**			
Sponsor:	**Jenni Douglas-Todd, Trust Chair**			
Date:	**30 January 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the Chair's action and application of the seal.			

1 Chair's Actions

The Board has agreed that the Chair may undertake some actions on its behalf. The following action has been undertaken by the Chair.

1.1 **Single Tender Action** for the provision of an Electrical Infrastructure for the Southampton Community Diagnostic Centre (CDC) Project Phase 2, by NHS Property Services Ltd, at a cost of £574,167 excluding VAT. The Trust, as host for the CDC project, has been granted funding from NHS England for the project. This action covers the cost of the Electrical Infrastructure works together with fees associated with the design of the work to RIBA Stage 2 plus 50% of RIBA Stage 3 in financial year 2023-24, to enable design to proceed. Approved by the Chair on 8 January 2024.

2 Signing and Sealing

2.1 **Licence to Alter** between University Hospital Southampton NHS Foundation Trust (Head Landlord), Akzo Nobel CIF Nominees Limited (Landlord), Compass Contract Services (UK) Limited (Tenant) and Compass Group Holdings Public Limited Company (Tenant's Guarantor) relating to Retail Unit 7 (Marks and Spencer) located at the Main Entrance and Retail Area of Southampton General Hospital, specifically refurbishment works and replacement of Co2 pack and Gas cooler located on the roof. Seal number 267 on 19 January 2024.

3 Recommendation

The Board is asked to ratify the Chair's action and application of the seal.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Review of Standing Financial Instructions 2023-24**			
Agenda item:	**8.2**			
Sponsor:	**Ian Howard, Chief Financial Officer**			
Author:	**Anna Schoenwerth, Assistant Director of Operational Finance**			
Date:	**30 January 2024**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The Standing Financial Instructions (SFIs) require an annual review and update. This paper outlines the key changes proposed.			
Response to the issue:	This paper outlines proposed changes to Trust SFIs for consideration and approval by Trust Board, following recommendation by the Audit & Risk Committee.			
Implications: (Clinical, Organisational, Governance, Legal?)	SFIs are a key governance document for the Trust.			
Risks: (Top 3) of carrying out the change / or not:	1. Lack of clarity about financial authorities and responsibilities. 2. Insufficient probity and accuracy in financial transactions 3. Financial transactions do not support the delivery of economy, efficiency, and effectiveness by the Trust			
Summary: Conclusion and/or recommendation	The Board is asked to recommend the proposed changes to SFIs following approval at the Audit and Risk Committee.			

1. Introduction and Background

The Trust's Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They require annual review with the last review having been completed in October 2022.

The review completed has included engagement with the following people:

- Associate Director of Corporate Affairs (Craig Machell)
- Director of Wessex Procurement Limited (WPL) (Rob Houston)
- Chief Procurement Officer (David Duly)
- Senior Contract Manager (Stuart Broughton)
- Head of Information Governance/Data Protection Officer (Judith Downing)
- Chief Information Office (Jason Teoh)
- Commercial Director (Pete Baker)
- Director of Planning and Productivity (Andrew Asquith)
- Charity Director (Ellis Banfield)
- Deputy Chief People Officer (Brenda Carter)
- Local Counter Fraud Specialist (Alec Gaines)
- Chief Financial Officer (Ian Howard)
- Director of Operational Finance (Phil Bunting)
- Assistant Directors of Finance (Natalie Jupp, Anna Schoenwerth)
- External auditors (Grant Thornton)
- Internal auditors (KPMG)

2. Changes to Core SFIs

The main changes to the SFIs are outlined below.

Section	Section Title	Overview of the Change	Rationale
All	All	All references to the 'Director of Informatics' have been changed to the 'Chief Information Officer' and 'Informatics' changed to 'UHS Digital'. References to the 'Commercial Director' have been updated to the 'Commercial and Enterprise Director'. Reference to the 'Director of Contracting' have been updated to the 'Director of Operational Finance'	Updates to the organisation structure.
3.5.2	Budgetary control and reporting	Seven bullet points pertaining to the responsibilities of each budget holder added.	These were taken from the NHS England SFIs to be specific as to what is expected of budget holders.
5.1.4	Government Bank Service Bank Accounts	Paragraph added regarding all bank accounts being solely in the Trust's name and overseen by the Trust finance team.	In response to a case where a team was operating a bank account for funds donated and using it to pay for department treats. This is to ensure that no teams operate their own banking arrangements.

6.3.3	Debt Recovery	Debt write offs limit of £1,000 added for the Assistant Director of Operational Finance.	To allow the team to process small write off variances throughout the year. A summary of these write offs will continue to be presented to the A&R Committee annually in October.
7.10.7 7.12.11	Quotation & Tendering Procedures	Paragraphs removed.	Local contract information is now provided via the central Atamis registry.
8.1.6	Service Contracts	Paragraph removed.	We have a commercial pricing model for non-NHS contracts, this creates a margin above our cost structure, and is not linked to tariff
9.2.1	Staff Appointments, Terminations and Changes	Added reference to the Recruitment Control Panel Terms of Reference.	Specifics added regarding regrading and that they are subject to RCP terms.
10.2.4	Requisitioning and Ordering Goods and Services	Removed most of the exemptions of the 'No Purchase Order, No Pay' policy.	As part of the financial recovery programme, the 'No PO no Pay' policy is being maximised to ensure adherence to financial controls and close monitoring of spend. This is being pushed, in the knowledge that for the previous exceptions, a PO can be set up. The previous financial system was replaced in 2018 and therefore new POs should have been set up in this time. 'Opticians' has been replaced by 'Patient voucher schemes (eg opticians) to be specific that this is not generally referring to opticians. Litigation and local authority costs can all be monitored via POs.
12.2.2/ 12.2.5	Approval of Capital Business Cases	Removed paragraph 12.2.5 referencing the IISS contract and included it within the table in paragraph 12.2.2. Added that all expenditure should be within the program budget as agreed by Trust Board on an annual basis.	For consistency with other defined groups with specific approval limits. Added specifics regarding expenditure for clarity.
13.1.3	Inventory and Receipt of Goods	Removed paragraph.	Inventory may be held across the Trust by various departments.
17.3.1	Fundraising & Incoming Funds	Added paragraph that the Charity is the only vehicle for the collection and administration of charitable funds.	In response to a case where a team was operating a bank account for funds donated and using it to pay for department treats. This is to ensure that no teams operate their own banking arrangements.
22.3	Employment Tribunals	Uplifted the £30k authorisation limit to £50k for the Chief People Officer and added the Chief Financial Officer.	Uplifted the limit to £50k needing approval from the Chief Executive Officer.
Annex 1	Losses, Gifts and Special Payments	Included the approval thresholds that require sign off by NHS England and Treasury.	As circulated by NHS England to all Trust CFOs, these have been included to highlight compliance with these thresholds.

Annex 2	Significant Transactions	Removed Annex.	The guidance from NHS England has changed. NHS England are included within the Annex 3 authorisation bodies table.
Annex 3 – Section 1	Authorisation Bodies and Limits	Divisional Management Boards – added reference to delivery of annual cost improvement target to revenue column. TIG threshold increased to the lower limit of F&IC (as TEC now to receive minutes from TIG for noting).	To avoid duplication of approvals process through TIG and TEC, it is proposed that TIG becomes the main decision-making point for investments prior to TB. TEC will oversee the decisions of TIG, and have recently updated terms of reference to ensure appropriate governance and membership.
Annex 3 – Section 2	Authorised Non-Pay Expenditure Limits	Removed Finance and Estates authorisation limits for specific roles, excluding Assistant Director of Finance. Added Chief Information Officer role to the matrix.	These are consistent with staff Bands and therefore do not have to be separated in the table. Consistent with other Chief roles, CIO is authorised for £1m.
Annex 3 – Section 3	Contracting – Financial Limits	For 'Building & Engineering' Procurement limits, amended the Director of Estates limit to £1.0m from £2.5m, added CFO for £1.0m-£2.5m. Reduced 'Bidding for Tenders' limits from £12.5m to £10m for Tender Steering Group, CFO. Added Head of Innovation into 'NDA'.	For consistency with other contract type Procurement limits which already had thresholds to £1.0m and £1.0m-£2.5m for CFO. The impact would be less than 10 contracts for CFO approval per year. For consistency with other financial limits rather than having a different threshold (consistent with NHS income tender limit)
Annex 3 – Section 3	Authorisation Framework for Procurement and Tendering	No changes to the limits, two tables have been condensed into one by including a column for 'area of spend'.	To assist the user and reduce the number of tables to refer to.
Annex 3 – Section 3	Waiving or Variation of Competitive Tendering/Quotation procedure	Approval limits have been amended to up to £1.0m for Directors/Chiefs, an increase from £75k. £1.0m-£2.5m for CEO/CFO, an increase from £75k-£500k. £2.5m+ for Board from £500k.	To align to other contract approval limits in Annex 3, this ensures waiver limits is consistent. It also avoids immaterial contracts requiring Board approval (such as a 5-year contract for £100k pa).

A tracked changes version of the SFIs is also enclosed within the appendix. Other changes around language and terminology are not explicitly outlined above but are included in the tracked changes document supplied.

Following the Audit and Risk Committee review, the change noted above for Annex 3 – Section 3 in relation to 'Building & Engineering' Procurement limits was included, which aligns the thresholds to other contract types. The Director of Estates has an approval limit to £1.0m, from £2.5m and the Chief Financial Officer has been added as an approval level for contracts from £1.0m-£2.5m.

In addition, the Waiver approval limits in Annex 3 – Section 3, were also suggested at the Audit and Risk Committee. This followed a discussion to ensure approval limits were aligned

and consistent across contract types. This is therefore put forward to Trust Board to approve.

Please note, following approval, the page and section numbering in the SFIs document will be reviewed to ensure they are sequential. This is pending approval as the current document has track changes enabled.

Please also note, these SFIs may need updating pending the new Procurement Act 2023 coming into force in October which will be captured in the review occurring at the end of 2024. The changes herein are based on the current organisational structure; the proposed changes do not adjust for future changes. For example, the document contains SFIs for the Charity, which is seeking independent status from April 2024 (as per agenda item 8.1) and will require its own SFIs. An amendment may therefore need to be made at the appropriate time.

3. Conclusion

In summary, this paper outlines proposed changes to SFIs following annual review and put forward for approval by the Audit and Risk Committee to Trust Board.

Following Trust Board approval, the SFIs will be circulated across the organisation and training will be delivered accordingly.

4. Recommendation

Trust Board is asked to approve the proposed changes to the SFIs for circulation across the organisation.

5. Appendices

Standing Financial Instructions – final version with track changes.

University Hospital Southampton NHS
NHS Foundation Trust

Standing Financial Instructions

Version:	**October 2023 Version**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	**~~30 November 2023~~~~30~~15 January 2024**
Signature of authorising Committee:	**Jenni Douglas-Todd, Trust Chair**
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:	**Ian Howard**
Date issued:	**1 ~~December 2023~~February 2024**
Review date:	**~~30 November 2024~~31 January 2025**
Target audience:	**All Divisions/Directorates**
Key words:	**Trust powers; Trust Board; Chair; 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:	**57**
Type of document:	**Level 1**

Standing Financial Instructions

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 England, which this document represents).

1.1.3 The *NHS Oversight Framework* details how NHS England oversees and supports all NHS Trusts. Additional financial guidance is included in *National Audit Office – Code of Audit Practice,* NHS Foundation Trust Annual Reporting Manual and the *Department of Health and Social Care Group Accounting Manual (DHSC 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, Subsidiary Boards 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 Officer (CEO), Chief Financial Officer (CFO)

1.2.4 The Chief Executive Officer 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 Officer is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health and Social Care, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive Officer has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive Officer 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.

1.2.7 In the event of absence of the Chief Executive Officer, the Deputy Chief Executive will temporarily be delegated the authorisation limits outlined within this document.

The Chief Financial Officer

1.2.8 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.

1.2.9 In the event of absence of the Chief Financial Officer, the Director of Operational Finance will temporarily be delegated the authorisation limits outlined within this document.

Board of Directors and Employees

1.2.10 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 England, the conditions of the NHS provider licence, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.11 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 Officer to ensure that such persons are made aware of this.

1.2.12 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 England's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS England'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 DHSC, 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 Officer, 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 Annual Governance Statement and Assurance Framework;

i) The Trust's compliance with the Care Quality Commission's fundamental standards.

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 Chair and Chief Executive Officer.

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 "DHSC 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 The 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 Officer and CFO shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate counter-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority counter-fraud requirements and guidance (informed by Government Functional Standard GovS 013: Counter Fraud).

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 counter-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Authority counter-fraud requirements and guidance.

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 counter-fraud requirements and guidance, the NHS Counter Fraud Manual, including 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 (Whistleblowing) 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 Government Functional Standard GovS 013: Counter Fraud in relation to counter-fraud, bribery and corruption work and the CFO shall sign-off the annual return 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 The Chief Executive Officer has overall responsibility for the safety and security of employees, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider and for keeping the Trust's premises secure. However, the management of security risks within the Trust has delegated to the Chief Operating Officer and also to the appointed Local Security Management Specialist ("LSMS") in line with Trust policies and procedures.

2.5.2 Any prosecution of other offences relating to fraud, bribery or corruption against the Trust not involving the LCFS should be authorised by the CFO and will be reported to the Audit and Risk Committee.

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 Officer 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 England.

3.1.2 The annual Operational Plan must be submitted to NHS England in accordance with NHS England's requirements.

3.1.3 The CFO will, on behalf of the Chief Executive Officer, 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 ongoing 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 Directors 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~~ Division and Director will be ~~asked~~ enabled to submit a list of proposed Business Cases and cost pressures for consideration in budget setting. Only approved ~~business cases~~ requests will be incorporated into delegated budgets. Funded business cases will require approval as per the Trust Approval Framework in Annex 2~~3~~, section 1.

3.2.3 The Chief Executive Officer and Chief Financial Officer will set an annual process for approving cases to be incorporated into the budget and Operational Plan.

3.2.4 The Trust's 'Production Plan' (NHS clinical income plan) will be set utilising internal data sources, approved UHS business cases, and after consultation with service managers alongside external data sources including Commissioner and Integrated Care Board plans.

3.2.5 The Chief Financial Officer will set a Cost Improvement Programme (CIP) savings target, delegated to each budget holder, and reduce the delegated expenditure budgets accordingly.

3.2.6 The Chief Financial Officer may set reserves to cover potential cost pressures and risks 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 utilise reserves;

c) To reflect where the distribution of income and expenditure has materially changed from the original plan, where this is net neutral for the Trust. ~~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~~ would require funding via additional income assumptions, release of reserves or additional savings above the required plan in another part of the budget.

3.4 Budgetary Delegation

3.4.1 The Chief Executive Officer, 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;

d) Achievement of planned levels of service;

e) The provision of regular reports.

3.4.2 Except where otherwise approved by the Chief Executive Officer, 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 Officer 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 Officer'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: ~~all no permanent employees are appointed without the approval of the Chief Executive Officer, other than those provided for within the budgeted workforce establishment. Any planned expenditure required beyond budgeted establishment will~~

~~require an in-year business case.~~prior approval in accordance with these ~~SFIs.~~

~~A~~a) all expenditure is lawful (in accordance with Managing Public Money) and is incurred in accordance with the No Purchase Order, No Payment protocol, see section 10.2.4;

b) all expenditure is incurred or committed in accordance with the SFIs, including the appropriate levels of internal and external approval;

c) planned and actual expenditure takes full account of the need to achieve value for money in terms of economy, efficiency and effectiveness;

d) all employees are appointed within the budgeted workforce establishment. Any planned expenditure beyond budgeted establishment will require prior approval in accordance with these SFIs;

e) they meet with the designated Finance Business Partner regularly;

f) forecasting of expenditure against budget is robust and where a budget allocation is no longer fully needed or where there is a risk of overspending this is reported to the Finance Business Partner; and

g) information can be supplied to the Chief Financial Officer as required to enable budgets to be compiled.

3.5.3 The Chief Executive Officer 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 England's Use of Resources regime.

3.5.4 The Chief Executive Officer will incorporate a Recruitment Control Panel, responsible for approving recruitment as per Terms of Reference agreed by the Trust Executive Committee. Proposed recruitment will be considered by the Recruitment Control Panel where within scope of the criteria contained within the Terms of Reference.

3.5.5 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 DHSC Group Accounting 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 Officer is responsible for ensuring that the appropriate monitoring forms and returns are submitted to NHS England. 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 and prioritised in principle during the setting of the Trust Operational Plan and therefore Budget Setting Process for the financial year ahead. These cases will then be ~~sent~~ prepared 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 23, section 1.

3.8.3 Revenue cost only business cases will be subject to the approval as outlined in ~~Annex 3~~Annex 22, 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 England and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS England 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 England 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 England (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 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 Chief Nursing Officer will prepare the Annual Quality Report in the format prescribed by NHS England and the Care Quality Commission and in accordance with the NHS Foundation Trust Annual Reporting Manual incorporating the requirements of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

4.8 The Chief Executive Officer and Chair shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Report" .

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 in accordance with these SFI's and the Treasury Management Policy.

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.

5.1.4 All bank accounts used solely for the purposes of Trust activity must be in the name of the Trust and overseen by the Trust Finance team.

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/Natwest 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 England or DHSC 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 financial regime as determined by NHS England where applicable. The CFO may agree alternative payment mechanisms with Commissioners or the Integrated Care Board.

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 and Social Care or by legislation. 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 3~~Annex 22, 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 £1,000	**Assistant Director of Operational Finance**
Up to £10,000	Director of Operational 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.

7.1.2 University Hospitals Southampton procurement services are provided through Wessex NHS Procurement Ltd ("WPL").

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

7.2.1 The tables outlined in the Trust Authorisation Framework in Annex 23 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 23, the Managing Director of Wessex Procurement Limited, Director of Estates, Facilities & Capital Development, ~~Director of Informatics~~Chief Information Officer, Divisional Directors of Operations and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Procurement Approval Document is signed by the relevant Trust authorised signatory.

7.2.4 The waiving or variation of the competitive tendering and quotation procedure can be approved subject to the limits outlined in Annex 23.

7.3 Electronic Tendering

7.3.1 All formal invitations to tender shall utilise the WPL on-line E-tendering solution. Where there are national framework providers facilitating tendering activity then those E-tendering solutions may be utilised, but records maintained by WPL.

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 WPL 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 or NEC 4 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 (IMechE) and the Association of Consulting Engineers (ICE) (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 Officer 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 & 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 Standing Orders, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2.

a) Tender documents will be issued by the office of the Director of Estates, Facilities & Capital Development via the Delta e-tendering portal administered by Wessex NHS Procurement Limited (WPL). All tenders will be returned via the Delta e-tendering portal and will opened automatically at the prescribed date/time set at the time tenders were published in accordance with the SFIs of the Trust.

b) Tender lists for building and engineering works will be compiled by the Director of Estates, Facilities & Capital Development from "Constructionline" the Trust's approved list of Contractors.

c) Before obtaining Tenders for the execution of any work the Director of Estates, Facilities & Capital Development will arrange for a pre-tender estimate to be prepared. This should include works, VAT, fees, equipment and any other costs.

d) Where there is a wide discrepancy (>10%) between the pre-tender estimate and the final total scheme cost involving an increase in expenditure this is to be reported by the Director of Estates, Facilities & Capital Development to the CFO for further instructions.

e) 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.

f) A tender report 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 signed by the Director of Estates, Facilities & Capital Development / Associate Director of Estates / Head of Estates Projects or the Chief Executive Officer in accordance with these SFIs.

g) 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, Facilities & Capital Development for approval or to seek authorisation, according to delegated limits.

h) Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

i) All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact, this

should include presenting it to the Associate Director of Corporate Affairs to meet the requirement for signing and sealing where required.

j) 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 3~~Annex 2, 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~~Chief Information Officer is authorised to place contracts for ~~Informatics~~ UHS Digital Contracts only.

7.10.4 When contracting with subsidiary companies and companies where UHS are shareholders, the trust will follow the goods and services authorisation framework. In examples where there is a conflict of approving personnel, due to individuals holding multiple directorships within each entity, the approval level will escalate to the next appropriate person in the hierarchy.

7.10.5 The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2.

7.10.6 The legally compliant tendering process will be advised by WPL.

~~7.10.7 Where the total contract value exceeds £25,000 (excluding VAT) 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.~~

7.10.8 Where the total contract value exceeds the published UK legislative thresholds (currently defined as the WTO GPA thresholds) then the Trust is committed to a compliant procurement process as advised by WPL.

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. Competitive Procedure Waivers will be required as part of the Procurement Approval Document for all waivers over £25,000 (excluding VAT).

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.

7.11.3 Waivers are not required in a limited number of circumstances. Firstly, if a partnership / joint venture contract exists that precludes the requirement for a competitive tendering process. This should be subject to confirmation by the Director of Wessex Procurement Limited and CFO. Secondly if a single supplier is mandated by NHS England or the contract is intra-NHS and not open to competition. Thirdly as part of a pay over agreement to another government entity. The Chief Financial Officer will maintain and monitor the list of exemptions, including:

a) Pay overs i.e. HMRC, Pensions, child voucher schemes, court fees;
b) Intra NHS Recharges;
c) NHS Litigation Services (NHS Resolution);
d) NHS Pensions Authority
e) Transactions between UHS Group entities e.g. WPL, UEL, UPL
f) University of Southampton shared service provisions i.e. consultant medical staff with joint contract
~~f)~~g) NHS Patient voucher schemes (eg opticians)

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~~Pre-Qualifications stages should be conducted for below threshold quotations/tenders in accordance with Public Contract Regulations 2015 (Regulation 111).

7.12.3 Quotations will be obtained 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 WPL and shall incorporate standard NHS Terms and Conditions of Contract.

7.12.6 After tenders/quotations have been opened, WPL will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.7.

7.12.7 A Procurement Approval Document and Ratification Report prepared by WPL should be submitted for approval according to delegated contract approval limits as specified in SFI 7.2.

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 (excluding VAT) and those over £75,000 (excluding VAT) approved by the Chief Executive Officer or Chief Financial Officer.

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 Managing Director of Wessex Procurement Limited 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 (excluding VAT) through the 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 (excluding VAT) in value ~~must~~ that result in a signed contract between the supplier and the Trust under agreed terms and conditions, should include clear specifications and KPI's where appropriate. These will be retained through the WPL Source To Contract System. Any exceptions to this are at the discretion of the Managing Director of Wessex Procurement Limited.

7.13 Non-Disclosure Agreements

7.13.1 Non-disclosure agreements (also referred to as NDAs or confidentiality agreements) may be entered into by the Trust when it is developing a new product, service or process with someone else. The agreement will restrict the way in which any confidential information shared by the Trust and the other party can be used and ensure that this information and the fact that the parties are working together are kept confidential. These agreements are entered into at the outset of the process and will not generally have a financial value associated with them.

7.13.2 Legal advice should be sought when the Trust is asked to enter into a non-disclosure agreement or the agreement entered into should follow the format of the template non-disclosure agreement used by the Trust. Non-disclosure agreements must be authorised and signed by any Executive Director, the ~~Director of Informatics~~Chief Information Officer, the Managing Director of Wessex Procurement Limited, Head of Innovation or the Commercial and Enterprise Director.

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 Officer, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Integrated Care Boards 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 and Social Care or NHS England 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 Officer should take into account:

(a) Costing and pricing (in accordance with the NHS England financial regime or any 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.~~6~~7 The CFO shall produce regular reports detailing actual and forecast income.

8.1.~~7~~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.~~8~~9 The authorisation limits for signing service contracts are set out in ~~Annex 3~~Annex 2.

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 Officer 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. This includes bidding for external sources of capital or revenue funding.

8.3.2 Delegated authority limits associated with tendering are outlined in ~~Annex 3~~Annex 2.

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 stated financial limits as per the Trust Authorisation Framework. All tender decisions will be reported to the Trust Executive Committee for noting.

8.3.4 Staff who participate in a tendering exercise must notify the Planning and Business Development team and/or commercial 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 Remuneration and Appointment Committee

9.1.1 The Trust Board shall establish a Remuneration and Appointment 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 £160k) must be referred to NHS England and onward opinion from 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 Control Panel (if applicable) and provided the post is within the limit of their~~his~~ approved budget and affordable staffing limit. ~~He/she~~They may also regrade employees after consultation with their Human Resources Business Partner and job evaluation has taken place in accordance with Trust policy; subject to the Recruitment Control Panel Terms of Reference.~~.~~

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 compliant with IR35 legislation and 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 England / 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 the creation of, local terms and conditions require approval by Pay Steering Group. Where necessary, for major changes, it may be appropriate for this to be authorised by either the Trust Board's Remuneration and Appointment Committee or Trust Board.

9.3 Processing Payroll

9.3.1 The Chief People Officer 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 / overpayments is contained in the Trust's Pay Policy.

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 Officer 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 3~~Annex 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 Managing Director of~~ Wessex Procurement Limited 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)~~a) Pay overs i.e. HMRC, Pensions, child support, court fees, salary sacrifice schemes;
~~c) Patient reimbursements, such as travel Salary sacrifice;~~
~~d) Opticians;~~
~~e)~~b) Intra NHS ~~R~~echarges;
~~f) General personal reimbursements;~~
~~g) Litigation;~~
~~h) Local Authority costs;~~
~~i) Payments controlled in other systems e.g. JAC for Pharmacy~~
c) Transactions between UHS Group entities e.g. WPL, UEL, UPL
~~j) NHS~~ Patient voucher schemes (eg opticians)

~~k)~~ Out of scope of the above are payments via purchase cards, expense claims and invoices processed in ~~other financial systems for the Trust such as~~ 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), tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

a) The following contracts should be submitted to the Finance department for review prior to seeking approval as they are likely to need submission to Trust Investment Group under revised accounting standard IFRS16:

- Equipment leases
- Property leases (including those with peppercorn rents)
- Other contracts which include the supply of equipment which include separate charges for that equipment (embedded leases)
- Other contracts which include the supply of equipment which do not include separate charges for that equipment (as the charging

mechanism may need apportioning between the supply of goods or services and the supply of equipment as an embedded lease)
- Other property guarantees

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the relevant approval body outlined in ~~Annex 3~~Annex 2;

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 UK legislation and WTO 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 England's NHS 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 Trust will comply with the guidance on dividend payments contained in the DHSC 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 England 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 two Executive Directors and chaired by the Chief Financial Officer to oversee its allocation of capital investment. The Chief Financial Officer 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 3~~Annex 2.

12.2.2 All expenditure should be within the program budget as agreed by Trust Board on an annual basis. Program reporting is required by Trust Investment Group (TIG) on a periodic basis ~~Defined groups with specific approval limits are as follows:~~

~~***Programme allocations within Capital Plan***~~	~~***Group/ individual responsible for approval***~~

~~Backlog Maintenance~~	~~Director of Estates, Facilities & Capital Development / Associate Director of Estates~~
~~Replacement leases~~	~~Leasing sub-committee~~
~~Health & Safety~~	~~Health & Safety Manager~~
~~Infrastructure, Development Infrastructure, Space Issues, Defects Resolution, Fire Safety, Advanced Design Fees, Contingency~~	~~Director of Estates, Facilities & Capital Development~~
~~Medical Equipment~~	~~Medical Equipment Panel~~
~~Theatres Equipment~~	~~UEL Board~~
~~Information Systems~~	~~Digital Board~~
~~Imaging Infrastructure Support Service (IISS)~~	~~IISS Investment Committee~~

~~All expenditure should be within the program budget as agreed by Trust Board on an annual basis. Program reporting is required by Trust Investment Group (TIG) on a periodic basis.~~

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%, whichever is greater, 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 (Imaging Infrastructure Support Service) managed service contract, up to a maximum value of £100k, can be approved by the Director of Operational Finance. All changes must be reported to the Trust Investment Group.~~

12.2.~~6~~5 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~~6 The Trust Investment Group will report on major issues to the Trust Executive Committee and Trust Board via the capital section of the monthly Finance Report and within the quarterly capital update.

12.2.~~8~~7 The Southampton Hospital Charity, or other charities, may choose to donate assets to the Trust. The governance outlined in Section 17 (Charitable Funds Held on Trust) shall apply. Any financial consequences on the Trust must be

approved by the appropriate body as outlined in the Trust Authorisation Framework (~~Annex 3~~Annex 2).

12.2.~~9~~8 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.~~10~~9 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 Officer 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 Officer.

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 the 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 £2.5 million (excluding VAT); and
c) Acquisition of property where the total value of the agreement is over £2.5 million (excluding VAT) by means of a lease, whether it is deemed to be capitalised or not under IFRS 16.

12.6.3 Property purchases, licences and leases up to £150,000 each (excluding VAT) may be authorised by the CFO and those at or above this value but not exceeding £2.5 million each (excluding VAT) may be authorised by the Trust Investment Group, provided in each case that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation. Licences connected with existing leases or other transactions previously authorised by the CFO, Trust Investment Group and Trust Board will not require separate authorisation provided that these do not result in significant changes to the Trust's Estate.

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 and Social Care 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 Officer.

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 £2.5 million (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 England.

12.6.11 Material or Significant Transactions, as defined in NHS England's transactions guidance, may require the approval of NHS England.

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 £2.5 million.

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 Managing Director of Wessex Procurement Limited. 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, Facilities & Capital Development. The control of stock within UHS subsidiaries shall be the responsibility of subsidiary directors and their respective Boards.

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 Managing Director of Wessex Procurement Limited, 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 Managing Director of Wessex Procurement Limited 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 Officer 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 Officer.

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 DHSC Group Accounting Manual and prepare a register. Approval limits where approval is required from NHS England and HM Treasury are defined in Annex 1.—

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 Fraud, Bribery and Corruption Policy).

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

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 Officer 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 Officer, supported by the ~~Director of Informatics~~Chief Information Officer, 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 2018 and the UK General Data Protection Regulation; 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 and ensure that appropriate technical and organisational measures are in place to achieve compliance. 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~~ UHS Digital 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~~ UHS Digital department.

The Trust's Digital Board has an approval limit of £300k for projects where within budgetary limits. It will be at the discretion of the ~~Director of Informatics~~ Chief Information Officer or other senior ~~Informatics~~ UHS Digital managers whether a case requires discussion at Digital Board.

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 Officer 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 and Social Care 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 Social Care and Department of Work and Pensions 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 overriding 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 Chief People Officer, 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 Charity 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 or nominated deputy 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 Director shall arrange for the following functions to be undertaken:

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 restricted accounts are managed 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 Charity 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 Chief People Officer and to the Southampton Hospital Charity 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 Charity Charitable Funds Committee and the Charity Commission.

17.3 Fundraising & Incoming Funds

17.3.1 The Director of Southampton Hospital Charity shall:

a) Ensure that the Charity is the only vehicle for the collection and administration of charitable funds. No other department may collect or administer funds without prior authorisation from the Charity team.

~~a)~~b) 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)~~c) Identify and prioritise, in conjunction with appropriate elements of the Trust, fundraising projects/appeals.

~~c)~~d) Market and promote fundraising while maintaining a unified brand and adhering to charity regulations;

~~d)~~e) Build, maintain and utilise donor records in accordance with the Data Protection and Freedom of Information Acts;

~~e)~~f) Work in close partnership with other charities supporting the hospital, performing a liaison role where appropriate;

~~f)~~g) Build and maintain a staff team and network of volunteers and funders;

~~g)~~h) Generate continuous and unrestricted income in order to become sustainable;

~~h)~~i) Alert the Charitable Funds Committee to any irregularities regarding the use of the charity's name or its registered charity number;

~~i)~~j) 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 Charity Charitable Funds Committee or if appropriate will be devolved to a sub-committee (to include the Charitable Funds Committee Chair, the CFO, and the Charity Director 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 Director, with support from the Trust Finance Team will:

a) Report investment performance to the Southampton Hospital Charity Charitable Funds Committee;

b) Minute investment decisions;

c) Allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Fund Expenditure and Grants

17.5.1 Day-to-day management of individual expenditure is delegated to the Charity Director 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 The Charity Director is responsible for ensuring appropriate fund holders are appointed to support the effective management and use of charitable funds. This includes periodic review of fund holders and their role.

17.5.4 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).

17.5.5 ***Levels of Authority***

The following levels of approval shall apply:

£ (excl VAT)	**Approval Process for designated funds**
All levels	Application made to the Charity funds officer. Proposed expenditure discussed with fund holders and approval code issued if agreement. The Charity will require additional sign-off in support of the application depending on amount requested: Up to £10k – Fund holders £10k to £75k – Fund holders + CGM (or THQ director) Above £75k – Fund holders + DDO (or THQ director)
	Once approval code is issued the following approval levels apply
Up to £5,000	Senior Funds Officer
£5,001 - £25,000	Head of Charity Operations
£25,001 - £75,000	Charity Director
£75,001 - £1m	Charitable Funds Committee *Requires a business case*

Over £1m	Trust Board as Corporate Trustee *Requires a business case*

For the purpose of the non-pay authorisation framework, the CFO will be the £1m approver and the CEO will be the unlimited approver.

17.5.6 Points to note:

a) If the Fund Holder is absent from work for an extended period of time or , in cases where, for example the Fund Holder and the Care Group Manager are one and the same, the Charity Director or Head of Charity Operations can exercise discretion to accept authorisation from fewer signatories, subject to the minimum of two.

b) 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 Director.

c) Expenditure above £75,000 must be supported by an appropriate business case.

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

17.5.8 The delivery of charitably funded 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 £10k or more than 5% 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.

17.5.9 Although exempt from public sector procurement roles, the Charity will follow the Trust's procurement processes except in situations where these rules are not appropriate or applicable to charitable purposes. In these cases approval will be sought from Charitable Funds Committee.

17.6 Asset Management

17.6.1 Charitable funds can be considered as a source of funds for the maintenance of assets granted to the Trust, subject to agreement between the Charity and the Trust.

17.6.2 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 other than where the Charity has agreed to fund the maintenance or revenue costs.

17.6.3 The Trust shall:

a) Be responsible for insuring, safeguarding and protecting all equipment and must pay its operating, maintenance costs (unless prior agreement to be funded by the Charity), 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 Director will be responsible for updating an annual risk register for agreement by the Southampton Hospital Charity 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 Officer 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 Standards of 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 in accordance with the Trust's Standard of Business Conduct Policy 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, Fraud, Bribery and Corruption, Standards of Business Conduct and Raising Concerns (Whistleblowing) 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 NHS fraud and corruption reporting line (0800 028 4060) or via the National Fraud Reporting website reportfraud.cfa.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive Officer shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS England/DHSC 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, Facilities & Capital Development
Building & Engineering Contracts	Director of Estates, Facilities & Capital Development
Estate Maintenance Contracts	Associate Director of Estates
Maintenance Contracts	WPL
Clinical Contracts	~~Director of Contracting~~Director of Operational Finance
WPL Contracts	Associate Director of Corporate Affairs
Contracts for goods and services other than the above	WPL

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 England/DHSC guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive Officer 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 Officer 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 lead contact on insurance matters and ensure Insurance Brokers are liaised with 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 Chief Nursing Officer shall:

a) Provide a central point of contact within the Trust for NHSR/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 NHS Resolution, in joint agreement with the Associate Director of Corporate Affairs, 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 and approved by the Trust Legal Services Facilitator and Head of Claims and Insurance.

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 DHSC 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 (Community Health and Standards) 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 Resolution, 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 Trust 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 Chief People Officer.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Chief People Officer and the Chief Financial Officer. In certain cases, additional approval should be sought from NHS England and/or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Chief People Officer 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 £530,000	Chief People Officer and Chief Financial Officer
£530,001 to £100,000	Chief Executive Officer
£100,000 plus	Trust Board

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

23. SUBSIDIARIES, SHAREHOLDINGS, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Subsidiaries and Shareholdings

23.1.1 Subsidiary companies and companies where UHS are joint-shareholder (e.g. WPL) are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries and shareholdings 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, with the exception of where the group position is directly impacted (e.g. Group CDEL limit for capital). Reference to the subsidiary's documentation will need to be made.

23.1.2 Whilst subsidiaries operate independently, their SFIs include a schedule of changes where prior written approval of the Shareholder is required. This includes alteration of any constitutional documents of the company. Any changes to the schedule of prior Shareholder approval will require approval of Trust Board, following review and recommendation by the Audit and Risk Committee.

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.

24. Force Majeure

24.1 In the event of a force majeure, such as a Pandemic, the existing Standing Financial Instructions and Scheme of Delegation should be followed as normal where possible.

24.2 If compliance with Standing Financial Instructions (SFIs) and Schemes of Delegation (SODs) is expected to generate delays to the procurement of goods (either revenue or capital expenditure) and such delay causes unacceptable detriment to patients and / or staff, the SFIs and SODs may be waived on the written authority of either the CFO or Director of Operational Finance. In the event that neither the CFO nor Director of Operational Finance is available, the CFO may delegate the authority to waive SFIs / SoD to another Executive Director.

24.3 If the value of the transaction exceeds £2.5m, the written authority of the Chair, or another Non-Executive Director nominated by the Chair, will also be required.

24.4 A schedule of transactions showing transactions where SFIs / SoD have been waived shall be maintained to include the date of waiver, name of supplier, description of goods ordered, name of approving officer and why the waiver was approved. This schedule shall be reported regularly to Trust Board and to each Audit and Risk Committee.

24.5 The Audit and Risk Committee are responsible for ratifying decisions made under force majeure.

24.6 The Trust Board and / or Audit and Risk Committee need to confirm when Force Majeure arrangements can come into force and when they are terminated.

24.7 The CFO or Director of Operational Finance can also waive section 10.3.3 of Trust SFIs relating to prepayments, where this is in line with HM Treasury policy regarding payments to Suppliers during a force majeure (for example “Procurement Policy Note 02: Supplier relief due to coronavirus”).

Annex 1

~~Writing Off of~~ Losses, Gifts 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

Type	Approval thresholds by NHSE and HMT
Special severance payments	All non-contractual payments
Special payments	£95k+
Losses	£95k+
Gifts	£300k+
Anything novel, contentious or repercussive	All must be approved

Annex 2

Significant Transactions

The Trust is obliged to report significant transactions to NHS England (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 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 England.

Significant transactions are defined by NHS England 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 England 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 2016).

~~Annex 3~~Annex 2 – Trust Authorisation Framework

Section 1 – Authorisation Bodies and Limits

Expenditure limits refer to per annum budget thresholds.

Group	Revenue (Annual Gross Cost)	Capital
Divisional Manageament Boards	Utilisation of approved expenditure budget only. ~~Delivery of an annual cost improvement target from revenue expenditure budgets is also required.~~	Up to £150k where this is within the annual capital allocation for the Division. All capital expenditure to be reported to TIG.
Defined groups ~~as outlined in Capital section~~	N/A	Up to £150k where this is within annual capital allocation: • Director of EFCD – backlog maintenance / Infrastructure / Advanced design fees. • Leasing sub-committee – replacement leases / buy-outs. • Medical Equipment Panel • UEL Board • IISS Investment Committee Up to £300k where this is within annual capital allocation: • Digital Board ~~Up to £150k (£300k for Digital Board), where this is within the annual capital allocation. All capital expenditure to be reported to TIG.~~
Recruitment Control Panel	~~For all recruitment - a~~As per Terms of Reference, reporting into TEC	N/A
~~**TEC (Trust Executive Committee)**~~	~~For noting: - new consultant business cases (non-service development) - replacement clinical consultant cases~~	~~N/A~~
DoOF or COO	Up to £50k – exceptional circumstances only.	Up to £50k – exceptional circumstances only. All capital expenditure to be reported to TIG.
CEO or~~f~~ CFO	Up to £150k	Up to £150k. All capital expenditure to be reported to TIG.
TIG (Trust Investment Group)	Up to £2.5m additional expenditure budget.~~.~~ Schemes over £2.5m and/or of significant strategic importance should include a recommendation from TIG to F&IC. ~~*TIG papers to be shared at TEC for noting and an update on key recommendations/decisions provided.~~	~~£0.0m -~~Up to £5.0m. Schemes over £5.0m and of significant strategic importance should include a recommendation from TIG to F&IC. ~~*TIG papers to be shared at TEC for noting and an update on key recommendations/decisions provided.~~
TEC (Trust Executive Committee)	Receive minutes and note decisions from TIG. • Business cases relating to staff recruitment / training programmes. • New consultant business cases • Replacement consultant business cases – for noting.	Receive minutes and note decisions from TIG. ~~N/A~~

	~~For noting:~~ ~~- new consultant business cases (non-service development)~~ ~~- replacement clinical consultant cases~~	
F&IC (Finance & Investment Committee)	£2.5m+ and schemes of significant strategic importance for commercial review and recommendation to Trust Board.	£5.0m+ -schemes of significant strategic importance for commercial review and recommendation to Trust Board.
Trust Board	£2.5m+ and: - schemes judged of significant strategic importance - major schemes with compliance arrangements	£5.0m+ and: - schemes judged of significant strategic importance - major schemes with compliance arrangements
NHS England	Major schemes with compliance arrangements	Major schemes with compliance arrangements

Group	Revenue (Including revenue implications of capital)	Capital (gross value)
Divisional Management Boards	Utilisation of existing expenditure budget only.	Up to £150k, where this is within annual Capital allocation for Division. All capital expenditure to be reported to TIG
Defined groups as outlined in Capital section of SFIs	N/A	Up to £150k (£300k for Digital Board), where this is within annual Capital allocation. All capital expenditure to be reported to TIG
Recruitment Control Panel	Recruitment of new posts and some replacements - as per Terms of Reference.	N/A
DoOF or COO	Up to £50k additional expenditure budget.	Up to £50k. All capital expenditure to be reported to TIG.
CEO or CFO	Up to £150k additional expenditure budget.	Up to £150k. All capital expenditure to be reported to TIG.
Trust Investment Group	Up to £1,000k additional expenditure budget. Schemes requiring significant clinical or stragetic input regardless of value - recommendation to Trust Executive Committee.	£0k to £2,500k. Unless approved by group above. All schemes over £2,500k should include a recommendation from TIG. Schemes requiring significant clinical or stragetic input regardless of value - recommendation to Trust Executive Committee.
Trust Executive Committee	£1,000k to £2,500k; and Schemes requiring significant clinical or stragetic input regardless of value All schemes above £2,500k should go to Trust Executive Committee for noting. New consultant business cases Replacement clinical consultant cases for noting	£2,501k - £5,000k; and Schemes requiring significant clinical or stragetic input regardless of value All schemes above £5,000k should go to Trust Executive Committee for recommendation to Trust Board.
Finance & Investment Committee	All schemes above £2,500k; and Schemes judged by Trust Executive Committee as of significant strategic importance should go to F&IC for review and recommendation to Trust Board.	All schemes above £5,000k; and Schemes judged by Trust Executive Committee as of significant strategic importance should go to F&IC for review and recommendation to Trust Board.
Trust Board	All schemes above £2,500k; and Schemes judged by Trust Executive Committee as of significant strategic importance Any proposed major scheme with FT compliance arrangement	All schemes above £5,000k; and Schemes judged by Trust Executive Committee as of significant strategic importance Any proposed major scheme with FT compliance arrangement
NHS Improvement	N/A	Any proposed major scheme within FT compliance arrangements

Section 2 – Non-Pay Authorisation Framework

Finance and Procurement System - Rulesets

Approver limits according to Hierarchy

		First Approver	Second Approver	Third Approver	Fourth Approver	Fifth Approver	Sixth Approver
Rule 1	Divisional Hierarchy	£5k	£25k	£75k	£250k	£1m	Unlimited
Rule 2	R&D Hierarchy	£5k	£25k	£75k	£250k	£1m	Unlimited
Rule 3	THQ Hierarchy	£5k	£75k	£250k	£1m	Unlimited	
Rule 4	Other Hierarchy - Inc. Capital, Estates	£75k	£250k	£1m	Unlimited		

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

	Limit £
All Staff	
Band 1-4	£0k
Band 5-7	£5k
Band 8a-8b	£25k
Band 8c-8d	£75k
Band 9	£250k
Trust Board/Directors	
Chief Executive Officer	Unlimited
Chief Financial Officer	Unlimited
Chief Operating Officer	£1m
Chief Information Officer	£1m
Other Executive Director	£1m
Director of Operational Finance	£1m
Finance	
Assistant Director of Finance	£250k
Pharmacy	
Chief Pharmacist	£250k

The expenditure limit is in respect of total contract/tender value. E.g. a three year contract with an annual value of £26k has a total value of £78k and has to follow protocol for signing off up to £250k.

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

Section 3 – Contracting – Financial Limits

Total Contract Value (Excluding VAT)	Type of Contract	Authorisation To Place or sign Contract
Nil	Non-Disclosure Agreements	Any Executive Director, the Director of Informatics, the Director of R&D, the Managing Director of Wessex Procurement Ltd or the Commercial Director
Up to £0.5m	Goods & Services	Director of Estates, Facilities & Capital Development, Director of Informatics, Chief Pharmacist, DoOF, DDO, Director of R&D
£0.5m - £1.0m	Goods & Services	CFO, Managing Director of Wessex NHS Procurement Ltd
£1m - £2.5m	Goods & Services	Chief Executive Officer
Over £2.5m	Goods & Services	Trust Board/Chair
Ensuring Procurement & Tender limits also complied with		
Up to £0.5m	Building & Engineering	Associate Director of Estates, Deputy Director of Estates, DoOF
£0.5m - £2.5m	Building & Engineering	Director of Estates, Facilities & Capital Development, CFO
£2.5m - £5m	Building & Engineering	Chief Executive Officer
Over £5m	Building & Engineering	Trust Board/Chair
Ensuring Procurement & Tender limits also complied with		
Up to £0.5m	Non-NHS Income	DDO / Commercial Director / DoOF / Director of R&D
£0.5m - £1.0m	Non-NHS Income	CFO
£1m - £2.5m	Non-NHS Income	Chief Executive Officer
Over £2.5m	Non-NHS Income	Trust Board / Chair
Up to £10m	NHS Income	Director of Contracting
£10m - £200m	NHS Income	CFO
Over £200m	NHS Income	Chief Executive Officer
Up to £0.5m	Bidding for Tenders	DDO / Commercial Director / Director of R&D
£0.5m to £12.5m	Bidding for Tenders	Tender Steering Group / CFO
£12.5m to £25m	Bidding for Tenders	Chief Executive Officer
Over £25m	Bidding for Tenders	Trust Board
Based on gross expenditure, not off-set with income.		

Total Contract Value (exc VAT)	Type of Contract	Authorisation to place/sign Contract
Nil	Non-Disclosure Agreements	Executive Director, Chief Information Officer, Director of R&D, Managing Director of WPL, Head of Innovation, Commercial and Enterprise Director
Up to £0.5m	Goods & Services	Director of Estates, Chief Information Officer, Chief Pharmacist, Director of Operational Finance, Director of R&D, DDO
£0.5m-1.0m	Goods & Services	Chief Financial Officer, Managing Director of WPL
£1.0m-£2.5m	Goods & Services	Chief Executive Officer
£2.5m+	Goods & Services	Trust Board, Chair

Ensuring Procurement and Tender limits also comply with

Up to £0.5m	Building & Engineering	Associate Director of Estates, Deputy Director of Estates, Director of Operational Finance
£0.5m-1.0~~2.5~~m	Building & Engineering	Director of Estates~~, Chief Financial Officer~~
£1.0m-£2.5m	Building & Engineering	Chief Financial Officer
~~£~~£2.5~~2.5~~m-£5.0m	Building & Engineering	Chief Executive Officer
£5.0m+	Building & Engineering	Trust Board, Chair

Ensuring Procurement and Tender limits also comply with

Up to £0.5m	Non-NHS Income	DDO, Commercial Director, Director of Operational Finance, Director of R&D
£0.5m-1.0m	Non-NHS Income	Chief Financial Officer
£1.0m-£2.5m	Non-NHS Income	Chief Executive Officer
£2.5m+	Non-NHS Income	Trust Board, Chair

Up to £10m	NHS Income	~~Director of Contracting~~Director of Operational Finance
£10m-200m	NHS Income	Chief Financial Officer
£200m+	NHS Income	Chief Executive Officer

Up to £0.5m	Bidding for Tenders	DDO, Commercial Director, Director of R&D, Director of Planning
£0.5-10~~2.5~~m	Bidding for Tenders	Tender Steering Group, Chief Financial Officer
£10~~2.5~~m-£20~~5~~m	Bidding for Tenders	Chief Executive Officer
£20~~5~~m+	Bidding for Tenders	Trust Board

Based on gross expenditure, not offset with income

Annex 23 – Trust Authorisation Framework

Section 4 – Authorisation Framework for Procurement and Tendering of expenditure

Area of spend	Contract Value (Exc VAT)	Quotations/ Tenders for Goods & Services	Min number invited to Quote/Tender	Form of Contract
All	Up to £10,000	No formal tender requirement	0	Purchase Order
All	£10,001 - £75,000	Quotation	3	Up to £24,999 - Purchase Order £25,000+ - Procurement Approval Document (PAD)
Products and Services Procurement only	£75,001 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
Building and Estates Engineering Procurement only	£75,001 - £499,999	Formal Local Tender	3	Contract as specified in Tender and Purchase Order
	£500,000 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
All	> published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender or via compliant framework process and Purchase Order

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 - Procurement Approval Document (PAD)
£75,001 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
>published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender or via compliant framework process and Purchase Order

Threshold limits represent the contract's lifetime value e.g., a 5-year contract of £25,000 per year requires £125,000 method and authorisation.

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 - Procurement Approval Document (PAD)
£75,001 - £499,999	Formal Local Tender	3	Contract as specified in Tender and Purchase Order
£500,000 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
>published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender or via compliant framework process 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, Facilities & Capital Development, Managing ~~Director of WPL, Director of~~ Informatics, Head of Estates Maintenance, DDO
As above	£75,001 - £499,999	Chief Executive Officer / CFO
As above	Over £500,000	Trust Board

Waiving or Variation of Competitive Tendering/Quotation procedure

Type of Contract	Monetary Value (Exc VAT)	Authorisation to place/sign Contract
Products/Services Building/Engineering/Works Contracts/Consultancy Services	Up to ~~£75,000~~1.0m	Director of Estates, Managing Director of WPL, Chief Information Officer, Head of Estates Maintenance, DDO
	~~£75,001~~1.0m - ~~£499,999~~2.5m	Chief Executive Officer, Chief Financial Officer
	~~£500,000+~~2.5m+	Trust Board

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance and Investment Committee Terms of Reference**			
Agenda item:	**8.3**			
Sponsor:	**Dave Bennett, Chair of Finance and Investment Committee**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 January 2024**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.			
Response to the issue:	No changes are proposed to the current terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Finance and Investment Committee are clear and support transparency and accountability in the performance of its role and comply with Code of Governance for NHS Provider Trusts.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006, the Code of Governance and the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Audit and Risk Committee. 3. The Board of Directors and the committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the terms of reference following review and approval by the Finance and Investment Committee on 29 January 2024.			

University Hospital Southampton NHS
NHS Foundation Trust

Finance and Investment Committee Terms of Reference

Version: ~~8~~9

Date Issued:	~~31 January 2023~~ 30 January 2024
Review Date:	January 20~~24~~25
Document Type:	Committee Terms of Reference

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1. Role and Purpose

1.1 The Finance and Investment Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the stewardship of the Trust's finances, investments and sustainability of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including planning, financial performance, capital expenditure and the delivery of the informatics and estates, facilities and capital development annual plans.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's financial position and capital and revenue investments to enable world-class people to deliver world-class care.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 three non-executive directors of the Trust, at least two of whom should be independent, including the chair of the Audit and Risk Committee;

3.1.2 the Chief Executive Officer;

3.1.3 the Chief Financial Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). The Committee Chair will not be the chair of the Audit and Risk Committee. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Director of Operational Finance/Deputy Director of Finance;

3.4.2 Director of Planning, Performance and Productivity; and

3.4.3 Associate Director Always Improving.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors (one of whom must be either the Committee Chair or the chair of the Audit and Risk Committee) and either the Chief Financial Officer or Chief Operating Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least ten times each year (usually once each calendar month) and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Financial planning and performance***

7.1.1 The Committee will review and monitor the following, ensuring these support the achievement of the Trust's objectives, and consider the adequacy and effectiveness of any corrective action proposed:

7.1.1.1 the Trust's long-term financial model;

7.1.1.2 the Trust's long-term and annual financial plans encompassing income, expenditure and capital;

7.1.1.3 the capital plan including any changes in the Trust's performance that may impact on the delivery of the long-term capital plan;

7.1.1.4 financial performance and forecasts and projections including achievement of the control total and other targets;

7.1.1.5 performance against revenue budgets at both Trust and divisional level;

7.1.1.6 capacity, activity and productivity including any significant variation and the impact on income;

7.1.1.7 cash, liquidity and working capital;

7.1.1.8 the use of any working capital facilities; and

7.1.1.9 performance of the Trust's subsidiaries and any joint ventures against agreed performance indicators.

7.2 ***Always Improving Value for Money***

7.2.1 The Committee will ensure that there is an Always Improving: Value for Money (**AIVFM**) programme in place each financial year that aligns with the Trust's annual plan.

7.2.2 The Committee will seek assurance that a recovery plan is in place and being implemented where any AIVFM schemes are at risk of delivery.

7.3 ***Investment***

7.3.1 The Committee will review business cases of £2.5 million or more in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.2 The Committee will review capital business cases over £5 million in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.3 The Committee will review all business cases identified by the Trust Executive Committee as of significant strategic importance regardless of value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.4 The Committee will assess benefits realisation through post-implementation reviews, ensuring any learning is shared.

7.4 ***Informatics annual plan***

7.4.1 The Committee will monitor and oversee the delivery of the Trust's annual plan for IT including funding and ongoing alignment with the Trust's objectives.

7.5 ***Estates, facilities and capital development annual plan***

7.5.1 The Committee will monitor and oversee the delivery of the Trust's estates, facilities and capital development annual plan including funding and ongoing alignment with the Trust's objectives.

7.6 ***Risk***

7.6.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.6.2 The Committee will establish and maintain an overview of the Trust's financial risks and risks to delivery of the Trust's informatics or estates, facilities and capital development plans and ensure the effectiveness and implementation of controls for financial risks and actions to mitigate risks to the delivery of the Trust's informatics or estates, facilities and capital development plans.

7.6.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.6.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.7 ***Reporting***

7.7.1 The Committee will review any key financial submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will review the National Cost Collection Index for the purposes of benchmarking the Trust's performance.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the financial statements and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

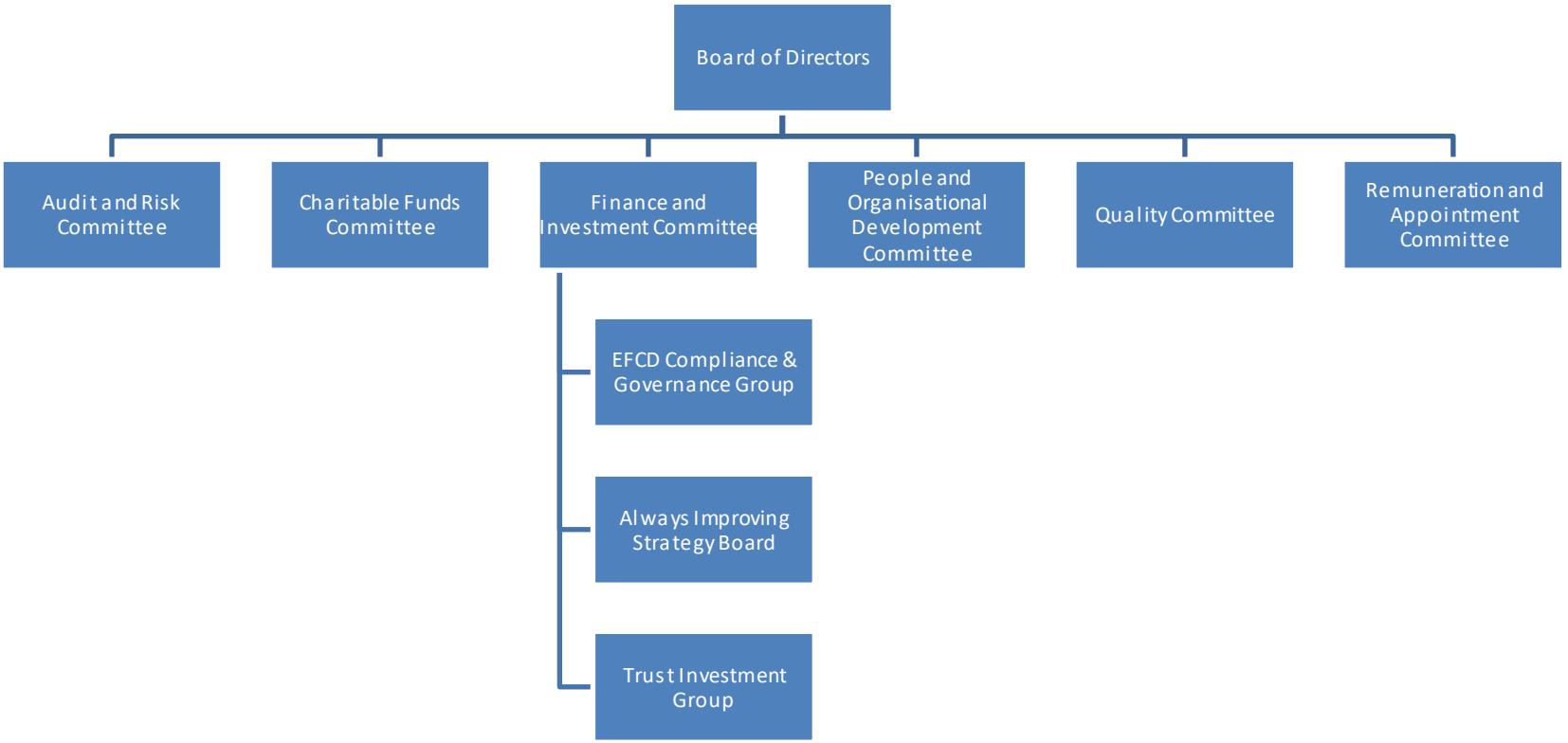
10.1 National Health Service Act 2006

10.2 NHS System Oversight Framework

10.3 NHS Improvement and Care Quality Commission Use of Resources: assessment framework

10.4 Standing Financial Instructions

Appendix A


Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
EFCD Compliance & Governance Group
Always Improving Strategy Board
Trust Investment Group

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~31 January 2023~~30 January 2024
Responsible Committee:	Finance and Investment Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	January 20~~24~~25
Target audience:	Board of Directors, Finance and Investment Committee, Staff
Key words:	Finance, Investment, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	No changes
Consultation:	Chair and Interim Chair
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Quality Committee Terms of Reference**			
Agenda item:	**8.4**			
Sponsor:	**Tim Peachey, Chair of Quality Committee**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 January 2024**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.			
Response to the issue:	No changes are proposed to the current terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Quality Committee are clear and support transparency and accountability in the performance of its role and comply with the Code of Governance for NHS Provider Trusts.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006, the Code of Governance and the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Audit and Risk Committee. 3. The Board of Directors and the committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the terms of reference following review and approval by the Quality Committee on 29 January 2024.			

University Hospital Southampton NHS
NHS Foundation Trust

Quality Committee Terms of Reference

Version: ~~5~~ 6

Date Issued:	~~31 January 2023~~30 January 2024
Review Date:	January 20~~24~~25
Document Type:	Terms of Reference

Contents

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled.
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1. Role and Purpose

1.1 The Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and the other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Deputy Director of Nursing (Quality);

3.4.2 Medical Lead for Safety (Patient Safety Specialist); and

3.4.3 patient representative(s).

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary of the Committee in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least eight times each year (at regular intervals throughout the year) and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Nursing Officer and the Chief Medical Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive reports on Trust-wide clinical outcomes presented to clinical assurance meeting for effectiveness and outcomes (CAMEO) meetings including patient outcomes and compliance with the other aspects of clinical effectiveness activity.

7.3.3 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS System Oversight Framework.

7.5.4 The Committee will seek to identify potential evidence and areas of health inequalities between different groups of people.

7.5.5 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.6 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 ***Risk***

7.6.1 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

7.6.2 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.6.3 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

7.6.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.7 ***Reporting***

7.7.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality accounts/quality report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 National Health Service Act 2006

10.2 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

10.3 Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission

10.4 Health Act 2009

10.5 National Health Service (Quality Accounts) Regulations 2010

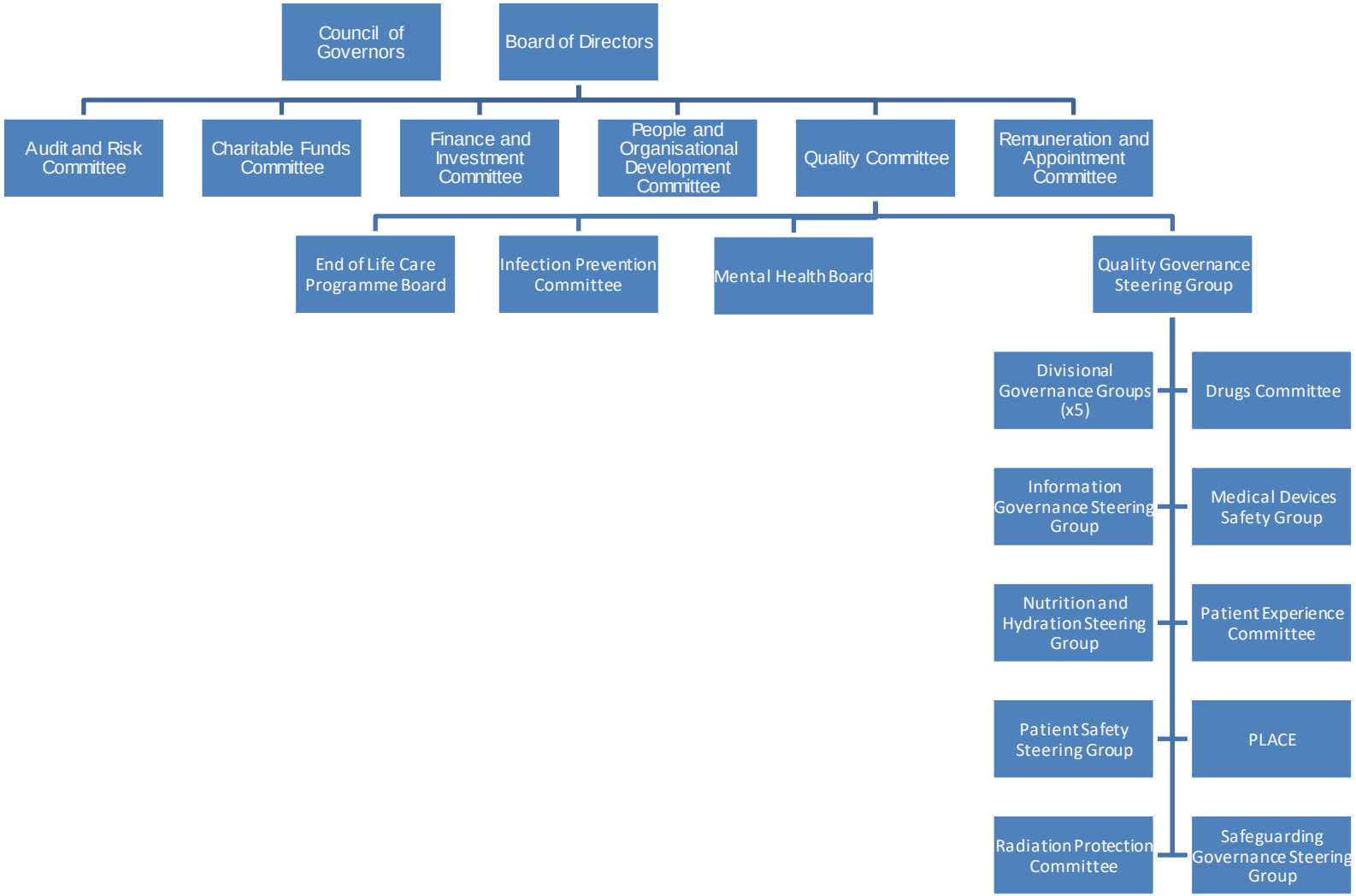
10.6 NHS Foundation Trust Code of Governance

10.7 NHS System Oversight Framework

10.8 NHS Foundation Trust Annual Reporting Manual

10.9 NHS England and NHS Improvement's requirements for quality accounts

Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

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Summary of most recent changes if applicable:	No changes
Consultation:	Chief Nursing Officer
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Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No