NHS
University Hospitals of North Midlands
NHS Trust

Trust Board (Open)

February 2020

Together Compassion Safe Improving

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th February 2020 at 9.30 am to 12.30 pm
Trust Boardroom, Third Floor, Springfield, Royal Stoke

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format
09:30	**PROCEDURAL ITEMS**				
30 mins	1.	Patient Story	Information	Mr D Wakefield	Verbal
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal
	4.	Minutes of the Meeting held 8th January 2020	Approval	Mr D Wakefield	Enclosure
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure
10 mins	6.	Chief Executive's Report - January 2020	Information	Mrs T Bullock	Enclosure
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**				
10 mins	7.	Quality Governance Committee Assurance Report (23-01-20)	Assurance	Prof A Hassell	Enclosure
10 mins	8.	Annual PLACE Inspection Scores 2019	Assurance	Mrs L Whitehead	Enclosure
10:40 – 10:50 COMFORT BREAK					
10:50	**ENSURE EFFICIENT USE OF RESOURCES**				
5 mins	9.	Performance & Finance Committee Assurance Report (21-01-20)	Assurance	Mr P Akid	Enclosure
10 mins	10.	Financial Performance Report – Month 9	Assurance	Mr M Oldham	Enclosure
11:05	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**				
15 mins	11.	Transformation and People Committee Assurance Report (24-01-20)	Assurance	Prof G Crowe	Enclosure
11:20	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**				
20 mins	12.	Integrated Performance Report – Month 9	Assurance	Mr P Bytheway Mrs M Rhodes Mrs R Vaughan Mr M Oldham	Enclosure
11:40	**GOVERNANCE**				
5 mins	13.	Audit Committee Assurance Report (23-01-20)	Assurance	Prof G Crowe	Enclosure
10 mins	14.	Board Assurance Framework – Quarter 3	Assurance	Miss C Rylands	Enclosure
10 mins	15.	Quarterly Speaking Up Report – Quarter 3	Assurance	Mrs R Vaughan	Enclosure
10 mins	16.	Standing Financial Instructions and Scheme of Delegation Policies	Approval	Mr M Oldham	Enclosure
12:15	**CLOSING MATTERS**				
5 mins	17.	Review of Meeting Effectiveness and Business Cycle Forward Look	Discussion	Mr D Wakefield	Enclosure
5 mins	18.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 31st January 2020 to claire.rylands@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal
12:25	**DATE AND TIME OF NEXT MEETING**				
	19.	**Wednesday 11th March 2020, 9.30 am – 12.30 pm, Trust Boardroom, Third Floor, Springfield, Royal Stoke**			
	EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC				
		Resolution: To exclude the press and public from the meeting at this point, on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. The press and public are requested to leave at this point (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960)			

Trust Board (Open)

Meeting held on 8th January 2020 at 9.30 am to 11.45 pm
Room 1, Postgraduate Medical Centre, County Hospital

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman											
Mr P Akid	PA	Non-Executive Director											
Ms S Belfield	SB	Non-Executive Director											
Mr P Bytheway	PB	Chief Operating Officer											
Mrs T Bullock	TB	Chief Executive											
Prof G Crowe	GC	Non-Executive Director						Chair					
Dr L Griffin	LG	Non-Executive Director											
Prof A Hassell	AH	Non-Executive Director											
Mr M Oldham	MO	Chief Financial Officer	JT	JT	JT								
Dr J Oxtoby	JO	Medical Director											
Mrs M Rhodes	MR	Chief Nurse	LR	LR	LR	TR							
Mr I Smith	IS	Non-Executive Director											
Mrs R Vaughan	RV	Director of Human Resources											

Non-Voting Members:			A	M	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy & Transformation											
Mr A Butters	AB	Director of Business Development											
Mr M Bostock	MB	Director of IM&T											
Ms N Duggan	ND	Director of Communications											
Miss C Rylands	CR	Associate Director of Corporate Governance											
Mr J Scott/ Mr P Orwin	JS/ PO	Chief Operating Consultant											
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI											

In Attendance:		
Mrs A Grocott	AG	Head of Patient Experience (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs N Haywood	NH	Patient Representative (item 1)
Mr J Tringham	JT	Operational Director of Finance (rep Mr M Oldham)

Members of Staff, Public & Press 1

No.	Agenda Item	Action
1.	**Patient Story**	
001/2020	Mrs Haywood recalled her mother's patient story since before her care was transferred to the University Hospitals of North Midlands and the lead up to the diagnosis of Motor Neurone Disease (MND). She referred to the way in which the diagnosis was delivered to her mother, without any relatives present, and in a rather factual manner, which she felt could have been improved upon. She recalled her mother's various hospital admissions, to numerous hospitals in the region, with respiratory failure, and described the difficulties in having to	

navigate through various different healthcare professionals, and explained that her aim was to try to keep her mother out of hospital. Mrs Haywood stated that after one admission for respiratory failure, she realised the importance of her mother having a Non-Invasive Ventilator (NIV) machine and cough assist machine, and tried to get these in place at home so that she could try to reduce the amount of times her mother came into hospital. She highlighted that her mother was only assessed for this equipment at home, when she was admitted to Royal Stoke, and upon discharge this equipment was provided which was welcomed by all of the family.

Mrs Haywood particularly highlighted the compassionate care provided by Dr Mustfa in the treatment of her mother, especially the way in which he listened to the family and recognised their contribution as carers. She referred to her role as care giver and the difficulty in navigating between the healthcare services, and stated that her mother had lived for 10 years after the initial diagnosis, although for 5 years, she was bed bound and her quality of life in those years was affected.

Mrs Haywood explained that a decision made by the local Clinical Commissioning Group (CCG) in changing the way in which NIV care was provided, had resulted in further challenges although she addressed this directly with the CCG which resulted in the care package being reinstated. She concluded by stating that she has since tried to 'give back' to the NHS and as such had been recruited as a lead patient volunteer at the Trust.

Mr Wakefield referred to the way in which the news was delivered to her mother and queried whether this had been addressed. Mrs Haywood stated that she did not raise this at the time, but that she had actively advocated better communication and conversations since then.

Dr Griffin thanked Mrs Haywood for sharing her story and referred to the difficulties in coordinating care across the system; he stated that in future, by working towards becoming an Integrated Care System (ICS), it would hopefully address some of the issues experienced. He queried what could have made her role as care giver easier and Mrs Haywood replied that clarifying where to go to for assistance would help and added that the introduction of the MND Centre would also help to support families. She stated that the other issue was ensuring relatives were involved in discussions.

Mrs Bullock commented that the care provided for patients with MND had positively changed over the past 10 years and this was particularly due to the creation of the MND Centre through the Trust and its partners.

Mr Wakefield summarised the need to remind clinicians providing bad news, to ensure relatives were involved so that they could support the patient. He referred to the work required to help patients navigate the health and social care system and stated that the Board should formally recognise the work being undertaken by Dr Mustfa. He stated that the story highlighted the importance of ensuring patients and their relatives felt able to liaise with CCGs regarding care packages and he thanked Mrs Haywood for becoming a patient volunteer.

The Trust Board noted the patient story.

Mrs Grocott and Mrs Haywood left the meeting.

Dr Oxtoby referred to the dedication of the respiratory team and the way in which they had pushed forward with the creation of the MND Centre.

2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
002/2020	Mr Wakefield welcomed members of the Board, public and press to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
003/2020	The standing declarations were noted.	
4.	**Minutes of the Meeting Held 11th December 2029**	
004/2020	The minutes of the meeting held on 11th December 2019 were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
005/2020	PTB/383 – Dr Oxtoby explained that he had asked for more detail in relation to the audit of transfers although this may not be ready by the time of the next Quality Governance Committee (QGC) meeting. PTB/408 – Mr Wakefield referred to the update into the review of harm for those patients waiting over 12 hours which would be taken to the QGC and requested a further update in the second part of the meeting. Dr Griffin referred to his previous request in relation to receiving an update in relation to the changes to junior doctors' contract and Mrs Vaughan explained that this would be taken to the Transformation and People (TAP) Committee and agreed to confirm the timeline.	**RV**
6.	**Chief Executive's Report**	
006/2020	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield queried why the vacancies in the Emergency Department had not been included within the report and Mr Bytheway agreed to raise this with the team as he thought that the recruitment was ongoing. However, it was noted that not all vacancies were included, only those where active recruitment was underway. Mr Smith referred to the Medical Examiner role and queried the progress being made. Dr Oxtoby stated that it was going well so far with no issues to date and stated that he would be taking a paper to the QGC in due course. Mr Wakefield thanked the Charity Team for their contribution to the amount of events held over the Christmas period. Professor Crowe requested further information in relation to the High Potential Scheme and asked to be involved with the visit from Prerana Issar. **The Trust Board received and noted the report.**	**JO** **RV**

PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (19-12-19)**	
007/2020	Mr Wakefield referred to the pressures in the Emergency Department over winter and queried how the Committee would receive assurance in relation to the lessons learnt if any serious incidents occurred over this period. Mrs Rhodes stated that the outcomes of any harm reviews for patients waiting over 12 hours would be considered by the Committee. **The Trust Board received and noted the assurance report.**	
8.	**Update on Influenza**	
008/2020	Mrs Rhodes referred to the increase in the number of Respiratory Syncytial Virus (RSV) and flu cases within the organisation and explained that flu arrived at the Trust earlier than predicted, with a rise in the number of cases from November with a peak in December. It was noted that the majority of cases were of influenza A, and it was expected that cases of influenza B would be seen later in the year, similar to that of western Australia. She highlighted that there had been a 150% increase in RSV cases when compared with the previous year which was, in the main, affecting children and babies. Mr Smith referred to the age group of those affected by flu who should have had a vaccination, he queried if the Trust was aware of the proportion of patients with flu who had not received the vaccine in order to understand whether this was a contributory factor for the increase. Mrs Rhodes stated that she was not aware of this but assumed that the data would have been documented. Mrs Rhodes agreed to discuss further with the Infection Prevention Team as well as linking in with Public Health England regarding the uptake of vaccinations. Professor Hassell suggested that a medical student could assist in undertaking such a project. Ms Duggan stated that the uptake of the nasal spray vaccine had been lower than previous years and Mr Bytheway added that the quicker turnaround of diagnosing patients with flu had been important in reducing the spread of infection. Dr Griffin queried the current position in relation to norovirus and Mrs Rhodes explained that there had been an increase in cases over the past 3 weeks, although it did not hit the Trust as early as expected. She stated that 9 local care homes were either restricted or closed due to norovirus. Dr Oxtoby agreed that it would be worthwhile obtaining the data in relation to uptake of vaccination and numbers of patients with flu and agreed to link in with any research project so that it included the input of medics, nurses and public health. Mr Wakefield referred to a statement whereby for the first time, the Trust recorded cases of flu in every month, and queried whether this should have been an indication of how bad it was going to be. Mrs Rhodes stated that the Trust had worked with Public Health England and followed national and international research and guidance in terms of planning and preparing for the vaccine. Mr Wakefield welcomed the suggestion of a research project and stated that once completed, the results needed to be shared with the public to raise awareness.	**MR/JO**

	The Trust Board noted the report.	
ENSURE EFFICIENT USE OF RESOURCES		
9.	**Performance and Finance Committee Assurance Report (17-12-19)**	
009/2020	Dr Griffin highlighted the following areas: • The Trusts financial performance was positive although there was concern regarding the broader system wide position • The Committee noted the continued demand on urgent care and were concerned regarding current cancer performance **The Trust Board received and noted the assurance report.**	
10.	**Financial Performance Report – Month 8**	
010/2020	Mr Tringham highlighted the following: • As at Month 8 the Trust's actual performance was a deficit of £1.9 m which was £4.6 m better than the forecast year end position • Pay has continued to underspend, and non-pay was £0.6 m overspent, mainly as a result of pass through drugs. • The Trust was ahead of plan in relation to the cash position and the Trust was on track to achieve the £5 m surplus at the year end • The system wide position at month 7 was £12.6 m behind plan although all partners had confirmed that they expected to achieve their financial plans Mr Smith queried the impact on the Trust if it was not able to repeat the level of cost improvements, given the level of non-recurrent savings made. Mr Tringham stated that the Trust had a plan of £32 m cost improvements for 2020/21 and that identifying the schemes had already commenced, although it was recognised that delivering the plan would be a challenge. Dr Griffin referred to the statement from partners that they all aimed to achieve their plans and queried, given the deficit of the CCG whether this was achievable. Mr Tringham stated that no risks had been identified in relation to any impact on the Trust in relation to all partners achieving their targets. Mr Wakefield queried the level of confidence in delivering the forecast levels of elective income and Mr Tringham stated that the plan had factored some reduction in activity although the risk was lower than in previous years, due to local income having been factored into the Intelligent Fixed Payment Mechanism. Mr Bytheway stated that elective orthopaedic work had been halved, and the team were establishing a plan to get back to operating as soon as possible. Mr Wakefield commented that last year the Trust lost £5 m a month, therefore the turnaround in finances had been astonishing. He suggested at some point reflecting on this and highlighting the good news to staff, particularly given that the Trust was forecasting a surplus. Dr Griffin stated that it had been agreed at the Performance and Finance Committee to share the message with staff and Mrs Bullock added that she referred to the improvement in various engagement sessions with staff and that this was very positively received. Ms Duggan added that the improvement would also be part of the thank you week taking place in March. Professor Crowe queried the level of vacancies being carried and whether this was having a negative impact on the Trust. Mr Tringham stated that there was	

	some underspend on management roles which had been consistent, therefore this would be considered as part of budgeting for 2020/21. Mrs Rhodes stated that gap between actual and budgeted nursing establishment was not causing an issue, although the establishment review had identified that the skill mix was being considered on a ward by ward basis. She stated that she aimed to present the findings from the nursing establishment review to the Board in March. Mr Wakefield summarised that the Trust had continued with positive financial performance, and that although the system wide position was recognised partners had stated that they would get back on track, with no implications on the Trust. He stated that the Board recognised the pressure on nursing and reiterated that the improvements made in the financial position needed to be shared with staff. **The Trust Board received and noted the report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
11.	**Integrated Performance Report - Month 8**	
011/2020	<u>Operational Performance</u> Mr Bytheway highlighted the following: • In relation to urgent care performance over winter the Trust was on track with recruiting additional nurses in the Emergency Department and nearly all SHOs had been recruited to. It was noted that workforce had been based on a lower number of attendances therefore this was being reviewed to establish what was required to cover the increase. • There had been high levels of bed occupancy during November and the Trust reached escalation level 4 twice during the month as a result of the high attendances. • The main focus continued to be on ensuring quicker discharges and the time to treatment required more focus Mr Wakefield referred to the previous year's 10% increase and queried if a further 10% increase was experienced whether the Trust could cope. Mr Bytheway stated that between December 2018 and December 2019, there had roughly been the same number of attendances, but 2019 had seen patients with higher acuity. He stated that more community beds and home first space had been provided than in the previous year which would be of benefit. Dr Griffin referred to the role of Vocare and queried whether this was having a positive impact on activity within the Emergency Department. Mr Bytheway stated that Vocare were seeing 110 patients a day and aimed to increase this further. Mr Smith requested further information in relation to the ambulance corridor metric whereby 3400 patients were nursed during the month. Mr Bytheway stated that patients could be nursed on the corridor for a short amount of time and the metric was a measure of pressure. Professor Crowe stated that the metric should be expanded upon to identify what this means for the Trust and whether it carries additional risk. Mr Bytheway stated that the Trust should not plan to nurse to patients on the corridor and Mrs Rhodes stated that its use should not become normalised. She added that if patients were being cared for on the corridor, patient experience would ultimately reduce.	

Professor Hassell queried if a Standard Operating Procedure (SOP) was in place for nursing the patients on the corridor to which Mr Bytheway confirmed. He added that there was also a nurse to patient ratio of 1:6, and added that care and comfort rounds were in place. Professor Hassell queried if adherence to the SOP was audited and Mr Bytheway stated that this was referred to on a daily basis.

Dr Griffin queried how often ambulance staff were required to stay with patients on the corridor due to there not being enough nurses in place and Mr Bytheway stated that during November this did not occur very often, although in December 6 to 8 patients were cohorted by ambulance staff.

Mrs Rhodes referred to the Care Quality Commission (CQC) section 31 notices in place regarding the ambulance waits on the corridor and triage times, and stated that this was reviewed on a weekly basis. She added that this needed to be discussed further at the QGC in terms of the actions being taken as these were not necessarily having the desired impact on performance.

Mr Smith queried how many patients in ambulances were being sent to Royal Stoke rather than County Hospital and Mr Bytheway stated that this did not occur as specific protocols were in place in terms of the types of patients which can be accepted at County Hospital.

Mr Bytheway highlighted the following in relation to cancer performance:

- The Trust did not achieve the trajectory in November
- There continued to be two main areas of challenge; colorectal and urology. He stated that there had been an initial delay in making changes to the colorectal pathway and this continued to affect the two week wait. He stated that improvements were expected in urology performance by February
- The Trust was focussing on reducing the number of 104 day patients as well as reducing the number of 62 day patients
- Actions were being taken to track cancer performance in order to become more action focussed

Mr Wakefield referred to the actions in place, and queried when the Trust expected to achieve the targets. Mr Bytheway stated that in relation to 62 day cancer performance, this should be achieved in quarter 2 of 2020/21, due to the particular challenges in colorectal. He stated that there were previously 1000 patients on the colorectal patient tracking list (PTL) which had been reduced to below 800 and until this was reduced to below 500 it would continue to jeopardise delivery.

Professor Hassell referred to theatre utilisation at County Hospital which was looking ‘flat’. Mr Bytheway stated that the overriding action was to decide which additional activity could be undertaken in the underutilised capacity and Ms Ashley referred to the work being undertaken to establish the procedures undertaken at Royal Stoke which could be done at County Hospital, as well as identifying procedures being done in the theatres at County Hospital which could be done in a different environment.

<u>Caring and Safety</u>
No further questions were raised.

<u>Financial Rating</u>
No further questions were raised.

	Organisational Health Mrs Vaughan highlighted the following: • Performance had remained stable and the challenges around sickness absence had continued, with an increase in in month sickness for November reaching 5.95%. It was noted that the impact of Empactis continued to be an issue and work was ongoing to ensure the system was becoming embedded; ensuring absences were being closed down and classified • In terms of appraisal rates, action was being taken to focus on those staff where it is usually easier undertake their appraisal during winter • There had been a slight improvement in statutory and mandatory training figures Mr Wakefield welcomed the improvement in statutory and mandatory training and queried whether the appraisal completion rate would impact on revalidation. Mrs Rhodes stated that a separate process was in place for nursing and Dr Oxtoby added that this was considered separately for clinical staff and reviewed by Dr Coleman. He stated that the main issue with clinical revalidation was timing, in that the majority of appraisals would be completed towards the end of the financial year. Mr Wakefield summarised the discussion in relation to pressures within the Emergency Department, nursing on the corridor, issues in relation to cancer performance, which was expected to improve by quarter 2 and the ongoing work to utilise theatres at County Hospital. He stated that the reduction in appraisal rates was due in part to timing, and recognised that sickness absence was higher than expected and the recent increase was partly due to the implementation of Empactis and this this would continue to be monitored. **The Trust Board received and noted the report.**	
TRUSTEE MATTERS		
12.	**UHNM Charity Annual Review and Financial Statements**	
012/2020	Ms Duggan referred to the report which had been discussed by the Charitable Funds Committee. She highlighted that going forwards the Committee would change to provide all Trustees with a better insight into all charitable funds related issues. Professor Crowe stated that in terms of the role as corporate Trustee, Trustees needed to be informed of future strategy and intent. Professor Crowe referred to the increase in more legacies having been received and queried the reasons for this. Ms Duggan stated that this was hard to quantify and Professor Crowe suggested that the Trust needed to consider the effort put into obtaining legacies. Professor Crowe referred to the interest on investments being negative one year and positive the next year and Ms Duggan agreed to confirm what this related to. Dr Griffin stated that the Charitable Funds Committee were keen for there to be a strategic direction in utilising charitable funds and this would be addressed once the Trust strategy had been refreshed to ensure that the charity was supporting the broader strategy. Mr Wakefield referred to the wording in relation to Trustees' Report and	**ND**

	management of charity and it was agreed that the section would be reworded. **The Trust Board approved the report, subject to the above amendments and it was agreed that Dr Griffin as Chair of the Charitable Funds Committee would subsequently sign off the report.**	**ND**
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness / Business Cycle Forward Look**	
013/2020	Professor Crowe felt that the meeting ran well and referred to the cycle of business whereby the nursing establishment review had been deferred. He stated that in hindsight an interim update could have been given. Dr Griffin referred to the need to include strategic items within the business cycle and Miss Rylands stated that this would feature within the cycle for 2020/21 as well as within the refreshed Board Development Plan.	
14.	**Questions from the Public**	
014/2020	There were no questions raised by the public.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 5th February 2020, 9.30 am – 12.30 pm, Trust Boardroom, Third Floor, Springfield, RSUH	

Trust Board (Open)

Post meeting action log as 29 January 2020

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed *or* B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/357	08/05/2019	Bi-annual Nurse Staffing Assurance Report	To include within future safe staffing reports considered by the Quality Assurance Committee, a reflection on the trends in relation to the 10 points in addition to the outcome of the audit of robustness of acuity being entered onto the system.	Michelle Rhodes	05/03/2020		A full nursing establishment review is currently being undertaken and will not be finished until Christmas. A paper is to be produced for the Board in March.	R
PTB/382	14/08/2019	Patient Story	To take the revised dementia strategy to the Quality Assurance Committee.	Michelle Rhodes	22/04/2020		Action not yet due.	GA
PTB/383	14/08/2019	Patient Safety Report - Q1	To take the results from the audit of transfers from County Hospital to Royal Stoke, to the Quality Assurance Committee.	John Oxtoby	23/01/2020	23/01/2020	Initial verbal update provided to the Committee in October and further update provided to the Committee in January 2020.	B
PTB/395	06/11/2019	Armed Forces Covenant Overview	To invite Col Griffin to talk to an existing senior nurse meeting.	Michelle Rhodes	05/02/2020		Invited Col Griffin on 17 Dec and followed up on 12 Jan. As of 29 Jan he has not responded to the invite.	GA
PTB/396	06/11/2019	Armed Forces Covenant Overview	To assist Col Griffin in highlighting the opportunities to existing Consultants.	John Oxtoby	31/01/2020	28/01/2020	Contact has been made with Colonel Griffin and we are awaiting a response so further discussion can take place to take this forward.	B
PTB/403	11/12/2019	Patient Story	To look at the ways in which communication could be improved with critical care patients, in addition to promoting the different meal choices available as well as listening to the family and patient in terms of their wishes and assessment of their capability.	John Oxtoby	31/03/2020		Action not yet due.	GB
PTB/404	11/12/2019	Patient Experience Report	To obtain further information in relation to comparison of FFT results with other Trusts, particularly in relation to reasons for people not recommending the Trust i.e. long waits and establish whether the way in which the data was analysed was statistically significant and take this to the Quality Governance Committee.	Michelle Rhodes	31/01/2020	29/01/2020	This information has been included in the Integrated Performance Report to Board and a verbal update was provided to QGC.	B
PTB/405	11/12/2019	Patient Experience Report	To discuss the purchase of the medication reminder alarms further with the teams.	Michelle Rhodes	31/01/2020	29/01/2020	Two medication reminder alarms have been purchased to trial.	B
PTB/406	11/12/2019	Patient Experience Report	To request an audit be undertaken of the length of time patients have waited for their medication .	Michelle Rhodes	29/02/2020		Action not yet due.	GB
PTB/407	11/12/2019	Patient Experience Report	To take the outputs from the review into the 4 areas whose CEF results had reduced, to the Quality Governance Committee.	Michelle Rhodes	29/02/2020		Action not yet due.	GB
PTB/408	11/12/2019	Winter Plan	To take the output of the harm reviews for the patients who had waited over 12 hours to the Quality Governance Committee.	Michelle Rhodes	31/01/2020	23/01/2020	Complete - considered at January's meeting.	B
PTB/409	11/12/2019	Information Management and Technology Strategy Progress Report	To provide a demonstration of the projects being undertaken in relation to digitalisation.	Mark Bostock	31/03/2020		Time scheduled on the Board agenda for March, for a demonstration to take place.	GA
PTB/410	11/12/2019	Information Management and Technology Strategy Progress Report	To identify any problem areas with Wi-Fi, before considering what solutions were available.	Mark Bostock Lorraine Whitehead	29/02/2020		Action not yet due.	GB
PTB/412	08/01/2020	Matters Arising	To provide a paper to the Transformation and People Committee, outlining the impact of the changes to the junior doctors contract.	Ro Vaughan	28/02/2020		Action not yet due. Paper to be taken to the next meeting of the Transformation and People Committee	GB
PTB/413	08/01/2020	Chief Executive's Update	To provide an update to the Quality Governance Committee regarding Medical Examiner Role.	John Oxtoby	31/03/2020		Action not yet due.	GB
PTB/414	08/01/2020	Chief Executive's Update	To invite Professor Crowe to the High Potential Scheme launch and to the visit from Prerana Issar.	Ro Vaughan	31/01/2020	28/01/2020	Professor Crowe received an invitation to the event	B
PTB/415	08/01/2020	Update on Influenza	To establish a research project into the numbers of patients with flu and whether they received the flu vaccine, linking in with Public Health England.	Michelle Rhodes John Oxtoby	TBC		Action not yet due.	GB
PTB/416	08/01/2020	UHNM Charity Annual Review and Financial Statements	To update the report in terms of Trustees' Report and confirm the correct information in relation to return on investments, before agreeing with Dr Griffin.	Naomi Duggan	31/01/2020	28/01/2020	Complete.	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on Wednesday 22nd January. The following provides a summary of the key items which were discussed:

- Updates from Divisional Chairs providing the latest achievements, challenges and performance following their most recent Divisional Board meeting.
- A presentation was provided by the Director of Primary Care in relation to the **creation of Primary Care Networks.**
- An update from the **Risk Management Panel** held on 13th December. The report provided an overview of Root Cause Analysis Investigations undertaken and their key findings and lessons learned which will be shared throughout the organisation.
- A report on **Research and Innovation** which provided updates in relation to latest performance and strategy. The report demonstrated some areas of underperformance, in particular around recruitment to clinical research although summarised the actions being taken. There were also a number of notable successes highlighted.
- A number of **Trust Policies** which were approved by the Committee including C64 Supporting Transgender Individuals, C67 Mental Health Act 1983 as amended by the Mental Health Act 2007, EF14 Prevention of Aspergillosis during Building Work, EF22 Electrical Safety, EF23 Estate Management, EF24 Asbestos Management, EF26 Lift Management, EF27 Control of Contractors, F01 Standing Financial Instructions, F02 Scheme of Reservation and Delegation of Powers, G21 Managing Visits by Celebrities, VIPs and other Official Visitors to UHNM, IG07 Information Governance Management Framework, MDM02 Use of Medical Devices /Equipment and RM08 Prevention and Management of Patient Slips, Trips and Falls
- The Month **9 Integrated Performance Report** covering latest performance in relation to finance, workforce, quality and operational metrics.
- The report on **Data Quality and Clinical Coding** which focussed on 3 main themes: assurance the data quality team and clinical coding, in particular u-codes. The Committee noted the commencement of the project and supported the use of the new assurance indicators for elements of the integrated performance report.
- Minutes of the **IM&T Programme Board** held in December 2019, detailing discussion regarding key IM&T schemes being overseen by the group.

1.1 Items to be Considered by Committees of the Trust Board

Quality Governance Committee	Performance and Finance Committee
• n/a	• Month 9 Integrated Performance Report

1.2 Key Items to be Escalated to the Trust Board

- There were no specific items agreed for escalation although the month 9 Integrated Performance Report will be considered by the Board in accordance with the Annual Business Cycle. In addition, Policies F01 Standing Financial Instructions and F02 Scheme of Reservation and Delegation of Powers will be approved by the Board.

Any Board member seeking to obtain further information regarding the items considered by the Trust Executive Committee should contact Claire Rylands, Associate Director of Corporate Governance.

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. During December, 6 contract awards, which met this criteria were made, as follows:

- **Lease of Urology Robot (REAF 3305)** supplied by Triple Point Leasing Limited (TPLL) at a total cost of £1,648,458.00 for the period 01/01/2020 - 31/12/2027, providing savings of £112,161.00, approved on 17/12/2019.
- **Instrumentation for Da Vinci X/Xi Robot for Urology (REAF 3278)** supplied by Intuitive Surgical for the period 01/01/2020 -31/12/2026, at a total cost of £2,005,668.00, approved on 17/12/2019.
- **Outsourcing of Printing Service (REAF 3258)** supplied by Synertec for the period 31/01/2020 – 30/01/2023, at a total cost of £1,877,117.60, providing savings of £111,000 (in Year 3), approved on 17/12/2019.
- **City Sprint courier contract comprising 4 individual contracts for the collection of Pathology samples (REAF 3256)** supplied by City Sprint for the period 01/10/2019 – 30/09/2021, at a total cost of £693,033.19, providing savings of £3782.00, approved on 23/12/2019.
- **Provision of Home Delivered Haemodialysis (REAF 3205)** supplied by Fresenius Medical Care & NxStage Medical UK Ltd for the period 01/12/2019 to 31/11/2021, at a total cost of £500,000.00, approved on 11/12/2019.
- **Drug Eluting Stents and Balloon Catheters (REAF 3182)** supplied by Abbott Vascular Ltd, Terumo UK Ltd & Biosensors International for the period 01/01/2020 – 31/12/2022, at a total cost of £1,880,121.00, providing savings of£167,400, approved on 05/12/2019.

In addition, the following contract was approved by the Performance and Finance Committee on 21st January, and due to the value of the contract, requires approval via the Trust Board:

Supply Chain Coordination Limited (SCCL) - Trust Wide Annual Expenditure Contract (REAF 3294)

Contract Value £14,300,000.00 Inc. VAT
Award of Contract
Duration 01/03/2020 to 31/03/2021
Supplier SCCL

This is a renewal of the SCCL annual contract for the purchase of products from NHS Supply Chain for the materials management service delivered by the Integrated Supplies and Procurement department and the purchase of goods via the NHS website.

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during January 2020:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Associate Tutor for SAS Doctors	Vacancy	Interview 30.01.20	TBC
Consultant Plastic Surgeon x2	New	Yes	TBC
Locum Consultant Spinal Surgeon	Vacancy	Yes	03/02/2020
Locum Consultant Spinal Surgeon	Vacancy	Yes	TBC
Consultant in Acute Medicine	Vacancy	Yes	TBC
Locum Consultant Orthopaedic Surgeon specialising in Fragility Fractures	New	Yes	20/04/2020

The following table provides a summary of medical staff who have joined the Trust during January 2020:

Post Title	Reason for advertising	Start Date
Consultant in Diabetes & Endocrinology	Vacancy	01/01/2020
Locum Consultant Cardiologist	New	01/01/2020
Locum Consultant Anaesthetist	Extension	02/01/2020
Consultant in Diabetes & Endocrinology	Vacancy	13/01/2020

Post Title	Reason for advertising	Start Date
Consultant Breast Surgeon	Vacancy	13/01/2020
Locum Consultant Cardiac Surgeon	Vacancy	14/01/2020
Locum PICU Consultant with HDU Interest	Vacancy	20/01/2020
Respiratory Consultant	Vacancy	20/01/2020

The following table provides a summary of medical vacancies which closed without applications / candidates during January 2020:

Post Title	Closing Date	Note
Consultant in Emergency Medicine	06/01/2020	5 posts – No applications
Respiratory Consultant - Interstitial Lung Disease	06/01/2020	No Applications
Locum Consultant in Dermatology	06/01/2020	No Applications
Locum Consultant - Winter Pressures / Elderly Care / General Medicine	07/01/2020	No Applications
Locum Consultant Neonatologist	12/01/2020	Candidate Withdrew

3. Where for Care

We have been working closely with the local media including Radio Stoke and The Sentinel and are pushing our 'Where for Care' campaign on social media to try and limit any non-essential attendances. We are also working with the CCG to get the message out to care and nursing homes that advice should be sought from a GP before sending frail elder patients to ED as this is so often not the right place for them and it is particularly distressing when our most vulnerable patients experience long waits.

4. Flu Vaccination Update

I'm really pleased that over 85% of our staff have been protected with the flu job – however we would really like to achieve 100%, especially as the number of patients attending hospital with flu is on the increase again. We are continuing to offer jabs right through until the end of February. There is a lot of flu out in the community and in our hospitals and so I have urged all staff to protect themselves, their families, colleagues and our patients by having the jab. We saw more cases of flu in our hospitals in December than we saw during the whole of the 2018/19 winter period.

5. National Lung Cancer Audit 2019

Although we await the published results from the National Lung Cancer Audit 2019, we have received confirmation that UHNM are doing extremely well in a number of areas and I have congratulated all involved in this.

6. Culture and Leadership Programme

Our Culture and Leadership Programme has commenced and we have established a 'Change Team' who are going to help us make UHNM a truly fantastic place to work. Ro Vaughan, Director of Human Resources and I are the Executive sponsors and we are very grateful to have such supportive and enthusiastic colleagues on board. The team have been interviewing members of the Board and all staff are being asked to fill in a survey about culture and leadership behaviours which we will use to inform our activities, the survey also includes our key external stakeholders. Further updates on progress will be provided as this work develops.

7. MP Engagement

As mentioned at the last Board meeting I have been meeting with all our new MP. I met Aaron Bell MP for Newcastle-under-Lyme just before Christmas and the MP for Stafford, Theo Clarke joined me for a tour of County Emergency Department and FMBU in January and was very impressed with both the facilities and attitude of everyone she met. I also met Jonathan Gullis MP for Stoke-on-Trent North, Kidsgrove and Talke in January and he is very keen to undertake back to the floor shifts which we will of course accommodate. I am looking forward to working with all our new MPs in the months ahead.

8. Sodexo Visit

Our Estates, Facilities and PFI Division and private sector partners Sodexo, are taking part in a Supplier Relationship Management Programme (SSRM), led by Cabinet Office and were asked by Cabinet Office to host a visit to the Royal Stoke site, to showcase the partnership in practice and all that has been achieved. The visit took place on Thursday, 9th January 2020 and was attended by Melinda Johnson, DH Commercial Director and representatives from her team, alongside senior representatives from Cabinet Office and NHSE/I.

Formal feedback from the visit was extremely positive as can be seen from the direct quotes provided below.

"We welcomed the opportunity to visit Royal Stoke University Hospital and see first-hand the excellent collaborative work you have been doing to improve service delivery and patient care, both from an NHS and Sodexo perspective. The feedback from all of us is extremely positive. We really enjoyed the warm welcome, and the great pride shown by everyone we met in their work. One of the key observations was that Sodexo and Trust staff worked so closely that it seemed like you were all part of the same team. We found watching the catering service especially interesting and very different to recent personal experience of NHS catering services. Seeing the Emergency Department in action was valuable insight and was a good reminder for us of the pressure NHS trusts are under and the importance of working together with local partners. We were particularly inspired by the young people on Project Search and the support they get is incredible.

Melinda has spoken about the Sodexo PFI relationship with RSH a few times, it's a great story. Our Commercial Director General is very impressed by the feedback, and has asked for some more detailed briefing from us to highlight your SSRM journey and collaborative approach. All in all, it was a great day so thank you for giving us the time.

9. Bug Affecting Memory Capacity on Switches

UHNM currently has a workaround in place to mitigate the impact of a bug that is affecting switch critical memory capacity on the access layer of our network. Planned controlled memory reloads are taking place each day to ensure there is no impact on Trust services whilst CISCO find a fix to the problem. Daily conference calls are taking place with all relevant stakeholders to manage the workarounds whilst CISCO urgently work on creating the fix.

Quality Governance Committee Chair's Highlight Report to Board

23rd January 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• High volumes of Flu and RSV cases being seen; Committee requested monthly Infection Prevention updates rather than quarterly • Executive Directors will pick up through Performance Review Process the levels of expected engagement from Divisions regarding fire safety • The harm review process focussing on 3 12 hour breaches has identified 3 cases which have been escalated for further follow up	• Investigation underway to review C Difficile cases given the higher volume of cases reported • Deep dive on Sepsis underway and being presented to the next meeting • Implementation of requirements associated with the Medical Examiner role; this will be presented to the Board • Harm Review undertaken focussing on 12 hour breaches within the ED; in December with 3 escalated for follow up – the review process will be repeated for January • Review of strategic risks for the Board Assurance Framework for 20/21
Positive Assurances to Provide	**Decisions Made**
• SHMI (July 18 to June 19) is 1.00 'as expected' and HSMR (September 18 to August 19) is 97.48 – below expected and improvements are being seen in relation to Septicaemia and Pneumonia • Improvements in the completion of mortality reviews being seen and additional resource has been identified to address any outstanding backlog – Committee will increase focus on learning, quality of reviews and outcomes • A positive audit of transfers from County to RSUH found no concerns – however this will be strengthened and repeated as it forms part of the Board Assurance Framework • Very positive feedback received following the Antenatal screening programme quality assurance visit – actions will be overseen by Quality and Safety Oversight Group • 90% has been achieved for Information Governance Training which is an improvement	• Going forward, the Staffing Report will be presented to the Transformation and People Committee with any safety concerns being referred to the Quality Governance Committee • Approved the Board Assurance Framework whilst noting the work being undertaken to refresh strategic risks for 2020/21
Comments on the Effectiveness of the Meeting	
• Meeting went well, lots of useful debate • Important to ensure that Executive Groups are functioning effectively in order to streamline routes of escalation – this will be addressed through the revised Governance Structure	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Q3 Infection Prevention HAI Report	Assurance	8.	CQC Inspection Update	Assurance
2.	Mortality Report	Assurance	9.	Clinical Audit Progress Report	Assurance
3.	Health and Safety Delivery Plan	Assurance	10.	Get it Right First Time Report	Assurance
4.	Quarterly Fire Safety Sub Committee	Assurance	11.	Data Security and Protection Training Update	Assurance
5.	Results from the Audit of Transfers	Assurance	12.	Q3 Board Assurance Framework	Approved
6.	Antenatal and New Born Quality Assurance Report	Assurance	13.	Quality and Safety Forum Highlight Report	Assurance
7.	Emergency Department Assurance Report	Assurance	14.	Effective Nursing and Midwifery Staff Utilisation – November 2019	Information

3. 2019 / 20 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Ms S Belfield	SB	Non-Executive Director (Chair)												
Dr L Griffin	LG	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Professor A Hassell	AH	Non-Executive Director												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Dr J Oxtoby	JO	Medical Director			GH									
Mrs M Rhodes	MR	Chief Nurse	LR	LR	TR	TR	TR							
Miss C Rylands	CR	Associate Director of Corporate Governance				NH	NH	NH	NH	NH				
Mr I Smith	IS	Non-Executive Director												
Mrs R Vaughan	RV	Director of Human Resources			EO				JH					

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th February 2020
Report Title:	UHNM Annual PLACE Inspection Scores 2019	**Agenda Item:**	8.
Author:	Nan Sharp, Head of Governance & Compliance, EFP Division		
Executive Lead:	Lorraine Whitehead, Director of Estates, Facilities and PFI		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:			
SO1		Provide safe, effective, caring and responsive services	✓
SO2		Achieve NHS constitutional patient access standards	
SO3		Achieve excellence in employment, education, development and research	
SO4		Lead strategic change within Staffordshire and beyond	
SO5		Ensure efficient use of resources	

Summary of other meetings presented to and outcome of discussion:

Summary of Report, Key Points for Discussion including any Risks:

Good environments matter to patients and the Patient Led Assessment of the Care Environment (PLACE) is an annual assessment of the quality of the patient environment across the NHS. For a second consecutive year, UHNM has scored above the national average against each assessment domain and attracted some outstanding comments from the inspection teams, made up of patients and their representatives. These results are testament to the hard work and commitment of our staff in providing a high quality environment and ensuring it is maintained to a high standard for the benefit of our patients.

Key Recommendations:

The Trust Board is asked to consider the contents of this report and note the very positive scores achieved.

UHNM Annual PLACE Inspection Scores 2019

1. Introduction

PLACE inspections were undertaken at the Royal Stoke University Hospital on 22nd October 2019 and 7th November 2019 at County Hospital. This report provides a description of the PLACE process and summarises the scores achieved. A small number of actions were identified following the inspections, which were minor in the nature and were mostly addressed on the day of the inspections.

2. PLACE Process and Changes Introduced in 2018/19

The PLACE collection underwent a national review, which started in 2018 and concluded in summer 2019. This review was undertaken to ensure the inspection process remains relevant and delivers its aims. As a result of the review, the question set has been significantly revised and guidance documents refreshed. All Trusts are requested to note that due to the significance of the changes made, the 2019 assessment results are not comparable on a like for like basis, to previous years collections. A summary of the changes is outlined below:-

- Changes to the documentation, making the questions less open to interpretation for assessors.
- Streamlined documentation and a reduction in the number of questionnaires to complete, making the process more user friendly.
- Introduction of a mobile App for collection of electronic data (this is a voluntary requirement and paper questionnaires are still available).
- Changes to the period within which inspections should be held. Previously this was between May to June. Inspections are now to be held between September to November. This is due to the period that the NHS Digital collection site is open for inputting date into.
- Changes to the publication date of results, now January, rather than August.

The national review included representatives from several Trusts and also included patient assessor involvement. A webinar was held and documentation was issued following the review in order for Trusts to receive updated guidance on the revised process.

Inspections are patient led by their nature and cannot take place without 50% patient representation. A number of patient assessors and managers were representatives across both PLACE inspections and ensured consistency in approach and opportunity to compare environmental standards across both sites. Trusts are given around six weeks' notice prior to a PLACE inspection being required. Within this period updated guidance and questionnaires are issued to Trusts for use in the inspections. This period also enables patient representatives to be invited to participate and trained in relation to the process and familiarisation with site orientation.

Inspection Teams

Five inspection teams inspected fifteen wards at Royal Stoke. Three teams inspected all wards at the County site. The number of wards inspected is determined by the number of beds/wards the site has. Patient representatives choose which specific wards they would like to inspect on the day, for those sites where all wards are not required to be inspected. Guidance advises patient representatives to choose different wards from those inspected in previous years, wherever possible.

The teams on each site comprised patient representatives, senior nursing/matron support, infection control, Trust Estates & Facilities Manager and Sodexo Management. This year saw several individuals shadow

the PLACE teams as part of their training and development to inform their understanding of the inspection process and to support them in their roles.

The patient representatives on both Royal Stoke and County site inspections included representatives who are part of the Trust's Patient HUG Meetings/Board of Governors and Health Watch organisations. Patient assessors can also be previous hospital users and/or carers of patients who use the hospitals services. It was pleasing to see several new patient representatives involved in this year's process alongside those who have undertaken inspections previously.

Domains Inspected

There are several compulsory areas that have to be assessed which include A&E, Outpatients areas, Common Areas and External Areas plus food tastings at ward level. The number of wards on site also pre-determines how many food tastings have to be completed. Detailed questionnaires are provided by NHS England to be completed at the end of each ward inspection by the team undertaking the inspection. The key domains inspected are outlined below:-

Cleanliness and Hygiene	Food
Condition, maintenance and appearance	Dementia
Privacy and dignity	Disability

External Validation

An external validator participated in both inspections and confirmed that the process was thorough and rigorous and in keeping with the NHS England guidance for PLACE. Guidance states that external validator input is not compulsory but is good practice. UHNM also provides external validator input for other Trusts across the UK as part of the PLACE process.

3. PLACE Inspection 2019

A summary of the wards and compulsory areas inspected has been produced along with positive comments noted on the day. Actions identified were minor in the nature, were shared with the Ward Manager/Matron for each area and the majority of which were addressed on the day of the inspection.

4. PLACE Scores 2019

PLACE scores were published nationally on 30th January 2020 and UHNM achieved scores well above the national average against all domains assessed, overall as a Trust and for each site respectively, as summarised below.

Site Name	CLEANING Score %	FOOD Score %	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.94	94.75	90.17	99.51	90.34	92.45
THE COUNTY HOSPITAL	100	96.75	99.56	99.88	96.47	96.10
UHNM TRUST SCORE	99.95	95.03	91.49	99.56	91.21	92.97
NATIONAL AVERAGE	**98.6**	**92.2**	**86.1**	**96.4**	**80.7**	**82.5**

Of particular note is the 100% cleaning score achieved at the County Hospital site for the second consecutive year. As stated above, although it is not possible to compare from previous years, this score indicates the continued level of confidence the patient assessors felt on the day of the inspection and is a credit to the County Hospital site.

It is recommended that Trust scores are compared against the national average in order to understand how the scores compare with other comparable sites. The scores achieved at both sites site demonstrate the continued progress made since integration in 2014 and the difference the refurbished ward areas are making to patient experience and to their perception of patient care regarding the environment.

5. Patient Representative Comments

In summing up the inspections our Patient Assessors provided very positive comments in relation to what they had observed on the day. These comments are confirmed below and are testament to the hard work and commitment of all staff, clinical and non-clinical and our private sector partners, in providing a high quality care environment.

UHNM – Royal Stoke PLACE Inspection Feedback 22nd October 2019. Our patient assessors said:- *"100% positive response from the patients they spoke to about the care and compassion they are receiving. We've never seen such dedicated staff in every single area they went to and although the areas are very busy every single ward area greeted us with a friendly welcome and a smile. The staff are clearly working together very well in teams from the cleaners to the head of the department. We definitely saw a more positive attitude from staff this year and we were very impressed with West Building and the older estate considering its age and layout. There was a definite improvement on site overall across each of PLACE domains from last year. The food on the wards that we tasted was excellent."* Rob Beddis and Margaret Foulkes – Patient Assessors

UHNM County Hospital Inspection Feedback 7th November 2019. Our patient assessors said:- *"The site was immaculately clean including the corridors and common areas and the environment was calm and supported patients privacy and dignity very well. The patient care we saw was second to none with very dedicated medical, nursing and support staff who were very open and welcoming who should be proud of their work. The grounds and gardens were also exceptionally well kept by the grounds team and the food we tasted on the wards was superb. It was evident that all the teams worked together to care for their patients and the continuity of staff on each area was noticeable and paid off. We felt very confident about the environment we saw".* John Duggan, Volunteer and Patient Assessor and David Hardy, Patient Assessor

External Validator – Rosemary Brown, Head of PFI and Commercial Services, Birmingham Mental Health NHS Trust said "the wards and departments were spotless and I couldn't fault anything throughout the inspections"

To acknowledge the outstanding comments received from our patient assessors, following both inspection days, a number of UHNM Values nominations in the "Improving" category were submitted by the PLACE team leaders, to recognise the excellent environment and practices identified on site, by the patient assessors on the inspections days. These included Estates Hard FM and Grounds and Gardens team County, Catering Team County, Facilities Team, Royal Stoke, Sodexo Team Royal Stoke and a number of the Ward Managers who met the patient assessors on the inspections.

3. Recommendations

The PLACE scores achieved in 2019 evidence the Trust's commitment to ensuring that patients are cared for with compassion and dignity in a clean, safe environment and appropriate recognition is given to how important the environment is to providing high quality, safe and effective patient care. The results achieved are testament to the investment in the environment made on both sites and the commitment towards protecting the investment by ensuring that the high standards are maintained.

The successful partnership with our PFI partners Project Co and Sodexo and the positive way in which clinical and non-clinical teams work together as one successful team, is evidenced in the PLACE results, as is the hard work and dedication of all non-clinical staff in delivering high quality non-clinical services. The second year of achieving a 100% score on cleaning for County Hospital is particularly pleasing to note.

- The Trust Board is asked to receive and note the contents of this paper and the scores achieved for 2019. There are no specific recommendations to note in this report.

Performance and Finance Committee Chair's Highlight Report to Board

21st January 2020

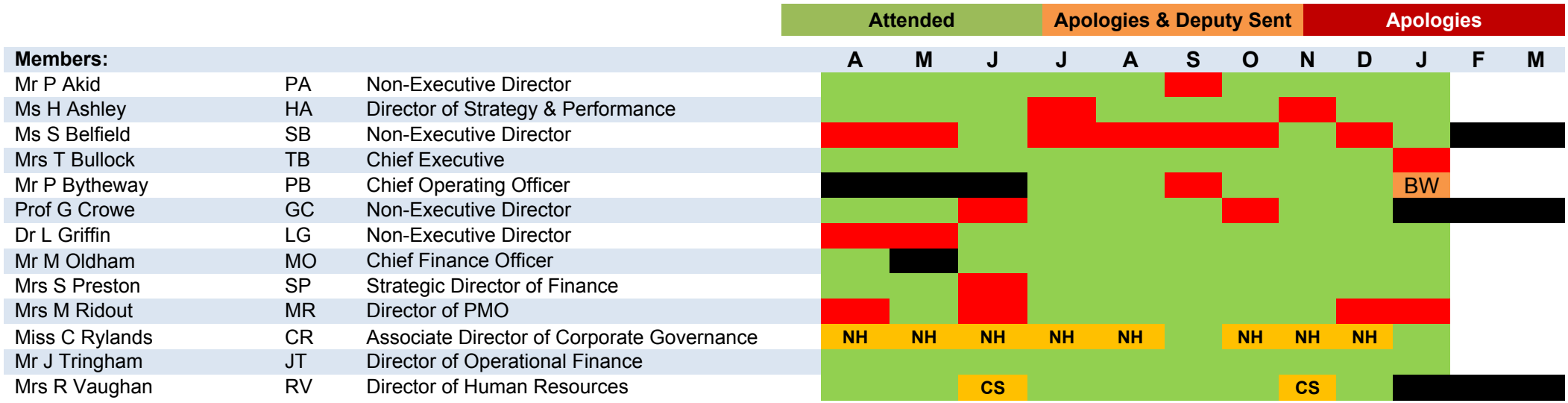
1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• There were 321 12 hour breaches which placed UHNM at the second to bottom place across the Country • Pace and processes are key areas which need to be focussed upon in the Urgent Care Improvement Plan – however assurance on more urgent actions and improvement is necessary • Cultural / workforce factors associated with ED to be considered by the Transformation and People Committee • There may be a risk to the year-end position if the TSA funding is not yet received	• Transfer of staff and partnership agreement associated with Pathology Network are being progressed • Urgent Care Improvement Plan will be developed by March / April although clinicians will be asked to describe a Rapid Improvement Plan to covering the actions being taken address immediate challenges • Cancer Improvement Plan underway with a view to improvements being seen Quarter 2 • Cost Improvement Programme for 20/21 remains under development • Review of Board Assurance Framework strategic risks for 20/21 will take place early February aligned to development of the Annual Governance Statement • Deeper analysis to be provided on the future operating model associated with the new procurement framework
Positive Assurances to Provide	**Decisions Made**
• The first phase of de-escalation following the operational challenges in December has gone to well and aligned to the plan • Financial breakeven has been achieved at month 9 with financial performance year to date at £5.6m better than plan	• The Committee approved the Quarter 3 Board Assurance Framework • Two contracts were awarded; REAF 3356 Occupational Health Services Contract and REAF 3294 Supply Chain Coordination Limited • Interim Long Term Financial Plan 2019/20 to 2023/24 approved by the Committee • The Committee approved the Quarter 3 Board Assurance Framework
Comments on the Effectiveness of the Meeting	
• Spent more than half of the meeting on Urgent Care and Cancer – this was necessary and further assurance is needed	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Month 9 Operational Performance Report	Assurance	2.	Month 9 Finance Report	Assurance
3.	Interim Long Term Financial Plan 2019/20 – 2023/24	Assurance	4.	Month 9 CIP Report	Assurance
5.	Quarter 3 Board Assurance Framework	Approval	6.	Business Case Approvals	Information
7.	Business Case Reviews – BC-0331 Integrated Procurement Function	Assurance	8.	Quarterly Procurement Update Report	Assurance
9.	Authorisation of New Contract Awards and Contract Extensions	Approval			

3. 2019 / 20 Attendance Matrix



Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th February 2020
Report Title:	Month 9 Finance Report – 2019/20	**Agenda Item:**	10.
Author:	Jonathan Tringham, Director of Operational Finance Sarah Preston, Strategic Director of Finance		
Executive Lead:	Mark Oldham, Chief Finance Officer		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	
SO2	Achieve NHS constitutional patient access standards	
SO3	Achieve excellence in employment, education, development and research	
SO4	Lead strategic change within Staffordshire and beyond	
SO5	Ensure efficient use of resources	✓

Summary of other meetings discussed with and outcome of discussion:

n/a

Summary of Report, Key Points for Discussion including any Risks:

This report presents the financial performance of the Trust for December (Month 9); key elements of the financial performance for the year to date are:

- The actual year to date performance of breakeven is £5.6m better than the Trust's plan for a £5.6m deficit for the first 9 months of the year.
- Total Commissioning income is £2.6m behind plan for the year to date; within this Electives and Critical Care are under recovered by £1.7m and £1.6m respectively offset by Tariff excluded Drugs income which is £3.6m above plan for the year to date.
- Pay expenditure is £6.1m better than plan with the most significant variances being within Registered Nursing (£3.5m) and NHS Infrastructure (£2.9m) which are both underspent for the year to date.
- Non pay expenditure is £0.7m overspent although within this pass through drugs is £4.0m overspent.
- The Trust has delivered £25.1 CIP for the year to date which is £1.4m behind plan; in month the Trust has delivered £3.0m CIP which is £1.7m behind the final plan submitted to NHSI in April.
- Capital expenditure for the year to date stands at £11.7m which is £1.0m ahead of plan.
- The month end cash balance is £19.4m which is £11.4m higher than plan.
- The Trust continues to assume that it will receive FRF and PSF funding in full.

Key Recommendations:

The Trust Board is asked to consider and review this report.

Finance Report 2019/20
Month 9

1. Overall Summary

The Trust achieved a surplus of £1.9m in Month 9 against a planned surplus of £0.9m. The Month 9 year to date plan is to deliver a £5.6m deficit; the actual performance of breakeven is a £5.6m positive variance to plan.

The table below provides a summary Income and Expenditure position for Month 9 and for the year to date.

I&E Summary (£'m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
NHS Patient Income	636.2	53.8	53.0	(0.8)	476.6	470.3	(6.2)
Tariff Excluded Drugs Income	53.6	4.2	5.0	0.7	40.1	43.7	3.6
Total Commissioning Income	689.7	58.0	58.0	(0.1)	516.6	514.1	(2.6)
Private Patients / ICR	4.1	0.3	0.3	(0.0)	3.1	3.8	0.7
Other Non Clinical Income	82.0	6.9	7.0	0.2	61.4	62.6	1.2
Total Income	775.8	65.2	65.3	0.1	581.1	580.5	(0.6)
Medical	(145.8)	(12.3)	(12.6)	(0.4)	(109.1)	(110.3)	(1.2)
Registered Nursing	(148.1)	(12.6)	(12.1)	0.5	(110.4)	(106.9)	3.5
Scientific Therapeutic & Technical	(54.8)	(4.7)	(4.6)	0.0	(40.9)	(40.6)	0.3
Support to Clinical	(63.5)	(5.4)	(5.1)	0.3	(47.3)	(46.9)	0.5
Nhs Infrastructure Support	(75.6)	(6.3)	(6.1)	0.2	(56.7)	(53.8)	2.9
Total Pay	(487.8)	(41.3)	(40.5)	0.8	(364.4)	(358.4)	6.1
Tariff Excluded Drugs Expenditure	(53.0)	(4.2)	(4.7)	(0.5)	(39.7)	(43.7)	(4.0)
Other Drugs	(21.8)	(1.8)	(2.1)	(0.3)	(16.5)	(16.1)	0.4
Supplies & Services - Clinical	(69.7)	(6.0)	(5.9)	0.0	(52.7)	(53.0)	(0.3)
Supplies & Services - General	(7.3)	(0.6)	(0.6)	0.0	(5.5)	(5.4)	0.1
Purchase of Healthcare from other Bodies	(12.0)	(1.0)	(1.1)	(0.1)	(9.1)	(9.3)	(0.2)
Consultancy Costs	(3.5)	(0.3)	(0.3)	(0.0)	(2.7)	(2.8)	(0.1)
Clinical Negligence	(20.6)	(1.8)	(1.8)	(0.0)	(15.9)	(15.9)	(0.0)
Premises	(28.3)	(2.4)	(2.6)	(0.2)	(21.4)	(20.7)	0.7
Depreciation	(27.8)	(2.4)	(2.3)	0.0	(20.4)	(20.2)	0.2
Other	(51.3)	(3.7)	(2.6)	1.1	(40.9)	(38.5)	2.5
Total Non Pay	(295.2)	(24.0)	(24.0)	0.1	(224.8)	(225.5)	(0.7)
Total Operating Costs	(783.1)	(65.3)	(64.5)	0.8	(589.3)	(583.9)	5.4
Surplus / Deficit from Operations	(7.2)	(0.1)	0.8	0.9	(8.2)	(3.5)	4.7
Finance Costs, Interest, PDC, etc.	(25.5)	(2.1)	(2.0)	0.1	(19.2)	(17.9)	1.3
Total Non Operating Costs	(25.5)	(2.1)	(2.0)	0.1	(19.2)	(17.9)	1.3
Total Costs	(808.6)	(67.5)	(66.5)	1.0	(608.5)	(601.8)	6.6
Net Surplus / Deficit	(32.8)	(2.3)	(1.2)	1.0	(27.4)	(21.4)	6.0
Donated Asset / Impairment Adjustment	(0.8)	(0.1)	(0.0)	0.1	(0.6)	(0.2)	0.4
Operational Net Surplus / Deficit	(32.0)	(2.2)	(1.2)	1.0	(26.8)	(21.2)	5.6
Mariginal Rate Emergenct Tariff	4.2	0.4	0.4	0.0	3.2	3.2	0.0
Providor Sustainability fund	15.9	1.6	1.6	0.0	10.3	10.3	0.0
Financial recovery fund	11.9	1.2	1.2	0.0	7.7	7.7	0.0
	0.0	0.9	1.9	1.0	(5.6)	0.0	5.6

2 Income

Total Commissioning income was under recovered by £0.1m in Month 9 against a plan of £58.0m and now stands at £514.1m for the first 9 months of the year which is £2.6m worse than plan.

The table below shows the Trust's Commissioning Income and activity position by point of delivery (POD)

Income from patient Activity to Month 9 2019/20	Annual Plan		Income In Month			Activity Year to date			Income Year to date		
	Activity	£m	Budget £m	Actual £m	Variance £m	Budget	Actual	Variance	Budget £m	Actual £m	Variance £m
Elective Inpatient Spells	15,409	65.7	5.2	5.2	(0.0)	11,279	10,650	(629)	49.0	47.3	(1.7)
Day case Spells	83,696	58.4	4.6	4.5	(0.1)	62,472	60,711	(1,761)	43.6	43.0	(0.6)
Non Elective Emergency Inpatient Spells	85,671	186.9	15.8	15.5	(0.4)	64,372	63,786	(586)	140.4	139.4	(1.0)
Non Elective Non Emergency Inpatient Spells	23,572	30.1	2.5	2.6	0.1	17,711	18,782	1,071	22.6	22.4	(0.2)
Outpatient Attendances & Procedures	719,001	88.1	6.9	6.9	(0.1)	536,075	526,563	(9,512)	65.7	66.2	0.5
Accident & Emergency Attendances	181,191	26.1	2.2	2.2	(0.0)	136,141	134,375	(1,766)	19.6	19.7	0.1
Critical care	31,796	39.2	3.3	3.0	(0.3)	23,883	23,088	(795)	29.5	27.8	(1.6)
Direct Access		13.2	1.0	1.0	0.0				9.9	9.9	(0.0)
Other		122.6	11.6	11.8	0.2				91.6	90.4	(1.3)
PBR Excluded & Chemotherapy Drugs (Pass through)		53.6	4.2	5.0	0.7				40.1	43.7	3.6
Pass through devices		10.1	0.9	0.7	(0.2)				7.8	7.6	(0.2)
Fines & Penalties		-	-	-	-				-	(0.2)	(0.0)
Emergency Threshold		(4.2)	(0.3)	(0.3)	0.0				(3.2)	(3.2)	0.0
Total	1,140,337	689.7	58.0	58.0	(0.1)	851,932	837,955	(13,978)	516.6	514.1	(2.6)

The year to date position is heavily influenced by an over recovery against plan of £3.6m for PbR excluded drugs and Chemotherapy Drugs (Pass through)

Income from Electives was on plan in month despite activity being 145 (12%) behind plan; this was as a result of an actual average tariff received per episode of £4,934 against a planned tariff of £4,280.

Income from Emergency activity under recovered by £0.3m in month and now stands at £1.0m under recovered for the year to date.

The following table provides a draft summary of Total Commissioning Income by Commissioner; further detail is included in Appendix 1 and 2.

Patient Income Position at Month 9 19/20	External Plan / Contract	Income (£m)				
		Finance (£m)	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS	416.8	416.6	312.3	312.3	0.0	0%
NHS ENGLAND	223.2	218.4	164.2	158.6	(5.5)	-3%
OTHER CCG ASSOCIATES	29.1	30.8	22.9	24.5	1.6	7%
OTHER NON NHS CONTRACTS	6.5	7.5	5.7	6.5	0.8	14%
NON CONTRACT ACTIVITY	4.2	4.2	3.1	3.0	(0.1)	-3%
OTHER	13.9	13.9	9.5	10.1	0.7	7%
	693.7	691.2	517.8	515.2	(2.6)	0%
Less Other Non Patient Income	(1.5)	(1.5)	(1.1)	(1.1)	-	0%
	692.2	689.7	516.6	514.1	(2.6)	0%

Income from Staffordshire CCGs is based on the Intelligent Fixed Payment Mechanism (IFPM) and is fixed for the year. Several additional contracts have been negotiated with the commissioners, repatriating activity previously carried out by GPs or independent providers, to UHNM. These additional contracts relate to Diagnostics in the form of plain film x-rays and non obstetric ultrasound and phlebotomy services at Leek. In addition the VirginCare Contract has now returned to East Staffs CCG responsibility and has been varied into the IFPM.

The income plan for NHS England is £4.8m lower than the contract value; this relates to Specialised Services. This is as a result of differing growth assumptions and pass though devices that have moved to a zero cost model during the year as opposed to pass through cost for which we have requested a contact variation.

Associate CCGs – the total income plan for these CCGs is £30.8m with the over recovery at Month 9 being £1.6m (7%). The most significant variance is against Shropshire CCG which is showing an over recovery of £0.7m (19% higher than plan for the year to date). The internal income plan is higher than the contract reflecting the increase in activity seen during the year which was transacted as part of the budget reset at Quarter 1.

Within the reported position for Total Commissioning income the Trust has made provision for £0.2m of fines; these relate to contracts with Associate CCGs and NHSE as under the IFPM fines are automatically reinvested. The table below provides details of the contractual fines for the first 8 months of 2019/20.

Contractual Fines 2019/20	Operational Standards	Consequence of breach	Staffordshire		Other		Total	
			Total	Value £000	Total	Value £000	Total	Value £000
52 Week waits	Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	0	0.0	0	0.0	0	0.0
C Difficile incidences	Minimise rates of Clostridium difficile	£10,000 for each breach above target	13	130.0	1	10.0	14	140.0
Cancelled Ops	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	96	172.4	41	137.2	137	309.6
MRSA Incidences	Zero tolerance methicillin-resistant Staphylococcus aureus	£10,000 in respect of each incidence in the relevant month	0	0.0	0	0.0	0	0.0
MSA Breaches	Zero tolerance against Mixed Sex Accomodation	£250 per day per patient	0	0.0	0	0.0	0	0.0
Urgent Ops	No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	0	0.0	6	30.0	6	30.0
Total			109	302.4	48	177.2	157	479.6

The table below shows the planned growth in activity for the first 9 months of the year and the actual change seen over the same period. It should be noted that the table below will not correlate to the actual variances against income reported elsewhere in this paper as income is fixed for Staffordshire CCGs and is not linked to actual activity delivered.

	2019/20 M1-9			2018/19 M1-9			
POD	Plan	Actual		Plan	Actual	Planned Growth	Actual Growth
Elective	11,306	10,666		12,422	11,124	1.6%	-4.1%
Day case	72,840	72,397		72,221	70,430	3.4%	2.8%
Emergency	82,090	82,571		70,535	80,323	2.2%	2.8%
Outpatient	582,016	553,957		580,831	558,090	4.3%	-0.7%
A&E Attendance	136,141	134,375		119,757	132,767	2.5%	1.2%

3. Expenditure

Pay expenditure was £40.5m in Month 9 generating an underspend of £0.8m with year to date pay expenditure now standing at £358.4m resulting in an underspend of £6.1m.

Overall Pay expenditure for the first 9 months of the year was 2.1% higher than for the first 9 months of 2018/19 against a planned increase of 4.6%.

Additional costs planned for winter were £0.8m in December with the actual costs being £0.5m; the underspend was mainly as a result of Ward 78 continuing to be used by the Medicine Division as part of its core bed base.

Registered nursing costs underspent by £0.5m in December with the actual pay costs of £12.1m in month being £0.2m higher than in November mainly due to the opening of additional Winter capacity.

NHS Infrastructure costs are underspent by £0.2m in month and now stand at £2.9m underspent for the year to date; Corporate functions account for £1.9m of the year to date underspend.

Medical pay overspent by £0.4m in December with the year to date overspend now standing at £1.2m. As in previous months this is predominantly within Emergency Medicine which is £0.3m overspent for the month and now stands at £2.1m overspent for the year to date. This is mainly driven by high levels of consultant vacancies across the ED and AMU as well as gaps in junior doctor rotas.

After 9 months of the financial year the Trust's expenditure on agency staff is £0.1m higher than the year to date profile of the ceiling set by NHSI of £18.0m. This is as a result of Medical agency costs being £0.1m higher per month on average than for 2018/19. The Trust will need to monitor performance closely to ensure that it does not breach it ceiling; performance for the year to date is shown in the table below.

Agency ceiling	Annual	In Month			Year to Date		
	Target £m	Target £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m
Total	**(18.0)**	**(1.5)**	**(1.6)**	**(0.1)**	**(13.3)**	**(13.4)**	**(0.1)**

Non-pay expenditure is underspent by £0.1m in December and now stands at £0.7m overspend for the year to date within this pass through drugs are overspent by £0.5m in the month and £4.0m for the year to date.

In Month 9 the Trust has released £1.3m of general reserves into the position in line with the forecast agreed at Month 6; this has been accounted for within Other Non-Pay expenditure.

4 CIP

The total original CIP plan for the year is £40.0m.

The table below summarises the performance against the CIP for the first 9 Months of the year; this performance is built into the Trust's position for the year. The planned performance is as per the final plan submitted to NHSI in April.

CIP 2019/20	Annual Plan	In month			Year to date		
		Plan	Actual	Variance	Plan	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m
Income	6.9	0.6	1.9	1.2	5.0	16.4	11.5
Pay	17.5	1.9	0.7	(1.2)	11.4	5.2	(6.2)
Non Pay	15.6	2.1	0.4	(1.8)	10.1	3.4	(6.7)
Total	40.0	4.7	3.0	(1.7)	26.5	25.1	(1.4)

The CIP delivery in Month 9 is £1.7m behind plan and £1.4m behind plan for the year to date. The CIP report contains further detail including a forecast for the year.

5 Capital

The Trust capital expenditure plan for 2019/20 is £25.9m and includes the changes reported to Finance & Performance Committee in November. The revised budget includes central funding relating to Imaging equipment where funding of £1.2m has been granted by NHSI. The emergency capital allocation of £1.5m relating to Project STAR is included and the funding has been confirmed in early January 2020. The Trust has spent £2.9m in Month 9 and £11.7m year to date against a planned spend of £10.7m, an over spend of £1m.

Capital Expenditure as at Month 9 2019/20 £m	Revised Budget	In Month			Year to Date		
		Budget	Actual	Variance	Budget	Actual	Variance
ICT Infrastructure	(4.7)	(0.4)	(0.6)	(0.3)	(3.7)	(3.6)	0.1
Estates Infrastructure	(3.6)	(0.1)	(0.2)	(0.1)	(1.9)	(1.7)	0.2
Medical Equipment	(2.4)	(0.2)	(0.2)	(0.1)	(1.0)	(1.3)	(0.3)
PFI lifecycle & equipment	(3.2)	(0.2)	(0.1)	0.1	(1.7)	(1.8)	(0.1)
PFI enabling	(0.3)	-	-	-	-	-	-
Pathology tracker - Finance Lease	(0.5)	-	(0.1)	(0.1)	(0.5)	(0.1)	0.4
Health & Safety Compliance	(0.2)	(0.1)	(0.1)	0.0	(0.2)	(0.1)	0.1
Other Central schemes	(1.3)	(0.1)	(0.0)	0.1	(0.7)	(0.4)	0.3
LIMS	(1.7)	-	(1.5)	(1.5)	-	(1.5)	(1.5)
PDC award for HSLI	(1.3)	(0.0)	-	0.0	(1.0)	(1.2)	(0.2)
Project STAR (to be confirmed)	(1.5)	-	(0.0)	(0.0)	-	(0.0)	(0.0)
NHSI imaging funding	(1.2)	-	-	-	-	-	-
Total capital expenditure	(21.8)	(1.1)	(2.9)	(1.9)	(10.7)	(11.7)	(1.0)
PFI equipment pre-payment	(4.1)	-	-	-	(4.1)	(3.3)	0.8
Total CDEL	(25.9)	(1.1)	(2.9)	(1.9)	(14.7)	(15.0)	(0.3)

Expenditure for the ICT sub-group is £0.1m behind plan. There is a £0.3m underspend on the EPMA scheme where required infrastructure work has been delayed, the forecast year-end underspend has been built in to the revised capital plan and a business case review is scheduled. This underspend is offset by expenditure on Windows 10 and the data centre being ahead of plan.

There is a £0.2m underspend on Estates Infrastructure expenditure mainly due to the fire alarm phase 3 replacement being behind plan. Increased expenditure is planned over the next 3 months relating to a number of schemes including Trent building heating pipework, accommodation for MPFT at County, electrical and fire safety work and further security work at the RI site.

Medical devices expenditure is £0.3m ahead of plan. Expenditure is planned over the next 3 months relating to a number of schemes including, pulmonary testing function, intensive care ventilators, replacement of blood gas analysers and MRI conditional patient monitoring.

PFI equipment is £0.1m ahead of plan due to the replacement PACS equipment being earlier than expected.

The Pathology Tracker is £0.4m behind plan; the equipment is a refresh via a finance lease and was carried forward from 2018/19. The equipment refresh is due to be completed by February and the required enabling work has now been undertaken.

Other central schemes are £0.3m behind plan; this is due to VAT now reclaimed on prior year expenditure and write off of prior year GRN's.

Expenditure on Pathology LIMS of £1.5m was incurred in month 9 via a bullet payment to the supplier on 31st December 2019; the budget was phased in month 10.

HSLI expenditure is £0.2m ahead of plan this is mainly due to a milestone payment for the Robotic Process Automation scheme being required to be paid earlier than anticipated. The Trust is awaiting documentation from NHSI to enable the cash draw down to take place for the expenditure incurred to date.

The remaining balance of the PFI pre-payment of £0.8m relates to the remaining Cath Lab replacement which is due to be replaced in February 2020.

6. Cash

The Trust holds cash of £19.4m at Month 9 which is £11.4m higher than plan.

Cash Summary at Month 9 2019/20		In Month			Year to date		
	Budget £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Opening balance	8.4	8.0	22.1	14.1	8.4	8.4	-
Contract Income 2019/20	658.7	57.3	58.5	1.2	511.8	512.2	0.4
Contract income 2018/19	3.2	-	-	-	3.2	12.1	8.9
Other Income	103.2	7.8	8.3	0.5	69.0	72.4	3.4
Uncommitted Revenue support facility 2019/20	-	-	-	-	13.2	18.9	5.7
PSF, FRF and MRET funding	32.0	5.6	3.2	(2.4)	12.9	12.9	-
Department of Health and NHS England Deficit support	24.8	-	-	-	12.4	-	(12.4)
Capital funding (PDC capital)	1.3	-	-	-	-	-	-
Total Receipts	823.2	70.7	70.0	(0.6)	622.5	628.5	6.1
Payroll (excluding agency)	(436.8)	(37.6)	(37.9)	(0.3)	(339.9)	(339.2)	0.7
Accounts payable	(366.3)	(31.6)	(31.9)	(0.3)	(267.2)	(264.6)	2.6
PDC Dividend	(1.5)	-	-	-	(0.4)	(0.4)	-
Capital	(19.5)	(1.5)	(3.0)	(1.5)	(15.3)	(13.3)	2.0
Total Payments	(824.1)	(70.7)	(72.8)	(2.1)	(622.8)	(617.5)	5.3
Closing Balance	7.5	8.0	19.4	11.4	8.0	19.4	11.4

Overall cash is £11.4m higher than plan at Month 9. This is mainly due to cash being received in Month 6 of £9m relating to the outcome of the 2018/19 expert determination and lower than planned payments.

Contract income relating to 2019/20 is higher than plan in month due to catch up of NHSE screening services SLA. Year to date actual is in line with plan.

The cash received for 2018/19 contract income is £8.9m ahead of plan year to date mainly due to cash relating to the outcome of the 2018/19 expert determination being received from commissioners in early September. A number of credit notes (£1.6m) relating to the prior year have not yet been taken by commissioners, this is being escalated as part of the month 9 Agreement of Balances exercise.

Other income is higher than plan in month and year to date (£3.4m); this is mainly due to higher than planned cash received from the VAT return (in prior months) and also payment of NHS invoices from 2018/19, not relating to contract income.

The Trust has not accessed any of its Uncommitted Interim Revenue Support Facility in Month 9. The Trust received the Q2 PSF cash of £3.7m in Month 9 however notification was not received prior to the NHSI deadlines for receiving cash flow forecasts to repay related borrowing in January.

The cash drawdown request is required to be submitted to NHSI a month in advance of the cash receipt date The 13 week cash flow forecast submitted on in January does not forecast further draw down of cash support. The Trust has not yet received confirmation as to when cash will be received relating to deficit support from DHSC and NHS England (via Stafford and Surrounds CCG), as a result is holding a higher than planned cash balance in order to reduce the risk of having to take out further cash support. This will need to be reviewed for February and March if confirmation of the deficit support is not received.

General accounts payable and capital payments are £2.6m and £2.0m behind plan mainly as a result of reported underspends on non-pay and the timing of capital payments.

The table below shows the actual and forecast cash position for 2019/20. The cash support received to date relating to deficit support and PSF/FRF funding and the expected repayment in year is also detailed.

Cash and borrowing position 2019/20	Actual 30/04/19 £m	Actual 31/05/19 £m	Actual 30/06/19 £m	Actual 31/07/19 £m	Actual 31/08/19 £m	Actual 30/09/19 £m	Actual 31/10/19 £m	Actual 30/11/19 £m	Actual 31/12/19 £m	Plan 31/01/20 £m	Plan 29/02/20 £m	Plan 31/03/20 £m	Total
Month end cash balance per NHSI plan	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	7.5	7.5
Month end cash balance actual/forecast	4.7	5.1	20.9	15.0	16.6	25.5	15.4	22.1	19.1				-
Deficit/Working capital cash support received	4.8	4.8	7.0	-	-	-	-	-	-	-	-	-	16.6
Deficit/Working capital cash repayment	-	-	-	-	-	-	(4.2)	-	-	-	-	(12.4)	(16.6)
Planned PSF/FRF cash received	-	-	-	-	-	4.2	-	2.4	3.2	-	-	8.3	18.0
PSF/FRF cash support received/repayment	0.9	0.9	0.9	1.9	1.9	-	-	-	-	(3.7)	-	(2.8)	0.0
DHSC & NHS England deficit support cash	-	-	-	-	-	-	-	-	-	-	24.8		24.8

It is forecast that at the year end the net cash support borrowing for the year will be nil, this is in line with plan. This is based on the Trust receiving the £24.8m deficit support from DHSC and NHS England (via Stafford and Surrounds CCG) by February 2020 to enable the £15.2m repayment of cash support borrowing in March 2019. The Trust is currently holding a higher than cash plan as confirmation has not yet been received as to when the deficit support cash will be received. The NHSI/DHSC deadline for submission of March cash support/repayment requests is likely to be in mid-Feb 2020.

The forecast is that £23m of loans at 6% interest rate will be repaid in the year; however there will be a net nil impact on overall borrowing. The quarter 4 PSF/FRF cash of £9.7m will be received in 2020/21.

7 Balance Sheet

The Month 9 Statement of Financial Position (Balance Sheet) is shown below.

Balance Sheet as at 31st December 2019	31/03/2019	31/12/2019			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	504.0	501.0	499.1	(1.9)	Note 1
Intangible Assets	22.1	21.9	21.8	(0.1)	
Total Non Current Assets	526.1	522.9	520.9	(2.0)	
Inventories	12.8	12.4	12.8	0.4	
Trade and other Receivables	40.9	47.2	49.4	2.2	Note 2
Cash and Cash Equivalents	8.4	8.0	19.4	11.4	Note 3
Total Current Assets	62.1	67.6	81.6	14.0	
Trade and other payables	(59.1)	(64.8)	(64.3)	0.4	
Borrowings	(23.4)	(22.9)	(22.9)	0.0	
Provisions	(3.3)	(3.3)	(2.4)	0.9	Note 4
Total Current Liabilities	(85.8)	(90.9)	(89.6)	1.3	
Borrowings	(462.0)	(467.4)	(472.3)	(4.9)	Note 5
Provisions	(0.9)	(0.9)	(0.9)	0.0	
Total Non Current Liabilities	(462.9)	(468.3)	(473.2)	(4.9)	
Total Assets Employed	39.6	31.3	39.7	8.4	
Financed By:				-	
Public Dividend Capital	407.1	408.4	407.1	(1.3)	Note 6
Retained Earnings	(466.4)	(476.0)	(466.6)	9.4	Note 7
Revaluation Reserve	98.9	98.9	99.1	0.3	
Total Taxpayers Equity	39.6	31.3	39.7	8.4	

The Month 9 Statement of Financial Position (Balance Sheet) is broadly in line with plan with the main variances explained below:

Note 1: Property Plant & Equipment is £1.9m lower than plan. Overall additions are lower than the original plan on Trust funded capital schemes by £1.0m. Depreciation is ahead of the planned phasing however will be in line with the plan by year-end.

Note 2: Trade and other receivables are £2.2m higher than plan. This is mainly due to invoices relating to the deficit support raised with the Department of Health and Social Care and also Stafford and Surrounds CCG (relating to NHSE deficit support), partly off-set by the lower than plan VAT debtor as cash was received prior to 31st December for the latest submitted claim.

Note 3: Cash is £11.4m higher than plan at Month 9. Cash received is higher than plan as the Trust received payment of invoices relating to the outcome of the 2018/19 Expert Determination in month 6. General account payable and capital payments are behind plan this is partly as a result of underspends on non-pay and the timing of capital payments.

Note 4: Provisions are £0.9m lower than plan and reflects redundancy payments in 2019/20 relating to provisions held at the year end.

Note 5: Borrowings are £4.9m higher than plan. The variance is partly due to the £4m working cash support requested earlier in the financial year relating to the increased 2018/19 deficit. The plan also reflects a timing difference on the repayment of 2019/20 borrowing relating to PSF/FRF funding, a repayment will now be made in Month 11.

Note 6: PDC is £1.3m lower than plan due to the Trust not yet being able to draw down capital PDC relating to HSLI capital expenditure that has been incurred to date in 2019/20.

Note 7: Retained earnings show a £9.4m variance from plan at Month 9. Of this £4m relates to the final adjustment to the prior year closing balance to reflect the outcome of the expert determination, this was not reflected in the plan due to timing. The remaining variance reflects the income and expenditure variance to position at Month 9.

7.1 Trade & Other Receivables

Total Trade and other receivables stood at £49.4m at 31st December 2019, £2.2m higher than plan. The main variances are explained below:

Trade / Other Receivables & Current assets Actuals	Actual 31/03/19 £m	Plan 31/12/19 £m	Actual 31/12/19 £m	Variance 31/12/19 £m	
Trade Receivables	42.3	23.1	33.6	10.5	Note 1
Deficit support invoice not yet due	-	-	(6.2)	(6.2)	Note 1
Prepayments	8.8	6.9	7.5	0.6	Note 2
Accrued Income	19.2	30.4	29.8	(0.6)	
Bad Debt Provision	(2.7)	(2.8)	(3.0)	(0.3)	
VAT Receivable	1.6	1.6	0.1	(1.5)	Note 3
Credit Note accrual	(30.0)	(13.6)	(13.4)	0.2	
Other Receivable	1.8	1.6	1.1	(0.5)	
Total	40.9	47.2	49.4	2.2	

Note 1: Trade receivables are £10.5m higher than plan as the Trust raised invoices to DHSC and Stafford and Surrounds CCG in Month 4 for the £24.8m 2019/20 deficit funding. The plan figure assumed that only £12.4m would be outstanding at the end of Month 9. Further details on aged receivables can be seen below. From a revenue perspective the deficit support for months 10-12 is not yet due, this balance of £6.2m is shown above as an adjustment to the receivables total.

Note 2: Prepayments are £0.6m higher than plan mainly due to the PFI equipment pre-payment outstanding relating to the Cath lab replacement.

Note 3: VAT receivable is £1.5m lower than plan as the cash was received prior to 31st December in relation to the VAT return submitted in December.

Trade receivables: The table below shows the ageing of the outstanding NHS and Non-NHS trade receivable debt and highlights the larger outstanding balances.

NHS Trade Receivables - Aged Debt	Actual 31/03/19 £m	Actual 30/11/19 £m	Actual 31/12/19 £m	
Less than 30 Days	24.3	2.6	3.1	£0.6m MPFT, NHS England £0.6m, £0.3m Royal Wolverhampton, £0.2m NHSI, £0.7m Mid Cheshire
31 to 60 Days	1.6	1.3	1.5	MPFT £0.6m, Royal Wolverhampton £0.3m, North Staffs Combined £0.1m
61 to 90 Days	0.5	1.7	0.6	Royal Wolverhampton £0.1m, North Staffs Combined £0.1m
91+ Days	12.3	27.7	26.1	DHSC £9.9m and Stafford & Surrounds CCG £14.9m for 2019/20 deficit support, NHS England £0.2m, NS Combined £0.4m
Total	38.7	33.3	31.3	
Non NHS Trade Receivables - Aged Debt	Actual 31/03/19 £m	Actual 30/11/19 £m	Actual 31/12/19 £m	
Less than 30 Days	1.4	0.5	0.6	Alliance Medical £114k, Katherince House Hospice £42k, BUPA £38k, Keele University £43k
31 to 60 Days	0.5	0.2	0.2	Vocare £54k, University of Liverpool £28k
61 to 90 Days	0.2	0.1	0.1	
91+ Days	1.5	1.4	1.4	£0.83m overseas visitors, £0.32m salary overpayments, Katherine House Hospice £29k.
Total	3.6	2.2	2.3	

The largest balance within the aged receivables is NHS debt over 90 days old. Of this £9.9m and £14.9m relate to 2019/20 deficit support from the DHSC and NHS England (via Stafford and Surrounds CCG) respectively. The revenue position includes £18.6m of this income to month 9. Discussions are on-going with NHSI in order for the Trust to receive this cash.

There are a number of outstanding invoices and credit notes with NHS bodies. The financial accounts team is reviewing the 2018/19 agreement of balances exercise and is continuing to liaise with NHS England and other NHS bodies where significant balances are outstanding for an update on when the Trust can expect the invoices and credit notes to be settled.

Older Non-NHS debt is proactively managed by the credit control department. This includes credit control, monthly conference calls with the Trust as well as increased referrals to a third party debt recovery service. The outstanding debt is being reviewed and a requirement for a write-off of debt being assessed, this will be reported to Audit Committee in January 2020. The benefits of this proactive action should be seen over the remainder of the year with a reduction in longer term non-NHS debt and a reduction in the bad debt provision.

7.2 Trade and Other Payables

Trade and other payables stood at £64.3m at 31st December 2019, which is £0.4m lower than plan. A breakdown of this figure and the reasons for the variance against plan are shown below:

Trade and Other Payables Actuals	Actual 31/03/19 £m	Plan 31/12/19 £m	Actual 31/12/19 £m	Variance 31/12/19 £m	
Trade Payables	(15.6)	(14.3)	(15.8)	(1.5)	Note 1
Manual Accruals	(12.0)	(17.1)	(14.9)	2.2	Note 2
Deferred Income	(5.0)	(6.5)	(6.3)	0.2	
GRN Accruals	(8.5)	(9.0)	(9.0)	0.0	
Tax/NI Payables	(9.8)	(9.5)	(9.9)	(0.4)	
Pension Payables	(5.9)	(6.2)	(6.3)	(0.1)	
Other Payables	(2.2)	(2.1)	(2.1)	-	
Total	(59.0)	(64.8)	(64.3)	0.4	

Note 1: Trade payables are £1.5m higher than plan this reflects outstanding invoices relating to Lloyds where a monthly £1m invoice (relating to October) was outstanding at 31st December and the timing of the Accounts Payable interface with the pharmacy system at the month end (payments were made in early Jan 2020).

Note 2: Manual accruals are £2.2m lower than plan which reflects the lower than plan non-pay position to Month 9.

The Better Payment Practice code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later, with a target of 95% compliance. The performance to month 9 can be seen in the table below.

Better Payment Practice Code	Actual 31/3/19	Actual 30/11/19	Actual 31/12/19
NHS £m			
Total Paid	31.6	23.8	25.7
Paid in terms	21.1	19.5	21.0
Percentage paid in terms	67%	82%	82%
NHS volume			
Total Paid	3,703	2,536	2,831
Paid in terms	2,962	2,044	2,309
Percentage paid in terms	80%	81%	82%
Non NHS £m			
Total Paid	458.9	275.1	313.0
Paid in terms	431.4	255.3	292.3
Percentage paid in terms	94%	93%	93%
Non NHS volume			
Total Paid	131,200	86,873	99,097
Paid in terms	122,292	81,104	92,891
Percentage paid in terms	93%	93%	94%

8 Forecast, Risks and Opportunities

The Trust carried out a full forecast for the year based on the Month 8 run rate which was presented to the Performance & Finance Committee in January; this forecast showed that the Trust still expected to meet its forecast surplus for the year of £5m. The reported position at Month 9 is £3k better than the forecast carried out at Month 8.

The Trust continues to hold a small number of specific reserves at Month 9 which are assumed to be committed during the year and have therefore been fully provided for within the Month 9 position; these are summarised in the table below The general risk reserve and non-pay inflation reserve are being released over the second half of the year in line with the forecast.

Reserve	Annual Value £m	YTD Value £m	Provided at Mn 9 £m
Winter	0.0	0.0	0.0
Risk Reserve	4.6	3.8	0.9
Activity Reserve	1.3	1.0	1.0
Windows 10	0.4	0.3	0.3
PFI RoE	0.1	0.1	0.0
Non Pay Inflation	1.7	1.6	0.7
Total Income	8.1	6.8	2.8

A “profiling” adjustment has also been made at Month 9 to ensure the Trust’s internal plan agrees with the external plan that NHSI use for the Performance Management of the Trust. This adjustment arises as we transacted £11.8m of additional CIP that has been profiled evenly throughout the year but the unidentified CIP schemes which have been removed were profiled for delivery in Q2-Q4. This profiling adjustment is neutral over the year; its impact in Month 9 is £2.2m.

The actual run rate performance at Month 9 is therefore

Underlying I&E	£m
Reported I&E deficit at month 9	0.0
Provision reserve	2.8
Profiling adjustment	2.2
Run rate performance	5.0

9 System Wide Position

At Month 8 (before PSF/CSF) the system reported a ytd deficit of £84.1m against a planned deficit of £70.4m resulting in an adverse variance of £13.7m. This is summarised in the table below alongside the amount of PSF/CSF assumed in the Month 8 position.

Organisation	M9 ytd £m			
	Annual Plan	ytd Budget	ytd Actual	Variance
CCGs	(73,915)	(44,153)	(62,452)	(18,299)
UHNM	(32,000)	(24,591)	(19,969)	4,622
MPFT	(2,477)	(1,702)	(1,857)	(155)
NSCHT	338	58	153	95
Aggregate system position before PSF/CSF	(108,054)	(70,388)	(84,125)	(13,737)
PSF/CSF/MRET				
CCGs	0	0	0	0
UHNM	32,000	18,095	18,095	0
MPFT	4,229	2,326	2,326	0
NSCHT	700	385	385	0
Ttoal PSF/CSF/MRET	36,929	20,806	20,806	0
Surplus/(deficit) after PSF/CSF/MRET	(71,125)	(49,582)	(63,319)	(13,737)

At Month 8 (before PSF/CSF) each organisation in the system is forecasting that it will meet its financial plan for the year with the exception of UHNM who are forecasting a £5m surplus. This results in an overall deficit for the system of £103.1m. In addition to this there is a further £27.8m of risk to internal savings plans that has been identified with the largest element relating to CCG QIPP risk. The system is forecasting that it will receive £36.9m of PSF/CSF resulting in an actual deficit of £66.1m

Within the forecast position the system is assuming £121.5m of internal savings and £1.2m of programme savings (against the £20m plan).

10 Conclusion/recommendations

The Trust was £1.0m better than plan in Month and within £3k of its forecast for the month. The favourable performance was supported by the position against expenditure which continues to underspend and the release of provisions made in the first half of the year. It is important that the Trust continues to maintain a tight control on expenditure over the last 3 months of the year.

There is nothing in the Month 9 position to suggest the Trust will not meet its revised forecast of a £5m surplus.

The Trust Board is asked to consider and review this report.

Appendix 1 – Patient income POD summary

Patient Income Position at Month 9	Annual Plan		Activity				Income (£m)			
	Activity	Finance (£m)	Plan	Actual	Variance	Variance	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS										
Daycase / Elective Inpatients	82,890	74.7	61,697	60,135	(1,562)	-3%	55.7	53.6	(2.1)	-4%
Non-Elective Emergency Inpatients	73,164	137.5	54,954	54,613	(341)	-1%	103.3	112.6	9.3	9%
Non-Elective Non Emergency Inpatients	21,442	21.4	16,109	17,222	1,113	7%	16.1	15.6	(0.5)	-3%
Critical Care	13,254	14.4	9,959	9,887	(72)	-1%	10.8	10.7	(0.1)	-1%
Excluded Drugs / Devices	12,638	13.3	9,397	9,352	(45)	0%	9.9	9.9	(0.0)	0%
Other	5,729,735	80.6	4,286,245	4,370,571	84,326	2%	60.3	61.6	1.4	2%
Outpatients	550,732	59.1	410,521	383,215	(27,306)	-7%	44.1	43.6	(0.5)	-1%
IFPS Adjustment		14.2					11.2	3.6	(7.5)	
	6,483,856	415.0	4,848,883	4,904,995	56,113	1%	311.2	311.2	0.0	0%
Other Non Patient Income		1.5					1.1	1.1	-	0%
	6,483,856	416.5	4,848,883	4,904,995	56,113	1%	312.3	312.3	0.0	
NORTH / SOUTH STAFFORDSHIRE CCGS NON BLOCK	-	-	-	-	-		-	-	-	
	-	-	-	-	-		-	-	-	
NHS ENGLAND										
Daycase / Elective Inpatients	23,576	39.9	17,632	18,158	526	3%	29.9	28.2	(1.6)	-5%
Non-Elective Emergency Inpatients	7,823	36.3	5,879	5,408	(471)	-8%	27.3	25.6	(1.7)	-6%
Non-Elective Non Emergency Inpatients	914	5.8	687	673	(14)	-2%	4.3	4.1	(0.3)	-7%
Critical Care	15,893	21.9	11,934	10,485	(1,449)	-12%	16.4	13.9	(2.5)	-15%
Excluded Drugs / Devices	741	42.2	555	526	(29)	-5%	31.8	34.4	2.5	8%
Other	212,654	48.6	159,096	160,989	1,892	1%	36.7	34.9	(1.8)	-5%
Outpatients	188,542	23.7	140,827	135,335	(5,492)	-4%	17.7	17.6	(0.2)	-1%
	450,143	218.4	336,609	331,574	(5,036)	-1%	164.2	158.6	(5.5)	-3%
OTHER CCG ASSOCIATES										
Daycase / Elective Inpatients	5,579	7.5	4,102	4,031	(71)	-2%	5.5	4.9	(0.5)	-10%
Non-Elective Emergency Inpatients	3,106	8.8	2,334	2,524	190	8%	6.6	6.8	0.2	3%
Non-Elective Non Emergency Inpatients	922	2.2	693	727	34	5%	1.6	1.9	0.2	13%
Critical Care	1,249	1.3	939	1,472	533	57%	1.0	1.6	0.6	62%
Excluded Drugs / Devices	2,572	3.2	1,912	2,041	129	7%	2.4	2.6	0.2	7%
Other	16,492	3.3	12,288	13,909	1,621	13%	2.5	2.8	0.3	12%
Outpatients	34,377	4.5	25,545	30,138	4,593	18%	3.4	4.0	0.7	20%
	64,297	30.8	47,813	54,843	7,030	15%	22.9	24.5	1.6	7%
OTHER NON NHS CONTRACTS										
Daycase / Elective Inpatients	181	0.8	136	159	23	17%	0.6	0.6	0.0	4%
Non-Elective Emergency Inpatients	455	2.7	365	448	83	23%	2.1	2.7	0.6	28%
Non-Elective Non Emergency Inpatients	109	0.5	84	64	(20)	-24%	0.4	0.3	(0.1)	-20%
Critical Care	1,235	1.6	928	1,012	84	9%	1.2	1.4	0.2	14%
Excluded Drugs / Devices	54	0.5	40	54	14	34%	0.4	0.5	0.0	12%
Other	3,456	1.1	2,636	1,316	(1,320)	-50%	0.8	0.8	0.0	6%
Outpatients	1,964	0.3	1,579	1,623	44	3%	0.2	0.2	0.0	4%
	7,455	7.5	5,768	4,676	(1,092)	-19%	5.7	6.5	0.8	14%
NON CONTRACT ACTIVITY										
Daycase / Elective Inpatients	498	1.3	372	363	(9)	-2%	1.0	0.8	(0.2)	-18%
Non-Elective Emergency Inpatients	1,004	1.4	754	730	(24)	-3%	1.0	1.0	0.0	1%
Non-Elective Non Emergency Inpatients	141	0.2	106	82	(24)	-23%	0.1	0.1	(0.0)	-31%
Critical Care	129	0.1	97	162	65	67%	0.1	0.2	0.1	87%
Excluded Drugs / Devices	86	0.1	64	81	17	26%	0.1	0.1	0.0	30%
Other	4,000	0.6	3,003	3,060	57	2%	0.5	0.5	0.0	4%
Outpatients	3,855	0.5	2,854	2,753	(101)	-4%	0.3	0.3	(0.0)	-7%
	9,713	4.2	7,250	7,231	(19)	0%	3.1	3.0	(0.1)	-3%
OTHER										
Daycase / Elective Inpatients	278	-	208	217	9	4%	-	0.0	0.0	
Non-Elective Emergency Inpatients	128	0.1	92	66	(26)	-29%	0.1	0.0	(0.1)	-94%
Non-Elective Non Emergency Inpatients	44	0.0	32	14	(18)	-57%	0.0	-	(0.0)	-100%
Critical Care	35	-	26	70	44	170%	-	-	-	
Excluded Drugs / Devices	2	4.4	1	6	5	301%	3.3	3.9	0.6	20%
Other	400	9.3	291	275	(16)	-5%	6.0	6.2	0.1	2%
Outpatients	1,046	0.0	763	908	145	19%	0.0	0.0	(0.0)	-95%
	1,932	13.9	1,414	1,556	142	10%	9.5	10.1	0.7	7%
	7,017,396	691.2	5,247,736	5,304,875	57,139	5%	517.8	515.2	(2.6)	0%
Less Other Non Patient Income	-	(1.5)	-	-	-		(1.1)	(1.1)	-	0%
TOTAL PATIENT INCOME	7,017,396	689.7	5,247,736	5,304,875	57,139	1%	516.6	514.1	(2.6)	0%

Appendix 2 – Patient income Commissioner summary

Patient Income Position at Month 9	Annual Plan		Activity				Income (£m)			
	Activity	Finance (£m)	Plan	Actual	Variance	Variance	Plan (£m)	Actual (£m)	Variance (£m)	Variance
NORTH / SOUTH STAFFORDSHIRE CCGS										
NHS CANNOCK CHASE CCG	370,305	21.9	277,008	283,598	6,590	2%	16.4	16.5	0.1	1%
NHS EAST STAFFORDSHIRE CCG	7,493	3.2	5,427	5,710	283	5%	2.3	2.8	0.5	20%
NHS NORTH STAFFORDSHIRE CCG	1,957,541	121.3	1,463,826	1,524,896	61,069	4%	90.8	94.4	3.6	4%
NHS SOUTH EAST STAFFS AND SEISDON PENINSULAR CCG	4,351	2.0	3,245	3,391	145	4%	1.5	1.5	(0.0)	-1%
NHS STAFFORD AND SURROUNDS CCG	1,335,622	72.8	999,050	991,986	(7,065)	-1%	54.5	55.6	1.2	2%
NHS STOKE ON TRENT CCG	2,808,544	179.7	2,100,326	2,095,415	(4,911)	0%	134.5	136.7	2.2	2%
IPFS ADJUSTMENT	-	14.2	-	-	-		11.2	3.6	(7.5)	-67%
	6,483,856	415.1	4,848,883	4,904,995	56,113	1%	311.2	311.2	0.0	0%
Other Non Patient Income		1.5					1.1	1.1	-	0%
	6,483,856	416.6	4,848,883	4,904,995	56,113	1%	312.3	312.3	0.0	
NORTH / SOUTH STAFFORDSHIRE CCGS NON BLOCK	-	-	-	-	-		-	-	-	
	-	-	-	-	-		-	-	-	
NHS ENGLAND										
CHESHIRE AND MERSEYSIDE AT DENTAL	1,431	0.3	1,071	1,085	14	1%	0.2	0.2	0.0	11%
CHESHIRE AND MERSEYSIDE AT SCREENING	4,614	0.5	3,451	2,980	(471)	-14%	0.4	0.3	(0.2)	-41%
NHS ENGLAND - ARMED FORCES	1,151	0.4	861	-	(861)	-100%	0.3	-	(0.3)	-100%
NORTH MIDLANDS AT DENTAL	37,692	7.9	28,197	27,655	(542)	-2%	6.0	6.2	0.3	5%
NORTH MIDLANDS AT SCREENING	14,977	6.0	11,203	9,327	(1,876)	-17%	4.7	4.5	(0.2)	-5%
SPECIALISED COMMISSIONING TEAM	390,278	203.3	291,826	290,526	(1,300)	0%	152.6	147.4	(5.1)	-3%
	450,143	218.4	336,609	331,574	(5,036)	-1%	164.2	158.6	(5.5)	-3%
OTHER CCG ASSOCIATES										
NHS BIRMINGHAM AND SOLIHULL CCG	1,159	0.7	863	1,065	202	23%	0.5	0.7	0.2	36%
NHS DERBY AND DERBYSHIRE CCG	1,957	1.0	1,461	1,541	80	5%	0.7	0.7	(0.0)	-5%
NHS DUDLEY CCG	514	0.3	382	350	(32)	-8%	0.3	0.2	(0.0)	-19%
NHS EASTERN CHESHIRE CCG	5,151	2.4	3,839	4,192	354	9%	1.8	1.9	0.2	9%
NHS REDDITCH AND BROMSGROVE CCG	179	0.2	133	151	18	14%	0.1	0.1	0.0	14%
NHS SANDWELL AND WEST BIRMINGHAM CCG	976	0.8	727	544	(183)	-25%	0.6	0.3	(0.3)	-48%
NHS SHROPSHIRE CCG	10,564	4.7	7,856	9,112	1,256	16%	3.5	4.2	0.7	19%
NHS SOUTH CHESHIRE CCG	28,337	12.6	21,074	24,188	3,114	15%	9.4	10.0	0.6	7%
NHS SOUTH WORCESTERSHIRE CCG	285	0.2	211	175	(36)	-17%	0.1	0.1	(0.0)	-26%
NHS TELFORD AND WREKIN CCG	6,413	3.1	4,743	5,048	305	6%	2.2	1.8	(0.4)	-18%
NHS VALE ROYAL CCG	5,018	3.2	3,738	5,272	1,534	41%	2.4	2.8	0.3	14%
NHS WALSALL CCG	1,189	0.5	883	1,152	268	30%	0.4	0.5	0.2	44%
NHS WEST CHESHIRE CCG	708	0.5	529	605	76	14%	0.3	0.5	0.1	39%
NHS WIRRAL CCG	199	0.1	149	177	28	19%	0.1	0.1	0.1	79%
NHS WOLVERHAMPTON CCG	1,432	0.6	1,065	1,124	59	6%	0.4	0.5	0.1	14%
NHS WYRE FOREST CCG	218	0.2	161	148	(14)	-8%	0.1	0.1	0.0	8%
	64,297	30.8	47,813	54,843	7,030	15%	22.9	24.5	1.6	7%
OTHER NON NHS CONTRACTS										
BETSI CADWALADR UHB	2,220	4.3	1,661	2,589	928	56%	3.2	4.0	0.8	26%
WALES	4,481	2.9	3,352	1,296	(2,056)	-61%	2.2	2.1	(0.0)	-2%
VIRGIN HEALTHCARE	754	0.3	754	791	37	5%	0.3	0.3	(0.0)	0%
	7,455	7.5	5,768	4,676	(1,092)	-19%	5.7	6.5	0.8	14%
NON CONTRACT ACTIVITY										
NON CONTRACT ACTIVITY	9,713	4.2	7,250	7,231	(19)	0%	3.1	3.0	(0.1)	-3%
	9,713	4.2	7,250	7,231	(19)	0%	3.1	3.0	(0.1)	-3%
OTHER										
CANCER DRUGS FUND	-	3.7	-	-	-		2.8	3.4	0.6	23%
NHS ENGLAND DRUGS - NON CONTRACT	-	0.6	-	-	-		0.5	0.5	0.0	10%
OTHER	505	9.5	347	455	108	31%	6.2	6.2	(0.0)	0%
OVERSEAS VISITORS	658	0.0	493	362	(131)	-27%	0.0	-	(0.0)	-100%
PRIVATE PATIENTS	768	-	575	739	164	29%	-	-	-	
	1,932	13.9	1,414	1,556	142	10%	9.5	10.1	0.7	7%
	7,017,396	691.2	5,247,736	5,304,875	57,139	5%	517.8	515.2	(2.6)	0%
Less Other Non Patient Income	-	(1.5)	-	-	-		(1.1)	(1.1)	-	0%
TOTAL PATIENT INCOME	7,017,396	689.7	5,247,736	5,304,875	57,139	1%	516.6	514.1	(2.6)	0%

Transformation and People Committee Chair's Highlight Report to Board

24th January 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Terms of Reference and Membership considered by the Committee; recognised that there is further work to be done and this will be undertaken following a review of Committee effectiveness in April 2020 – these are appended for approval of the Board	• Work underway to review risks set out within the Board Assurance Framework • Review / development of Executive Governance Groups remains ongoing, which will include the amalgamation of Strategy / Transformation with Research and Innovation • To explore the possibility of providing the Committee with benchmarked information on Freedom to Speak Up concerns to provide insight/context • Development of Speaking Up Charter and regular senate event to set out what can be expected when a concern has been raised • Development of a clear current status and future plan for Transformation strategy and delivery • Report on the approach to aligning various initiatives under culture, improvement practice, pathways and transformation into a coherent plan.
Positive Assurances to Provide	**Decisions Made**
• Action Plan linked to the Research and Innovation MHRA review is on track as planned with a view to completion by the end of March 2020 • 3000 staff have received a values award over the past two years • All areas in the Improving our People Practices Action Plan are now business as usual and the effectiveness of investigation processes is being subject to Internal Audit	• None required

Comments on the Effectiveness of the Meeting

- Positive establishment meeting and discussion on future approach/areas of focus
- Effectiveness will be reviewed ahead of the start of the new financial year, as part of the broader annual effectiveness review process

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference and Membership	Approval	7.	Q3 Formal Conduct Case Report	Information
2.	Arrangements for Effectiveness Review	Information	8.	Transformation Programme Update	Assurance
3.	Board Assurance Framework	Approval	9.	Research and Innovation Update	Assurance
4.	Q3 Speaking Up Report	Assurance	10.	Roadmap to Strategy Development	Assurance
5.	Month 8 Workforce Performance Report	Assurance	11.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information
6.	Learning Lessons to Improve our People Practices	Assurance	12.	Summary of Actions and Agreement of Items for Escalation to the Trust Board	Approval

3. 2019 / 20 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Professor Gary Crowe	GC	Non-Executive Director (Chair)												
Mrs Helen Ashley	HA	Director of Strategy and Transformation												
Ms Sonia Belfield	SB	Non-Executive Director												
Mr Paul Bytheway	PB	Chief Operating Officer												
Dr Leigh Griffin	LG	Non-Executive Director												
Mr Mark Oldham	MO	Chief Finance Officer												
Miss Claire Rylands	CR	Associate Director of Corporate Governance												
Mrs Ro Vaughan	RV	Director of Human Resources												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th February 2020
Report Title:	Operational Performance, Month 9	**Agenda Item:**	12
Author:	Performance & Information team		
Executive Lead:	Helen Ashley, Director of Strategy & Performance		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings discussed with and outcome of discussion:

Summary of Report, Key Points for Discussion including any Risks:

1. OPERATIONAL PERFORMANCE

EMERGENCY CARE

The 4 Hour Access Standard in December achieved 73.34% (November 74.92%) against the NHSI 90% performance trajectory. There were 321 12 hour trolley breaches recorded in December.

Summary:

Nationally UHNM ranked 85th for A&E 4 hour performance in December however nationally UHNM were an outlier for performance for 12 hour breaches. This was partly down to ED processing time increases due to flu testing, cohorting of flu patients in ED, mobilising side room capacity and demand for overnight beds.

The increase in paediatric overnight admissions seen in the last two weeks of November continued until the last week of December. CWD saw the weekly admissions over 1 day increased from an average of 137 Early November to 171 mid-December.

Despite attendances to Type 1 A&E remaining similar to December 2018, the patient profile attending Royal Stoke shifted, with 344 more patients over the age of 55 (106 over 80) seen this December and 276 more patients under 16 years.

Type 1 ambulance attendances to Royal Stoke continued to rise in December, which saw an increase of 64 more arrivals than in November (1.1% rise). There were 190 ambulance handover delays of over 60 minutes across both sites.

A total of 58 escalation beds were used at Royal Stoke in December in line with the Winter plan. Medical beds occupied at midnight rose to 508 which is in line with that seen in December 2017 (the year the winter plan demand is based on). Despite opening escalation beds, Medical bed occupancy remained above 99% at RSUH due to extended LoS/higher acuity.

This is evidenced by the number of emergency admissions needing an overnight bed increasing through December indicating a higher level of acuity of patients attending ED together with a higher rolling average of stranded patients (7+ days) per week.

The Trust percentage of DTOC in November rose to 5.2% (compared to a standard of 3.5%).

The drivers for December 2019 performance are increased demand, higher acuity patients and flu. As a result of these factors, there were 321, 12 hour trolley breaches in December. In both October and November the 92nd percentile was 10 hours with no wait breaching the 12 hour mark. In December (with the average trolley wait time increasing by 1.5 hours) the 92nd percentile moved to 12 hours meaning all patients in the top 8% breached the 12 hour standard.

Next Steps:

- Debrief and lessons learnt exercise based on December to inform planning for February/March 2020.
- System partner discussions commenced around de-escalation of bed capacity to prepare for further IPC risks.
- CRIS continues to expand to support admission avoidance.
- Winter Plan to continue to be enacted to support flow / increased admissions through ED
- Additional winter money allocated to expedited TTO management / ED transfer team
- Neurology and Surgical SPRs to support ambulatory pathway to improve discharge from ED.
- Bed hub developed in the West with improved grip and control sub-acute medical and MFFD patients to support more timely bed allocation and discharge of patients into community/home.
- Community MADE to continue on a more frequent basis to address challenging pathways requiring senior input and support.

RTT

The RTT Incomplete Pathway standard in December achieved 81.00% against an Internal trajectory of 84.16% and a NHSI operational plan of 83.0% (subject to further validation).

The number of incomplete pathways is tracked against the waiting list size required to deliver 92% and 85%. Currently the waiting list size is 48,140 (November 48,047) which is an increase of 93 on November. The internal target is 46,803 and the NHSi target of 44,203. End of year target is 45,103.

Key issues:

Key issues for December include patient initiated delays and some elective cancellations due to emergencies. This resulted in a reduced number of clock stops particularly for the admitted pathways more notable in Surgery but also in T&O. This, in addition to the on-going issues related to specific specialties (the prioritisation of cancer patients in Colorectal and Urology; sickness affecting validation of pathways) has resulted in an increase in the number of RTT pathways and the numbers over 18 weeks.

Theatre touch time Utilisation in December was 79.9% (the same as November) but an improvement of 0.4% on December of the previous year.

Next steps:

- Review waiting list monthly treatments required to maintain and reduce PTL and continue upward trajectory for RTT performance, acknowledging Trust is currently on fixed block arrangement.
- Tracking of the over 40/52 week position with expedited escalation and mapping of specialty service changes (Bariatrics/general surgery/gynae)
- Tactical Validation oversight of Incomplete Waiting List to keep focus on attainment of trajectory at month end
- Risk Stratification of the follow ups waiting list
- Validation Rules for the identified follow up cohorts
- Support development of the SOPs in relation to the follow up backlog.

CANCER

	Nov-2019	Dec-2019	Dec-2019 Trajectory (NHSI)	Dec-2019 Trajectory (Internal)	Standard
Two Week Wait	79.14%	78.49%	95.61%		93%
2ww Breast Symptom	95.52%	89.36%	97.30%		93%
31 Day First Treatment	94.15%	94.55%	97.39%		96%
31 Day Subsequent Surgery	85.48%	86.00%	94.92%		94%
31 Day Subsequent Anti-Cancer	100.0%	94.44%	100%		98%
31 Day Subsequent Radiotherapy	92.25%	91.20%	98.18%		94%
62 Day (2ww) First Treatment	67.73%	71.83%	85.24%	74.60%	85%
62 Day Screening First Treatment	88.89%	80.00%	92.00%		90%

Data Last Updated: 06/01/2020 *December 2019 cancer performance is still provisional and finalised 05.02.2020

Performance / Assurance

A 12 week plan developed in October 19 predicted an upward trend in performance from the end of December with a tactical plan to pull forward breached treatments into November and is the reason for the deterioration. The un-validated position for December is showing improvements for specialties against the range of cancer modalities except Colorectal and Urology.

To maintain focus on performance the recovery plan is currently being strengthened and the weekly cancer performance cycle has now been reconfigured to include a forecast and feedback meeting with Divisional Associate Directors to ensure Senior Level involvement and ownership of the plan is maintained.

A Colorectal Triage to Test Pilot commenced on 09 December, 89 patients were successfully triaged directly to diagnostic tests. Based on this two additional rapid triage sessions are planned with dates to be confirmed as part of the internal improvement actions for the GI service.

Next Steps:

- Launch of Best Practice Pathway improvements (Colorectal, Respiratory, Upper GI & Prostate) – commenced October 19 (e.g. Triage to Test trial for colorectal, 2 dates agreed for the 9th & 16th December).
- Focused improvement plan initiated with CWD for Cancer Diagnostics deep dive as this is the rate limiting factor to delivery of treatments in target.
- Shadow monitoring the 28 day standard has been in place since April 2019 ahead of the National Standard being introduced from April 2020.
- Investment in AI technology to support future workforce planning, pilot commencing in January 2020 to assist the reporting of CT scans for the lung screening project.
- Focussed improvement actions on 104 days. Clinician system engagement sessions on our most challenged specialties to commence from December, 2019. Colorectal is the first specialty to have this level of support.

The Trust has engaged the support of key stakeholders across the region (NHSE/ WMCA/ CCG) to discuss the significant increase in GI referrals outstripping the capacity available to meet this demand with the first session Friday 17th January 2020. This is the first time there has been recognition of the size of the challenge for UHNM around demand management with a commitment to support with enabler actions that are out with the remit of the Trust. Key facts of note:

- UHNM receives 63.1% of all Staffordshire and S-O-T 2ww referrals. This has increases from 60.7% in the last 3 years. More cancer activity is referred to UHNM than other planned care activity and it is growing as a proportion.
- UHNM receives 68.8% of all Staffordshire and S-O-T lower GI 2ww referrals.
- Lower GI activity from Staffordshire and S-O-T CCGs to UHNM has grown 48% in the last 3 years (growth from SOT CCG is less [42%])
- Lower GI activity from NS CCGs to UHNM has grown 54 % in the last 3 years. If we disregard East

Cheshire reductions this equates to 48% growth to UHNM not offset by reductions elsewhere so the East Cheshire reduction does explain some of why NS growth is higher. It doesn't fully explain the differences in growth between NS and SOT.

Of further concern the conversion rate to a diagnosis has fallen over the past four years against this increase in demand.

DIAGNOSTICS
The standard achieved 99.31%

2. CARING AND SAFETY

The Trust achieved in December 2019:

- Zero mixed sex accommodation breaches
- Written Complaints (17.62 Vs. a target of 35 per 10,000 spells)
- Zero never events
- The Family & Friends for Inpatients and Maternity were above target for positive reporting
- Zero MRSA Bacteraemia Infections
- Achieved the target reduction for all categories of Hospital Acquired, Trust Apportioned, Pressure Ulcers

The Trust failed the set standards for:
- Family & Friends for A&E, 65.2% positive response against a National target of 70%
- VTE, 92.07% against an operational standard of 95%
- C-Diff cases were 11 for the month against the plan of 8
- The number of patient falls resulting in low harm or above (61 vs. 60, internal target)

3. FINANCE

The financial position for the Trust at Month 9 is a breakeven position, which is £5.6m positive variance against the £5.6m deficit plan.
Operating income at month 9 of the financial year is £583.9m; this is £0.6m below plan.
Pay expenditure is £358.4m at Month 9, £6.1m positive variance to plan. Non Pay spend is £225.5m at Month 9 which is an overspend of 0.7m.
The CIP Target within the plan is £40.0m. At month 9 the Trust has achieved £25.1m of savings, which is £1.4m below plan.
The Trust's Planned Capital Expenditure for the year is £23.2m. The Trust has spent £15.0m to Month 9.
The Trust's current liabilities exceed its current assets by £8.0m.

4. ORGANISATIONAL DEVELOPMENT

In December, the in-month sickness rate reduced to 5.85% (5.95% in November) and the 12m Cumulative Rate reduced to 4.58%.
The sickness rate is in line with previous year trends over the winter period and an increase in reported absence was expected with the implementation of Empactis.
The PDR rate improved slightly from 80.89% to 81.20%
The Statutory and Mandatory training rate at 31st December 2019 was 90.20% (90.64% at 30 November 2019). The Statutory & Mandatory training rate shows compliance against the seven (Core for All) 3 yearly competency requirements and 83.98% of staff has completed all 7 modules.

Key Recommendations:
To note performance

University Hospitals of North Midlands NHS
NHS Trust

PROUD TO CARE

Author: Karan Allman: Head of Performance
Executive Lead: Helen Ashley: Director of Strategy & Performance

Month 9 2019/20 Integrated Performance Report

Contents

Dec-19

Page 1

Context & NHS I Single Oversight Framework

The NHS Improvement (NHSI) single oversight framework was implemented from October 2016 and revised August 2019. The framework is comprised of 35 metrics across the following domains:
1. Finance and use of resources
2. Operational performance
3. Organisational health
4. Quality of Care - safety, caring and Effectiveness

Changes to oversight is categorised by several key principles: NHSE & NHSi speaking with a single voice; a greater emphasis on system performance,working with and through system leaders,matching accountability for results; greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The metrics identified i the framewor are used as triggers by the regional teams to identify potential concerns and support levels required. There are four levels of support, ranging from 1. maximum provider autonomy to 4. special measures. As a consequence of the application of financial special measures the Trust has been placed in 4.

The following sections of this performance report provide detail in relation to performance drivers and recovery actions at Trust and Hospital Site level in relation to the NHSI single oversight framework indicators.

Performance against National Constitutional Standards
The NHSI single oversight framework includes five constitutional standards:
1. A&E
2. Diagnostic six week waits
3. RTT 18-weeks
4. All cancer 62 day waits
5. 62 day waits from screening service referral

NHS Improvement Single Oversight Framework

The following report is designed to present performance, by exception, against the NHS Improvement Single Oversight Framework. In addition the Trust is developing other domains against which to view performance; however additional domains will be constructed over time. Spotlight reports are also included where performance against indicators that sit outside current domains have been flagged as exceptions, or where specific areas require highlighting.

Operational Performance:

The following performance standards were achieved in December 2019:

• Zero 12 hour trolley waits
• Zero > 52 weeks RTT waits
• 6 week Diagnostic wait (0.69%) - national standard of 1%

The following standards were not achieved in December 2019:
• Cancer, 2ww Suspected Cancer (77.67%) - national standard 93%
Cancer, 2ww Symptomatic Breast (89.36%) – national standard 93%
• Cancer, 31 Day First Treatment (94.70%) - national standard 96%
Cancer, Subsequent Surgery (83.93%) - national standard 94%
• Cancer, Subsequent Anti-Cancer Drug (94.74%) - national standard 98%
• Cancer, Subsequent Radiotherapy (87.80%) - national standard 94%
• Cancer, 62 day (69.82%) – national standard is 85%
• Cancer, 62 day screening (80.0%) – national standard 90%
• 4 hour emergency access standard (73.34%) – national standard 95%
• 18 week referral to treatment (RTT) standard (81.0%) – national standard 92%

*cancer performance for Decmber remains provisional at 20/01/20, deadline for submission is 6th February 2020.

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Context

12 month rolling		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Variance of current vs. pervious month (no adjustments for Nos. of days in the month)
A&E	A&E Attendances - RSUH, County, Emerg Eye Clinic, WIC & MIU	20170	20370	19247	21008	21165	21355	20872	22366	21483	21163	21697	21697	21099	-598
	Urgent Care Centre only - Vocare	1599	1585	1663	1821	1897	1879	1624	1735	1541	1557	1637	1757	2325	**568**
	Total A&E Attendances	21769	21955	20910	22829	23062	23234	22496	24101	23024	22720	23334	23454	23424	-30
	Daily average for total attendances	702.2	708.2	746.8	736.4	768.7	749.5	749.9	777.5	742.7	757.3	752.7	781.8	755.6	-26.2
Inpatients	Elective - overnight	1108	1206	1216	1253	1141	1201	1180	1210	1196	1221	1326	1235	1067	-168
	Elective - day cases	7069	8427	7692	8481	7825	8111	7537	8238	7797	7854	8273	7999	7327	-672
	Non-Elective discharges	10917	11203	10168	10797	10720	11288	10459	10741	10685	10416	11137	10942	10532	-410
	Other - regular day/ night	357	432	352	353	389	386	353	402	367	357	405	370	361	-9
Outpatient	First new	25315	31553	28074	30027	28186	27861	25402	27366	24489	26833	29839	26093	24970	-1123
	Subsequent	35331	45244	40271	41620	39811	43611	40055	43912	39530	40751	45515	42264	36594	-5670

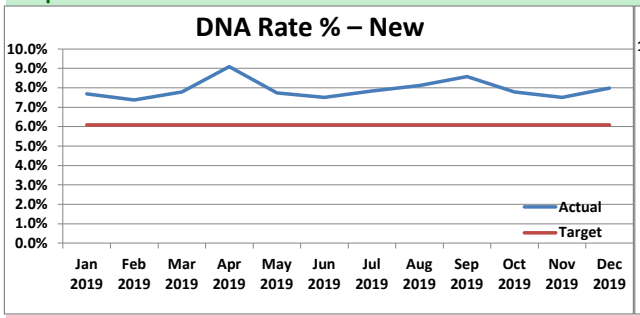
Summary:
All activity in Non-elective care was up this month compared to last month even though a30 day month.

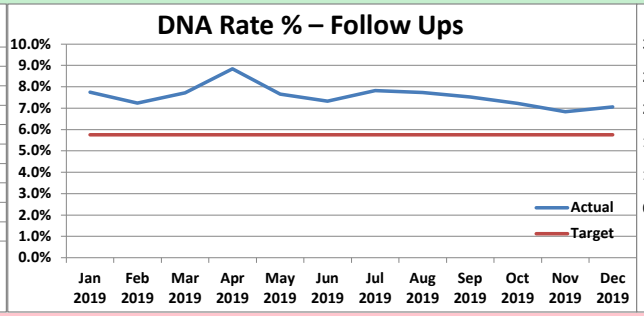
A&E attendances in November were up by 6.7% from the same period last year. This equates to 34 more patients per day compared to Nov-18.
he daily average numbers, for the total were 781.8, compared to 752.7 in October and 719.9 for the same period last year.

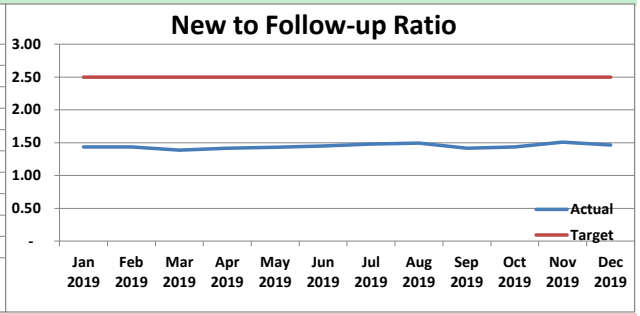
Total RSUH & County 15,930 vs. internal plan of 15,347

Productivity

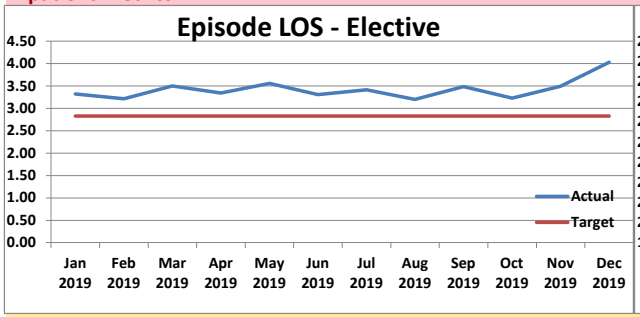
Outpatient Metrics

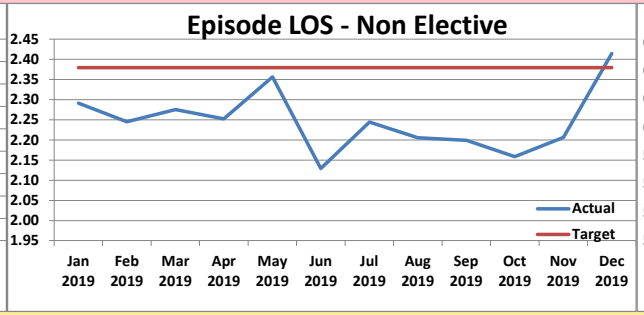


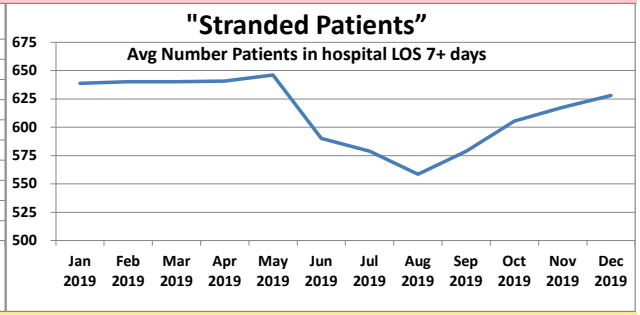




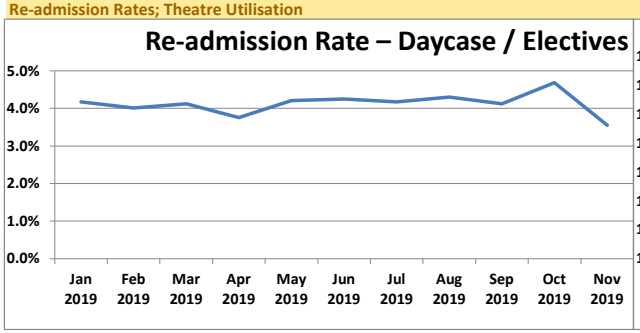
Inpatient Metrics

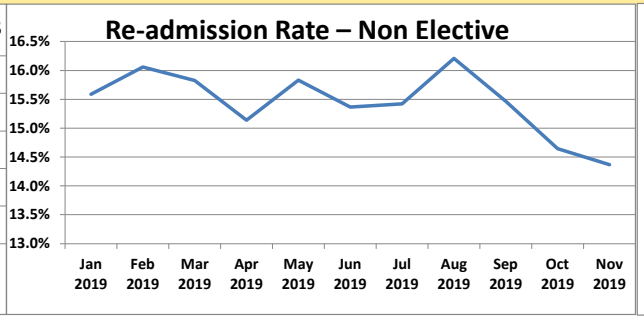


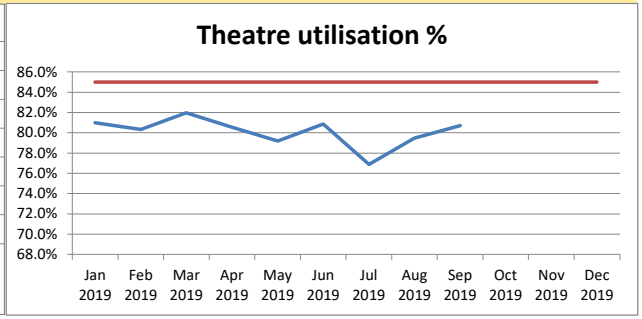




Re-admission Rates; Theatre Utilisation







re-admission rates are reported for previous month

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019 -20				
		Q3	Q4	Q1	Q2	Oct-19	Nov-19	Dec-19	Q3	**Q3**
Financial Rating	Capital service capacity	4	4	4	4	4	4	4	4	G
	Liquidity (days)	4	4	3	3	3	3	3	3	G
	I&E margin	4	4	4	4	4	4	4	4	G
	Distance from financial plan*	3	3	1	1	1	1	1	1	G
	Agency spend	1	1	1	1	1	1	1	1	G
Operational Performance	A&E- 95% of patients admitted, transferred or discharged within 4-hours	84.91%	80.76%	80.81%	79.38%	76.71%	74.92%	73.34%	74.99%	R
	Diagnostic 6-week wait performance 99% target	98.47%	98.59%	97.89%	98.61%	99.73%	99.36%	99.31%	99.47%	G
	RTT 18-weeks incomplete pathways - 92%	81.15%	80.02%	79.98%	79.81%	81.79%	82.63%	81.00%	81.81%	R
	All Cancer 62 day wait for first treatment:									
	from urgent GP referrals - 85%	82.07%	76.38%	71.43%	71.78%	69.14%	67.49%	69.82%	68.32%	R
	from a screening service - 90%	89.87%	82.28%	79.33%	87.43%	96.20%	88.89%	80.00%	85.44%	R

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019-20				
		Q3	Q4	Q1	Q2	Oct-19	Nov-19	Dec-19	Q3	**Q3**
Organisational health	Staff Sickness (12m cumulative rate as at end of each quarter)	4.49%	-	5%	4.47%	4.51%	4.59%	4.58%	4.51%	**R**
	Staff turnover (Leavers in previous 12 months as % of Average Headcount)		-	10%	9.53%	9.05%	9.13%	8.85%	9.05%	**G**
	Statutory and Mandatory Training Rate - for seven 3 yearly competencies	91.31%	-	93%	91.55%	90.20%	90.64%	90.20%	90.20%	**R**
	Proportion of Temporary staff (as a % of budgeted establishment) In month figure only	6.29%	-	6%	6.16%	6.27%	6.19%	5.49%	6.27%	
	Appraisal rates (12 month rolling average) - Trust (excl Consultant Medical Staff)	92.13%	-	92%	84.87%	83.44%	80.89%	81.20%	83.44%	**R**
	Staff Friends & Family Test % Recommended- Care, Quarterly (HR)	72.0%	80.4%	n/a		n/a	n/a	n/a	n/a	**G**
	Agency costs as a % of total pay cost	4.54%	-	4%	4.01%	4.05%	3.94%	3.92%	4.05%	
Caring	Written Complaints- rate (per 10,000 spells)	22.5	29.87	32.88	29.7	45.32	19.48	17.62	28.69	**G**
	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	**G**
	Inpatient Scores from Friends & Family Test- % positive	98.10%	97.90%	98.20%	98.4%	98.3%	98.5%	97.80%	98.3%	**G**
	A&E Scores from Friends & Family Test- % positive	69.50%	69.70%	68.40%	67.0%	65.1%	67.0%	65.20%	65.1%	**R**
	Maternity Scores from Friends & Family Test- % positive	95.40%	100.00%	100.00%	100.0%	100.0%	98.5%	100.00%	99.1%	**G**

NHS Improvement Framework

		Rolling Qtr. 18/19/20				2019-20				
		Q3	Q4	Q1	Q2	Oct-19	Nov-19	Dec-19	Q3	**Q3**
Safe	Never Events	2	2	3	0	1	0	1	2	G
	Emergency C-section Rate (as a % of total births)	13.60%	15.03%	14.93%	13.01%	12.98%	14.72%	15.08%	14.24%	
	VTE Risk Assessment	95.34%	94.67%	93.79%	93.99%	93.98%	93.74%	92.07%	93.29%	R
	Clostridium Difficile- variance from plan	-6	-9	-1	1	2	0	11	13	R
	Clostridium Difficile- numbers	12	11	23	25	9	8	18	35	R
	MRSA bacteraemia	0	0	0	0	0	0	0	0	G
	Potential under-reporting of patient safety incidents	-	-	-	-	-	-	-	-	
Effective	Hospital Standardised Mortality Ratio (HED)*	105.58	tbc	tbc	tbc	tbc	tbc			G
	Hospital Standardised Mortality Ratio- Weekend admission (HED)*	113.3	tbc	tbc	tbc	tbc	tbc			G
	Summary Hospital Mortality Indicator*	1.07	tbc	tbc	tbc	tbc	tbc			G
	Emergency re-admission within 30 days following an elective or emergency spell at the Provider - 1 month behind	3332	3378	3732	3692	1064	1033	not yet available	2097	G

1. FINANCIAL RATING

Domain Scorecard

Dec-19
Page 9

	Ref	Indicator	Exception Triggers			Period	Performance			
			Month Target	Step Change	Conti. Limit		This Period Target	Last Period	This Period	YTD
Financial Planning	F1	Capital service capacity	4			Dec-19	4	4	4	4
	F2	Liquidity (days)	4			Dec-19	4	3	3	3
	F3	I&E margin	4			Dec-19	4	4	4	4
Financial Control	F4	Distance from finance plan	1			Dec-19	1	1	1	1
	F5	Agency spend	1			Dec-19	1	1	1	1

Finance KPI Ratings Key

			Ratings			
			1	2	3	4
Financial Sustainability	**F1**	Capital service capacity (times)	>2.5x	1.75-2.5x	1.25-1.75x	<1.25x
	F2	Liquidity (days)	>0	(7) - 0	(14) - (7)	<(14)
Financial Efficiency	**F3**	I&E margin (%)	>1%	1-0%	0 - (1)%	< - (1)%
Financial Controls	**F4**	Distance from financial plan (%)	> = 0%	(1) - 0%	(2) - (1)%	< = (2)%
	F5	Agency spend above ceiling (%)	< = 0%	0% - 25%	25 - 50%	>50%

1. FINANCE - Key Metrics - Trust Wide	Domain Scorecard	Dec-19 Page 10

	£millions	2019/20 Year To Date	RAG Year To Date		
Trust Deficit	Budget	-5.6	G	↑	The financial position for the Trust at Month 9 is a breakeven position which is £5.6m positive variance against the £5.6m deficit plan
	Actual	0.0			
	Variance	5.6			
Trust Income	Budget	581.1	A	↓	Operating income at month 9 of the financial year is £583.9m; this is £0.6m below plan.
	Actual	580.5			
	Variance	-0.6			
Operating Expenditure	Budget	-589.3	G	↑	Pay expenditure is £358.4m at Month 9, £6.1m positive variance to plan. Non Pay spend is £225.5m at Month 9 which is an overspend of 0.7m.
	Actual	-583.9			
	Variance	5.4			
Cost Improvement	Budget	26.5	A	↓	The CIP Target within the plan is £40.0m At month 9 the Trust has achieved £25.1m of savings, which is £1.4m below plan.
	Actual	25.1			
	Variance	-1.4			
Capital Spend	Budget	-14.7	A	↓	The Trust's Planned Capital Expenditure for the year is £23.2m. The Trust has spent £15.0m to Month 9.
	Actual	-15.0			
	Variance	-0.3			
Working Capital	Current Assets	81.6	A	↑	The Trust's current liabilities exceed it's current assets by £8.0m
	Current Liabilities	-89.6			
	Total	-8.0			

Key to RAG Status

Colour Indicates YTD status of variance / working capital position(green is favourable, red is adverse) Arrow indicates change in the metric since last month(up is improving, down is deteriorating)

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Conti. Limit	Period	Performance: This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Breakdown: RSUH ED only	Site Breakdown: County ED only	Site Breakdown: UHNM total	Except.
Waiting Times	R1	A&E 4 Hours Waiting Time	R			Dec-19	85%	74.92%	73.34%	78.37%	56.08%	76.61%	73.34%	✓
	R7	Cancer 62 days from Urgent GP Referral	R			Dec-19	85%	69.14%	69.82%	70.28%				✓
	R13	Cancer 62 Days from Screening Programme	R			Dec-19	90%	96.20%	80.00%	85.97%				✓
	R6	Diagnostic Waits Under 6 Weeks	G			Dec-19	>99%	99.36%	99.31%	98.71%			99.31%	
RTT- 18 Weeks	OP34	RTT Incomplete	R			Dec-19	92%	82.63%	81.00%	80.53%			81.00%	✓
Service User Support	R30	Duty of Candour	G			Dec-19	100.0%	100.0%	100.0%	100.0%				

The 4 Hour Access Standard in November achieved 73.34% (74.92% in November)

Summary:

LHE attendances in December were up 5.7% from the same period last year. This equates to 41 more patients per day compared to Dec-18. Despite attendances to Type 1 A&E remaining similar to Dec-2018 the age of patients attending Royal Stoke shifted, with 344 more patients over the age of 55 (106 over 80) seen this December and 276 more patients under 16 attending also.
There were 190 ambulance handover delays of over 60 minutes across both sites. The operational plan for handovers > 60 mins is 10.
Type 1 ambulance attendances to RSUH continue to rise in December, which saw an increase of 64 more arrivals than in November (1.1% rise). This is the highest month in 2019 but down on previous year. Ambulance corridor occupancy rose in December to 3638 from 3455 patients in November.
An total of 58 escalation beds were used at RSUH in December in line with the Winter plan. Medical beds occupied at midnight rose to 508 which is in line with that seen in December 2017 (the year the winter plan demand is based on).
Despite opening escalation beds, Medical bed occupancy remained above 99% at RSUH.
The drivers for December 2019 performance are increased demand, higher acuity patients and flu. As a result of these factors, there were 321 12 hour trolley breaches in December. In both October and November the 92nd percentile was 10 hours with no wait breaching the 12 hour mark. In December (with the average trolley wait time increasing by 1.5 hours) the 92nd percentile moved to 12 hours meaning all patients in the top 8% breached the 12 hour standard.

The fall in SDEC was mainly down to a drop in patients being discharged the same day from AMRAU and CDU. Both Wards saw a rise of patients needing to stay overnight of 25%.
The number of emergency admissions needing an overnight bed increased through December indicating a higher level of acuity of patients attending ED. (slide 10 – top left graph shows the drop in SDEC which coincides with bottom right graph the rise in overnight admissions)
The average number of stranded patients (7+ days) per week also saw an increase in December further indicating a longer length of stay for patients admitted in December. (slide 11 – top left graph shows the increase in LoS)
The Trust percentage of DTOC in November rose to 5.2% (compared to a standard of 3.5%). Although this is lower than the start of the year where the percentage was 5.7%.
The increase in paediatric overnight admissions seen in the last two weeks of November continued until the last week of December. CWD saw the weekly admissions over 1 day increased from an average of 137 early November to 171 mid December.
Flu impacted the Trust earlier this year than previous years. 560 case in December compared with 209 in 2018 and 84 in 2017.

Positive Assurances:

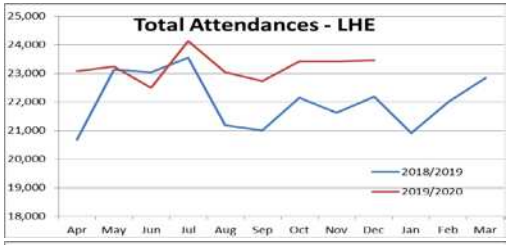
The dramatic increase in paediatric attendances seen towards the end of November continued into December. More paediatric attendances treated within 4 hours than the same period last year (114 more seen in time). To cope with the increased demand Rapid access slots were doubled within the Children's Assessment Unit.
The median time to initial assessment was 12 mins, below the 95th percentile target of 15 mins. This was 11 mins at the same time last year and with a 5.7% increase in overall attendances.
Nationally UHNM ranked 85th for A&E 4 hour performance in December.
Growth in attendances was mainly seen in Type 3 activity with the UCC seeing 34 more patients a day than the previous year indicating streaming at the front door success but therefore a higher level of need left in the type 1 patients attending.
System wide week long MADE in December helped ensure the average number of MFFD patients at Royal Stoke improved slightly. MFFD averaged 17 less than the Winter plan assumption of 120 in December.
Super Stranded patient numbers, although higher than previous year, tracked the same positive trend as seen in 2018.
The majority of patients that are admitted to a short stay portal are staying on that portal for less than 48 hours.

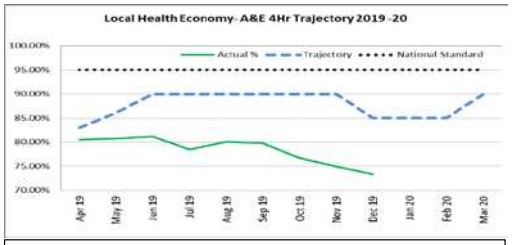
Next Steps:

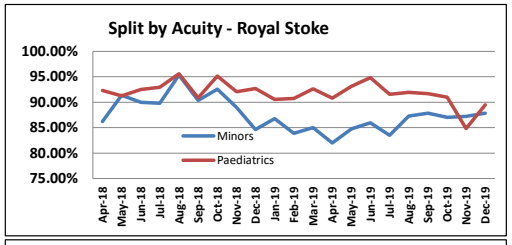
Winter Plan to continue to be enacted to support flow / increased admissions through ED
Continue with the additional Divisional “grip and control” measures put in place, including a Divisional Support Centre model in times of escalation with a particular focus on timely and effective flow/discharge
Continue with the improved oversight simple/complex discharges against demand on a daily/weekly basis through review of performance reports (MADE)
Neurology and Spinal pathway redesign to improve specialised admitted performance – winter funding allocated
ED transfer policy to be reviewed
Medical Workforce Review utilising ECIST model as benchmark
Transformation programme around improved flow and discharge to be the focus of the Division/Trust during 2020/21
Continue with the improved oversight simple/complex discharges against demand on a daily/weekly basis through review of performance reports (MADE).
Emphasis to be on Simple & Timely and Complex discharges whilst escalation capacity in full use.
Escalation beds to remain open in line with Winter plan plus additional capacity (ward 110 -14 beds) for medicine to manage the demand.
Review system/Trust frailty model with focus on front door turn around with MPFT.
Refresh of Long Stay reduction strategy in alignment with NHSE Long Stay Ambition plan commenced with wards review every Wednesday to maintain super stranded performance and push for improved LOS reduction in stranded.
Red bag scheme to continue to be rolled out to aid care home patient stays.

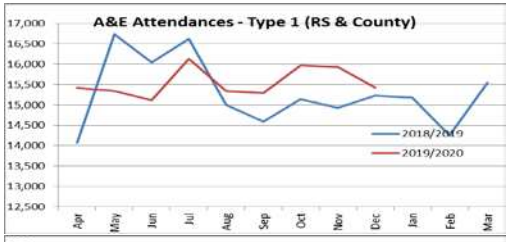
Risks:

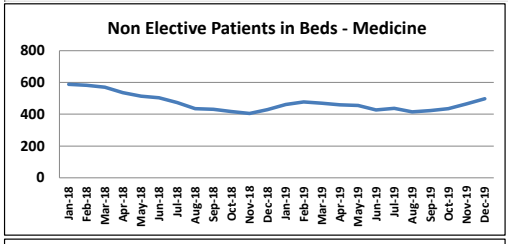
The possibility of prolonged surges particularly with Flu and Noro Virus
Capacity to process surges and unexpected activity as well as the vulnerabilities in the workforce (such as high sickness and morale) are risks to delivery. This is mitigated by the implementation of robust workforce plans.
Ability of UHNM to drive timely simple discharges through improved planning - Availability of system capacity to support more complex discharges. EMI/Specialist mental health, out of county repats.
MFFD clearance to time is not sustained in the South. LHE asked for assurance around investments to support delivery to avoid breach of DTOC KPIS.

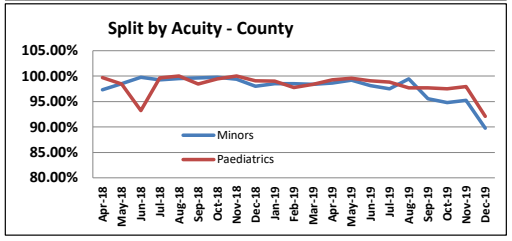


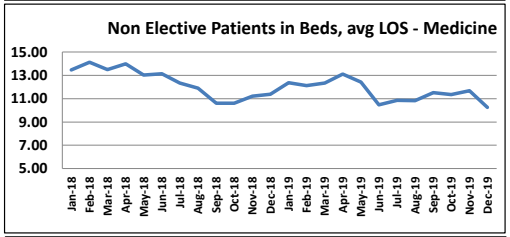


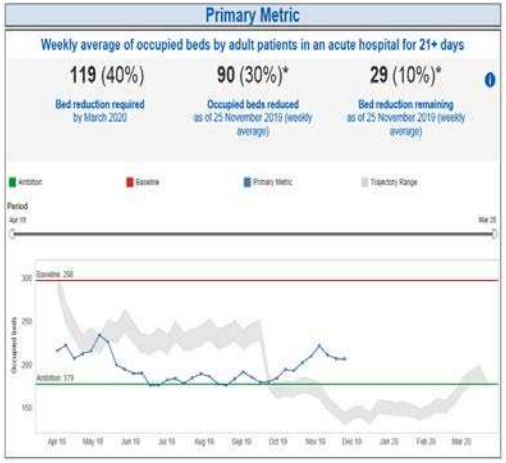


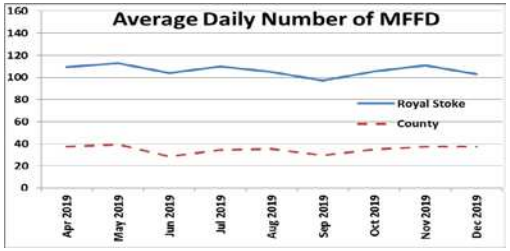


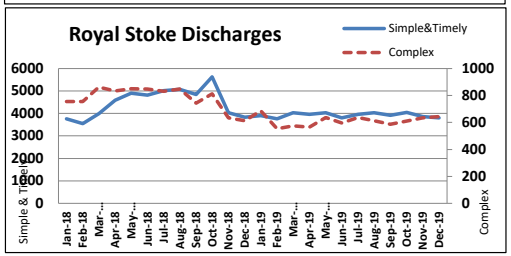








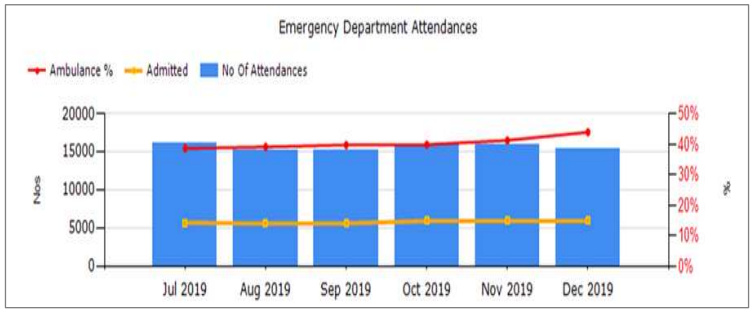


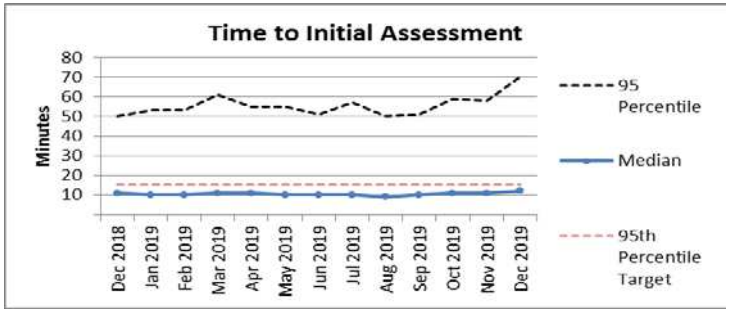


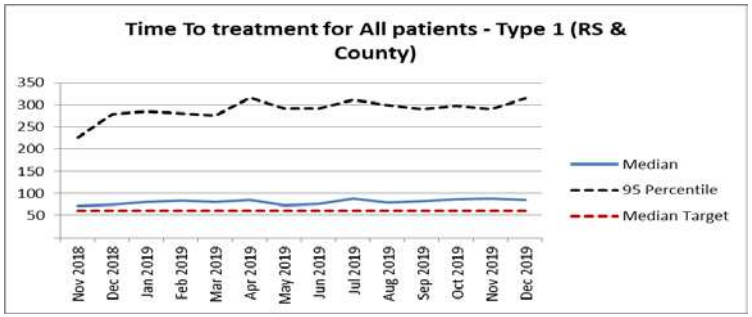
Summary
Operational A&E performance was 73.34% against the national standard (95% of patients seen and treated / transferred in A&E within 4-hours).
In Medicine, the number of non-elective patients in beds in Medicine continued the rise which began in November and reached an average of 498 per day, the highest number since May 2018 (after the severe Winter). The total number of occupied beds in Medicine at midnight, shown in the graph above, indicates a rise above that seen in 2017/18, by 12 patients.

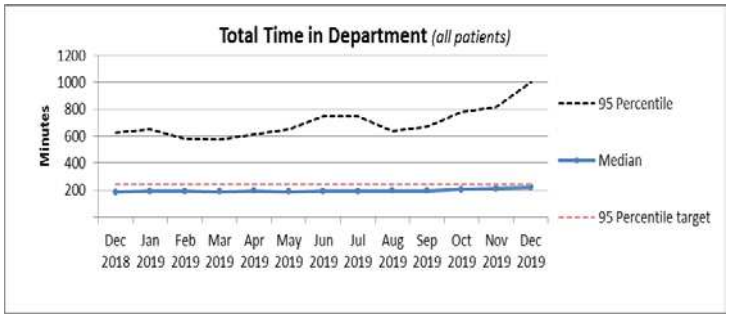
The average number of stranded patients (7+ days) per week also saw an increase in December further indicating a longer length of stay for patients admitted in December.

The number of simple & timely and complex discharges, at Royal Stoke, have remained fairly static for the past year. The number of MFFD patients fell in December by an average of 8 patients.









Summary

Initial Assessment

The initial assessment is when a patient is assessed by an emergency care doctor or nurse to allow them to determine a priority for treatment (sometimes called triage). The assessment would normally include a brief history of the patient's condition, pain score and vital signs (blood pressure, temperature, pulse).

The median Time to initial Assessment for Type 1 attendances was 12 minutes (November 10 mins) and the average for the year was 10 minutes against the standard of 15 minutes. The 95th percentile was minutes versus the 64 minutes in December (with an average of 55 over the year).

Target: A 95th Percentile time to assessment at or below 15 minutes

Treatment time

The treatment time is the time when a patient is seen by a doctor who can diagnose the problem, decide the management plan for the patient and arrange or start treatment if required.

Time to treatment (95th percentile) increased again in December to 314 minutes (up 225mins from November 19 and up 35 compared to the same period last year). The average for the year was 296 minutes.

Target: A median wait at or below 60 minutes

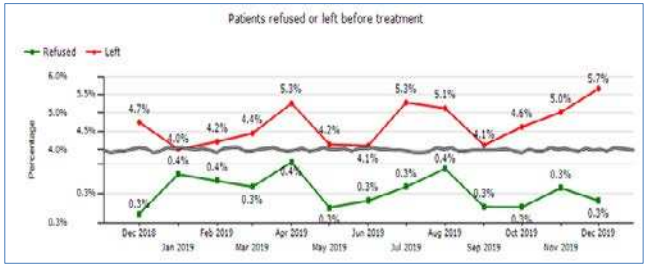
Total time in department

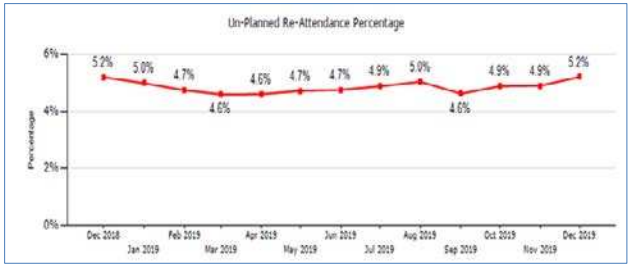
The time a patient spends in the A&E department under the care of hospital staff.

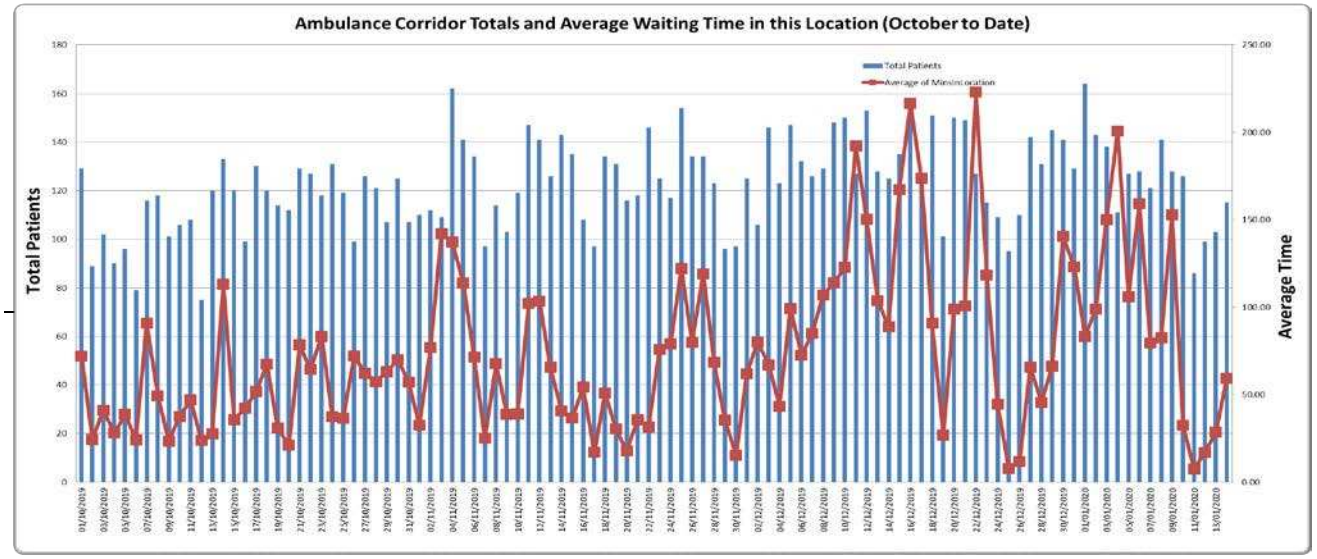
In December. the 95th percentile rose to 910 minutes (November 750 mins and up from 283 in Dec-18).

Target: A 95th percentile wait at and below 4 hours.

This is based on a total number of attendances for Royal Stoke & County, Type 1 of 15,431.







Summary

Left without being seen

A patient who leaves without being seen is one who registered with the receptionist in the ED but then left the department before they saw a doctor.
Patients leaving before being seen for Type 1 attendances (Royal Stoke and County) was 5.7% (left) and 0.3% refused.
Target: A rate at or below 5%.

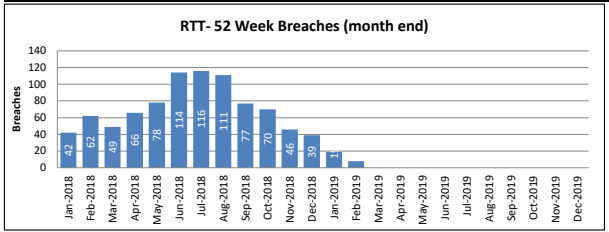
Unplanned re-attendance

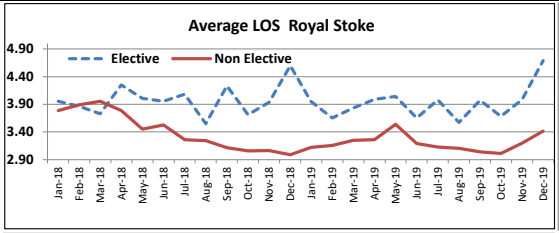
An unplanned re-attendance is where a patient returns to an ED within 7 days of a previous ED attendance. This may be for the same condition or a different one.
For Type 1 (Royal Stoke and County), Re-attendances in December are at 5.2% - just above the threshold of 5%.
Target: A rate at or below 5%.

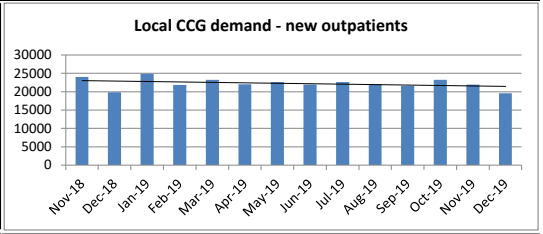
Ambulance Corridor

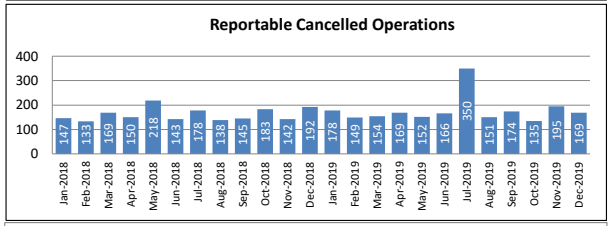
Ambulance corridor occupancy continued to rise in November with the average number of minutes waited also increasing (numbers increased from 3455 patients in November to 3638 in December.

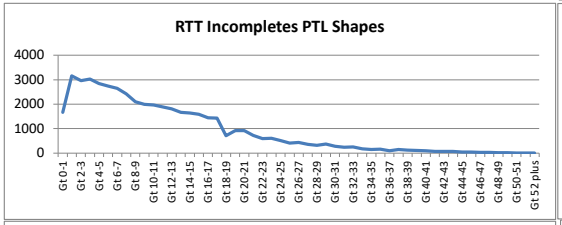
OP34: RTT Incompletes- Key Drivers

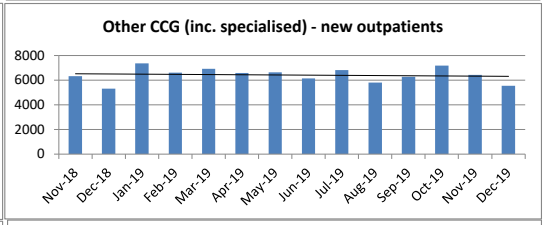


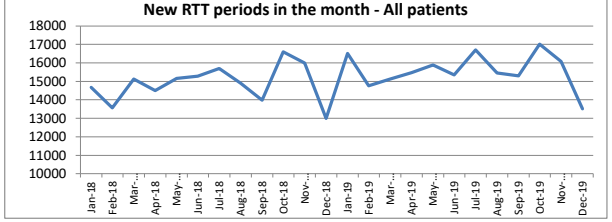


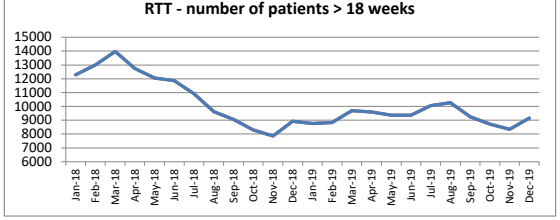


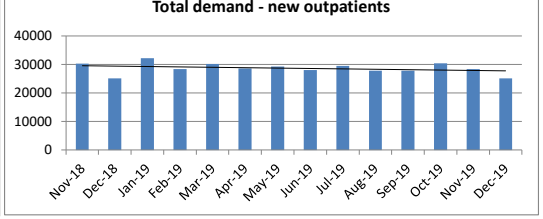












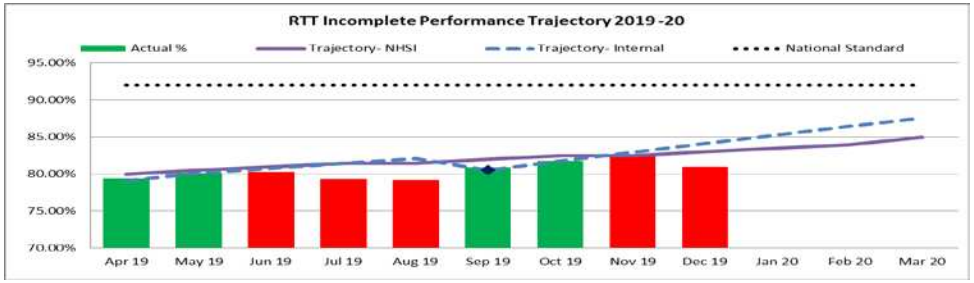
Summary
The graphs above present the key drivers for the Trust RTT performance against the national standard The NHS Single Oversight Framework requires Trusts to maintain the current waiting list as a measure of operational performance, however failure to deliver this is used as a trigger in relation to NHSI considering appropriate levels of support for providers. The performance for December 2019 is 81.0%, which is below the internal target of 84.16% and the NHSi target of 83.0%. The Trust reported zero 52 week waits again for December.

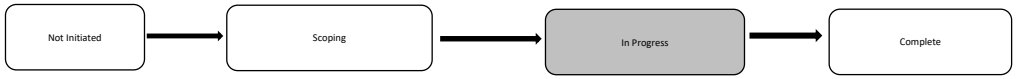
The number RTT incomplete pathways are tracked against the waiting list size required to deliver 92% and 85%. Currently the waiting list size is 48,140 which is an increase on the numbers reported in November (48, 047) This is above the internal target of 46,803.

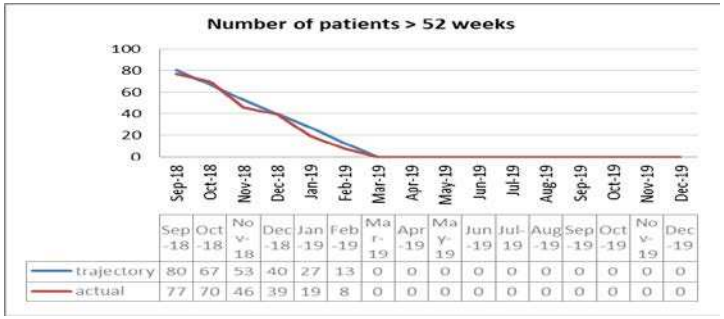
Key issues for December include patient initiated delays and some elective cancellations (on the day). 45 operations cancelled on the day due to other emergencies - key areas T&O, Cardiology/ Cardiothoracic, 59 cancelled due to insufficient beds/ ITU - Cardiothoracic/ Thoracic, Paediatrics respiratory, Gynaecology and Ophthalmology. 37 cancelled due to overun theatre time - vascular & ENT. This resulted in a reduced number of clock stops particularly for the admitted pathways more notable in Surgery but also in T&O. This, in addition to the on-going issues related to specific specialties (the prioritisation of cancer patients in Colorectal and Urology; sickness affecting validation of pathways) has resulted in an increase in the number of RTT pathways and the numbers over 18 weeks.
Theatre touch time Utilisation in December was 79.9% (the same as November) but an improvement of 0.4% on December of the previous year

The Trust saw a reduction in the number of reportable cancelled operations on the day to 169 (November 195).
The remaining top 4 reasons for cancellations:
1. No Consultant available
2. Consultant - Cancelled for an emergency - this increased
3. No Suitable Beds Available
4. No theatre time available

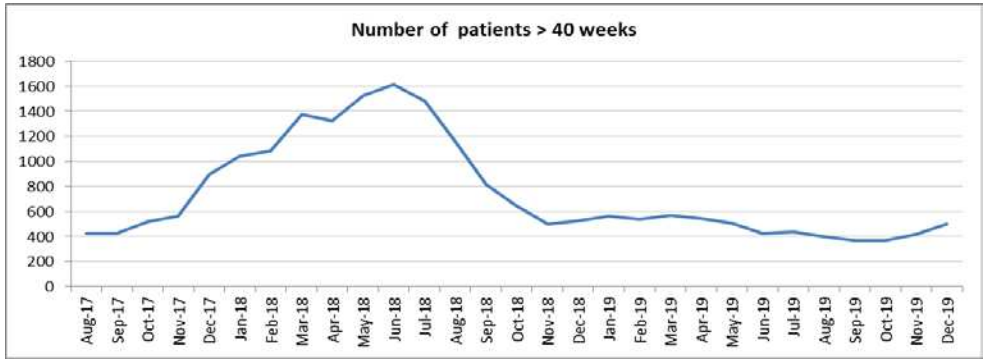
DEMAND: The three demand graphs represent - Total demand and demand split by local CCG's and other CCG's (which includes specialised commissioning). Overall demand is decreasing.
For Total demand - there has been an 0.2% fall compared to the same time last year (December 18).
For local demand there was a decrease of 1.4%.

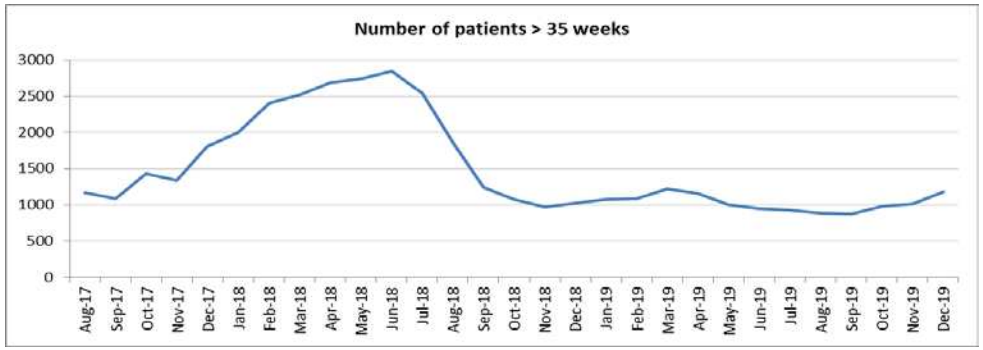


Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Delivery of the standard RTT performance is 81.00% against an Internal trajectory of 84.16% and a NHSi trajectory of 83.0%. The number of incomplete pathways are tracked against the waiting list size required to deliver 92% and 85%. Currently the waiting list size is 48,140 (November 48,047) which is an increase of 93 on November. The internal target is 46,803 and the NHSi target of 44,203. End of year target is 45,103. Key issues for December include patient initiated delays and some elective cancellations due to emergencies (T&O had 10 cancelled operations due to emergencies against the average of 3 and some elective lists were cancelled due to ED pressures). This resulted in a reduced number of clock stops particularly for the admitted pathways more notable in Surgery but also in T&O. This, in addition to the on-going issues related to specific specialties (the prioritisation of cancer patients in Colorectal and Urology; sickness affecting validation of pathways) has resulted in an increase in the number of RTT pathways and the numbers over 18 weeks. Theatre touch time Utilisation in December was 79.9% (the same as November) but an improvement of 0.4% on December of the previous year. **Positive Assurance:** December has proved a challenging month with the pressures from the non-elective attendances, admissions. and cancelled operations. However some specialties were able to maintain or improve on their RTT performance. Ophthalmology have maintained their performance against trajectory, up 5% since Mar-19 Upper GI Surgery: Whilst the trajectory was not met the specialty improved on November's performance and remains the highest it has been since March 19. UGI have improved performance by 4.2% since March 19. The same applies to Vascular Surgery who have improved by 3.1% since March-19. Plastics have maintained performance against trajectory and Dermatology are consistently achieving 98% – 99% Paediatrics are all at trajectory apart from Cardiology, however they are improving performance month on month even though they have seen a rise in the number of RTT pathways. No patient is waiting over 40 weeks. **Risks to Delivery and Mitigation** Capacity gap due reduction of TI sessions. Review by Date - PTL impact evaluation. Pressures in Emergency department and increase in surgical non elective demand December/January – adverse impact on elective operations due to extended NCEPOD lists.	Enhanced governance grip through a revised Accountability Framework; Weekly Divisional Access meetings. Weekly COO led Divisional check and challenge performance meetings with ADs. The Trust is working to improve the position of the long waiters currently on the PTL by conducting targeted validation within our most challenged specialties.40 week plans have been developed and the required capacity to improve the position is being sourced. Improvements are also being made to operational grip and performance assurance processes in this area. RTT Recovery Plans are currently been populated by the operational teams this to be monitored via the COO led Access & performance meetings. Working with CCG to manage demand ,external providers assisting in activity clearance (SHS),incentivised internal lists ,increase in length of theatre lists	A
	Next Steps: Divisional performance improvement trajectories reset to end of March to ensure 52 ww compliance and tracking of RTT standard. Weekly monitoring 40/52 wk position with expedited escalation and mapping of specialty service changes (Bariatrics/general surgery/gynae) Tactical Validation oversight of Incomplete Waiting List to keep focus on attainment of trajectory at month end Risk Stratification of the follow ups waiting list Validation Rules for the identified follow up cohorts Support development of the SOPs in relation to the follow up backlog.	A
		



	Sep -18	Oct -18	Nov -18	Dec -18	Jan -19	Feb -19	Mar -19	Apr -19	May -19	Jun -19	Jul -19	Aug -19	Sep -19	Oct -19	Nov -19	Dec -19
trajectory	80	67	53	40	27	13	0	0	0	0	0	0	0	0	0	0
actual	77	70	46	39	19	8	0	0	0	0	0	0	0	0	0	0

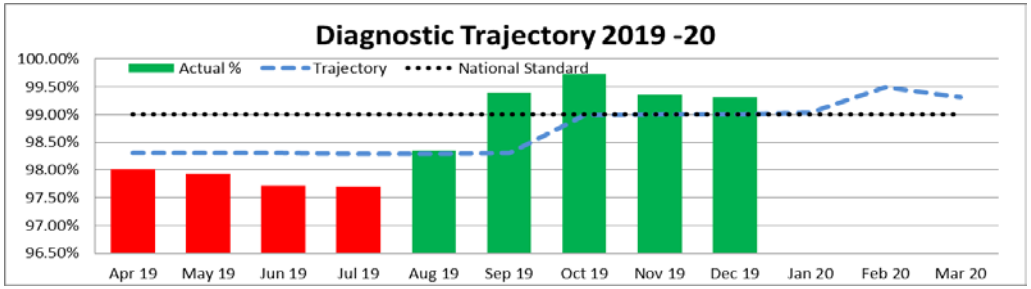




Over 40 week patients

Treatment Function	Total
100 General Surgery	11
101 Urology	64
104 Colorectal	56
106 Upper Gastrointestinal Surgery	43
107 Vascular Surgery	6
108 SPINAL Surgery	39
110 Trauma & Orthopaedics	12
120 ENT	8
130 Ophthalmology	2
140 Oral Surgery	1
143 Orthodontics	0
144 Maxillo-Facial	10
160 Plastics	3
301 Gastroenterology	46
320 Cardiology	7
340 Respiratory Medicine	147
400 Neurology	19
502 Gynaecology	8
other	19
Grand total	501

The number of patients waiting over 35 weeks and 40 weeks are monitored and reported weekly. Following a significant reduction in both the > 40 weeks and > 35 weeks the number of patients > 40 weeks from June-Dec 2018, there has been a levelling out as a result of the capacity constraints. December has seen a rise due to the challenges outlined in teh RTT performance.
The over 40 weeks and over 35 weeks trajectory will be monitored through the new Performance and Governance meetings.



Diagnostic Trajectory 2019 -20												
	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Trajectory	98.30%	98.30%	98.30%	98.30%	98.30%	98.30%	99.00%	99.00%	99.00%	99.03%	99.50%	99.31%
National Standard	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
Actual %	98.01%	97.93%	97.72%	97.70%	98.35%	99.39%	99.73%	99.36%	99.31%			

Imaging	Magnetic Resonance Imaging	
	Computed Tomography	
	Non-obstetric ultrasound	
	Barium Enema	
	DEXA Scan	
Physiological Measurement	Audiology - Audiology Assessments	1
	Cardiology - echocardiography	7
	Cardiology - electrophysiology	
	Neurophysiology - peripheral neurophysiology	
	Respiratory physiology - sleep studies	20
	Urodynamics - pressures & flows	
Endoscopy	Colonoscopy	24
	Flexi sigmoidoscopy	18
	Cystoscopy	13
	Gastroscopy	9
	Total	92

Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Delivery of the standard: The standard achieved 99.31% (as at 09/01/20) The number of breaches > 6 weeks breaches has increased slightly to 92 in December (Apr 253, May 242, June 260, July 262, Aug 172, Sept 45, October 39, Nov 90) **Positive Assurance:** The national standard continued to be delivered. There has been a marked improvement in performance with realisation against actions put in place in the Respiratory sleep service and Cardiac MRIs. **Risks to Delivery and Mitigation:** Resource issues that may affect delivery of sleep studies – capacity/ resources diverted to deliver RTT	**Next Steps:** Continue to monitor actuals in Respiratory sleep and cardiac MRI against. Review of Cystoscopy breaches (Urology).	G

Progress

Not Initiated → Scoping → In Progress

OUTPATIENTS

All graphs/information derived from the OP Session Slot Utilisation DNA and Hosp Cancellations Report, and OP Appts Hospital / Patient Cancellation Grid (08/12/19), for clinics flagged as 'yield'.

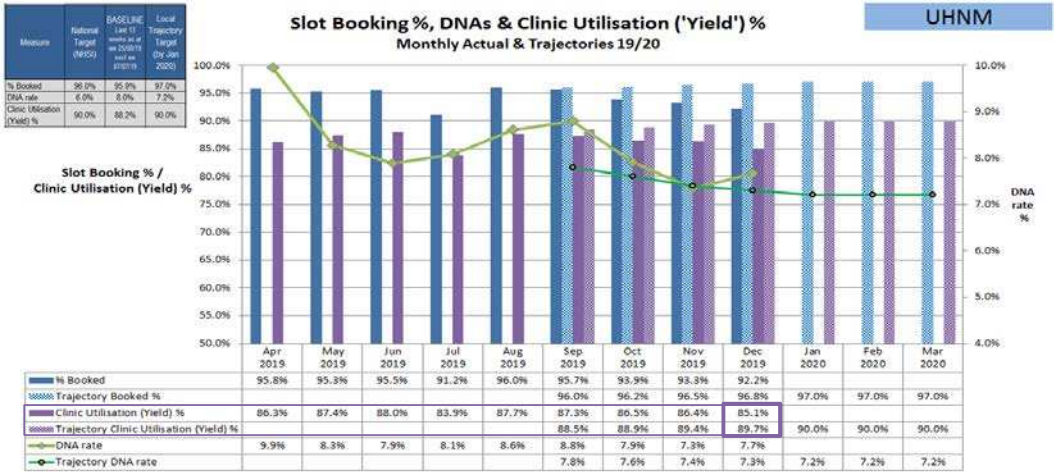
KPI Descriptions:

- Clinic Utilisation ('Yield') = Slot booking % x (1-DNA rate)
- Slot Booking % = Patients Booked Total / Capacity Total
- DNA (Did not attend) = Patients who didn't attend / Total Booked
- Hospital initiated Cancellations (HICs) <6 weeks = Booked appointments cancelled by the trust less than 6 weeks before the appointment date / Total hospital initiated Cancellations.

KPI Targets: January 2020

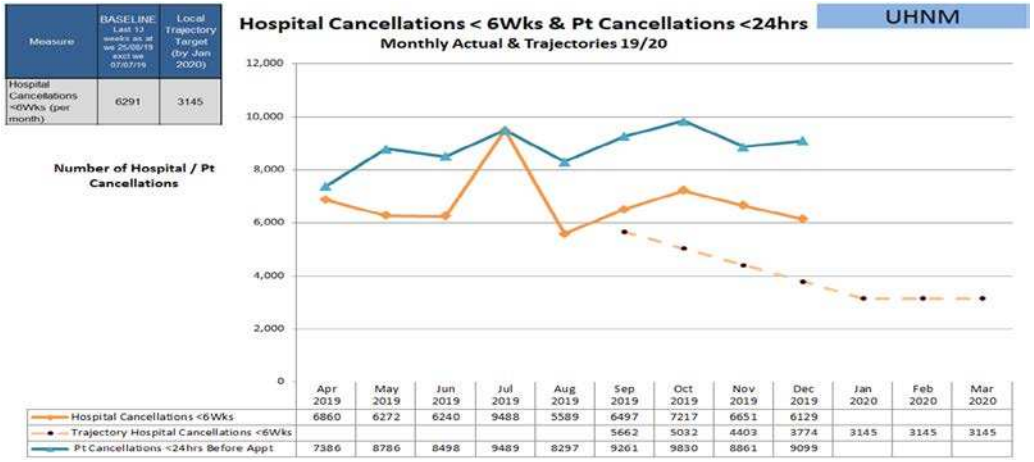
- Clinic Utilisation ('Yield') = 90% (Trajectory Dec 89.7%)
- Slot Booking % = 97% (Trajectory Dec 96.8%)
- DNA (Did not attend) = 7.2% (Trajectory Dec 7.3%)
- HICs < 6 Weeks = Half baseline of 6291 per month: 3145 (Trajectory Dec 3774)

Measure	National Target (NHSI)	BASELINE Last 13 weeks as at we 25/08/19 excl we 07/07/19	Local Trajectory Target (by Jan 2020)
% Booked	98.0%	95.9%	97.0%
DNA rate	6.0%	8.0%	7.2%
Clinic Utilisation (Yield) %	90.0%	88.2%	90.0%



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
% Booked	95.8%	95.3%	95.5%	91.2%	96.0%	95.7%	93.9%	93.3%	92.2%			
Trajectory Booked %						96.0%	96.2%	96.5%	96.8%	97.0%	97.0%	97.0%
Clinic Utilisation (Yield) %	86.3%	87.4%	88.0%	83.9%	87.7%	87.3%	86.5%	86.4%	85.1%			
Trajectory Clinic Utilisation (Yield) %						88.5%	88.9%	89.4%	89.7%	90.0%	90.0%	90.0%
DNA rate	9.9%	8.3%	7.9%	8.1%	8.6%	8.8%	7.9%	7.3%	7.7%			
Trajectory DNA rate						7.8%	7.6%	7.4%	7.3%	7.2%	7.2%	7.2%

Measure	BASELINE Last 13 weeks as at we 25/08/19 excl we 07/07/19	Local Trajectory Target (by Jan 2020)
Hospital Cancellations <6Wks (per month)	6291	3145



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Hospital Cancellations <6Wks	6860	6272	6240	9488	5589	6497	7217	6651	6129			
Trajectory Hospital Cancellations <6Wks						5662	5032	4403	3774	3145	3145	3145
Pt Cancellations <24hrs Before Appt	7386	8786	8498	9489	8297	9261	9830	8861	9099			

Clinic Utilisation % (Key composite target) 90% by January 2020. **85.1%** vs trajectory of **89.7%** trajectory

Booking % (92.2% vs target 96.8%) – % bookings have continue to reduce; fortnightly specialty meetings include the identification of outlier clinics (prospectively & retrospectively). Specific Specialties requiring urgent intervention have been identified. A number of Outpatient-focussed meetings including most specialty level meetings were cancelled during December due to site pressures.

DNA% (7.7% vs target 7.3%) – Whilst the DNA rate has increased compared to last month and is slightly above trajectory, it has remained lower than all other previous months this financial year. From discussions with BI, the Netcall load is no longer dependent on the timing of the data warehouse load so this risk has now been successfully mitigated (whilst reminders may be not be based on the most recent changes if a load is delayed). Divisions are being challenged to identify specialty-specific actions to improve on their performance, and a rollout plan for movement to partial booking is being confirmed. SOP for clinicians for viewing DNAs in iPortal has been shared in clinics to help apply DNA policies, with a supporting letter sent via Deputy Medical Director.

Hospital cancellations (6129 vs target 3774) – Reasons for cancellations now being provided; further clarification sought; there are over 40 drop down options. Reduction from previous month but still significantly above trajectory target. Divisions have committed to tighten up on the CAF process, and Division-specific measure have been introduced. Specialised Division have implemented a weekly confirm and challenge for hospital cancellations, whilst gynaecology are undergoing a detailed analysis to identify contributing factors and will share outcomes with view to adopting a similar approach in other specialties. CAF analysis of reasons to be shared with Divisions. Electronic CAF to be progressed.

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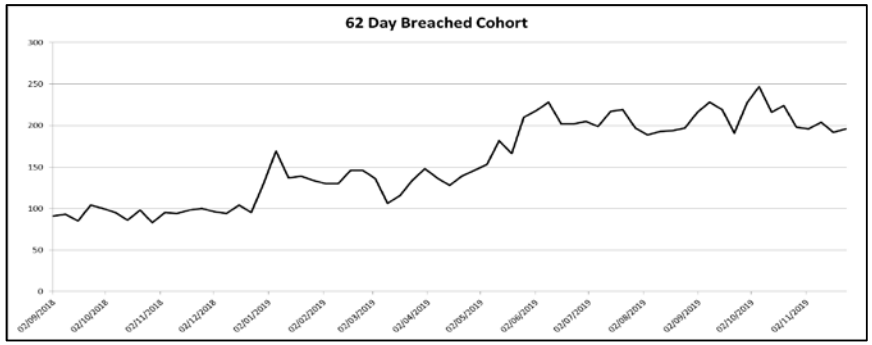
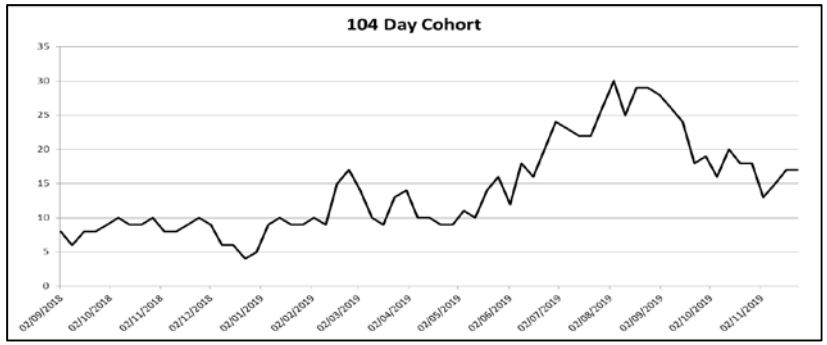
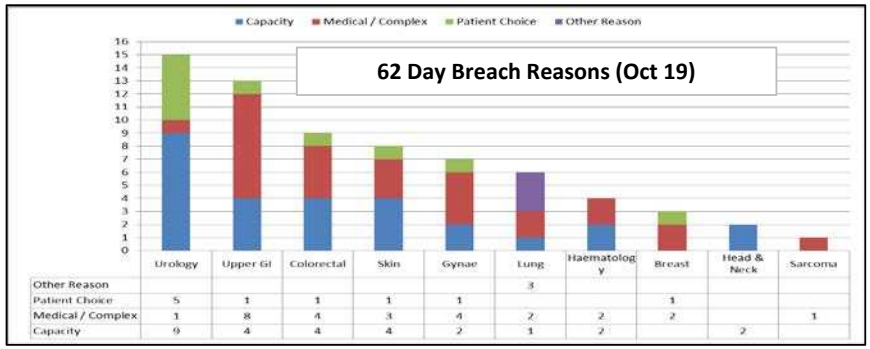
OP KPIs Summary Update

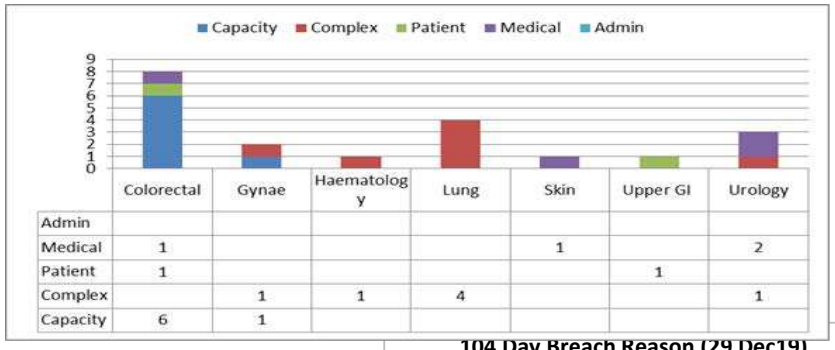
			Dec 2019			
Level	KPI	Jan 2020 Target	Trajectory Target	Current Performance	RAG	vs last month
UHNM	Clinic Utilisation %	90.0%	89.7%	85.1%	A	-1.3%
	Bookings %	97.0%	96.8%	92.2%	R	-1.1%
	DNAs %	7.2%	7.3%	7.7%	A	0.4%
	Hospital Cancellations	3145	3774	6129	R	-522
CWD	Clinic Utilisation %	90.0%	89.7%	84.9%	A	-1.0%
	Bookings %	96.3%	96.1%	91.2%	R	-1.4%
	DNAs %	6.6%	6.7%	6.9%	A	-0.3%
	Hospital Cancellations	579	695	1178	R	10
Medical	Clinic Utilisation %	85.9%	84.9%	80.9%	A	1.4%
	Bookings %	96.0%	95.1%	90.8%	R	1.6%
	DNAs %	10.5%	10.7%	11.0%	A	0.1%
	Hospital Cancellations	329	395	594	A	-96
Specialised	Clinic Utilisation %	89.1%	88.8%	84.3%	A	-0.8%
	Bookings %	96.5%	96.3%	91.6%	R	-0.2%
	DNAs %	7.7%	7.8%	8.0%	A	0.7%
	Hospital Cancellations	762	914	1413	R	-85
Surgical	Clinic Utilisation %	92.3%	92.1%	86.6%	R	-2.4%
	Bookings %	98.7%	98.6%	93.2%	R	-2.2%
	DNAs %	6.5%	6.6%	7.1%	A	0.4%
	Hospital Cancellations	1476	1771	2944	R	-351

R7: Cancer 62 Days- Key Drivers

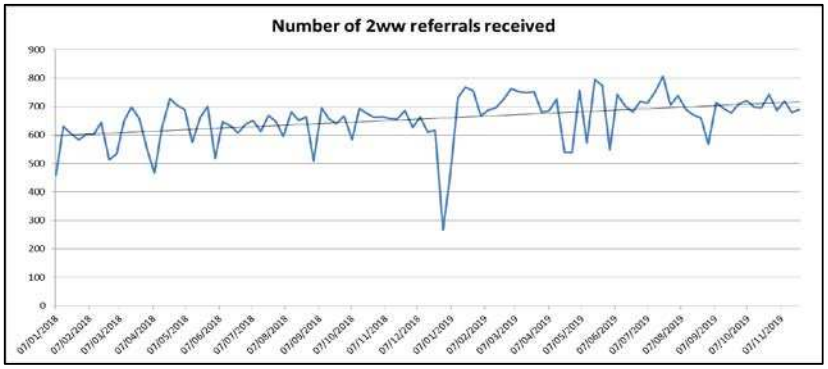








104 Day Breach Reason (29 Dec19)



The graphs above present the key drivers for the Trust 62 day Cancer performance against the national standard (85% of patients treated within 62 days from referral). The NHS Single Oversight Framework requires Trust's to achieve the national 85% standard as a measure of operational performance, however failure to deliver the this is used as a trigger in relation to NHSI considering appropriate levels of support for providers. The provisional Trust level performance for 62 day Urgent GP referrals in December is 69.82% (as at 20.01.20).
Due to the increase in colorectal GP 2ww referrals the Trust has not achieved the 2ww standard in December (77.67% as at 20.01.20), as predicted.
104 Day improvement actions in place since September 2019. Plan is for the directorate teams to closely monitor this cohort of patients and to reduce capacity delays down to minimum so we can baseline the expected number of pt. choice/complex tertiary pathway delays we would expect given our cancer centre status and volumes of referrals for discussion with NHSE/I. A Cancer Recovery Plan has been drafted that supports short, medium and long term improvement actions with weekly monitoring at Access & Performance.

R7: Cancer 62 Days of Urgent GP Referral

62 Day Standard (GP 2ww Referrals) — 85.0% National Standard (treated within 62 days)

University Hospitals of North Midlands NHS

Provisional Data *Last Updated 20/01/2020*

Dec-19

Confirmed Diagnosis:		Actual Patients			Accountable Patients			
Cancer Site	Location	<62 days	>62 days	Total	<62 days	>62 days	Total	%<62
Brain/CNS (Specialised)	UHNM Combined	0	1	1	0.0	1.0	1.0	0.00%
Breast (Surgery)	UHNM Combined	19	4	23	19.0	3.5	22.5	84.44%
Breast Symptom (Surgery)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Colorectal (Surgery)	UHNM Combined	3	2	5	3.0	2.0	5.0	60.00%
Gynae (CSS/W&C)	UHNM Combined	13	6	19	12.5	6.0	18.5	67.57%
Haematology (Medicine)	UHNM Combined	5	3	8	5.0	3.0	8.0	62.50%
Head & Neck (Surgery)	UHNM Combined	3	3	6	3.0	3.0	6.0	50.00%
Lung (Medicine)	UHNM Combined	5	5	10	4.0	4.0	8.0	50.00%
Other	UHNM Combined	1	0	1	1.0	0.0	1.0	100.00%
Paediatrics (CSS/W&C)	UHNM Combined	0	0	0	0.0	0.0	0.0	
Sarcoma (Specialised)	UHNM Combined	0	1	1	0.0	0.5	0.5	0.00%
Skin (Surgery)	UHNM Combined	26	8	34	26.0	8.0	34.0	76.47%
Upper GI (Medicine)	UHNM Combined	4	5	9	4.0	4.5	8.5	47.06%
Urology (Surgery)	UHNM Combined	37	15	52	37.0	14.0	51.0	72.55%
Trust Exc Breast Symptom	UHNM Combined	116	53	169	114.5	49.5	164.0	69.82%
Trust Inc Breast Symptom	UHNM Combined	116	53	169	114.5	49.5	164.0	69.82%

	Nov-19	Dec-19	Dec-19 Trajectory NHSi	Dec-19 Trajectory Internal	Standard
Two week wait	79.14%	77.67%	95.61%		93%
2ww Breast symptomatic	95.52%	89.36%	97.30%		93%
31 Day First Treatment	94.15%	94.70%	97.39%		96%
31 Day Subsequent Surgery	85.48%	83.93%	94.92%		94%
31 Day Subsequent Anti-Cancer	100.00%	94.74%	100.00%		98%
31 Day Subsequent Radiotherapy	92.25%	87.80%	98.18%		94%
62 Day (2ww) First Treatment	67.29%	69.82%	85.24%	74.60%	85%
62 Day Screening First Treatment	88.89%	80.00%	92.00%		90%
28 Day FDS	60.31%	58.01%	Shadow Reporting / Standard Not Yet Set		

Data last updated 20/01/20. October 2019 cancer performance is still provisional until fuinal position reported 06/02/20

Root cause analysis/ Key lines of enquiry

Positive Assurance:
- Since implementation of the 12 week plan, December has seen an improvement in 62 day performance 67.11% - 69.82%.
- In order to prioritise cancer patients a second robot was purchased and is installed. The newly recruited Consultant Urologist due to commence early February is qualified to use robotic equipment and additional surgical sessions will be allocated in February 2020.
- Cancer transformation work with support from WMCA will commence week commenced 13.01.20 priorities will be Colorectal, Urology and 28D
- Check and challenge of cancer performance and improvement plans will be discussed in the weekly assurance meeting with the COO.
- Clinical teams have been requested to validate the current backlog on a weekly basis to support and sustain performance.
- A Colorectal Triage to Test Pilot commenced on 09 December, 89 patients were successfully triaged directly to diagnostic tests. Based on this two additional rapid triage sessions are planned with dates to be confirmed as part of the internal improvement actions for the GI service.

Delivery of the 2ww and 62 day standards:
A 12 week plan developed in October 19 predicted an upward trend in performance from end of December with a tactical plan to pull forward breached treatments into November and is the reason for the deterioration. The un-validated position for December is showing improvements for specialties against the range of cancer modalities; except Colorectal and Urology.

To date, the Cancer 62 day performance is 69.82% against an internal trajectory of 74.6%. Key issues:
To maintain focus on performance the recovery plan is currently being strengthened and the weekly cancer performance cycle has now been reconfigured to include a forecast and feedback meeting with Divisional Associate Directors to ensure Senior Level involvement and ownership of the plan is maintained.
The main areas that underperformed against trajectory was Gynaecology; Skin and Colorectal.

Skin: 2WW achieved consistently, cancelled operations in November have seen patients tip over to December and the reduced treatment numbers have further compound performance. One whole theatre list cancelled for more urgent case (8 patients). **Actions to recover:** Scoping additional capacity to treat those patients tipped over to December; Deliottes engaged to support design of 'one stop shop' pathway; trial in place for two clinics per week; • Engaging CCG to discuss Teledermatology pathway to improve referral quality / redirect to non cancer pathway (circa 2000 patients attended 2ww last year and were discharged – no further treatment).
Gynaecology: One key issue is late referrals from other providers, other issues include delays in histology reporting, complex pathways (inoperable conditions; multiple diagnostics required). **Actions:** Inter specialty partnership working to facilitate earlier handover of patients, pilot for one stop clinic to commence the beginning of December, dedicated gynaecology oncologist surgery specific, conversion of outpatients slots to 2ww to shorten 2ww time to 1-7 days, improved processes to identify gynae histology requests (blue labels now in use).
Colorectal: The key issue is the continuing increase in 2ww demand following changes to NICE guidelines. November saw an average of some 165 weekly referrals, compared to 135 at the same point last year. As a direct result waits for the 2ww are at circa 3 weeks delaying the entire pathway. The increased demand also challenges earlier diagnostics (Colonoscopy, CT). **Actions:** Revised pathway in discussion to introduce Triage to Test, to identify the cancers earlier; revise the pathway for those patients with Non-cancer; introduction of FIT testing. Pathways are agreed in principle with more work required regarding administrative processes.
Total cancer 62 day treatments for November '19 to date are 162. However, there are an additional 77 treatments (45 skin) with no confirmed diagnosis many of which are waiting histology results, this may yield more treatments and improve the month end.

External Pressures / Increased Referral Rates
- UHNM receives 63.1% of all Staffordshire and S-O-T 2ww referrals. This has increased from 60.7% in the last 3 years. More cancer activity is referred to UHNM as a proportion, than other planned care activity and this percentage is growing, confirmed by NSHE.

- UHNM receives 68.8% of all Staffordshire and S-O-T lower GI 2ww referrals.

- Lower GI activity from Staffordshire and S-O-T CCGs to UHNM has grown 48% in the last 3 years (growth from SOT CCG is less [42%])

- Lower GI activity from NS CCGs to UHNM has grown 54 % in the last 3 years. If we disregard East Cheshire reductions this equates to 48% growth to UHNM not offset by reductions elsewhere so the East Cheshire reduction does explain some of why NS growth is higher. It doesn't fully explain the differences in growth between NS and SOT.

- Of further concern for Lower GI is the conversion rate to a diagnosis which has fallen over the past four years against the increased demand. In 15/16 the demand was 4538 with a conversion rate of 4.4% whereas in 18/19 the demand was 6731 (48% increase) with aconversion rate of 2.9%. This is a targeted area for improvements.

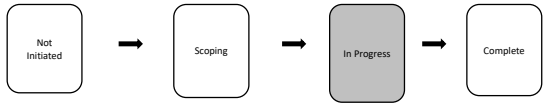
Action Plan

Next Steps:
- The Head of Cancer is currently working with the Divisions and key stakeholders in the development of a Trust Wide Five Year Cancer Strategy against the themes of the Cancer National Strategy and LTP
- The Head of Cancer is currently working with Divisions in the development of a Cancer Transformation, Improvement and Recovery Programme to be completed by month end.
- Development of a new cancer referral business card to be given to the patient in primary care at the point they are referred to our hospital. The card will advise reason for referral, importance of attending tests / appointments together with relevant contact details; and is designed to support an improvement in patient compliance with the cancer fast track.
- An AI pilot to support future workforce planning will commence in January 2020 to assist CT reporting scans for the lung screening project.

RAG

A

Progress



62 Day Standard (Screening Referrals) 90.0% National Standard (treated within 62 days)

University Hospitals of North Midlands NHS

Provisional Data *Last Updated 20/01/2020*

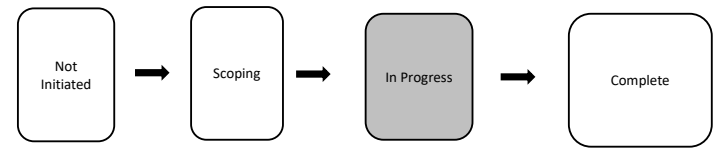
Confirmed Diagnosis:		Dec-19						
		Actual Patients			Accountable Patients			
Cancer Site	Location	<62 days	>62 days	Total	<62 days	>62 days	Total	%<62
Breast (Surgery)	UHNM Combined	19	3	22	19.0	3.0	22.0	86.36%
Colorectal (Surgery)	UHNM Combined	2	4	6	2.0	3.5	5.5	36.36%
Gynae (CSS\W&C)	UHNM Combined	1	0	1	1.0	0.0	1.0	100.00%
Trust	UHNM Combined	22	7	29	22.0	6.5	28.5	77.19%

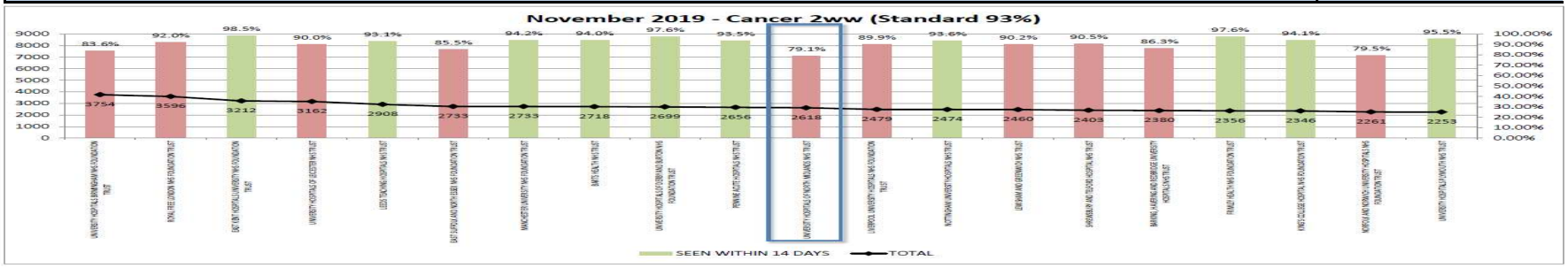
Cancer 62 Day screening			
Site	*Dec-18*	*Dec-19*	*Variance*
UHNM	92.0%	77.2%	-14.8%

Month	Within	Outside	Total	%
Apr-19	28.5	5	33.5	85.07%
May-19	13	5	18	72.22%
Jun-19	18	5.5	23.5	76.60%
Jul-19	26	5	31	83.87%
Aug-19	23	3.5	26.5	86.79%
Sep-19	24	2	26	92.31%
Oct-19	38	1.5	39.5	96.20%
Nov-19	16	2	18	88.89%
Dec-19	22	6.5	28.5	77.19%

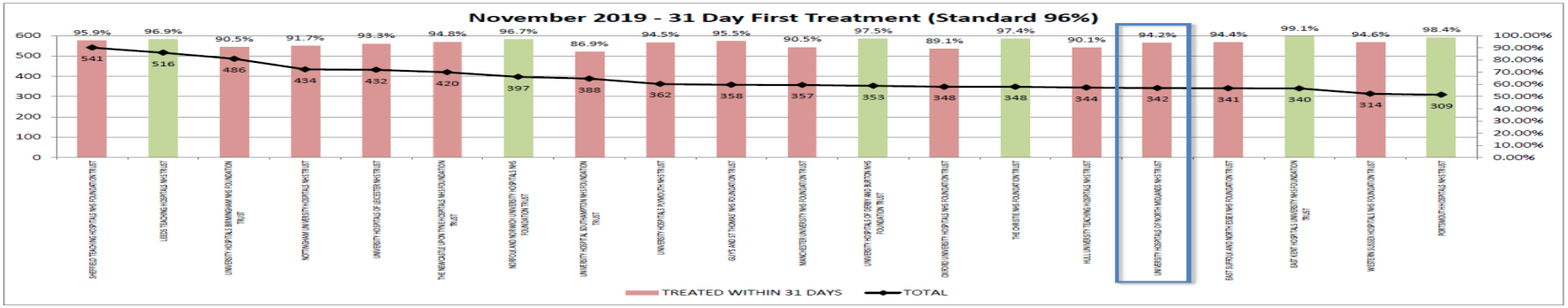
Root cause analysis/ Key lines of enquiry	Action Plan	RAG
The patients on the 62 day cancer screening pathway are patients referred from the national screening programme. The operational standard is 90%. The number of patients in this category are low and as a general rule any more than 1 or 2 breaches will result in under achievement of the standard. There were 6.5 breaches in December, 3 breast (1 patient, 2 LORIS trial change of plan) & 3.5 colorectal (0.5 tertiary to UHNM treated within 24 day target, 1 medical reason, 1 patient choice, 1 outpatient capacity), data remains provisional at the moment.	• Breast screening pathway representatives from screening and generally surgery attend cancer forecast meetings	G
	• The weekly cancer PTL meetings continue, each individual patient's pathway is discussed to identify updates and actions to mitigate delays in the pathway.	G

Progress

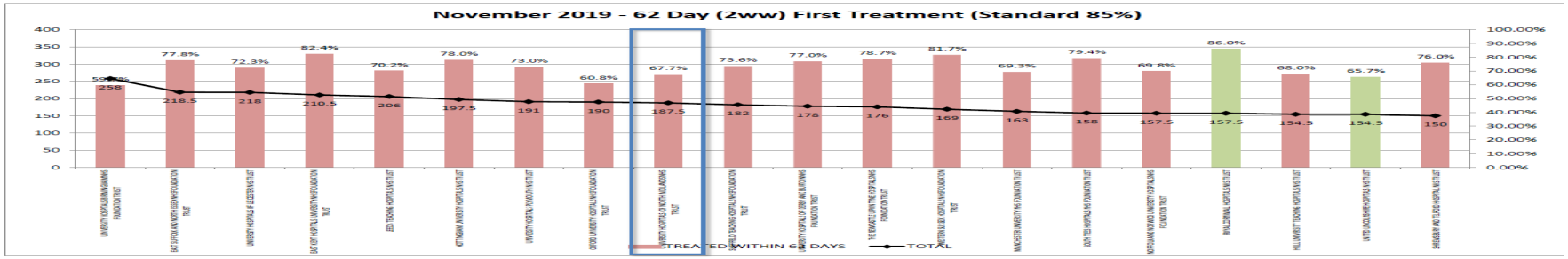




The 2ww comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts. UHNM is 20th in performance out of ALL the Trusts.



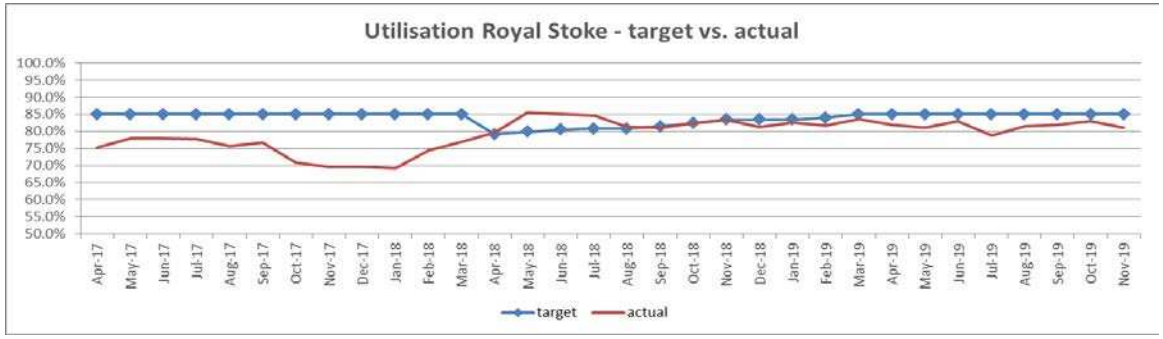
The 31 Day comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts. UHNM is 15th in performance out of ALL the Trusts.



The 62 Day comparison chart above, shows the TOP 20 Trusts out of all England NHS Trusts. UHNM is 17th out of ALL the Trusts, with only two other Trusts achieving the standard

Cancer - Regional data comparisons

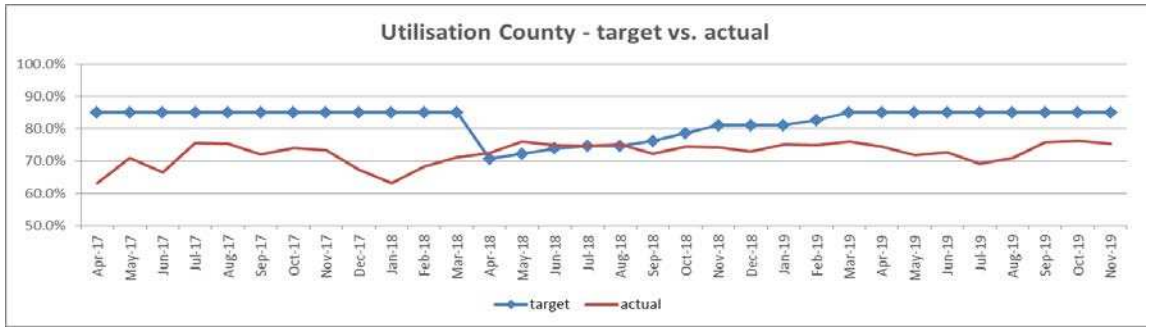
Compared to the Region, UHNM has the 3rd highest number of 2ww referrals and 8th best performing and 2nd highest number fo 62 day treatments and 6th best performing.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	75.2%	77.8%	77.9%	77.7%	75.7%	76.7%	70.9%	69.6%	69.5%	69.2%	74.5%	76.9%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
target	79.2%	79.9%	80.5%	80.8%	80.8%	81.5%	82.4%	83.4%	83.4%	83.4%	84.0%	85.0%
actual	79.7%	85.4%	85.0%	84.6%	81.4%	81.1%	82.3%	83.4%	81.3%	82.5%	81.6%	83.6%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	82.0%	81.1%	82.9%	78.8%	81.4%	81.9%	83.0%	81.1%				

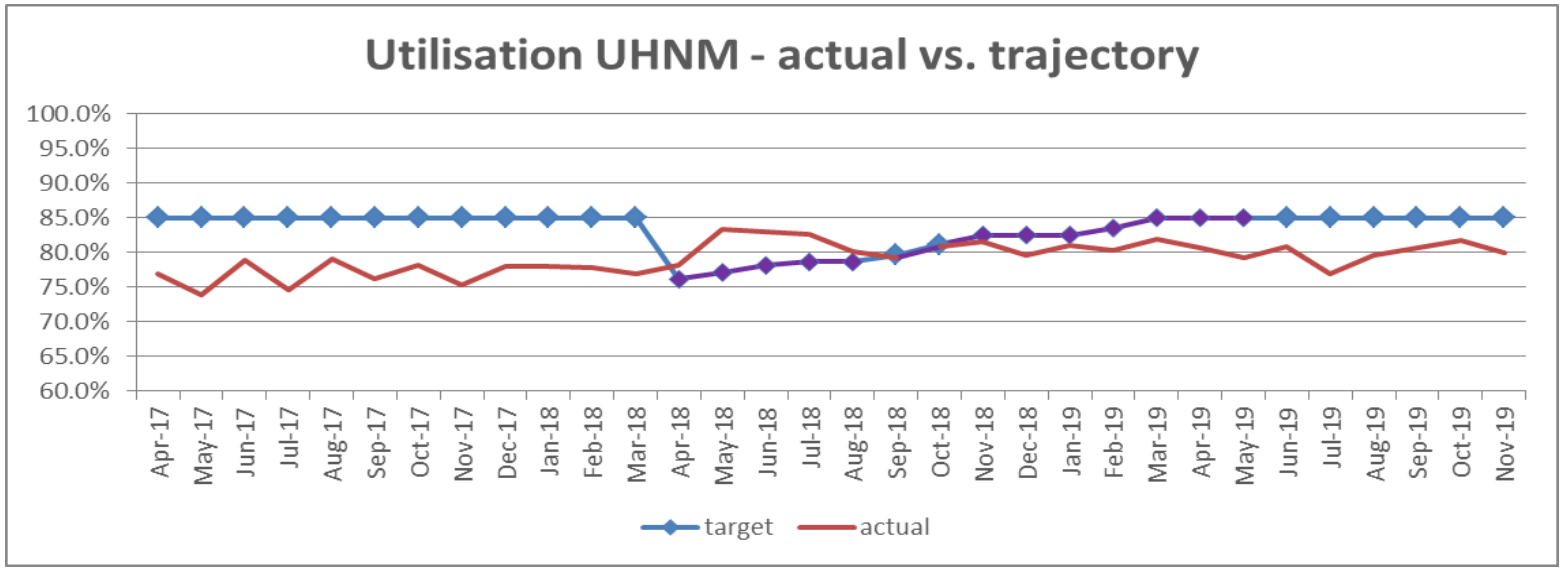


	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	63.1%	70.9%	66.5%	75.6%	75.3%	72.1%	73.9%	73.3%	67.3%	63.1%	68.2%	71.0%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
target	70.6%	72.2%	73.8%	74.6%	74.6%	76.2%	78.6%	81.0%	81.0%	81.0%	82.6%	85.0%
actual	72.4%	75.9%	75.0%	74.6%	75.1%	72.2%	74.5%	74.3%	72.9%	75.1%	74.9%	75.9%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	74.4%	71.7%	72.6%	69.1%	70.9%	75.8%	76.2%	75.3%				

Theatre Utilisation



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	76.9%	73.8%	78.8%	74.6%	79.1%	76.2%	78.2%	75.2%	77.9%	77.9%	77.7%	76.8%

trajectory	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
actual	76.1%	77.1%	78.1%	78.6%	78.6%	79.6%	81.1%	82.5%	82.5%	82.5%	83.5%	85.0%
	78.2%	83.3%	83.0%	82.6%	80.2%	79.2%	80.8%	81.6%	79.5%	81.0%	80.3%	82.0%

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
actual	80.6%	79.2%	80.9%	76.9%	79.5%	80.7%	81.7%	79.9%				

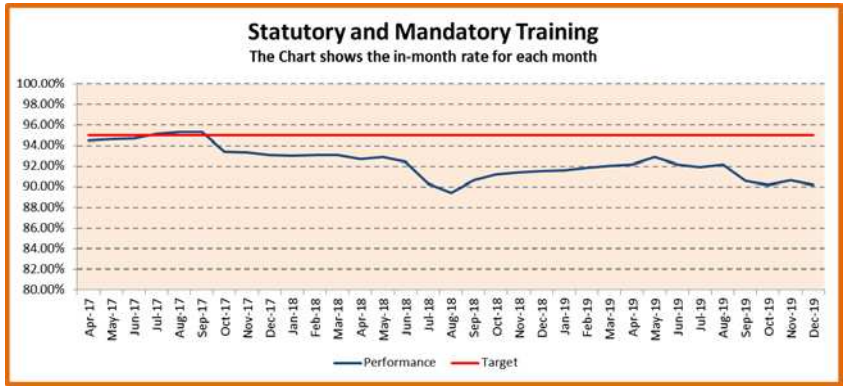
theatre utilisation includes Obsterics

3. ORGANISATIONAL	Domain Scorecard	Dec-19 Page 28

	Ref	Indicator	Exception Triggers			Period	Performance				Site Breakdown			Except.
			Month Target	Step Change	Conti. Limit		This Period Target	Last Period	This Period	YTD	RSUH	County	UHNM	
Workforce	OH5	Executive Team Turnover	G			Dec-19	3.00%	0.00%	0.00%					
	W19	Turnover Rate	G			Dec-19	<11%	9.13%	8.85%					
	OH7	Proportion of temporary staff (snapshot)				Dec-19		6.19%	5.49%					
	W20	Sickness Absence Rate **12m Cumulative Rate**	R			Dec-19	<3.39%	4.59%	4.58%					✓
	W22	Appraisal Rate	R			Dec-19	>95%	80.89%	81.20%					✓
	W23	Agency Costs as a % of Total Pay Costs				Dec-19		3.94%	3.92%					
Patient Feedback	OH4	CQC Inpatient Survey (annual)					-	-	-					
Staff Feedback	OH6	NHS Staff Survey (annually) Staff Engagement Rate				Reporting in Feb 20		-	-					
Compliance	W50	Mandatory and Statutory Training	R			Dec-19	>95%	90.64%	90.20%					✓

site breakdown not available

3. ORGANISATIONAL HEALTH	W50: Statutory and Mandatory Training	Dec-19 Page 29



The Statutory and Mandatory training rate at 31st December 2019 was 90.20% (90.64% at 30 November 2019). The Statutory & Mandatory training rate shows compliance against the following seven (Core for All) 3 yearly competency requirements and 83.98% of staff have completed all 7 modules

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Duty of Candour - 3 Years|	9928	9928	8965	90.30%
205|MAND|Security Awareness - 3 Years|	9928	9928	8951	90.16%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	9928	9928	8981	90.46%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	9928	9928	8964	90.29%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	9928	9928	8875	89.39%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	9928	9928	8969	90.34%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	9928	9928	8981	90.46%

Compliance rates for the Annual competence requirements, completed via e-learning, were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	9816	9816	7604	77.47%
NHS|CSTF|Information Governance and Data Security - 1 Year|	9816	9816	8789	89.54%

(Note: Face to Face Fire Training cannot be reported from ESR)

Root cause analysis/ Key lines of enquiry

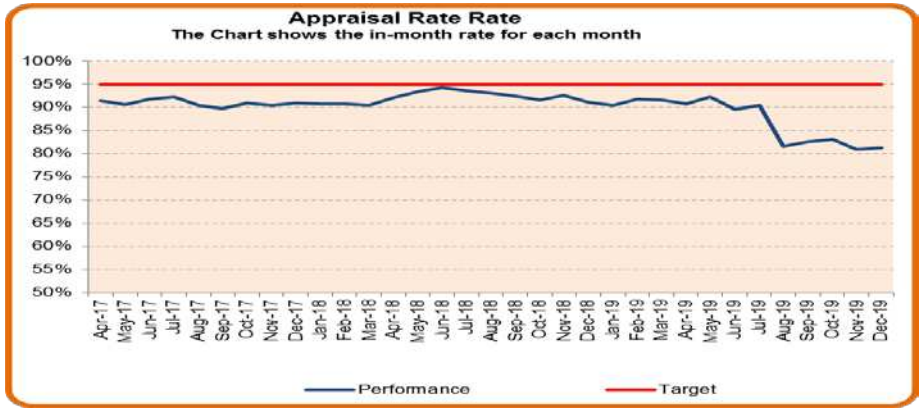
Actions taken include:
• Work is being undertaken to follow up on the staff who were emailed in December who were out of date with all 7 competence requirements.
• Centrally, the recruitment process is being reviewed to ensure Statutory and Mandatory training is undertaken by Applicants (ie prior to their start date) and is transferred to their employee record when the hire takes place.
Updates to the ESR Portal mean that staff can "click and play" their statutory and mandatory e-learning directly from their home page without having to search for the training.

Action Plan	
Improve signposting to eLearning guides by adding a “Local Links” portlet to ESR which directly links to the Sops. In progress	G
Ensure that the correct “Essential to Role” training requirements are identified for each role on ESR so that finding relevant training is easier	G
Monthly data quality check. Use ESR to identify any records that remain “confirmed” and follow up with the trainer. Additional training to be provided if required.	G

Progress

Not → Scoping → **In Progress** → Complete

W22: Appraisal Rates (PDR's)



The PDR rate improved slightly from 80.89% to 81.20%

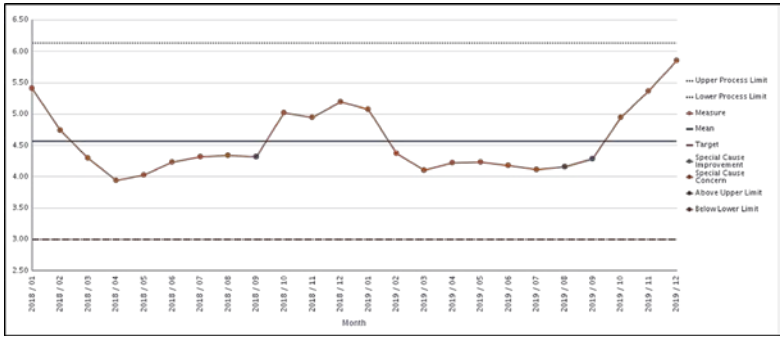
Overall, 79.10% of Non-Medical PDRs were recorded in ESR as at 31/12/19. As the performance measured via ESR is at the same level as the manually collated PDR data, performance will be reported only via the ESR System from January 2020

Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Actions being taken to improve the PDR compliance rate include: • A Letter has been sent to Specialised, CWD and Central Functions Divisions advising that from 1st January 2020, reporting on PDRs will only be from the ESR System and asking that they ensure all appraisals are inputted directly into ESR. • These Divisions have been asked to assure themselves that PDRs are being completed ahead of their next performance review so that the Division and Executive team all have a clear picture of the delivery of this important performance metric. • Divisions have been asked to focus on the completion of Admin and Clerical PDRs over the winter period • Managers with low compliance rates are being contacted and offered support	Support with data uploads continues to be provided.	G
		G
		G

Progress

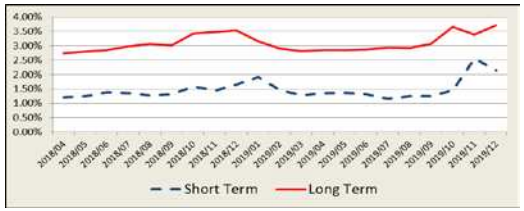
Not Initi → Scoping → In Progress → Complete

3. ORGANISATIONAL HEALTH	W20: Sickness Absence Rate	Dec-19 Page 31



Standard Deviation	Mean
0.52	4.57

In December, the in-month sickness rate reduced to 5.85% (5.95% in November) and the 12m Cumulative Rate reduced to 4.58%.
The sickness rate is in line with previous year trends over the winter period and an increase in reported absence was expected with the implementation of Empactis.
Managers and staff are being supported to close down sickness absence episodes in a timely manner.



Root cause analysis/ Key lines of enquiry

In December 2019, the top reasons for sickness absence were:

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illness	206	207	4,167	20.5
S99 Unknown causes / Not specified	715	717	4,037	19.9
S12 Other musculoskeletal problems	129	129	2,525	12.4
S25 Gastrointestinal problems	249	250	1,533	7.6
S98 Other known causes - not elsewhere classified	78	78	1,531	7.5

Work is ongoing to allocate the S99 Unknown sickness to the correct reason once confirmed with the employee. S99 Unknown causes / not specified is the default option where no reason for absence has been transferred from Empactis into ESR, for example, where the reason has not been clarified with the employee.

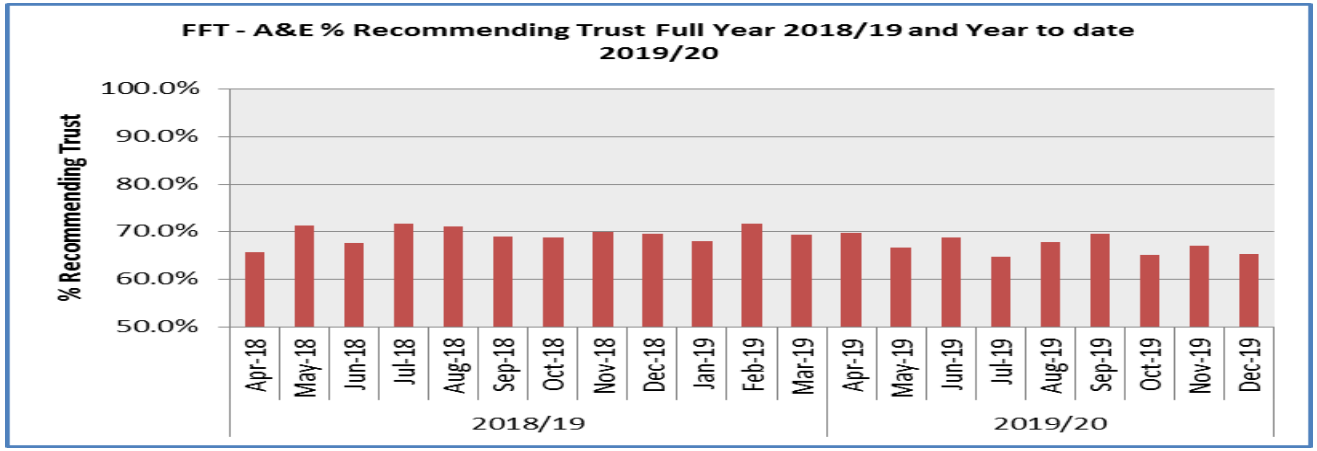
Action Plan	RAG
Escalate / fast-track a change request with supplier to automate the absence type and reason based on the callers response to the trigger questions.	G
Open absences where the expected date of return has lapsed have been cross checked against Allocate and closed where applicable.	G
Managers have been identified for further training and employees reminded to close absences in Empactis	G

Progress

Not Initiated → Scoping → In Progress → Complete

	Ref	Indicator	Exception Triggers			Period	Performance				Site Breakdown			Except.
			Month Target	Step Change	Conti. Limit		This Period Target	Last Period	This Period	YTD	RSUH	County	UHNM	
Patient Feedback	C12	Mixed Sex accommodation breaches	G			Dec-19	0	0	0	0	0	0	0	
	C7	Written Complaints Rate (per 10,000 spells)	G			Dec-19	35.00	21.44	17.62	30.48	19.19	10.91	17.62	
	C1	FFT Recommended %- Inpatients	G			Dec-19	95.0%	98.5%	97.8%	98.3%	98%	99%	97.8%	
	C2	FFT Recommended %- A&E	R			Dec-19	85.0%	67.0%	65.2%	67.4%	63%	72%	65.2%	✓
	C3	FFT Recommended %- Maternity	G			Dec-19	95.0%	98.5%	100.0%	99.6%	100.0%	100.0%	100.0%	
Staff Feedback	C6	Staff FFT Percentage Recommended- Care - Qtr.	G			Qtr4	70.0%	n/a	n/a	n/a	-	-	-	

C2 - A&E FFT Score



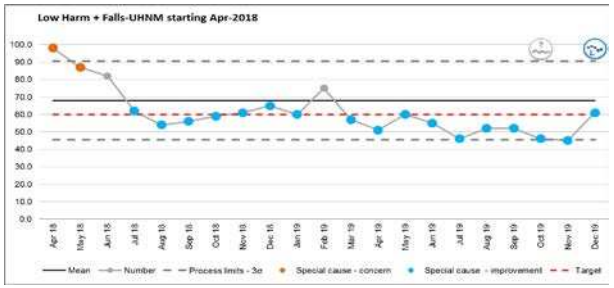
Root cause analysis/ Key lines of enquiry	Action Plan	RAG
What do the results tell us? • Patients do not always feel they are provided with adequate information about their condition and treatment or that the doctors and nurses listened to them. They also do not feel they are updated about waiting times. What are we going to do next? * An improvement plan has been developed based on those areas that have been identified as mattering most to our patients. *Role specific teaching sessions include complaint themes,/barriers, how to gain feedback and why this is important.. *Encourage patients to ask questions and confirm understanding following the "It's OK to ask" campaign and using "teach back" methodology. * Common themes for complaints and actions made as a result of these. are displayed in the handover room and are discussed both at the morning and evening handover. * Specific training for A&E Staff includes Dementia and Health Literacy Awareness * Staff ensure the patient is aware of who to contact post discharge should they have any worries or concerns. * Patient Experience listening event workshops are held with patients invited in to talk about their experience in the A&E Department. * Improving the pathway through A&E to reduce waiting times. * The new escalation plan includes a directive for the nurse in charge to keep patients and relatives who may be queuing in the corridor updated during busy periods. * Our Head of Patient Exeperience is contacting peer Trusts who have successfully achieved higher performance to enable improvements to be made.	The team are proactively seeking feedback to improve the response rate and ensure FFT feedback is accurate. The UHNM A&E departments currently rate best in the country for response rates measured through National Benchmarking.	G
	To review the potential for adding direct communication to patients regarding waits over 4 hours to the SOP	A
	Staff are actively encouraging patients to ask the questions that matter to them. Introduce the use of the It's Ok to Ask postcards and pencils	G
	Health Literacy training- work towards gaining Health Literacy accreditation	A
	Comfort rounds are carried out on all patients at least every 2 hours and facilities are in place for additional food and drink during periods of long waits. This is montored during Quality & Safety Team safety visits	G
	Patient experience team gather patient stories and share with team in order to improve practice with regard to patient experience- Patient Experience have slot on stat/mand training days. Interviews with a selection of patients who have experience 12 hour waits in the department to identify if any themes/suggestions for improvement.	G
	Progress	
	Not Initiated → Scoping → In Progress → Complete	

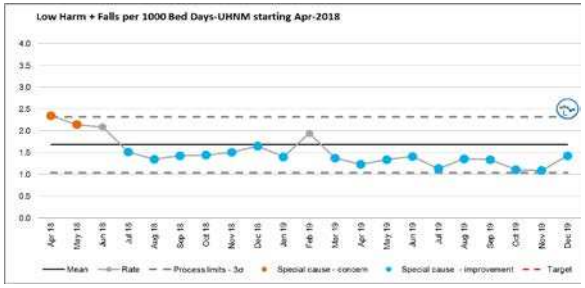
Domain Scorecard

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Conti. Limit	Period	Performance: This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Breakdown: RSUH	Site Breakdown: County	Site Breakdown: UHNM	Except.
Infection Control	S10	Clostridium Difficile- Infection number	G			Dec-19	8	8	18	83	16	2	18	✓
	S11	Clostridium Difficile- Variation from Plan	G			Dec-19	8	0	11	13	10	1	11	✓
	S2	Avoidable MRSA cases	G			Dec-19	0	0	0	0	0	0	0	
Incidents	S3	Never Events	R			Dec-19	0	0	1	5	1	0	1	✓
	S19	Falls Resulting in Harm (Including Low - Excluding Collapses and Managed Falls)	G			Dec-19	60	45	61	468	48	13	61	✓
	S25	Medication Errors: Rate per 10,000 bed days	G			Dec-19	-	48.2	40.3	44.8	39.5	46.3	40.3	
Harm Free Care	S38	Pressure Ulcers- Hospital Acquired Category 2 Trust Apportioned	G			* Nov-19	8	4	2	38	2	0	2	
	S38	Pressure Ulcers Hospital Acquired Category 3 Trust Apportioned	G			* Nov-19	4	3	2	24	2	0	2	
	S29	Pressure Ulcers Hospital Acquired Category 4 Trust Apportioned	G			* Nov-19	0	0	0	1	0	0	0	
	S17	Emergency C-Section Rate as % of total births	G			Dec-19	-	14.72%	15.08%	14.04%			13.91%	
Screening	S36	VTE risk assessments	R			Dec-19	95.0%	93.74%	92.07%	93.7%	91.0%	97.2%	92.1%	✓

*reported for previous month

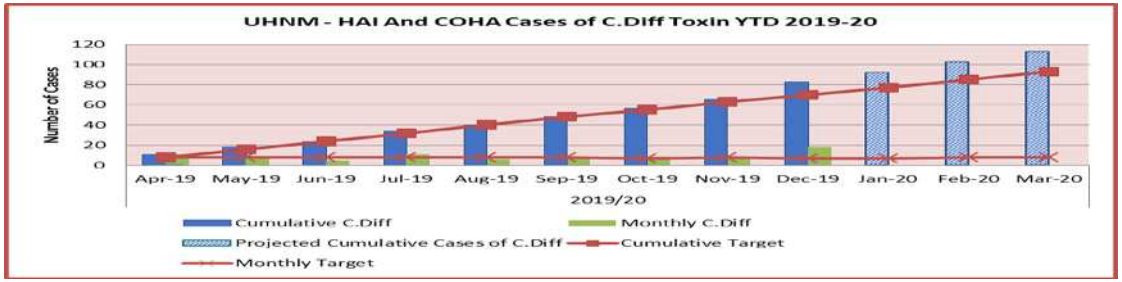
All Falls (Low Harm or Above - Excluding Collapses and Managed Falls) SPC Charts





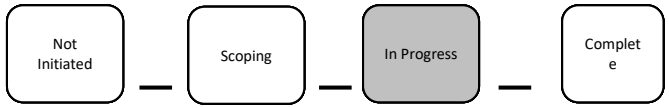
Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Falls with harm have now completed the validation process and the number provisionally confirmed for the month of December is 61 (excluding collapses & managed falls). It is worth noting that this number is still provisional as although validation has taken place there remain 7 incidents where the ward/department is yet to complete the investigation so the level of harm may change when this is completed. The Statistical Process Control charts above demonstarte that 61 falls is normal variation. The rate of falls with moderate harm or above per 1000 bed days in December 2019 is 0.16. The average rate YTD is 0.12, which is lower than the past 3 years and below the national average of 0.19. 54 out of 61 patient falls with harm (excluding collapses & managed falls) were recorded as low harm (88.5%), 4 with moderate harm (6.6%) and 3 with severe harm (4.9%) There is no particular theme in terms of location of these falls with moderate harm and above. The average monthly number of falls resulting in Low Harm or worse for the year to date is 52 – well below the target of 60. Looking at the data on an SPC chart indicates that a value of 61 is not likely to be due to any special cause, but rather falls well within expected 'common cause variation'. The Trust continues to review falls and The Falls Steering Group identify themes from incidents and Serious Incidents. Falls Risk Assessments and the Falls Bundle continue to be promoted and work is continuing with the wards to ensure that risk assessments and falls bundle are fully completed and updated During December 2019 the Trust rate of falls per 1000 bed days is 5.42 which is below the target of 5.6 (national average based on RCP National Audit) . The current rate for UHNM YTD rate is 5.25, which remains within SPC chart limits. This is telling us that whilst not consistently achieving the reduction target of 60 falls with harm or less per month, there is a reduction in moderate harm and above to patients despite the trust opening additional bed capacity since the reduction target was agreed (based on 2016/17 baseline figures). A comprehensive Falls Report is presented on a monthly basis to the Falls Steering Group, Quality & Safety Forum and has recently been presented to the Quality Assurance Committee following request by the committee members for further information and assurance regarding the types, location and harm associated with falls.	Falls documentation continues to be monitored; throught CEF, Falls reviews of areas highlighted in the weekly falls report, Monthly falls bundle audit and as part of the Falls Prevention CQUIN audit	G
	New Falls Champion and refresher training ongoing - 2020 training dates have now been set and released for booking. Ward training will be delivered as required for high falling wards and for those with out current champions. Sessions have also been set up specifically for bank staff.	G
	Falls CQUIN continues (Q3) changes made to audit process to support the delivery of the CQUIN and changes have been made to the patient Risk Assessment Book to prompt staff to record the lying and standing B/P of patients 65yrs and over and to document the provsion of a walking aid	G
	New process being developed for RCA Fall action plans to monitor progress of actions in order to improve timely completion	A
	New adult Trolley rail protocol developed for those areas that use trolleys, rolled out in A&E, plan to roll out to other areas where trollys are used e.g Endoscopy	G
	New paediatric Bedrail assessment developed in conjunction with Paediatric team - now in use following approval at divisional governance	G
	The Proud to Care Bedrail Assessment has been updated to include a question about the patients capacity and understanding of bedrail use	G
	Falls Quality Improvement Facilitators working closely with Mental Health Team and Falls Clinical Lead to inrease awareness of Delirium, in addition changes agreed to the Proud to Care Risk Assessment Book in relation to the inclusion of a Delirium sceening Tool	A
	Weekly monitoring of top falling wards continues. Interventions are in place to visit and support these areas, these include ward 7, ward 225, ward 228	A
	The falls bundle audit has been updated to refect current challenges and to assist with compliance with the flls CQUIN	A
	Progress	
	Not Initiated → Scoping → In Progress → Complete	

5. Safe	S11 - C-Diff	Dec-19 Page 37

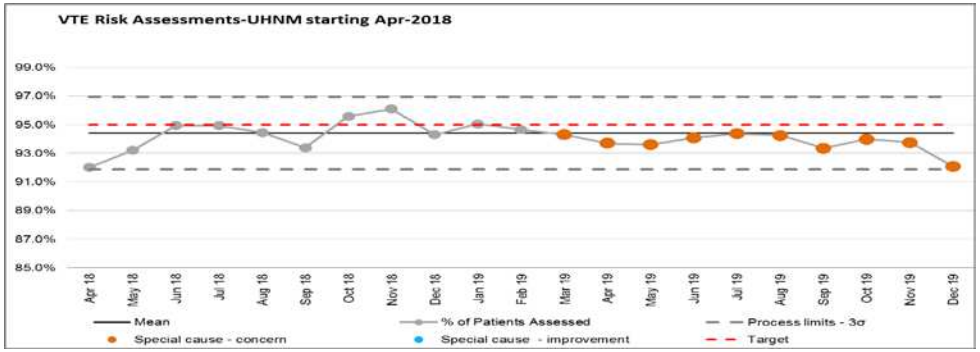


Root cause analysis/ Key lines of enquiry	Action Plan	RAG
In April 2019 new national definitions for C difficile (C diff) cases were announced, with further clarification received from NHSi in late July regarding the reporting of cases. This has resulted in UHNM having 83 cases of C diff to report at the end of December 2019 against a target of 70. The new definitions are: • Cases sampled C diff toxin positive on day 3 or more of admission are classed as hospital acquired (HAI). Previously these cases would have been non-trust apportioned. • Cases sampled C diff toxin positive within 28 days of discharge from hospital is classed as community acquired healthcare associated (COHA) and are now apportioned to the trust. Previously these cases would have been non-trust apportioned. As at YTD at the end of December 2019: 45 of the 83 cases would have been attributed as hospital acquired under the previous definition; whereas 38 would have been non-trust apportioned (9 'Day 3' samples and 29 COHA cases). Clearly there are many factors outside the trust control within 28 days from discharge, including stool samples sent by GPs/Care Homes, antimicrobial prescribing by primary care or other regional centres participating in a patients shared care. This change affects every trust in England. Each case undergoes an RCA. Three of the 18 cases reported in December are from one particular ward, and immediate control measures were instigated, including terminal cleans with Virusolve (our standard disinfectant/sporicidal agent), daily presence of IP team to ensure cleaning/PPE etc. There have been no further cases since. A further PII meeting has been organised (we have already had one), and ribotyping is awaited. This is being dealt with this as presumed transmission – our last Cdiff transmission was in the Summer of 2016. An investigation is currently underway of all 18 cases to see if there are any links that can be elicited, or whether they are an unusual coincidental increase. The Trust saw 560 influenza A cases during December, many of whom were poorly so we will be looking to see if there is any link to antimicrobials to treat secondary bacterial infection, and Norovirus.	Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission	G
	Continue to work with health economy colleagues around antimicrobial prescribing	G
	3. MPFT to refresh primary care and care homes around not sending repeat stool specimens to check for C diff clearance	G
	PII (Periods of Increased Incidents) meeting to discuss three cases from the same ward area to determine whether transmission has occurred	A
	Investigation of all 18 cases to see if there are any links that can be elicited, or whether they are an unusual coincidental increase in relation to the influenza A cases during December to see if there is any link to antimicrobials to treat secondary bacterial infection, and Norovirus	A
	Progress	
	Not Initiated → Scoping → In Progress → Complete	

Root cause analysis/ Key lines of enquiry	Action Plan	RAG
Reported on 12th December 2019 - and related to Surgical/Invasive Procedure - wrong site nerve block administered to patient. Patient referred for right side nerve root injection to provide pain relief for severe pain in right buttock and leg. In error the Patient was given the injection into their left lower back which would help with pain in their left hand side. The patient went to PALS on 27/11/19 to inform them that they had found out that the injection went into the incorrect side.	Incident reported and RCA underway with independent allocated investigators	G
	Logged as Serious Incident	G
	Completed RCA due to be presented at Risk Management Panel in July 2019	G
	Outcome to be shared with patient and CCG following review at RMP	A
	Progress	



5. Safe	S36 - VTE risk assessments	Dec-19 Page 35



Dec-19	
Target	95%
Dec-18	93.74%
Dec-19	92.07%

Root cause analysis/ Key lines of enquiry	Action Plan	RAG
VTE assessments on admission are reported quarterly to Unify. The definition of the Indicator is the number of inpatients aged 16 and over reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool divided by the number of adults who were admitted as inpatients (includes day cases, maternity and transfers; both elective and non-elective admissions). For December 2019 92.07% of VTE risk assessments were completed within 24 hours of patient admissions (all inpatient admissions during December 2019 captured on the WIS), which falls short of the National 95% target. However, results from the monthly point prevalence Safety Express audit shows that for the last six months, over 99.0% of VTE risk assessments have been completed (ward based audit of every inpatient on one specified day of the month). This suggests that VTE Risk Assessments completed on admission but not uploaded accurately onto the WIS Board. This is supported by the internal audit of UHNM Quality Account 2018/2019, which concluded that UHNM was under-reporting compliance with VTE risk assessments. Continued focused work is ongoing to improve compliance with timely inputting of VTE risk assessments onto WIS. The VTE Steering Group are also liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.	Development of an E-Learning package to instruct users how to accurately upload VTE risk assessment times on the Ward Information System (WIS) and how to avoid loss of data. Available on ESR from January 2020. Uptake of training will be monitored by the Corporate Quality & Safety Team.	G
	The Corporate Quality & Safety Team are providing focused support to admission portals to improve compliance with VTE risk assessment completion and data capture, as required.	A
	Areas of non-compliance are escalated to the relevant matron by the Corporate Quality & Safety Team, on a monthly basis.	G
	The VTE Steering Group are liaising with other Trust working groups to explore other means of data collection of VTE risk assessment compliance, including Vitalpac and EPMA.	A
	A workstream is underway to improve compliance with NICE Guidance on VTE risk assessment for patients aged 16-18 years (April 2019).	G
	Progress	
	Not Initiated → Scoping → In Progress → Complete	

Audit Committee Chair's Highlight Report to Board

23rd January 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
For information: • The Committee noted the continued refinement of the Board Assurance Framework, and noted the ongoing work in terms of refreshing the risks for 2020/21. The Committee challenged the gap between the target risk score and the date for which this was to be achieved, given the current score on a number of the risks. • The Committee was concerned of the continuing levels of SFI breaches and single tender waivers (STWs), although it was noted that the STWs had demonstrated compliance with the SFIs, with a legitimate reason being noted.	• To re-consider the way in which internal audit recommendations are presented to the Committee, and to include the business as usual monitoring in place for the specific recommendations. • To work with the procurement team regarding cross-referencing the information on the Declaration of Interests Register with the information held with Procurement in terms of Consultant involvement in procurement decisions. • To provide a report to a future Committee regarding the outcome of the External Audit AQR review • In terms of Informing the External Audit Risk Assessment, clarification was requested to the reference to whistleblowing and whether this should be extended to cover Freedom to Speak Up • Further analysis to be undertaken in terms of the SFI breaches in order to confirm the actions being taken to reduce these going forwards.
Positive Assurances to Provide	**Decisions Made**
• 3 internal audit reports were presented to the Committee; PFI Contract Management and PMO Governance which were rated as significant assurance with minor improvement opportunities, and review of the EASY System which concluded with significant assurance. • Positive feedback was provided in relation to the effectiveness of both the internal and external audit services • The Committee noted the 100% response rate for the annual declaration process and noted the ongoing actions to make subsequent requests for declarations more robust.	• The Committee agreed to re-open two previous internal audit recommendations, given that a spot-check audit had identified that these had not been completed. • The Committee approved the revised Standing Financial Instructions and Scheme of Delegation Policies and requested that a more detailed summary of changes would be provided to the Trust Board
Comments on the Effectiveness of the Meeting	
• The Committee was pleased to report that it had have completed the majority of its work programme as planned, with the exception of the risk management review, which was being undertaken by Internal Audit and would be reported in April 2020.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Progress Report	Assurance	2.	Review of Effectiveness of Internal Audit	Assurance
3.	Internal Audit Recommendation Tracker	Assurance	4.	Corporate Governance Report	Assurance
5.	Q3 Board Assurance Framework	Assurance	6.	Counter Fraud Progress Report	Assurance
7.	External Audit Plan and Progress Report	Assurance	8.	Informing the Audit Risk Assessment	Assurance
9.	Review of Effectiveness of External Audit	Assurance	10.	International Financial Reporting Standard 16 (IRFS 16) Implementation Update	Assurance
11.	Q3 Losses and Special Payments	Assurance	12.	Q3 SFI Breaches and Single Tender Waivers	Assurance
13.	Annual Accounts Timetable	Assurance	18.	SFIs and Scheme of Delegation Policies	Approval
19.	Property, Plant and Equipment Disposals	Information			

3. 2019 / 20 Attendance Matrix

Attended | **Apologies & Deputy Sent** | **Apologies**

Members:			Apr	May	Jul	Oct	Jan
Prof G Crowe	GC	Non-Executive Director (Chair)					
Mr P Akid	PA	Non-Executive Director					
Ms S Belfield	SB	Non-Executive Director					
Attendees:			Apr	May	Jul	Oct	Jan
Mr R Percival	RP	External Audit					
Mrs E Mayne / Ms N Combes	EM/NC	External Audit					
Mr A Bostock	AB	Internal Audit					
Mr R Chidlow	RC	Internal Audit					
Mr S Stanyer	SS	LCFS					
Ms H Ashley	HA	Director of Strategy & Performance					
Mr J Dutton	JD	Corporate Governance Officer (Minutes)					
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance					
Mr M Oldham	MO	Chief Finance Officer	JT	JT			
Mrs S Preston	SP	Strategic Director of Finance					
Miss C Rylands	CR	Associate Director of Corporate Governance			NH		

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th February 2020
Report Title:	Board Assurance Framework (Q3 19/20)	**Agenda Item:**	14.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Chief Operating Officer, Chief Nurse, Medical Director, Director of Estates, Facilities & PFI, Director of IM&T, Director of Human Resources		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings presented to and outcome of discussion:

Extracts of the Quarter 3 BAF for 2019/20 have been considered by Committees as follows:

- Performance and Finance Committee on 21st January 2020
- Quality Governance Committee on 23rd January 2020
- Audit Committee on 23rd January 2020
- Transformation and People Committee on 24th January 2020

Summary of Report, Key Points for Discussion including any Risks:

The enclosed report provides the Board with the updated Board Assurance Framework (BAF) as at Quarter 3 2019/20. The framework has been updated by Executive Leads in order to set out the latest position with regard to levels of strategic risk, controls, assurances and further actions required.

The Index and Summary BAF at section 4 provides a high level overview of the content of the BAF, demonstrating changes in risk level when compared to quarter 2 along with an overview of controls / assurances aligned to the three lines of defence model. This aims to provide a visual overview of areas where there are weaknesses in any of the key lines of defence and should inform the identification of further actions required.

- There are 4 risks which have seen a change in risk level when compared to Quarter 2; all of which have seen a reduction.
- There are 10 risks where a gap in any of the three lines of defence has been identified. However, it should be noted that as the model is being newly introduced, there may be additional controls / assurances to include within future versions without there necessarily being a gap / weakness.
- No new risks have been included, and one risk has been closed: Local Health Economy response to Emergency Pressures, this was due to the information being captured within risks 5 and 6.

The risk associated with 'Retention of the Royal Infirmary' remains the highest risk at 'Extreme 25'; a risk which the Board are well sighted on in terms of mitigating actions.

Key Recommendations:

To approve the Board Assurance Framework as at Quarter 3

NHS
University Hospitals of North Midlands
NHS Trust

Board Assurance Framework (BAF)

Quarter 3 2019/20

1. Introduction

The Board Assurance Framework (BAF) provides a structure and process that enables the Board to focus on the key risks which might compromise the achievement of the organisation's Strategic Objectives and is presented under the headings of the 5 Strategic Objectives as set out within the 2025Vision.

These strategic risks have been identified by the Executive Team and should be defined as those which concern the organisations purpose and could impact the achievement of our key objectives (e.g. Data Loss, Leadership Capability); as well as the big external events/perils and how we can become more resilient e.g. Economic Downturn, Terrorist Attack, Extreme Weather or Cyber Attacks). With this in mind, it should be noted that a workshop is being held in January 2020 with the Executive Team to revisit the content of the BAF.

The BAF maps out the key controls which are in place to support delivery of those objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These controls and assurances have been set out in line with the '3 lines of defence' model, which aids easy identification of any areas of weakness.

The 'Strategic Risk Heat Map' at section 5 of this document is drawn from the content of the BAF and aims to illustrate at a high level the degree of risk exposure associated with the Strategic Objectives. This is set out alongside a summary of the organisations most significant strategic risks, which highlights those which have been scored as 'Extreme'.

2. Committee / Board Consideration of Risk

The Quarter 3 BAF for 2019/20 has been considered by Committees as follows:

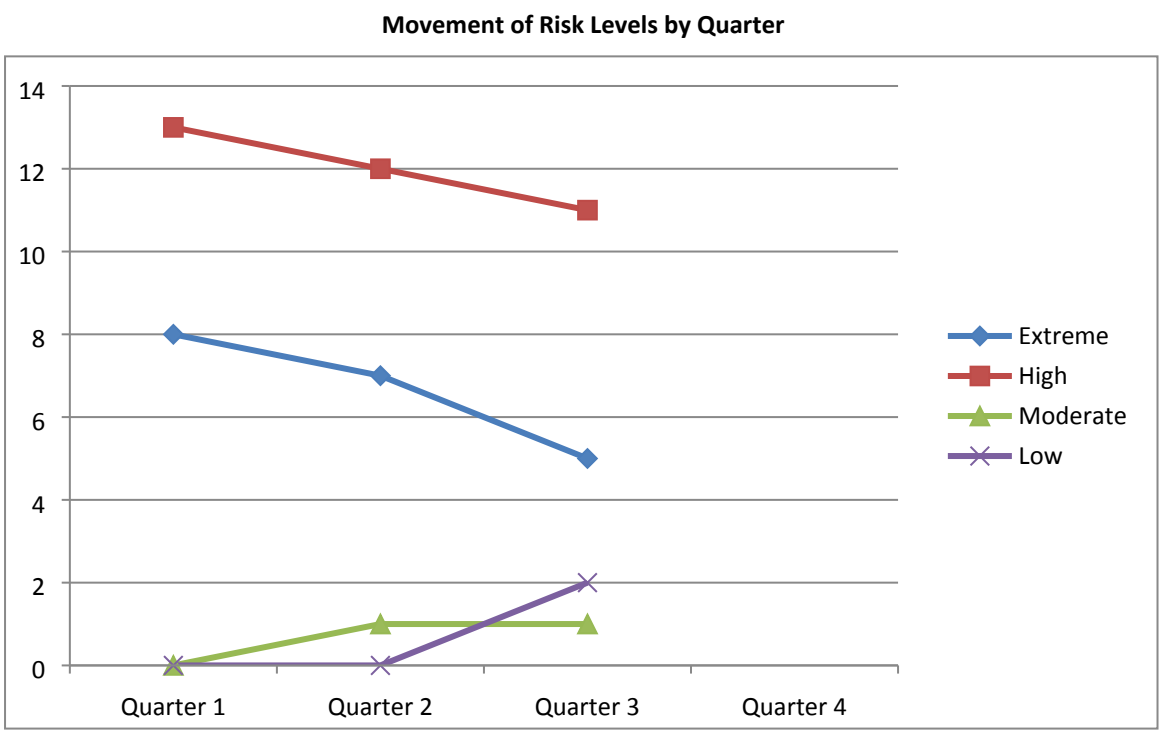
- Performance and Finance Committee on 21st January 2020
- Quality Governance Committee on 23rd January 2020
- Audit Committee on 23rd January 2020
- Transformation and People Committee on 24th January 2020

Committees were asked to consider the following questions, based on the evidence provided on the BAF for each objective:

- Are the levels of risk assigned to each risk appropriate, in particular when compared to other risks within the BAF?
- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current risk score?
- What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps? Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?
- What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?

3. Index and Summary Board Assurance Framework as at Quarter 3 2019/20

Ref / Page	SO	Summary Risk Title	3 Lines of Defence					Change in Risk Score				
			1st Line of Defence		2nd Line of Defence		3rd Line of Defence	Q1	Q2	Q3	Q4	Change
			Controls	Assurances	Controls	Assurances						
n/a		Application of Mental Capacity Act / Deprivation of Liberty Safeguards	n/a	n/a	n/a	n/a	n/a	High 9	Closed	Closed	Closed	n/a
n/a		CQC Section 31: Mental Health Act / Patients in Emergency Department	n/a	n/a	n/a	n/a	n/a	Ext 16	Closed	Closed	Closed	n/a
BAF 1 Page 7		Ability to deliver harm free care	✓	✓	✓	✓	✓	new	High 9	High 9	n/a	→
BAF 2 Page 9		Cyber Security	✓	✓	✓	✗	✓	Ext 16	Ext 15	Ext 15	n/a	→
BAF 3 Page 11		Fire Safety	✓	✓	✓	✓	✓	High 10	High 10	High 10	n/a	→
BAF 4 Page 13		Transfer of patients from County Hospital	✓	✓	✓	✗	✓	High 12	High 10	High 10	n/a	→
BAF 5 Page 14		Capacity / demand – impact on Emergency Care	✓	✓	✓	✓	✓	Ext 20	Ext 20	Ext 20	n/a	→
BAF 6 Page 16		Capacity / demand – impact on Elective Care	✓	✓	✓	✓	✗	High 12	High 12	High 12	n/a	→
n/a		Local Health Economy response to Emergency Pressures	n/a	n/a	n/a	n/a	n/a	Ext 20	Ext 20	Closed	Closed	n/a
BAF 7 Page 18		Impact on UHNM of a no deal Brexit	✓	✓	✓	✓	✓	new	High 9	Low 3	n/a	↓
BAF 8 Page 19		Recruitment of Workforce	✓	✓	✓	✓	✓	High 12	High 12	High 9	n/a	↓
BAF 9 Page 21		Staff Engagement / Retention of Workforce	✓	✓	✓	✓	✓	High 12	High 12	High 12	n/a	→
BAF 10 Page 23		Delivery of 7 Day Services	✓	✗	✓	✓	✓	Ext 15	Ext 15	High 10	n/a	↓
BAF 11 Page 24		Infrastructure to deliver the Research & Development Strategy	✓	✗	✓	✓	✓	High 12	High 12	High 12	n/a	→
BAF 12 Page 25		Delivery of System Priorities	✓	✗	✓	✓	✗	High 12	High 12	High 12	n/a	→
n/a		Oversight of Strategic Partnerships	n/a	n/a	n/a	n/a	n/a	High 12	Closed	Closed	Closed	n/a
BAF 13 Page 26		Achievement of Financial Plan	✓	✗	✓	✓	✗	High 12	High 8	High 8	n/a	→
BAF 14 Page 28		County Phone System Failure	✓	✓	✓	✓	✗	Ext 15	Ext 15	Ext 15	n/a	→
BAF 15 Page 29		Loss of Network (KCOM)	✓	✓	✓	✓	✓	High 12	High 8	Low 3	n/a	↓
BAF 16 Page 31		Annual Statutory and Lifecycle Maintenance Programme	✓	✗	✓	✓	✓	High 9	Mod 6	Mod 6	n/a	→
BAF 17 Page 32		Capital Funding Allocation – Estate	✓	✗	✓	✓	✓	High 9	High 9	High 9	n/a	→
BAF 18 Page 34		Retention of Royal Infirmary	✓	✓	✓	✓	✓	Ext 25	Ext 25	Ext 25	n/a	→
BAF 19 Page 37		Insufficient capital – IM&T	✓	✓	✓	✓	✓	Ext 16	Ext 16	Ext 16	n/a	→



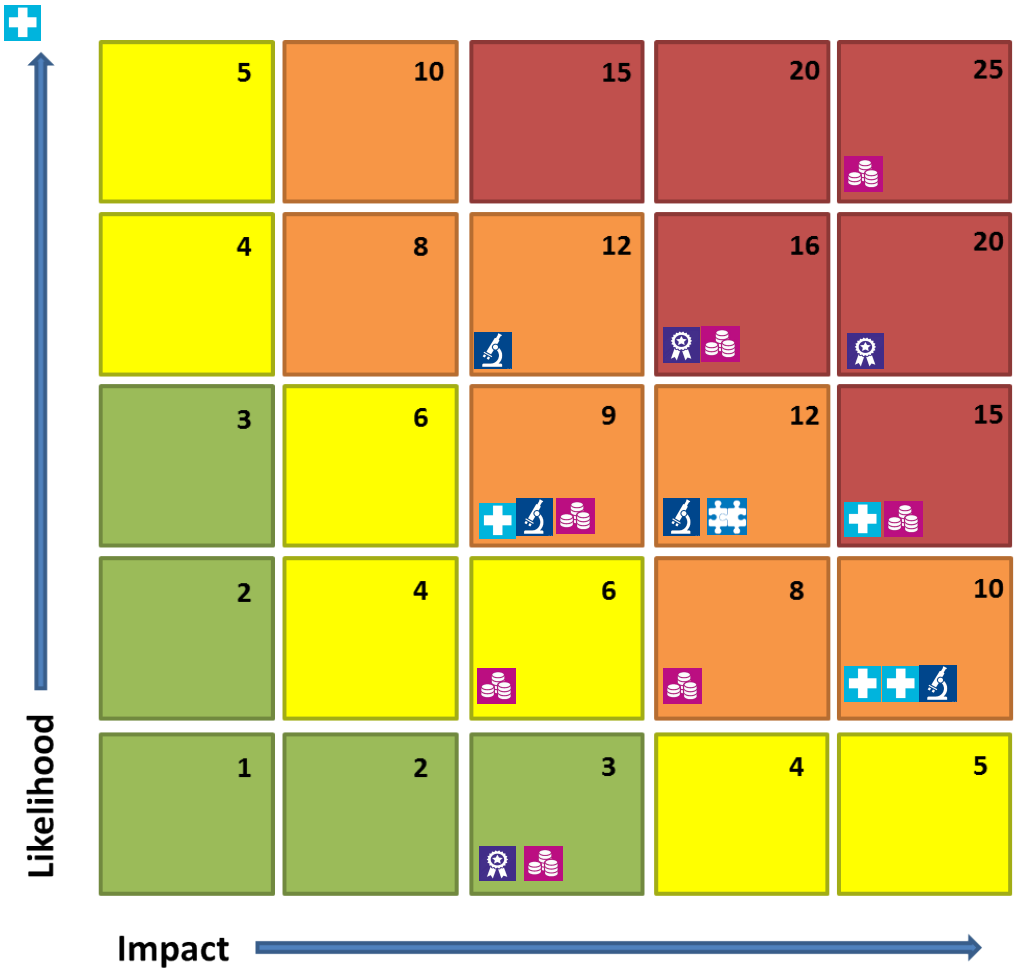
This graph represents the movement in risk levels by quarter, demonstrating that:

- The number of extreme and high risks has reduced between quarters 2 and 3
- The number of moderate risks has remained the same as quarter 2
- The number of low risks has increased at quarter 3

The table below sets out the number of changes in risk level at quarter 3:

Change		No.
→	No change in risk score since previous quarter	**15**
↑	Increase in risk score since previous quarter	**0**
↓	Reduction in risk score since previous quarter	**4**
New	New risk at quarter 3	**0**
Closed	Removed risk at quarter 3	**1**

4. Strategic Risk Heat Map and Extreme Risk Summary



EXTREME RISK SUMMARY				
No.	**SO**	**Summary Risk Title**	**Score**	**Change**
1		Retention of Royal Infirmary	25	→
2		Capacity / demand – impact on Emergency Care	20	→
3		Insufficient capital – IM&T	16	→
4		Cyber Security	15	→
5		County Phone System Failure	15	→

Key Messages:

- 5 of the 20 risks included in the Quarter 3 2019/20 BAF are scored at Extreme
- These risks threaten the achievement of 3 out of 5 of our Strategic Objectives
- Retention of Royal Infirmary remains the most significant risk

SO1: Safe, caring, effective, responsive | SO2: Achieve constitutional patient access targets | SO3: Excellent employment, education, teaching, research | SO4: Lead strategic change in Staffordshire and beyond | SO5: Ensure efficient use of resources

5. Three Lines of Defence Model

Audit Committee

Senior Management

1st Line of Defence

Functions that own and manage risk – i.e. front line staff.

- Operational Management
- Internal Controls
- Managerial and supervisory controls
- **Preventative controls** – controls designed to limit or reduce impact should a risk materialise
- Effectiveness determined by overall control environment and culture
- Awareness of controls must be established and maintained by management and staff

Nature of Assurance:

- Comes direct from those responsible for delivering specific objectives or operation;
- provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved
- may lack independence and objectivity, but its value is that it comes from those who know the business, culture and day to day challenges

2nd Line of Defence

Functions and personnel that oversee risk

- Risk Management Processes
- Compliance, including compliance with laws and regulations
- Contract management arrangements
- Financial control monitoring financial risks and reporting
- Quality
- IT
- Other control departments

Core purpose to ensure that the first line of defence is properly designed and operating as intended.

- **Directive:** designed to ensure a particular objective is achieved
- **Detective:** designed to identify particular occasions when undesirable outcomes have been realised
- Key aspects of maintaining policies and produces and ensuring staff receive training in relation to first line of defence.

Nature of Assurance:
This assurance provides valuable management insight into how well work is being carried out in line with set expectations and policy or regulatory considerations.

It will be distinct from and more objective than first line assurance.

3rd Line of Defence

Function that provide independent assurance

- Internal Audit
- External Audit
- Local Counter Fraud Services (LCFS)
- Care Quality Commission
- Regulators – NHSI/E
- Other external assurance providers (i.e. external accreditation / inspections)

Nature of Assurance:

- Independent of the first line and second lines of defence.
- Internal audit operates to professional and ethical standards in carrying out its work, independent of the management line and associated responsibilities.
- External Audit operates similarly and reports mainly to Parliament.

In October 2019, the Well Led Developmental Review undertaken by NHSE/I recommended the introduction of the Three Lines of Defence model to the BAF.

The Three Lines of Defence model provides a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

To ensure the effectiveness of the risk management framework, the board and senior management need to be able to rely on adequate line functions – including monitoring and assurance functions – within the organisation. As illustrated here, the Three Lines of Defence model provides a means of explaining the relationship between these functions and as a guide to how responsibilities should be divided:

- the first line of defence – functions that own and manage risk
- the second line of defence – functions that oversee or specialise in risk management, compliance
- the third line of defence – functions that provide independent assurance

From Quarter 2 2019/20, the Three Lines of Defence Model was incorporated into the BAF against each Strategic Risk. Whilst this is expected to evolve further, it provides an alternative 'lens' for Board and Committee members to consider – particularly around identifying areas of potential weakness.

6. Board Assurance Framework 2019/20

Strategic Objective 1:
Deliver safe, effective, caring and responsive services

Assurance Committee:	Quality Governance Committee	Executive Leads:	Chief Nurse and Medical Director

Risk Description:	If the Trust does not deliver harm free care, then the trajectory reduction in Trust apportioned Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and infection rates may not be achieved, resulting in increased patient harm and poor patient experience.

Key Source of Objective	
2025 Vision	✓
2019/20 Financial & Operational Plan	✓
CQC Recommendations	✓

Links to Corporate Risk Register:	Title	Current Risk Score
	ID 8877 Risk of Avoidable Hospital Acquired Infections	High 12

Executive Director Lead:	Chief Nurse	BAF Reference:	BAF 1

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	n/a	3	3	n/a	The score has remained the same as the previous quarter. Likelihood has been scored as 'possible' as patient harm might happen despite implementation of controls and assurance; consequence scored as 'moderate' due to the potential implications on patient safety and experience if controls are not fully implemented.	Likelihood:	2	31 March 2020
Consequence:	n/a	3	3	n/a		Consequence:	2	
Risk Level:	n/a	High 9	High 9	n/a		Risk Level:	Mod 4	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis.	• Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm • Root Cause Analysis (RCA) Scrutiny Panels in place for Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework in place	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM)

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	• Training Programmes in place for all key harms. • Patient experience team in place		
Assurance:	• Quality dashboard available on Intranet • Patient Experience dashboard in place • Monthly Patient Safety Reports from Ward to Board • Training Records available at Ward and Corporate level • Care Excellence Framework Visit Reports shared with Ward and Divisional Team	• Scrutiny of level of Patient Harm and Patient Experience within Executive-Led Divisional Performance Reviews on a monthly basis • Outcome letters as a result of RCA Panels sent to Senior Sisters/Charge Nurses, Matrons and Associate Chief Nurses • Audit programme to monitor compliance with relevant Trust policies • Action plan developed and presented to Quality Assurance Committee in September 2019 in relation to External Audit of Quality Account. • Patient stories reported to the Trust Board on a monthly basis • Friends and family test results are reported and monitored on a regular basis	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	Quality & Safety Improvement Strategy to be finalised	Chief Nurse	31/03/2020	Quality & Safety Improvement Strategy developed and presented to Quality & Safety Forum in July 2019. To be amended and presented to Quality Assurance Committee – due date extended.	
2.	To complete the Nursing Establishment review	Chief Nurse	31/03/2020	Currently underway. Initially expected to be completed in February 2020, however upon receipt of initial information, expected to be completed in March 2020.	
3.	To review the clinical governance framework including the strengthening of the Quality and Safety Forum	Chief Nurse	31/03/2020	Changes have been suggested to the corporate governance structure with the aim of implementing new executive groups from 1st April 2020.	
4.	To review and strength the quarterly Patient Experience Report	Chief Nurse	11/03/2020		

Risk Description:	If the organisations infrastructure and clinical systems are not adequately protected from either a targeted or indirect attack then this could compromise the operation and delivery of care within the hospital resulting in a loss of IT systems for potentially a prolonged period, and potential cancellation of some services, as well as reputational damage, increased backlog of patients and operations and potential fines of up to 4% Trust budget by NHS England.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 13595 Trust Network compliance with Cyber Essentials Plus requirements	High 12	ID 8843 Unsupported (OS) and Unprotected (AV) Vulnerable Clinical and Medical Devices on the Network	High 10

Executive Director Lead:	Director of IM&T	BAF Reference:	BAF 2

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	3	3	n/a	The likelihood of the risk has reduced based on the actions being taken, however as cyberware becomes increasingly sophisticated it makes it almost impossible to quantify the risk. The impact of the risk has increased; if the Trust was infected by a cyber-attack, it is possible that this may spread across every office and ward at both hospitals. The organisation has already been subject to a Cyber Attack (WannaCry) and Cyber Security remains a real and relevant threat to the NHS.	Likelihood:	2	30 June 2021
Consequence:	4	5	5	n/a		Consequence:	4	
Risk Level:	Ext 16	Ext 15	Ext 15	n/a		Risk Level:	High 8	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Investment already made in enhanced Cyber Tools and defence (Intercept-X) to protect against 'wannacry' type attacks. • Server and PC patching in place and enhanced network firewalls and other network perimeter controls. • Cyber Action plan in place • Dedicated Cyber defence lead role appointed to • Deployment of Microsoft Advanced threat detection to improve cyber defences	• Implementation of National Cyber Security Centre recommendations on passwords • Raised staff awareness and understanding of cyber security through education and communication • NHS Digital accredited awareness training provided to Board members • NHS Digital Cyber essentials best practice being progressed • IM&T Programme Board in place	• Auditing from NHS Digital and other agencies undertaken during 2018 to demonstrate good practice and areas for improvement (which have been addressed). • External Penetration Testing has been undertaken and a remediation plan developed
Assurance:	• During Q1 there have been no significant threats to cyber security		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**RAG**
1.	Deployment of Windows 10 with improved in built security and based on National Cyber Security Centre and Microsoft best practice	Director of IM&T	31/03/2020	Design and infrastructure underway. Deployment commenced in November 2019. Deployment schedule to hit circa 2,000 devices by the end of March 2020. Remaining deployment dependent upon the financial leasing agreement due to be completed by October 2020.	
2.	Implementation of DarkTrace - uses Artificial Intelligence / Machine Learning to detect and respond to subtle, stealth attacks inside the network — in real time. Does not require previous experience of a threat or pattern of activity in order to understand that it is potentially threatening.	Director of IM&T	31/03/2020	HSLI Funding secured; Software implemented across both Royal Stoke and County Hospital sites. The Software changed from alerting of potential threats to blocking potential threats, and the next phase is to enable the autonomous mode of monitoring due to be enabled in January.	
3.	Continue work towards Cyber Essentials (plus) and ISO27001 compliance	Director of IM&T	30/06/2021	NHS Digital sponsored engagement with PA Consulting in progress to provide a readiness assessment for Cyber Essentials Plus.	

Risk Description:	If there continues to be storage of combustibles on the hospital streets and other escape routes then there is increased opportunity for deliberate fire (arson), and obstructed escape routes, resulting in physical damage to the building, potential spread of fire / smoke through the building and congested evacuation, compromising the safety of all occupants (staff, patients, members of the public) and regulatory enforcement action as a result of failing to carry out duties imposed by the Regulatory Reform Fire Safety Order 2005, reputational damage as a result of media coverage and interruption to service delivery / adverse impact on patient activity and associated income.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	
		CQC Recommendations	✓

Links to Corporate Risk Register:	Title	Current Risk Score
	Risk of Fire/smoke spread in individual buildings	Mod 4 – High 9

Executive Director Lead:	Director of Estates, Facilities & PFI	BAF Reference:	BAF 3

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2	n/a	Regular inspections conducted throughout Trust premises identify that combustible materials and other items such as beds and equipment are left in unsupervised public access areas such as the Hospital Streets and other escape routes.	Likelihood:	1	29 Feb 2020
Consequence:	5	5	5	n/a		Consequence:	4	
Risk Level:	High 10	High 10	High 10	n/a		Risk Level:	Low 4	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• KPI's established as part of the CEF process. • Trust Fire Safety Policy in place. • Security Management Policy and associated procedures and practices in place (includes reference to Arson prevention). • Housekeeping Task and Finish Group with representation from all Divisions in place to oversee ongoing actions relating to Housekeeping • Theatre compartmentalisation work completed in tandem with statutory maintenance programme.	• Mechanism for 'on the spot' issue of improvement notices in place. • Fire Safety Training in place. • Consolidated Fire Safety Action Plan in place	• Fire Enforcement Notice lifted in March 2019 and Fire Service assured that all recommendations had been delivered
Assurance:	• Trust wide information demonstrates expected standard of housekeeping • Security risk assessments linked with arson awareness demonstrates the importance of maintaining appropriate security measures to reduce the risk of arson	• Regular reporting arrangements are in place via the Trust Health and Safety Committee, Estates and Facilities to Quality Safety Forum, TJNCC • Fire prevention linked with Care Excellence Framework (CEF) demonstrates an acceptance of a level of prevention and fire safety management locally • Trust fire safety management team ad-hoc inspections with ability to issue on the spot improvement notices,	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		demonstrates continued performance monitoring • Monitoring of the consolidated Fire Safety Action Plan at Trust Board demonstrates that all actions have now been completed with the exception of ongoing actions which relate to Housekeeping.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	RAG
1.	Task and Finish Group for Housekeeping to continue to meet and conduct regular visits of all Trust premises reporting back findings to the Operational Fire Group	Director of Estates & Facilities and PFI	31/03/2020	Housekeeping continues to be monitored by the Housekeeping Group until further notice.	

Risk Description:	If clinicians at County Hospital are unable to facilitate rapid clinical specialty review or arrange for urgent patient transfer to Royal Stoke University Hospital, then there is a risk of patients receiving delayed specialist review / input, resulting in significant patient harm and reputational damage as a result of complaints and adverse incidents.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score
	n/a	

Executive Director Lead:	Medical Director	BAF Reference:	BAF 4

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	2	n/a	The score has remained the same as the previous quarter;, reflecting the current controls in place and assurances received to date.	Likelihood:	2	31 March 2020
Consequence:	4	5	5	n/a		Consequence:	4	
Risk Level:	High 12	High 10	High 10	n/a		Risk Level:	High 8	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• New agreed transfer standard operating procedure agreed and implemented which clearly defines the process for transferring patients between County Hospital and Royal Stoke • Standard operating procedure agreed and implemented to clarify the anaesthetic support required for patients prior to transfer	• Medical Director communication to all Consultant / Medical Staff regarding the acceptance of patients being transferred from County Hospital • The Task & Finish Group has agreed on clear clinical specialty input arrangements for staff/patients at County Hospital	• CQC review
Assurance:	• Monitoring of adverse incidents within the divisional governance forums and escalation of concerns. • Information on transfer related incidents included within existing governance reports.		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	To agree formal referral criteria for direction of ED attendance between sites (County of RSUH)	Medical Director	31/03/2020	Discussions remain ongoing with UHNM and WMAS to agree the protocol criteria for attendance at RSUH or County Hospital.	
2.	Audit of transfers between County and RSUH to identify effectiveness of the pathway to be undertaken and any areas of escalation to be formalised to the Medical Director	Medical Director	31/01/2020	An initial audit has been undertaken and additional work has been requested from the Medical Director to formalise this process. A further report is to be provided to the Quality Assurance Committee in January 2020.	

Strategic Objective 2:
Achieve NHS constitutional patient access standards

Assurance Committee:	Performance and Finance Committee	Executive Lead:	Chief Operating Officer

Risk Description:	If unplanned emergency demand exceeds UHNM capacity then capacity will not be sufficient to deliver emergency access targets, leading to potential regulatory enforcement, fines, risk of harm to patients and cancellation of elective work.

Key Source of Objective	
2025 Vision	✓
2019/20 Financial & Operational Plan	✓
CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 9209 Risk of capacity being exceeded due to demand	Ext 20	ID 9214 Risk of increase in MFFDs compromising patient flow	Ext 20

Executive Director Lead:	Chief Operating Officer	BAF Reference:	BAF 5

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	5	5	5	n/a	Current performance illustrates the high likelihood of this recurring on a regular basis.	Likelihood:	3	31 Dec 2020
Consequence:	4	4	4	n/a		Consequence:	4	
Risk Level:	Ext 20	Ext 20	Ext 20	n/a		Risk Level:	High 12	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• ED Emergency footprint has been reviewed. Business Case for ED staffing confirmed and recruitment in train. • Medicine and Deloitte redrafting 2020 improvement plans • Revised Corporate bed meeting structure in place	• 3 Multi agency MADE events to create on-going capacity • Urgent Care Delivery Group Monitoring • Divisional Performance reviews • CRIS impact as programme scales up • UHNM and LHE Winter Planning	• NHSI winter funding to support acute frailty and in reach to nursing homes
Assurance:	• Fortnightly reports from Medicine/Deloitte detailing actions against plans and performance	• Monthly Performance reports demonstrating; 4 hour ED performance, Stranded Patient Numbers, MFFD numbers	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	Impact of amendments to ED footprint and emergency floor to be reviewed.	Chief Operating Officer	28/02/2020	Action not yet due. Deloitte supported ED improvement plan drafted with monitoring via Urgent Care Programme to support further floor changes	
2.	Arrange winter debrief session that informs a refreshed urgent care plan for 2020/21.	Chief Operating Officer	31/03/2020	Action not yet due.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**RAG**
3.	On call out of hours and in hours operational management structures under review.	Chief Operating Officer	28/02/2020	Action not yet due. We are currently benchmarking ourselves against other NHS and revised on call structure included within the formal management of change launched January 2020.	

Risk Description:	If demand for elective activity exceeds capacity then this will impact on our ability to meet relevant planned care access targets and cancer targets, resulting in longer wait times and risk of harm to patients.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 10333 Increase in waiting times and inability to deliver planned care pathways	High 12	ID 10342 Insufficient capacity to cope with increased 2WW referrals	Ext 16

Executive Director Lead:	Chief Operating Officer	BAF Reference:	BAF 6

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	n/a	Improvements in Elective Access performance (RTT and Cancer)	Likelihood:	2	30 Sept 2020
Consequence:	4	4	4	n/a		Consequence:	4	
Risk Level:	High 12	High 12	High 12	n/a		Risk Level:	High 8	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• IST Modelling completed and updated to support 2020/21 IBP to identify capacity gaps for Cancer and RTT. • Divisional improvement plans drafted for RTT and Cancer plan first draft completed with additional detail being appended linked to performance improvement impact. • Revised Corporate Trust and Performance Access meetings in place to monitor elective care performance. • Interim Head of Cancer commenced 6.1.19 to support cancer improvement and performance.	• Validation Teams in place with weekly targets to sustain RTT recovery (NHSI trajectory met December 2019) • Theatre productivity plans • Outpatient productivity plans • Cancer Recovery Plan and monitoring in place • Divisional Performance reviews • Review of tax laws will support additional TI capacity for 2ww, 62 days and 52 ww patients. This capacity reduced in 2019 as a consequence of the tax law changes to detriment of the PTL.	
Assurance:	• Revised format for cancer PTL, forecast and performance monitoring introduced November 2019 linked to cancer improvement trajectory.	Monthly Performance Report demonstrating: • Incomplete patient episodes • 18 week backlog • The number of patients waiting over 52 weeks • Planned Care Delivery Group chaired by Deputy Medical Director for monthly monitoring of improvement actions. • RTT performance improved by 10% since implementation of Planned Care Recovery Programme.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**RAG**
1.	Review Impact of <6 weeks Hospital Cancellations on capacity	Chief Operating Officer	31/01/2020	Action not yet due – work in progress.	
2.	Task and Finish Group to be convened to scope work plans and support delivery of improvements regarding legacy review by date issues	Chief Operating Officer	31/03/2020	Action not yet due.	

Risk Description:	If the United Kingdom Leaves the European Union without a deal then UHNM may not be able to deliver essential services resulting in failure of access targets and potential patient harm.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score

Executive Director Lead:	Chief Operating Officer	BAF Reference:	BAF 7

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	n/a	3	1	n/a	Risk reduced as there is currently no possibility of a No Deal EU Exit. The UK leaves the EU and enters into the transitional period from 31st January 2020. This will see all current arrangements with the EU maintained whilst trade deals, border organisation and movement of people issues are negotiated with the EU. The risk of a No Deal Exit is now pushed back to the end of this transitional period in December 2020.	Likelihood:	2	31 Dec 2020
Consequence:	n/a	3	3	n/a		Consequence:	2	
Risk Level:	n/a	High 9	Low 3	n/a		Risk Level:	Mod 4	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Brexit Response Group in place with weekly meetings from October 3rd 2019 • Brexit Work stream leads identified in order to manage Brexit specific risks • UHNM Command and Control Structure in place to work in tandem with UHNM Winter Room and EPRR Function	• UHNM part of Staffordshire Resilience Forum No Deal EU Exit planning forums • Regional Command and Control structure in place for escalation of operational issues	• National contingencies in place implemented by DFT and DHSC • National Command and Control structure in place
Assurance:	• UHNM have completed NHSE/I baseline assurance template with positive assurance on all criteria. • Assurance provided by work stream leads that all areas are working within NHSE guidance	• UHNM took part in Staffordshire Resilience Forum led NO Deal EU Exit workshop and exercise with assurance provided on NHS and wider preparations	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	UHNM EPRR team developing No Deal EU Exit Concept of Operations	Chief Operating Officer	31/12/2020	Risk to be kept under review as the Trust moves towards December 2020.	

Strategic Objective 3:
Achieve excellence in employment, education, development and research

Assurance Committee:	Transformation & People Committee	Executive Lead:	Director of Human Resources and Medical Director

Risk Description:	If we fail to recruit staff then premium pay costs will be incurred, staff sickness may increase and staff may become disengaged, all of which will impact on the delivery of services to our patients

Key Source of Objective	
2025 Vision	✓
2019/20 Financial & Operational Plan	✓
CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 9149 unengaged staff	Mod 6	ID 9154 staff wellbeing	High 9
	ID 9151 mismatch between Trust culture and values	High 9	ID 15136 pension tax	High 9

Executive Director Lead:	Director of Human Resources	BAF Reference:	BAF 8

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	3	n/a	There are pockets of specialities where recruitment is challenged, although these largely reflect national difficulties. Some headway has been made into recruiting permanently to the 'Hard to Recruit' posts, particularly Consultant posts, hence the reduction in risk. However, there still remains a number of long term/high cost agency locums in post. The staff engagement rate is slightly below national average, Turnover and stability rates remain consistent. Sickness rates are not reducing.	Likelihood:	3	31 March 2020
Consequence:	3	3	3	n/a		Consequence:	3	
Risk Level:	High 12	High 12	High 9	n/a		Risk Level:	High 9	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Workforce planning process ensures alignment with activity and financial plans • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes underway including Recruitment Open Days	• People Strategy and supporting HR Delivery Plan, with performance reported to the TEC on a quarterly basis and annually to the Trust Board • A consistent and cost effective approach to deploying medical workforce across the Trust and support improvements in medical productivity is in place (Medic On Duty, Medic Online, Activity Manager) • Partnership working with the STP to introduce a range of Recruitment and Retention initiatives • Establishment review is being undertaken for both medical and nursing which will provide a baseline	• Annual NHS Staff Survey – the results of the 2019 Survey are due February/March 2020 • Periodic pulse checks – The Q2 Staff Friends and Family Test showed an increase in the percentage of staff saying they would recommend the Trust as a place to work from 51.16% in Q1 to 57.36% in Q2
Assurance:	• HRM's report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews	• Monthly reports to Finance and Performance Committee cover hard to recruit posts and long term agency	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	• The impact of the pension tax rules on some senior NHS staff has been presented to the Nominations and Remuneration Committee. • Risk assessments have been completed with regards to the impact on workforce from Brexit.	Analysis of data and historic trends, reported in monthly performance reports to TEC, FPC and Trust Board show: • Sickness rates – the overall sickness rate for the 12 months ending **30/11/19 had increased to 4.59%.** This increase in reported absence was expected as there was evidence that sickness absence was under-reported prior to the implementation of Empactis. Also, the increase is in line with previous year trends as winter pressures begin to impact • Turnover for the 12 months ending **30/11/19 had reduced slightly to 9.13%** • Stability rates for the 12 months ending **30/11/19 had improved to 90.132%** • The vacancy level at **31/08/19 had improved to 9.49%**	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	Improve staff recommendation of the organisation as a place to work from 57.20% to better than National average (*62.6% in 2018*) (as evidenced in the NHS Staff Survey)	Director of Human Resources	31/03/20	The 2019 Annual Staff Survey has been completed and the results are due in February/March 2020	
2.	To maintain staff turnover (excl Junior Doctors on rotation) to less than 11% per annum: *Measure = Number of Leavers (excl Junior Doctors on rotation) in preceding 12 months as % of Average Headcount*	Director of Human Resources	31/03/20	Turnover for the 12 months ending 30/11/19 was 9.13%	
3.	To increase the number of apprenticeships from 167 to 200	Director of Human Resources	31/03/20	As at 31/12/19, there were 159 apprentices in the Trust. All Divisions have been set targets for achieving apprentice numbers.	
4.	To support at least 300 Work Experience Placements (placed on programme) in 2019/20 (75 placements Trust-wide in each quarter)	Director of Human Resources	31/03/20	Between April and December 2019, there have been 455 successful Work Experience placements.	

Risk Description:	If the workforce feel disengaged, with low morale, then we will fail to retain staff which will impact on service delivery; increase turnover and pressures to recruit; increase premium pay costs; increase staff sickness	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 9151 mismatch between Trust culture and values	High 9	ID 9154 staff wellbeing	High 9

Executive Director Lead:	Director of Human Resources	BAF Reference:	BAF 9

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4	n/a	The Q2 Staff Friends and Family Test showed an increase in the percentage of staff saying they would recommend the Trust as a place to work from 51.16% in Q1 to 57.36% in Q2. Also, the percentage of staff who would recommend the Trust as a place to receive care improved slightly from 83.69% (Q1) to 83.75% (Q2). The Operational Excellences State of Readiness report indicated that staff engagement was good, albeit based on a small sample. The risk rating has not been reduced at this time as the key assurance will come from the NHS Staff Survey results, due February/March 2020	Likelihood:	3	31 March 2020
Consequence:	3	3	3	n/a		Consequence:	3	
Risk Level:	High 12	High 12	High 12	n/a		Risk Level:	High 9	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Workforce planning process ensures alignment with activity and financial plans • Ongoing recruitment processes underway	• People Strategy and supporting HR Delivery Plan, with performance reported to the TEC on a quarterly basis and annually to the Trust Board • Partnership working with the STP to introduce a range of Recruitment and Retention initiatives	
Assurance:	• HRM's report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • The diagnostic phase of the NHSi Culture and Leadership Programme is currently in progress and will provide an additional indicator of staff engagement	• Monthly reports to Finance and Performance Committee cover hard to recruit posts and long term agency Analysis of data and historic trends, reported in monthly performance reports to TEC, FPC and Trust Board show: • Sickness rates – the overall sickness rate for the 12 months ending **30/11/19 had increased to 4.59%.** This increase in reported absence was expected as there was evidence that sickness absence was under-reported prior to the implementation of Empactis. Also, the increase is in line with previous year trends as winter pressures begin to impact • Turnover for the 12 months ending **30/11/19 had reduced slightly to 9.13%** • Stability rates for the 12 months ending **30/11/19 had improved to 90.132%** • The vacancy level at **31/08/19 had improved to 9.49%**	• Annual NHS Staff Survey and periodic pulse checks • The Q2 Staff Friends and Family Test showed - an increase in the percentage of staff saying they would recommend the Trust as a place to work from 51.16% in Q1 to 57.36% in Q2 - the percentage of staff who would recommend the Trust as a place to receive care improved slightly from **83.69% (Q1) to 83.75% (Q2)**

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**RAG**
1.	To identify all service critical roles (Band 7 and above) and ensure succession plans are in place for all those identified.	Director of Human Resources	30/06/20	47 roles have been identified with successors. This is 33% of the planned 141 roles.	
2.	To ensure 879 (40%) of identified Band 6 & 7 leaders have completed a leadership development masterclass [Baseline = 2207]	Director of Human Resources	31/03/20	798 completions of Band 6/7 staff by 25/09/19 = 33%	
3.	To reduce the 12m cumulative sickness rate to 3.39%	Director of Human Resources	31/03/20	Trajectories to attain the sickness rate target have been set with Divisions. Divisions are off trajectory and, based on current performance, the 12 month rolling sickness rate is forecast at around 4.2%. Performance against trajectories is monitored via the Divisional performance review process. The Trust Wellbeing plan Is being implemented Divisional people plans are in place and bespoke work is ongoing in the Divisions to identify and address causes of absence. The Empactis System implementation went live from 30 September 2019	
4.	To maintain staff turnover (excl Junior Doctors on rotation) to less than 11% per annum *Measure = Number of Leavers (excl Junior Doctors on rotation) in preceding 12 months as % of Average Headcount*	Director of Human Resources	31/03/20	Turnover for the 12 months ending 30/11/19 was 9.13%	
5.	Improve staff recommendation of the organisation as a place to work from 57.20% to better than the national average (62.6% in 2018)	Director of Human Resources	31/03/20	The diagnostic phase of the NHSi Culture and Leadership Programme is in progress. The 2019 Staff Survey has concluded and the results will be published February/March 2020	

Risk Description:	If there is insufficient workforce supply to ensure the safety and sustainability of clinical services, including 7 day services, then there will be compromised patient safety	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	n/a			

Executive Director Lead:	Medical Director	BAF Reference:	BAF 10

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	2	n/a	The reduction in risk score reflects the improved ability to fill posts, particularly in A&E although there remains some vulnerability.	Likelihood:	1	31 March 2020
Consequence:	5	5	5	n/a		Consequence:	5	
Risk Level:	Ext 15	Ext 15	High 10	n/a		Risk Level:	Mod 5	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Targeted recruitment campaigns and open days to attract new employees, focussing on 'hard to fill' posts • Establishment control processes in place • Rotas and rota coordinators • Directorate and divisional management teams to monitor staffing levels • 7 Day Services Working Group in place	• Developing the recruitment and selection skills of managers to include values-based assessment techniques to improve recruitment processes • Strategy for Nursing Associates • Action Plan to achieve 7 day services compliance	• External assessment/review of Trusts 7 Day Service arrangements
Assurance:		• 7 Day Services self-assessment returns • Quarterly assurance reports to QGC on compliance progress against the standards • Submission provided to NHSE in November 2019, demonstrating full compliance with standards 2, 5 and 6.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	7 day services steering group to specifically target improvement in weekend performance against CS8, agreeing a local standard (in an appropriate form) covering the requirements for Consultant directed continued review and delegation	Medical Director	31/03/20	Action not yet due. Compliance in relation to remaining standard to be confirmed in next submission.	

Risk Description:	If we don't adequately recruit staff and infrastructure to deliver the Trust's R&D Strategy then this will lead to loss of patients being admitted on to trials resulting in loss of income and reputation as a leading healthcare organisation	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 11125 Sustainable research and development	High 9	ID 9607 risk of inability to meet legal GCP and MHRA requirements	High 8

Executive Director Lead:	Medical Director	BAF Reference:	BAF 11

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	n/a	The risk score remains the same given that the Department are still recruiting to staff posts and rolling out the actions and QMS following the recent Medicines and Healthcare products Regulatory Agency (MHRA) inspection	Likelihood:	2	31 March 2020
Consequence:	4	4	4	n/a		Consequence:	3	
Risk Level:	High 12	High 12	High 12	n/a		Risk Level:	Mod 6	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• New Quality Management System implemented to provide clear infrastructure and governance within the R&I Department • Following restructure, staff are now being appointed to fill significant capacity gaps. Despite the low staff levels, patient recruitment to clinical research studies is starting to grow	• Reviewed and published new Research & Innovation Strategy • Action plan in response to the MHRA R&D inspection reported to the QGC and regular updates provided	• The recommendations from the MHRA inspection have been completed and signed off by the regulator who are satisfied with the progress made
Assurance:		• Membership of West Midlands Clinical Research Network Partnership Group, with monthly reports of performance to this group and to the National Institute for Health Research • Update provided to the Trust Board in December 2019 with further updates to be provided to the Quality Governance Committee	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	To continue to recruit to staff posts to address capacity gaps within R&D structures	Medical Director	31 March 2020	Progress continues to be made in terms of recruitment to posts.	

Strategic Objective 4:
Lead strategic change within Staffordshire and beyond

Assurance Committee:	Performance & Finance Committee	Executive Lead:	Director of Strategy

Risk Description:	If necessary resource, infrastructure and focus is not given to system priorities, then programme objectives may not be delivered, resulting in an imbalance between capacity and demand, inability to provide 'care closer to home' in line with the NHS Long Term Plan.
Links to Corporate Risk Register:	n/a

Key Source of Objective	
2025 Vision	✓
2019/20 Financial & Operational Plan	✓
CQC Recommendations	

Executive Director Lead:	Director of Strategy	BAF Reference:	BAF 12

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	n/a	Failure to deliver the programme objectives would impact upon the whole organisation and would have consequences for patient experience, ability to achieve the financial plan and delivery operational standards.	Likelihood:	1	31 March 2020
Consequence:	4	4	4	n/a		Consequence:	4	
Risk Level:	High 12	High 12	High 12	n/a		Risk Level:	Mod 4	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Identified project sponsors and project leads for each programme	• Programme Management Arrangements (system wide) in place • Chief Executive Forum oversight of delivery	
Assurance:		• Fortnightly progress reporting introduced as a source of assurance to the Chief Executives Forum • TDU Assurance Reports to Executives Forum demonstrate delivery of milestones although they lack assurance with regard to outcomes / benefit	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	To review the delivery infrastructure across the system to ensure delivery of programmes to deliver the 5 year plan.	Director of Strategy and Transformation	31/03/20	Review of infrastructure underway.	

Strategic Objective 5:
Ensure efficient use of resources

Assurance Committee:	Performance & Finance Committee	Executive Lead:	Chief Finance Officer

Risk Description:	If individual key performance indicators associated with the financial plan are not achieved then the Trust will fail to deliver its overall financial plan resulting in, continued regulatory enforcement action, a requirement for additional borrowings, an increased CIP for future years and reputational damage.

Key Source of Objective	
2025 Vision	✓
2019/20 Financial & Operational Plan	✓
CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 14674 Delivery of Cost Improvement Programme	Ext 15	ID 14675 Intelligent Fixed Payment System	High 12

Executive Director Lead:	Chief Finance Officer	BAF Reference:	BAF 13

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	2	n/a	The Trust is £4.6m ahead of plan at month 8. Provisions are still being held to cover the expected costs of winter and the Trust's expected exposure under the STP Risk Share. The Trust forecasting that it will achieve a surplus of £5m for the year and whilst there are a number of risks that need managing it is confident that it will deliver this surplus supporting the overall STP financial position.	Likelihood:	2	31 Dec 2019 - achieved
Consequence:	4	4	4	n/a		Consequence:	4	
Risk Level:	High 12	High 8	High 8	n/a		Risk Level:	High 8	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Budgetary Control and Performance Management Systems • Identification of non-recurrent schemes to reduce in year impact • Identification of 2020/21 CIP schemes with value of £6.9 m as at month 8	• Exec Team oversight and management of £3m activity reserve	
Assurance:		• Month 8 Finance Report to Trust Board and Finance Committee shows a £4.6m favourable variance • Month 8 Cost Improvement Programme report to Finance Committee shows £0.3 m ahead of plan • Budget Reset Paper at Q1 approved by F&P Committee identified schemes to mitigate the shortfall in the CIP programme	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**RAG**
1.	Pursue receipt of TSA funding from DH and CCGs	Chief Finance Officer	31/03/2020	The business case has been shared with NHSI to support the receipt of non-recurrent funding for the Modular Theatres/Wards (£2.8m). The Trust is continuing to pursue the receipt of TSA funding from DH and CCGs with support from NHSI – invoices have been issued to both the CCGs and DH. The target date has been amended to the end of March, reflecting the ongoing discussions.	
2.	Ensure Trust's exposure under IFPM Risk Share is minimised	Chief Finance Officer	31/01/2020	The latest modelling by the STP finance team does not identify any financial exposure to the Trust (the Trust having accepted all of the financial risk on the £7m system savings attributed to it) under the IFPM risk share. In addition to this there is a risk of up to £0.6m on the risk sharing agreement with NSC which is factored into the Trust's forecast.	

Risk Description:	If there is a system failure and the onsite team or third party supplier is unable to restore the system, then 60% of phones at County Hospital will be unusable, resulting in staff being unable to make phone calls, impacting clinical services.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	n/a			

Executive Director Lead:	Director of Information Management & Technology	BAF Reference:	BAF 14

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	n/a	Given the age of the system there is a reasonable chance of it experiencing a fault that renders it unusable and the supplier is unable to restore the system. In this instance, staff would be unable to make calls from 60% of phones at County Hospital which would have a potentially catastrophic impact upon patient care in the event of a cardiac arrest.	Likelihood:	1	31 March 2020
Consequence:	5	5	5	n/a		Consequence:	4	
Risk Level:	Ext 15	Ext 15	Ext 15	n/a		Risk Level:	Mod 4	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Onsite engineers providing in house support	• Support contract in place albeit limited in the context of the system being end of life • Proforma raised for the provision of a replacement service, which is addended to the RSUH system.	
Assurance:	• The County Phone system is a Legacy system that is out of support; Hardware supported on a reasonable endeavour basis only, no software support available and no active maintenance or patching of hardware or software • Recent audit completed to estimate handset requirements	• Capital secured in 19/20 to replace the system. • Contractual approval sought from Project Co to attach a replacement system to the RSUH PFI solution	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	Confirm replacement solution design based on supplier quotes	Director of IM&T	31/10/2019	Works required from 3rd party (PO raised) as well as with KCOM. Awaiting engagement with KCOM to provide quote and confirm timescales for enabling works.	

Risk Description:	If there is a loss of network there is a risk of significant service interruption across patient facing services and potential breaches, cancellation of procedures, impact to patient targets, financial loss and adverse publicity.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 11066 Network Support	Mod 6	ID 9035 Network Kcom Processes for Planned and Reactive Changes	High 12

Executive Director Lead:	Director of Estates, Facilities & PFI	BAF Reference:	BAF 15

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	1	n/a	Likelihood and consequence has been reduced following the transfer of Medway services from the old to new core network, along with the intersite connections between Royal Stoke & County Hospital and the WAN links to other sites. All services are now provided on the new core network. The independent review is yet to be concluded.	Likelihood:	1	31 March 2020
Consequence:	4	4	3	n/a		Consequence:	2	
Risk Level:	High 12	High 8	Low 3	n/a		Risk Level:	Low 3	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Access to network configuration limited to key service provider only. • Network access limited to Trust staff and approved access only.	• Monitoring of performance of Kcom in delivering network and voice services delivered through contract performance management regime applied consistent with PFI contractual requirements. • This includes, but is not limited to, monthly performance and operational meetings and validation of performance reports, including network uptime/refresh and any deviations from required performance levels. • Multi-disciplinary attendance at formal performance and operational meetings is in place, including an intelligent client function, supported by IM&T representatives. This helps to ensure critical interface issues between the Trust network and Trust critical IM&T systems, of which clinical teams are dependent on, are managed appropriately. • All network hardware and software is supported by a lifecycle replacement programme that's progress is formally monitored and reviewed as part of the contract performance management arrangements • A resolution plan was agreed to temporarily release the overloaded network traffic and allow the switch to be restarted safely. • Recovery Group established and meeting twice weekly,	Independent review agreed following occurrence of the network incident, and following discussions at the network incident task and finish committee. An independent body CAE has been commissioned to review the incident, response and suitability of network and communication infrastructure /solutions at UHNM. CAE's findings in respect of their review received on 16/12/19. Report circulated for comments in respect of factual accuracy to key stakeholders. Output of the review will be used to identify any further actions which are to be discussed and agreed at the Network Sub-Group on 15th January, ahead of the Task and Finish Committee on 24th January 2020. Further review and feed-in from NHS bodies, such as; NHS Digital, NHS I, and other NHS Trusts will be actioned in order to be assured best practice is in place for managing and supporting the network service, mitigating risk and agreeing a policy for security and resilience.

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		chaired by the Deputy Chief Operating Officer. • Trust Network Critical Incident Task and Finish Committee established to oversee the implementation of all recommendations (from technical RCA) and from the Trust Post Incident de-brief.	
Assurance:	• Incidents are recorded through Trust Datix system in addition to PFI formal reporting processes, consistent with requirements of the contract. • UHNM Post incident 'Hot' de-brief/stakeholder session held 18th July 2019 • UHNM Internal Post Critical Incident Event Debrief held	• Contract Performance Management Framework in place that monitors the performance of voice and data services. • These arrangements are applied consistent with the contract requirements and performance achieved is subject to Trust Board reporting (Finance and Performance Committee). • Formal Root Cause Analysis completed into what caused the network issues.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	RAG
1.	Independent review of network incident, handling and suitability of network /telecoms solution in place.	Director of IM&T	25/12/2020	Action agreed at T&F committee to update timelines and expected completion date once order has been placed with independent review co. Order placed, independent review concluded and findings reported. Any further actions to be identified at Network Sub-Group for consideration at Task and Finish Committee on 24th January 2020.	

Risk Description:	If access to departments to carry out annual statutory and lifecycle maintenance cannot be provided then the Trust could fail to meet its statutory and contractual (PFI) obligations resulting in exposure to legal challenge, taking back elements of risk (statutory compliance, environmental safety / conditions) from Project Co. for which the Trust pays for, under the contract, a reduction in environmental conditions taking buildings below that of Condition B, higher backlog maintenance costs and reputational damage.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 9186 Risk of fire / smoke not being contained	Low 2		

Executive Director Lead:	Director of Estates, Facilities & PFI	BAF Reference:	BAF 16

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	2	n/a	This year's programme is not due to complete 31st March 2020, due to capacity issues the decant plan has had be rescheduled a number of times to date.	Likelihood:	2	January 2020
Consequence:	3	3	3	n/a		Consequence:	3	
Risk Level:	High 9	Mod 6	Mod 6	n/a		Risk Level:	Mod 6	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Published program of works on the intranet for 19/20 and emailed to stakeholders to inform all PFI contractual requirements • Local meetings between providers and users • Reduction of clinical / non-clinical activity to free up beds / departments	• Monthly maintenance group meetings with ADs / Deputy ADs to ensure progress. Minutes recorded and held by EFP & PFI.	• Evidence (held by P Co) that work is being completed
Assurance:		• Current program is running to plan	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	On-going meetings to review revised decant plan and 19/20 programme for wards following reduced A&E programme and ward 123 heating.	Director of Estates, Facilities & PFI	31/06/2020	Further works are required (Trent heating system repairs /replacement which requires decant to be extended). Decant plan and programme agreed and W123 to commence September. Ward 123 completed and handed back in October 2019. 2019/2020 PFI Clinical wards programme completed.	

Risk Description:	If there is a reduction in the Trust's estates capital funding allocation then this may result in service	Key Source of Objective

	disruption and potential loss of building and clinical services and potentially increase the risk of Health Care Associated Infections (HCAI) resulting in increase in risk exposure of clinical estate and infrastructure failures; increase in backlog maintenance liability for the Trust; introduction of health & Safety associated environmental issues due to physical condition (backlog maintenance) of engineering plant and equipment and statutory compliance including building integrity; impact on the patient experience by increased limited functionality of the built environment building services.	2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	n/a			

Executive Director Lead:	Director of Estates, Facilities & PFI	BAF Reference:	BAF 17

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	n/a	Failure to invest £16.725m to reduce the risk associated with the physical condition will increase the risk of clinical estate and infrastructure failures, introduce environmental and health and safety issues, reduce the patient experience by increased levels of poor aesthetics and limited functionality of the facilities. Additional resources and control measures have been put in place to monitor the trust infrastructure and identify the high risk backlog elements which may be subject to immediate failure and prioritise these items within the capital funds available for 2019/20.	Likelihood:	2	31 March 2020
Consequence:	3	3	3	n/a		Consequence:	4	
Risk Level:	High 9	High 9	High 9	n/a		Risk Level:	High 8	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Operational policies in place for Estate Management and maintenance. • Planned preventative maintenance (ppm) and inspection is carried out at pre-determined intervals or corresponding to pre-described criteria. • Trained competent estates personnel on site including Authorised Persons across estates disciplines to deliver maintenance programmes.	• Specialist Service Contracts are in place for service and maintenance • Estates Capital bids submitted to Trust Capital Investment Group (CIG)for 2019/20 take from 7 facet findings are namely (Bid no: 3830 Backlog / condition- £10.934m, Bid no: 3831 Statue Compliance - £5.791m) • Re-prioritisation of estates capital 2019/20 undertake	• Authorising Engineers appointed to provide external audit and assurance (governance) of building services and associated maintenance regimes. • Estate-code 7 facet property appraisal conducted to inform 10 year estates capital replacement programme and inform annual Trust capital bid process.
Assurance:		• Monthly Divisional performance estates maintenance reports • Report on the impact of reduced estates capital allocation 18/19 for UHNM retained estate taken to pre-execs and CIG • Validation and audits in place • Paper presented to Executive Team on 27th June 2019 highlighting the risks of failure to invest.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**RAG**
1.	Continuous on going review of maintenance system and performance reports by the senior estates managers and teams to identify any trends in respect to plant and equipment failure due to plant and equipment lifecycle. Any identified trends to be monitored and escalated from estates operational meetings.	Director of Estates, Facilities & PFI	31/01/2020	On-going review mechanism in place.	

Risk Description:	If the Trust continues to retain the Royal Infirmary Site which consists of unoccupied and deteriorating buildings, then the Trust will be liable for any injuries as a result of authorised or unauthorised access, resulting in death or serious injury; financial loss as a result of claims; breaches of statutory duty, long term health effects to both staff and public; adverse publicity; business and service interruption.	Key Source of Objective	
		2025 Vision	✓
		2019/20 Financial & Operational Plan	✓
		CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	n/a			

Executive Director Lead:	Director of Estates, Facilities and PFI	BAF Reference:	BAF 18

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	5	5	5	n/a	Future consequence is scored as catastrophic as the consequence of a person entering the building or site is death, permanent incapacity, a prosecution by the HSE / criminal investigation under the Occupiers Liability Act, multiple complaints following an injury or through environmental incident the likelihood of this is almost certain given the number of trespassers on the site and the wilful activity that is recorded as having taken place within the buildings. The mitigation of this risk is constantly challenged by the continual deterioration of the fabric of the building, which in parts date to over 150 years. Works are now complete in respect of the safe isolation of the HV/LV Electrical distribution to the derelict buildings. . However, there is still a live HV/LV supply to the sub-station located in the centre of the site, that feeds neighbouring properties. Works are underway to relocate this sub-station to the boundary of the site which is owned by Western Power. Whilst the risk of harm from electrocution has reduced there remains other significant hazards e.g. substances hazardous to health such as asbestos, unsafe flooring, underground ducts, falling debris and vermin. , Funding to erect a robust site perimeter and increase the manned guarding should reduce the likelihood of trespass and therefore reduce the risk once completed.	Likelihood:	1	31 March 2020
Consequence:	5	5	5	n/a		Consequence:	3	
Risk Level:	Ext 25	Ext 25	Ext 25	n/a		Risk Level:	Low 3	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• External areas locked and lower level windows are secured / screwed shut. • Internal areas locked off in some parts of the buildings. • Manned guarding security on site 24/7 which has been increased short term from September 2018. A request for additional funding to continue this service is being progressed.	• LSMS working with local Police • Business Case for additional security measures approved by the Trust Executive Committee • Police use selected buildings to undertake training on site providing a high profile deterrent • Options being considered for the disposal of the land / reduction of risk through demolition of buildings dependant on available funding and solution to relocate services	• NHSE/I completed a site visit 21/11/19 to support application of emergency funding.

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	• Areas checked and secured after break in; reactive maintenance. • CCTV available for a very limited part of the estate. • Single vehicle access. • Authorised access to buildings controlled by Permit to Work • Additional perimeter fencing installed. • Mortuary windows boarded • Fire Risk Assessment undertaken for derelict buildings • Project team established	currently accommodated on the site. Provision of a separate electrical feed to supply the EFP building and car parking lighting and CCTV only has now been agreed with Western Power Distribution. This will enable the existing electrical infrastructure on the RI site to be fully isolated and switched off. Project completed December 2019. Work is underway to relocate the remaining HV/LV supply that feeds to the adjacent neighbouring properties to the perimeter of the site. • Work is underway on a proposal with STP partners to deliver a potential solution to expedite the clearance / demolition of the site and re-provide the car parking. • Regular meetings are in place between senior STP / Trust representatives and key activities currently being progressed relate to the development of the Heads of Terms and Legal Partnership Agreement.	
Assurance:	• There have been 304 recorded incidents of trespass and break-ins at the Royal infirmary since September 2017. These include significant incidents such as theft of copper cable and medical pipework, assault on security attendant, removal of a lift shift cover, lighting of candles, tampering of electrical equipment, evidence of smoking and drug taking and removal and deliberate damage to CCTV and window boarding. • Incidents are recorded through Datix and through APCOA. • Incident reports are monitored and used to inform the security strategy • Incidents of break-ins in progress are reported to the Police. • There has been an increased discussion and awareness of the site through social media and specifically web sites relating to urban exploration. This has significantly changed the nature of the activity on site. Recent postings on social media continue to attract urban explorers to the site	• Security reports are presented at the Divisional Management Team meetings. • This risk is reviewed and updates on current position are provided at the risk meeting of Divisional Management Board with minutes transcribed • Support from the Police, presence on site and attendance to reports of criminal activity in progress on site. • Site conditions are discussed at the Estates H&S meetings with minutes transcribed • Regular updates are provided to Trust Board. • Project team established, regular meeting are held including project milestones for example planning applications, reserved matters and design development.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**RAG**
1.	To continue with reactive repairs following break ins / damage caused / general building deterioration	Director of Estates, Facilities & PFI	Ongoing	This remains on-going as and when damage occurs.	
2.	Work is underway on a proposal with STP partners to deliver a potential solution to expedite the clearance / demolition of the site and re-provide the car parking.	Director of Estates, Facilities & PFI	21/02/2020	Negotiations on-going with all stakeholder is reaching a solution. Main barrier to progress is funding.	
3.	Regular meetings are in place between senior STP / Trust representatives and key activities currently being progressed relate to the development of the Heads of Terms and Legal Partnership Agreement.	Director of Estates, Facilities & PFI	21/02/2020	Negotiations on-going with all stakeholder is reaching a solution. Main barrier to progress is funding.	
4.	A further option is being explored at pace with national colleagues. This will involve the potential for a loan to UHNM to complete all demolitions / clearance works on site and re-provide displaced car parking. This will potentially be reviewed and agreed through an accelerated Business Case process and will include the potential for emergency funding to support the provision of boarding around the perimeter of the RI site to reduce the incident of trespass and associated risks.	Director of Estates, Facilities & PFI	21/02/2020	Regular calls are taking place between Trust and national colleagues to progress.	
5.	Refresh on critical enabling documents	Director of Estates, Facilities & PFI	07/02/2020	Estates Strategy, sustainability policy and travel plan reviews in progress	
6.	Develop full business case based on the outcome of the options appraisal	Director of Estates, Facilities & PFI	21/02/2020	Consultants have been appointed to support and develop the business case for NHSE/I following the options appraisal workshops. Weekly on-going conference calls and fortnightly project strategy meetings in place.	

Risk Description:	Insufficient capital to replace end of life / out of warranty / low specification devices. The volume of breakdowns could increase, devices may no longer be fit for purpose and offer effective support for the latest operating systems and UHNM IT systems. This will result in in a negative impact upon the digitalisation programme and paperless clinics. Devices will not be suitable for Windows 10 and not meet the requirements of clinical users. The Trust will be more vulnerable to cyber attack

Key Source of Objective	
2025 Vision	✓
2019/2020 Financial & Operational Plan	✓
CQC Recommendations	

Links to Corporate Risk Register:	Title	Current Risk Score	Title	Current Risk Score
	ID 9912 Capital funding for Microsoft products end of life Jan 2020	High 12		

Executive Director Lead:	Director of Information Management & Technology	BAF Reference:	BAF 19

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4	n/a	There has been limited capital for device replacement for the last 4 years. Devices are approaching end of life and are not able to meet the increasing demands required of them. It is highly likely that some users will experience issues with devices that has a major impact on the ability to perform essential clinical tasks on them.	Likelihood:	3	31 March 2020
Consequence:	4	4	4	n/a		Consequence:	4	
Risk Level:	Ext 16	Ext 16	Ext 16	n/a		Risk Level:	High 12	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Replacement of devices in key clinically critical errors in response to feedback from medical staff	• Monitoring of the age of all IT equipment across UHNM to track systems that are approaching end of warranty period. • The requirement for capital to address this risk is made clear at appropriate forums e.g. CIG. This has been raised this year with full documentation with a critical replacement programme for the next 3 years. • IM&T 3 year capital replacement plan	• Existing single user devices whose asset life has been 'sweated' are monitored for failure trends due to the volume numbers of those devices and to pick up early and mean time between failure indicators. This has been identified as good practice previously by KPMG, and is standard ITIL problem management
Assurance:	• Asset registers for all systems and devices across the UHNM estate. • Monthly IM&T incident reporting for trends in device failures and issues	• Customer (end user) satisfaction survey whereby number of complaints received regarding end of life devices.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	RAG
1.	Configuration of devices to 'log off' dormant windows sessions from devices and release computing resource to other users	Director of IM&T	28/06/2020	Testing in pilot area so far successful. Continue to monitor pilot before a trust wide roll out.	
2.	Raise risk at CIG	Director of IM&T	28/06/2020	Ongoing.	
3.	Review alternate options of acquiring replacement ICT Infrastructure	Director of IM&T	30/11/2019	Working group set up to progress including IM&T, Finance and Procurement. Proposal received for review.	

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th February 2020
Report Title:	Quarterly Speaking Up Report – Quarter 3	**Agenda Item:**	15.
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of Human Resources		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings presented to and outcome of discussion:

Transformation and People Committee – 24th January 2020. Report received and actions for next quarter confirmed.

Summary of Report, Key Points for Discussion including any Risks:

It was established that quarterly reports would be submitted on speaking up activity for consideration and learning. This report details progress made since the previous report of October 2019 in relation to developing our speaking up culture together with a summary of concerns raised for the Quarter 3 period of October - December 2019.

During the quarter 15 concerns were recorded on the speaking up tracker. One of the concerns was raised anonymously. One concern was received via the Care Quality Commission. Concerns recorded include issues raised with the Freedom to Speak Up Guardians and those raised to the Executive Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker.

This report also summarises contacts made to our Employee Support Advisors during the Quarter.

Progress against the FTSU Index Gap Analysis action plan is included as an Appendix.

Key Recommendations:

Trust Board is asked to consider the themes and type of concerns raised during Quarter 3 and the actions proposed during Quarter 4 of 2019-20 to further encourage and promote a culture of speaking up at UHNM.

Quarterly Speaking Up Report
January 2020

1. Introduction

The UHNM Freedom to Speak Up Guardian has logged concerns raised since 1st April 2016. At the time of this report, 170 concerns have been raised either directly to a FTSU Guardian, or the Guardian has been notified of concerns raised with a Designated Officer within the Trust or reported within a department or via another route, such as the Chief Executive office or CQC.

This Quarter 15 concerns have been reported on the speaking up tracker, and 15 contacts made to our Employee Support Advisors.

2. Learning and Sharing from National Guardians Office Case Reviews and National Guidance

The National Guardians Office (NGO) has not released any Case Reviews or speaking up guidance during the quarter.

NGO Freedom to Speak Up Index Report 2019 Gap Analysis

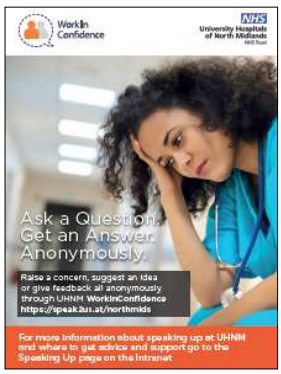
In October 2019 the NGO with NHS England and NHS Improvement published the first Freedom to Speak Up Index report, designed for Trust Boards to use as a measure of the speaking up culture within their organisation. In November 2019 a Gap Analysis against the Index was presented to the Quality Assurance Committee meeting. The Action Plan created to close the gap between UHNM performance and the acute trust average scores is attached as an Appendix.

3. Supporting a Speaking Up Culture

Work in Confidence

The anonymous reporting system Work in Confidence was launched on 27th November, initially as a pilot for doctors in training at UHNM. Work in Confidence is an anonymous communications system, which enables doctors in training to have a conversation confidentially and anonymously with their postgraduate education team and wider organisation. It can be used to raise an issue, concern or idea for improvement without needing to reveal your identity, there is also discussion board functionality enabling open conversations about topical issues.

All doctors in training have been communicated with to inform them of this new system, with posters developed:



PROUD TO CARE

Funding is available for 12 months and the pilot will be reviewed after 3 months and the system leads – Maggie Babb, Doctors Support Lead and Charlotte Lees, FTSU Guardian will report back at 6 months on the success of the pilot. A summary report of issues raised through the system will be reported through the Medical Local Negotiating Committee.

Just and Learning Culture

The revised Speaking Up Policy, Speaking Up Plan and updated Disciplinary Policy now have the Just and Learning Framework embedded. This demonstrates the Trust vision for a healthy speaking up culture with a focus on learning and improving and not who is responsible or to blame.

Speaking Up Training

In August 2019 the NGO released national guidelines on Freedom to Speak Up training in the health sector in England. These guidelines are set out in three parts covering three broad groups of workers:

Section	Workers
Core training	All workers Line and middle managers Senior leaders
Line and middle management training	Line and middle managers Senior leaders
Senior Leader training	Senior leaders

The guidance specifies the elements the NGO expects to be included within training delivered to NHS workers. It is for individual trusts to decide how to provide the training.

A Trust Board Development Session was held on Tuesday 14th January, led by Tom Grimes from NHS England & NHS Improvement, and this has covered the senior leader training requirement. The next steps will be to review the UHNM Speaking Up Self Review Tool.

Core training for all staff will be included within the statutory and mandatory Equality, Diversity and Dignity at Work training package. Line and middle management training to be included in the Gateway to Management, a manager e-learning master class package and Connects Leadership programme.

Appointment to Associate Freedom to Speak Up Guardian

Expressions of interest were sought from across the organisation for the Associate Freedom to Speak Up Guardian role, to replace Trish Rowson. Following interviews on 10th January 2020 Su Lapper, Clinical Development Nurse, and Karen Henshall, Outpatient Matron have been appointed to the role. Posters and communications will follow to promote these new appointments.

Anti-Bullying Week 2019

The 11 – 15th November was national anti-bullying week. The week marked the launch of our Cut it Out campaign, with a focus on direct messages about the impact and detriment of bullying and harassment in the workplace. Each division in the Trust has been issued with a resource pack and posters to display in their areas. An updated infographic and Cut it Out intranet page have been developed with guidance and information to signpost staff to emotional support, advice and confidential support from Employee Support Advisors/FTSU Guardian and trade union and relevant leadership development.

PROUD TO CARE

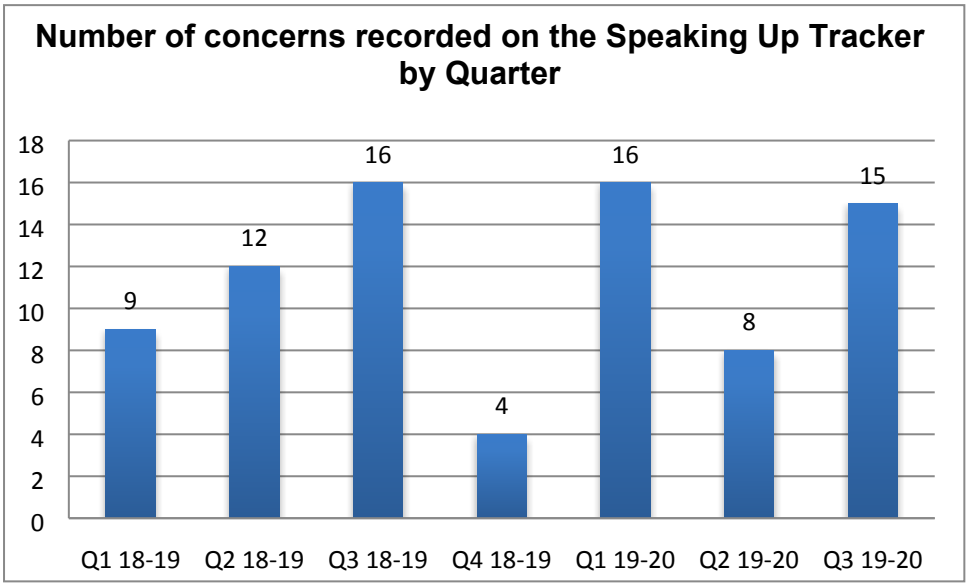
4. Quarterly Speaking Up Cases – Quarter 3 – October to December 2019

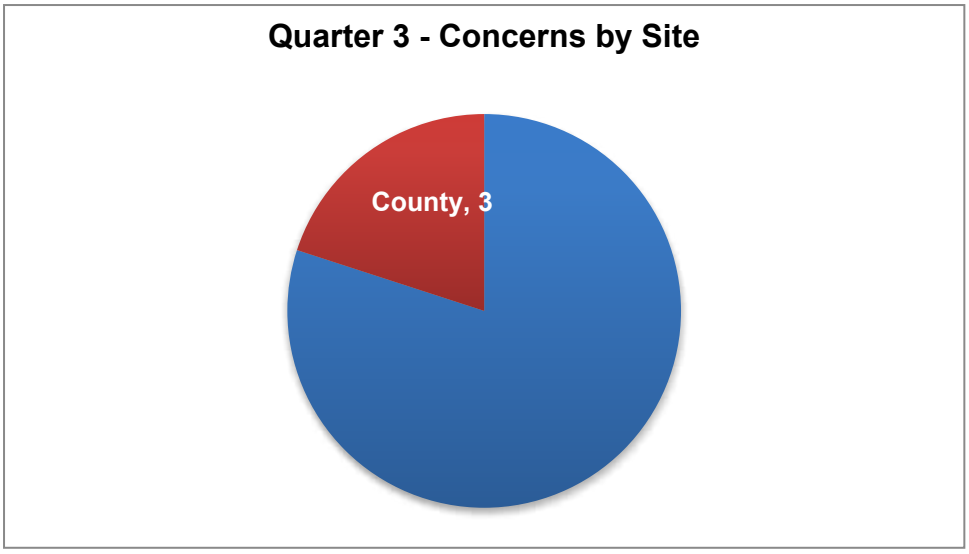
The following information reflects concerns that have been recorded on the Speaking Up tracker. Concerns are recorded in accordance with guidance from the National Guardians Office. Concerns are themed in line with categories issued to NHS Trusts by the NGO. The following information is presented so that patterns emerge over time, whilst being mindful about the need for confidentiality. The data is intended to draw attention to particular issues, patterns of activity or themes.

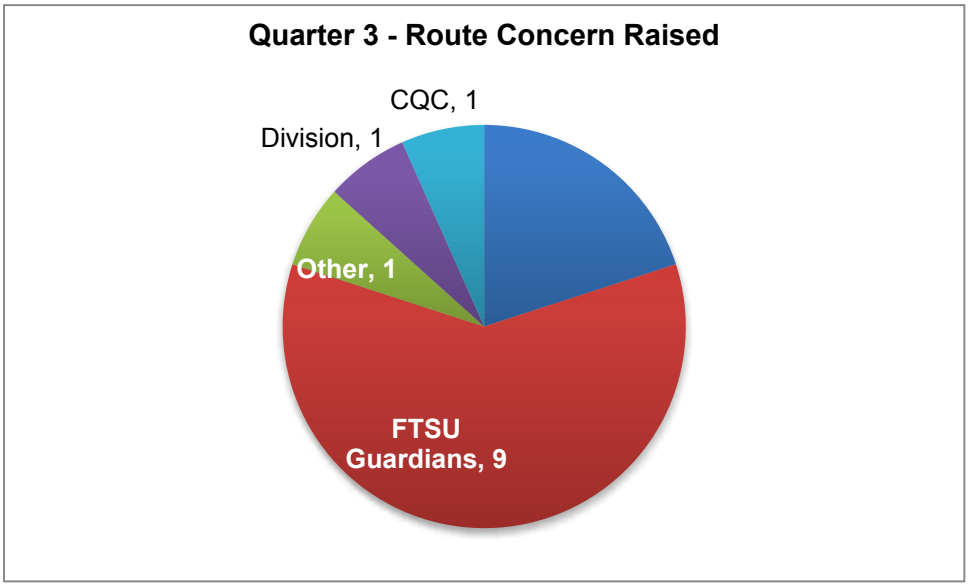
Month	No. of concerns raised in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
October	8	1	6	0
November	4	0	1	0
December	3	0	1	0
Total	**15**	**0**	**8**	**0**

Positively, only one concern was reported anonymously. A signal of a health speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	9
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	2
Quality and safety	3
Patient experience	0
Performance capability	0
Service Changes	0
Other	1
Total	**15**







Detail of Speaking Up Cases – Quarter 3 2019-20

No.	Theme	Summary	Status
1.	Quality & Safety	Concern raised to CEO about issues of attitudes and behaviours, training and competence and management of change.	Chief Nurse met with reporter. Fact finding review commissioned and undertaken by independent senior nurse. Eight recommendations made within the review. Active.
2.	Attitudes & behaviours	Individual wrote to CEO with concerns about their management in 3 different work locations and bullying behaviours.	Independent review undertaken by HR Manager of application of trust policies. Evidence indicated that whilst the individual raised concerns in the areas they worked that these had been addressed either informally or formally resulting in action being taken. Response provided to reporter. Closed.
3.	Policies, procedures and processes	Concern raised about management of surgical patient list and response to an incident form.	Reporter supported by FTSUG and advised of options to take concerns forward. Reporter decided to not take any further action. Informal action taken has

No.	Theme	Summary	Status
			included reminder via Divisional Chairs for medical managers to promptly respond when concerns are raised with them. Closed.
4.	Attitudes & behaviours	Individual concerned about employee relations investigation and the management action taken when dignity at work issues had been previously raised.	Support and guidance provided by FTSUG. Status of the process sought and assured that procedures are being correctly applied. Individual is supported by trade union representative and accessing staff support. Active.
5.	Attitudes & behaviours	Contact to CEO about injury at work and attitudes and behaviours in previous work location.	Meeting held with senior manager and HR manager to understand the issues. No further action required. Open door offered from the senior manager. Other related issues have formed part of a wider investigation which has now concluded with concerns upheld and appropriate action taken. Closed.
6.	Attitudes & behaviours	Email contact to FTSU Guardian by individual about treatment by line manager and belief that they being treated unfairly.	Employee signposted to Employee Support Advisor but does have a trade union representative. Information about informal resolution and dignity at work process provided. Closed.
7.	Other	FTSU Guardian contacted as individual concerned about employee relations case.	FTSU Guardian liaised with Human Resources and issue addressed to reporters satisfaction. Closed.
8.	Attitudes & behaviours	Anonymous letter sent to a division about line manager behaviours.	Series of staff drop in sessions and senior divisional leadership visits arranged to speak with staff. No issues of concern raised. Subjects of letter made aware of contents. Closed.
9.	Quality & Safety	Concern raised via CQC about the number of patients nursed in the ED Corridor on the 4th November 2019 and associated risks to patient harm and staff wellbeing. The Royal Stoke Emergency Department experienced high levels of attendances (463) and 208 ambulance conveyances with a total of 179 admissions in to a ward bed. This is 50 more attendances compared to same day last year and 16 more ambulance conveyances.	Response to CQC acknowledged that the hospital was under significant pressure and as a result declared an internal incident to ensure that there was an appropriate level of response, this was upgraded on the 5th November 2019 to a Critical Incident due to the on-going pressures - this was in line with the organisation's winter plan and management of incidents. The priority of the Trust was to maintain patient & staff safety at all times and actions and decisions were taken in line with this priority. The internal incident was overseen by the Chief Operating Officer with regular updates to the CEO and Executive Team. Each Clinical Division operated a Divisional Incident (Command & Control) Centre which oversaw the

No.	Theme	Summary	Status
			response to the internal incident, overseen by the Divisional Associate Directors, with senior clinicians supporting the process. Following on from this the CEO and Chief Nurse have met with Senior nurses within the ED to ensure that the team are engaged with support from the Exec team.
10.	Policies, procedures and processes	Individual contacted FTSU Guardian with concerns related to management action, bullying behaviours and low morale in the department.	FTSU Guardian met with individual and outlined routes to raise issues. Individual escalated concerns to next level manager. Active.
11.	Attitudes & behaviours	Concerns raised to FTSU Guardian about management behaviours in previous work location.	Meeting held to discuss concerns. Parties considering options about raising concerns through a speaking up route. Active.
12.	Attitudes & behaviours	As above.	As above.
13.	Quality & safety	Issues raised about training, staff numbers and behaviours on a medical ward.	FTSU Guardian escalated to Associate Chief Nurse. Review of quality and safety indicators to be undertaken. Feedback provided to reporter who is satisfied with action proposed. Closed.
14.	Attitudes & behaviours	Contacted FTSU as feeling bullied and harassed by line managers. Also raised issues of intimidating behaviour impacting on quality of care.	FTSU Guardian escalated to Associate Director. Fact finding undertaken. Active.
15.	Attitudes & behaviours	Employee raised issues with behaviours of colleague which they feel are racist and discriminatory in nature.	Individual supported to follow dignity at work process and raised issues with line manager in accordance with Dignity at Work Policy. Active.

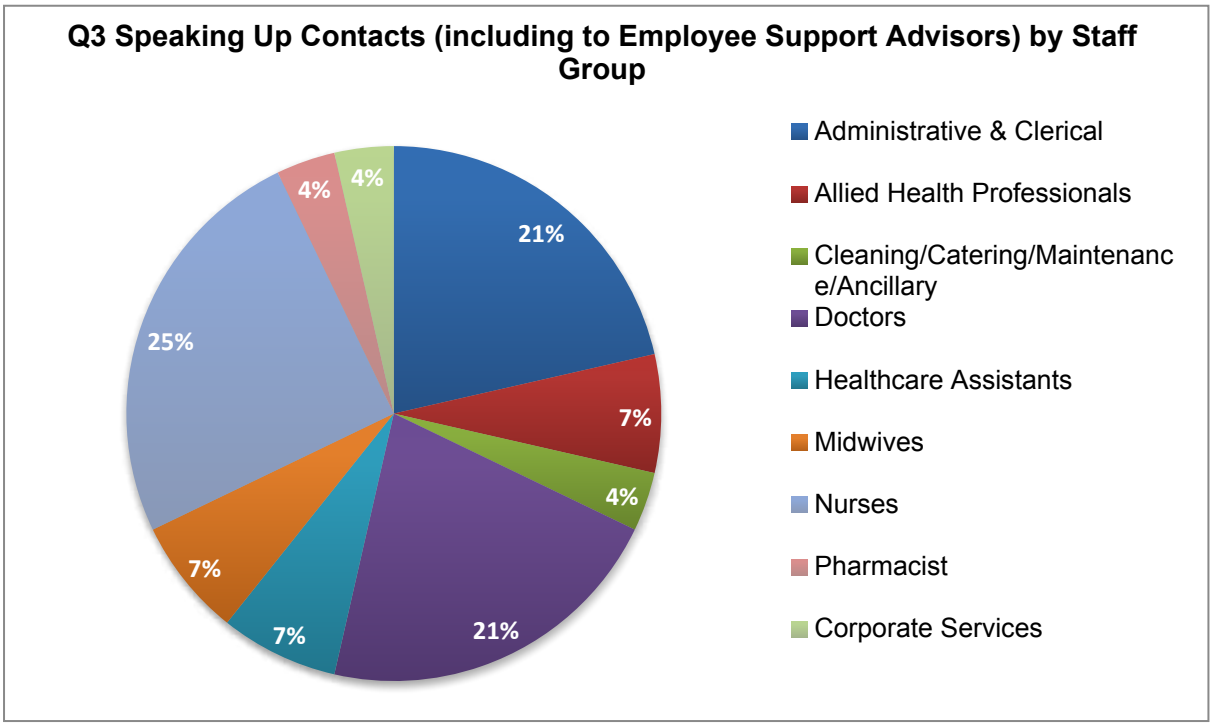
It should be noted that concerns raised may have more than one theme, and the theme identified above is the main theme of the concern.

Issues raised with our Employee Support Advisors

The NGO requests on a quarterly basis the number of concerns raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors not only support our staff for dignity at work issues but also act as speak up champions and therefore their activity is included in NGO data submissions. Where appropriate ESA's may escalate or signpost contacts to FTSU Guardians, and hence some of the contacts recorded below may also be reflected in concerns recorded on the raising concerns case tracker. During the quarter our ESA's have received 15 contacts relating to the following themes:

Theme	Number
Attitudes and behaviours	11
Equipment and maintenance	0

Staffing levels	0
Policies, procedures and processes	4
Quality and safety	0
Patient experience	0
Performance capability	0
Service Changes	0
Other	0
Total	**15**



5. Learning from Cases

Attitudes and behaviours continues to be the most reported theme through speaking up routes with 10 out of the 15 concerns recorded on the speaking up tracker being related to workplace cultures and behaviours. The majority of these relate to the impact of line manager behaviours on individuals.

Action has been taken during the quarter in response to concerns raised about a range of issues at County Theatres in Quarter 2. The FTSU Guardian facilitated a meeting with the reporter and the acting Deputy Associate Chief Nurse for Surgery and following a fact finding exercise a number of actions have been implemented as a result. The case highlighted that a greater management presence was needed and both the Theatres Directorate and wider divisional team have increased their visibility at County. Positively, a follow up meeting with the reporter to update on the concerns and action taken provided assurance to the reporter that the issues raised have been taken seriously and they are satisfied with the action taken to date.

6. Next Steps

The focus going forward over the next quarter will be:

- Continue to implement the actions from the Freedom to Speak Up Index Gap Analysis and Action Plan
- Review and update the UHNM Freedom to Speak Up Self Review following the Board Development session
- Promote the appointment to the Associate Freedom to Speak Up Guardian roles and contact details for the FTSU team
- Develop a Speaking Up Charter
- Develop terms of reference for a quarterly Speaking Up Summit

Appendix 1: FTSU Index Gap Analysis and Action Plan

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
% of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly	55.9%	58.5%	2.6%	• Ongoing communications promoting Speaking Up Policy, which is based on NGO best practice and enables concerns to be raised anonymously or confidentially and that the policy clearly states that the harassment or victimisation of workers that raise issues will not be tolerated, nor any attempt to bully a worker into not raising a concern.	Ongoing	GA
				• Ongoing promotion of the Just and Learning Culture framework. The Just and Learning Culture Framework Decision Tree is used to support the consistent, constructive and fair evaluation of the actions of workers involved in an incident.	Ongoing	GA
				• Introduce Speaking Up training as part of the statutory and mandatory provision for all workers in accordance with NGO national guidelines on Freedom to Speak Up training in the health sector in England (August 2019). To include the Just and Learning framework.	March 2020	GA
				• Ratify and communicate the updated Disciplinary Policy (including Just and Learning approach) across the organisation.	December 2019	GA
				• Update all Speaking Up Policy supporting materials to ensure these include the Just and Learning approach and maintain focus on learning not blaming.	December 2019	GA
				• Continue to promote our Speaking Up Plan as part of a regular communications strategy.	Ongoing	GA
				• Include information on detriment in FTSU quarterly reports.	January 2020	GA

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
				• Widely promote Policy HR22 – Supporting Staff involved in an Incident, Complaint or Claim (the revised policy was approved at November 2019 TJNCC meeting).	January 2020	GA
% of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents	82.3%	88%	5.7%	• Speaking Up training to be introduced for all workers as part of statutory and mandatory training with an emphasis on importance of speaking up and the routes available to do so.	May 2020	GA
				• Continue to invest in compassionate leadership development, and update the Speaking Up training for line and middle management in line with the July 2019 NGO training guidance - Creating the right environment to encourage workers to speak up - Supporting speaking up and listening well - Conflicts - Induction and exit - Feedback	May 2020	GA
				• Further Board development session planned on FTSU to include NGO training for senior leaders to cover: - Regulation of speaking up - The benefits of speaking up - The role of senior leaders - Demonstrating leadership - Supporting FTSU Guardians - Measures - Protection - Communication - Learning - Continuous improvement	14.01.2020	GA

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
				• On-going messaging encouraging a culture of speaking up from Board members, FTSU Guardian, HR and governance teams via electronic communications and face to face listening events such as ward and department visits, Care Excellence Visits CEO Time to Talk sessions and conferences and leadership events, such as Leaders Network.	Ongoing	GA
% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice they would know how to report it	93.2%	94.2%	1%	• Review FTSU messaging at Induction.	December 2019	GA
				• Update and promote Speaking Up Page and Staff Experience section of new intranet.	December 2019	GA
				• Launch revised 'all workers' FTSU training and revise training delivered through Gateway to Management and Connects to reflect NGO requirements for line and middle managers. To include the routes available and how to raise issues.	May 2020	GA
				• Review communications strategy to ensure a programme of regular messaging that reinforces the message that speaking up is welcomed and how to raise issues. This needs to take into account ways in which more inaccessible workers can be reached.	December 2019	GA
% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice	65.4%	69.2%	3.8%	• Trust wide communications and divisional championing of the Just and Learning Culture Framework.	In place and ongoing	GA
				• Promote zero tolerance approach to victimisation of workers who raise concerns.	December 2019	GA
				• Introduce newsletters and updates with a creative and engaging communication strategy to tell positive stories about speaking up	Quarterly	GB

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
				• Have a sustained and on-going focus on the reduction of bullying, harassment and incivility, which in November 2019 will include the launch of the 'Cut it Out' campaign.	November 2019 and ongoing	GA

CURRENT PROGRESS RATING		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed *or* B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th February 2020
Report Title:	Update to Standing Financial Instructions (F01) and Scheme of Reservation and Delegation of Powers (F02)	**Agenda Item:**	16.
Author:	Sarah Preston, Strategic Director of Finance		
Executive Lead:	Mark Oldham, Chief Financial Officer		

Purpose of Report:					
Assurance		**Approval**	✓	**Information**	

Alignment to Strategic Objectives:		
SO1	Provide safe, effective, caring and responsive services	✓
SO2	Achieve NHS constitutional patient access standards	✓
SO3	Achieve excellence in employment, education, development and research	✓
SO4	Lead strategic change within Staffordshire and beyond	✓
SO5	Ensure efficient use of resources	✓

Summary of other meetings discussed with and outcome of discussion:

The changes set out in this report were approved by the Executive Team on 15 January 2020. The report was presented at Trust Executive Committee on 22nd January 2020 for comments and information and the policies were approved at Audit Committee on 23 January 2020.

Summary of Report, Key Points for Discussion including any Risks:

A full review of the Trust policies 'Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation of Powers (Scheme of Delegation) has taken place. Relevant sections have been reviewed by departmental leads as required. Their comments, updates and corrections have been included as changes in the documents. A log of changes has been made.

The changes in both documents are categorised as:

- Updated Reference – updates on titles of postholders, committees, policies, organisations and guidance
- Additional Information – relevant to previous item
- New Entry – where there is a new information required
- Removed and outdated / not required – no longer relevant

Along with:

- Change of Authorisation – where the update reflects changes previously agreed in board sub-committees or trust policies along with changes as part of this policy update
- Clarification of requirement – to reflect current practice or changes agreed as part of this review

It is the final two categories that should be focussed on for agreement by the committee. They are highlighted in the changes log.

The log of changes is ordered as they appear in the policy documents and gives the rationale and Trust lead (person who has specified the change) for the update.

The paper sets out the main changes classified as a Change of Authorisation or Clarification of requirement in both documents.

In addition to the paper there are 3 attachments:
1. The SFIs showing proposed track changes
2. The Scheme of Delegation showing proposed track changes
3. The changes log, with 2 tabs (one for the changes relating to SFIs and one for the changes relating to the Scheme of Delegation) highlighting where there has been a change of authorisation or clarification of requirement.

Once approved by the Trust Board the documents will be amended to ensure the numbering, and formatting is correct before publishing. All Authorised signatories within the Trust will be informed of the changes by e-mail and Trust communications.

Key Recommendations:

That the Trust Board considers and approves the proposed changes to the Trust Policies in relation to Standing Financial Instructions (F01) and Scheme of Reservation and Delegation of Powers (F02).

Update to Standing Financial Instructions (F01) and Scheme of Reservation and Delegation of Powers (F02)

February 2020

1. Main Changes

Below are set out the main changes to the above Policies. The full details of the changes can be seen in the documents attached to this report.

2. Standing Financial Instructions (F01)

2.1 Departmental Manager

A definition has been included to clarify the seniority of this role as it is often referred to in HR policies and has previously been undefined.

Departmental Manager - Director or Employee at Band 8a or above responsible for authorisation in line with Human Resources policies

2.2 Budget Virements

Section 4.4.6 sets out the approval for budget virements. These have changed to reflect clarification of roles and linkages with other Trust systems.

From:

Virement	Authorisation Required from:
Re-phasing of Budgets	Budget Holder and Deputy Director of Finance
Budget moves between income, pay or non pay	Budget Holder and Deputy Director of Finance
Budget moves between pay to pay or non pay to non pay	Deputy Director of Finance, Associate Directors and/or Directorate Managers

To:

Virement	Authorisation Required from:
Re-phasing of Budgets	Chief Financial Officer
Budget moves between income, pay or non pay	Budget Holder and Deputy Director of Finance
Budget moves between pay to pay or non pay to non pay	Budget Holder and Deputy Director of Finance
CIP transactions	As above + Director of PMO
Changes to Nursing Establishment	As above + E-Rostering Manager
Changes to Medical Establishment	As above + Head of Medical Staffing

2.3 Business Case Approvals

Section 4.6 sets out the approval for Business Cases. These have changed to reflect and increased scrutiny by Trust Boards and sub-committees. The role of TEC as an approver has been removed to reflect this. The changed business case approval limits are also reflected in the capital Business Case table in section 13.5.2.

From:

Business Case Approval Limits	Incremental (additional) income or revenue (higher of) including VAT					
	<£25k	> £25k to £250k	> £250k to £1m	> £1m to £3m	> £3m to £15m	> £15m
Authority Delegated to:	Chief Financial Officer	Formal Executive Meeting (FEM)	Trust Executive Committee (TEC)	Performance and Finance Committee (PFC)	Trust Board	NHSI/E

To:

Business Case Approval Limits	Incremental (additional) income or revenue (higher of) including VAT				
	<£25k	> £25k to £250k	> £250k to £1m	> £1m to £15m	> £15m
Authority Delegated to:	Chief Financial Officer	Formal Executive Meeting (FEM)	Performance and Finance Committee (PFC)	Trust Board	NHSI/E

2.3 Annual Reports and Accounts

The wording in section 5.2 and 5.4 has been amended to reflect the requirement that the Trust's Audited Accounts and Annual Report must be approved by the Trust Board, removing the authority previously delegated to Audit Committee. The same update is included at section 18.4.5 with regard to the UHNM charity reports and accounts.

From	To
The Trust's audited annual accounts, and any report of the auditor on them, must be presented to the Trust Board for approval. **Or by the Audit Committee as delegated by the Trust Board**	The Trust's audited annual **reports and** accounts, and any report of the auditor on them, must be presented to the Trust Board for approval
The Trust will publish an annual report, in accordance with guidelines on local accountability. This will be presented to the Trust Board for approval. **Or to the Audit Committee as delegated by the Trust Board for approval.**	The Trust will publish an annual report, in accordance with guidelines on local accountability. This will be presented to the Trust Board for approval.

2.4 Debt Recovery

The authorisation of debt write off has been amended to reduce the limits authorised prior to Trust Board approval.

From	To
Where sums to be written off exceed **£150,000, the Chief Financial Officer will seek the consent of the Chief Executive and the Trust Board**.	Where sums to be written off exceed **£1,000, the Chief Financial Officer will seek the consent of the Chief Executive and items exceeding £50,000 will require consent of the Trust Board**.

2.5 Single Tender Quotation / Waivers

Section 8.1.2 updates the authorisation of Single Tender Waivers from the Director of Procurement to the Chief Financial Officer

From	To
Single quotation documentation to be completed and authorised by Associate Director, Procurement and Commercial Services	Single quotation documentation to be completed and authorised by Chief Financial Officer

2.6 Requisition and Invoice Authorisation Limits

The authorisation levels for the requisition of goods and services have been amended to reflect the Reaf system in place at UHNM where requisitions over £20k are authorised by the Director of finance and above. The authorisation levels have also been amended to reflect revised authorisation levels and committees above that level, along with the authorisation of Non PO invoices. The revised table is shown at section 11.1.2

From:

Authority Delegated To	
Budget Administrators	£0 to £5,000
Budget Managers	£0 to £25,000
Budget Holders	£0 to £50,000
Director of Finance	£50,001 to £100,000
Chief Financial Officer	£100,001 to £500,000
Chief Executive	£500,001 to £1,000,000
Performance and Finance Committee	£1,000,001 to £3,000,000
Trust Board	£3,000,001 and above

To:

Authority Delegated To	Requisition of Goods and Services	Authorisation of Non Purchase Order Invoices
Budget Administrators	£0 to £5,000	£0 to £5,000
Budget Managers	£0 to £20,000	£0 to £20,000
Budget Holders	£0 to £20,000	£0 to £20,000
Director of Finance	£20,001 to £100,000	£20,001 to £100,000
Chief Financial Officer	£100,001 to £250,000	£100,001 to £250,000
Chief Executive	£250,001 to £500,000	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,000,000	£500,001 to £1,000,000
Trust Board	£1,000,001 and above	£1,000,001 and above

There are some invoices that can be paid without a Purchase Oder (PO) being in place. There has been an additional clause included within the SFIs at section 11.2.1 to clarify how this is managed

The Supplies and Procurement Department, with input from the Finance Department, will be responsible for maintaining the list detailing the areas of expenditure that do not require a Purchase Order. This list will be known as the 'Agreed Non Purchase Order List'. Any areas of expenditure contained within the Agreed Non Purchase List will not require a purchase order and will therefore be exempt from the Trusts requisition approval process.

An additional table has been added in section 11.1.2 to reflect the authorisation levels for Pharmacy Requisitions and invoices. This reflects the additional authority given to pharmacy who are responsible for the procurement and supply of drugs. The update reflects the increased price of the drugs and the current pharmacy structure.

From:

Authority Delegated To	
Stock Control or Procurement and Stock Control Technician	£0 to £35,000
Senior Procurement Technician or Chief Clinical Information Technician or Chief Technician Procurement of High Cost Medicines and Homecare Pharmacist	£0 to £60,000
Pharmacy Directorate Manager, Deputy Clinical Director of Pharmacy or Clinical director of Pharmacy	£0 to £90,000
Director of Finance	£90,001 to £100,000
Chief Financial Officer	£100,001 to £500,000
Chief Executive	£500,001 to £1,000,000
Performance and Finance Committee	£1,000,001 to £3,000,000
Trust Board	£3,000,001 and above

To:

Authority Delegated To	Requisition of Goods and Services (Drugs and Pharmacy Consumables)
Senior Assistant Technical Officer (ATO) Procurement and Senior Pharmacy Technician	£0 to £35,000
Lead Procurement Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Pharmacy Supply Chain Manager (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b).	£35,001 to £120,000
Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c).	£120,001 to £170,000
Chief Financial Officer	£170,001 to £250,000
Chief Executive	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,000,000
Trust Board	£1,000,001 and above

3. Scheme of Reservation and Delegation of Powers (F02)

A number of the updates in this document have been made to reflect the changes in the Standing Financial Instructions (F01) and the changes to Board Committee structures as agreed.

4. Recommendations

That the Trust Board considers and approves the proposed changes to the Trust Policies in relation to Standing Financial Instructions (F01) and Scheme of Reservation and Delegation of Powers (F02).

University Hospitals of North Midlands NHS Trust

Policy No. F01
Trust Policy for Standing Financial Instructions

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

Version:	~~7~~9
Ratified By Executive Committee:	**Trust Audit Committee** and Trust Board
Date Ratified:	~~June 2017~~February 2020
Date of Issue via Intranet:	~~June 2017~~February 2020
Date of Review:	~~J~~February 2022~~une 2020~~
Trust Contact:	~~Assistant Director of Finance – Chief Accountant~~Strategic Director of Finance
Executive Lead:	Chief Financial Officer~~Director of Finance~~

Version Control Schedule

Final Version	Issue Date	Comments
1	March 1999	
2	March 1999	
3	June 2006	
4	March 2008	
5	December 2011	
6	November 2014	
7	June 2017	
8	January 2020	Approved by Audit Committee ~~xx~~ 23 January 2020
95	February 2020	Approved by Trust Board 05 February 2020

University Hospitals of North Midlands NHS
NHS Trust

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the “right and freedom” of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

CONTENTS

1. INTRODUCTION

1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree SFIs 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).

1.2 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 Scheme of Reservation and Delegation of Powers adopted by the Trust.

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

1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer~~Director of Finance~~ **must be sought before acting**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.5 The failure to comply with SFIs will be recorded by the Chief Financial Officer~~Director of Finance~~. **Failure to comply with SFIs is a disciplinary matter and could result in dismissal.**

1.6 Where appropriate, failure to comply with SFIs will be reported to the Audit Committee with full details of the non-compliance and any justification for the non-compliance. The Audit Committee will then either refer for action or ratify the non-compliance.

1.7 All members of the Trust Board and employees have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer~~Director of Finance~~ as soon as possible.

2. STATEMENT

2.1 To provide detailed financial responsibilities, policies and procedures to be adopted by the Trust and its employees or representatives.

3. SCOPE

3.1 This policy applies to all areas of the Trust and all individuals employed by the Trust including contractors, voluntary workers, students, locum and agency staff and those holding honorary contracts.

4. DEFINITIONS

4.1 Detailed below is a list of terms used in this document and a definition of their meaning.

Term	Definition
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, where appropriate, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority from the Chief Executive (to a limit of £50,000 inclusive of VAT) to manage finances (income and expenditure) for a specific area of the organisation
Departmental Manager	Director or Employee at Band 8a or above responsible for authorisation in line with Human Resources policies
Chairman	The person appointed to lead the Trust Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole
Chief Executive	Chief officer of the Trust and Accountable Officer
Chief Financial Officer ~~Officer for Finance and Performance~~	Chief Financial Officer of the Trust
Director of Finance	Financial Director for the Trust with powers delegated from the Chief Financial Officer~~Chief Officer for Finance and Performance~~
He/she or his/her	Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes
Scheme of Reservation and Delegation of Powers. Policy number F02	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. Referred to as 'the Scheme of Delegation' within this document.
Standing Financial Instructions (SFIs). Policy number F01	Document detailing the financial responsibilities, policies and procedures adopted by the Trust. Referred to as 'the SFIs' within this document.
~~Trust~~Standing Orders. Policy number G19	Document which sets out the regulation of the Trust proceedings and business. Referred to as the SOs in this document.
Trust	University Hospitals of North Midlands NHS Trust
Trust Board	Board of the Trust

Table 1

4.2 Wherever the title Chief Executive, Chief Financial Officer~~Director of Finance~~ or other nominated officer is used in these SFIs, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

4.3 Wherever the term "employee" and the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

5. ROLES AND RESPONSIBILITIES

5.1 Role of the Trust Board

5.1.1 The Trust Board exercises financial supervision and control by:

(a) Formulating the financial strategy

(b) Requiring the submission and approval of budgets within approved allocations/overall income

(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 responsibilities placed on members of the Trust Board and employees as indicated in the Scheme of Delegation document

5.1.2 The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other committees as the Trust Board has established.

5.1.3 Under the Trust's scheme of delegation, amendments to these instructions need to be approved at a Trust Board meeting.

5.2 Role of Chief Executive

5.2.1 The Chief Executive will, as far as possible, delegate his/her detailed responsibilities, but they remain accountable for financial control.

5.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Trust Board, and, as Accountable Officer, to the Secretary of State, for ensuring that the Trust Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Trust Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

5.2.3 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and understand their responsibilities, within these SFIs.

5.3 Role of Chief Financial Officer (CFO)~~Director of Finance~~

5.3.1 The Chief Financial Officer~~Director of Finance~~ will, as far as possible, delegate his/her detailed responsibilities, but they remain accountable for financial control.

5.3.2 The Chief Financial Officer~~Director of Finance~~ is responsible for:

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

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

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

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

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

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

5.3.3 The Chief Financial Officer~~Director of Finance~~ will maintain a register of the required readers of the SFIs. These readers will predominantly be any authorised signatory for the Trust.

5.4 Role of all Directors and Officers

5.4.1 Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a matter in which their judgment was likely to be cause for public concern.

5.4.2 This policy shows only the "top level" of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other procedures within the Trust.

5.4.3 In the absence of a Director or Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officers deputy unless alternative arrangements have been requested by the Trust Board.

5.5 Role of all Trust Board members and employees

5.5.1 All members of the Trust Board and employees, severally and collectively, are responsible for:

(a) The security of the property of the Trust

(b) Avoiding loss

(c) Exercising economy and efficiency in the use of resources

(d) Conforming to the requirements of SOs, SFIs, financial procedures and the Scheme of Delegation

5.5.2 Individuals who are included on the register of required readers of the SFIs are responsible for ensuring they understand the guidance and will acknowledge this in writing to the Chief Financial Officer~~Director of Finance~~.

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

5.5.4 All members of the Trust Board and employees are expected to adhere to the Nolan Principles which are the basis of ethical standards expected of public office holders. The seven principles of public life apply to anyone who works as a public office holder and all people appointed to work in public services including all people working within the health sector.

5.5.5 The seven principles are:

(a) Selflessness – holders of public office should act solely in terms of the public interest

(b) Integrity – Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships

(c) Objectivity – Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

(d) Accountability – Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

(e) Openness – Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

(f) Honesty – Holders of public office should be truthful

(g) Leadership – Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

5.6 Role of contractors and their employees

5.6.1 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~~comply with these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

6.1 The Finance Department will ensure that training is available to all authorised signatories and any other staff member who requires training.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

7.1.1 In accordance with SOs, the Trust Board shall formally establish a committee of independent members, as an Audit Committee, with formal Terms of Reference, which includes ensuring compliance with the SFIs.

7.1.2 Failure to comply with this policy will be recorded by the Chief Financial Officer~~Director of Finance~~. Failure to comply with the policy is a disciplinary matter, which may be reported to the Audit Committee, and could result in dismissal.

7.1.3 All members of the Trust Board and employees have a duty to disclose any non-compliance with this policy to the Chief Financial Officer~~Director of Finance~~ as soon as possible.

7.2 Review

7.2.1 This policy will be reviewed two years post ratification, unless changes in national legislation override this or there has been a specific request to review earlier.

8. REFERENCES

Standing Orders – G19
Scheme of Reservation and Delegation of Powers ~~Trust's Scheme of Delegation~~ – F02

Appendix A – STANDING FINANCIAL INSTRUCTIONS

1. AUDIT

1.1 Audit Committee

1.1.1 The Audit Committee's primary role is to conclude upon the adequacy and effective operation of the Trust's overall internal control system. In performing that role the Committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

1.1.2 As a result, the Committee has a pivotal role to play in reviewing the disclosure statements that flow from the Trust's assurance processes. In particular this includes the Annual Governance Statement, included in the Annual Report, and this document should be presented to the Committee before being submitted for approval to the Trust Board.

1.1.3 It is clearly the job of the Trust Board, Chief Executive and Executive Directors to establish and maintain process for governance. The Committee independently monitors, reviews and reports to the Trust Board on the processes of governance, and, where appropriate, facilitates, supports, through its independence, the attainment of effective processes.

1.1.4 In accordance with SOs, the Trust Board shall formally establish an Audit Committee, that includes independent members, with formal Terms of Reference to perform such monitoring, reviewing and other functions as are appropriate and following guidance from the NHS Audit Committee Handbook 2018~~05~~, which will provide an independent and objective view of internal control by:

(a) Overseeing Internal and External Audit services and assessing the work and fees of external audit on an annual basis to ensure that the work is of a sufficiently high standard and that the fees are reasonable

(b) Reviewing financial systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments

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

(d) Monitoring compliance with SOs and SFIs

(e) Reviewing schedules of losses and compensations and making recommendations to the Trust Board

(f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Trust Board and advising the Trust Board accordingly

1.1.5 The Trust Board should satisfy itself that at least one member of the Committee has recent and relevant financial experience.

1.1.6 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee

wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Trust Board. Exceptionally, the matter may need to be referred to the ~~Department of Health~~ Department of Health and Social Care, Local Counter Fraud Office or the police (but should be referred to the Chief Financial Officer~~Director of Finance~~ in the first instance).

1.2 Internal Audit

1.2.1 It is the responsibility of the Chief Financial Officer~~Director of Finance~~ to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is re-appointed, extended or changed.

1.2.2 The Chief Financial Officer~~Director of Finance~~ is responsible for:

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

(b) Ensuring that the purpose, authority and responsibility of Internal Audit is adequate, meets the NHS mandatory audit standards, and is formally defined by the Trust in Terms of Reference with regard to professional best practice

(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Trust Board. The report must cover:

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

(ii) Major internal financial control weaknesses discovered

(iii) Progress on the implementation of internal audit recommendations

(iv) Progress against plan over the previous year

(v) Strategic audit plan covering the coming three years

(vi) A detailed plan for the coming year

(e) In line with best practice, the Trust will undertake a market testing exercise for the appointment of internal audit service provider at least once every 5 years

1.2.3 The Chief Financial Officer~~Director of Finance~~ or designated internal and external 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 or an employee's control

(d) Explanations concerning any matter under investigation

1.2.4 Internal Audit will, in accordance with recognised professional best practice, 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, efficiency and application of management's systems of internal control (incorporating the Trust's system of internal financial control)

(c) The suitability of financial and other related management data

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

(i) Fraud and other offences

(ii) Waste, extravagance, inefficient administration

(iii) Poor value for money or other causes

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the ~~Department of Health~~ Department of Health and Social Care.

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

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

1.2.7 The Head of Internal Audit's formal annual report to the Chief Executive, as Accountable Officer, and the Audit Committee should present the opinion of the overall adequacy and effectiveness of the organisations risk management, control and governance processes.

~~1.2.8~~ The Head of Internal Audit shall be accountable to the Chief Financial Officer~~Director of Finance~~. The reporting system for internal audit shall be agreed between the Chief Financial Officer~~Director of Finance~~, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. ~~The reporting system shall be reviewed at least every three years.~~

~~1.2.9~~1.2.8

~~1.2.10~~1.2.9 Internal Audit shall report findings of work completed, in the first instance, to the appropriate Executive Director who shall refer audit reports to the appropriate

members of staff. Failure to take any necessary remedial action within a reasonable period shall be reported to the Audit Committee.

~~1.2.11~~1.2.10 Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall seek the advice of the Chairman of the Audit Committee.

~~1.2.12~~1.2.11 All reports and responses from relevant Executive Directors will be reported by the Head of Internal Audit to Audit Committee.

~~1.2.13~~1.2.12 The Head of Internal Audit shall coordinate internal audit plans and activities with line managers, external audit and other review agencies to ensure the most effective audit coverage is achieved and duplication of effort is minimalised.

~~1.2.14~~1.2.13 The Trust will provide the Head of Internal Audit with every facility and all information which he may reasonably require for the purposes of his functions under the Terms of Reference.

1.3 External Audit

1.3.1 The External Auditor is paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditors and referred on if the issue cannot be resolved.

~~1.3.1~~1.3.2 It is the responsibility of the Chief Financial Officer to ensure an adequate External Audit service is provided and the Audit Committee shall be involved in the selection process when/if an External Audit service provider is re-appointed, extended or changed.

2. FRAUD AND BRIBERY

2.1 Fraud is defined as ~~any person who dishonestly makes a false representation to make a gain for himself/herself or another or dishonestly fails to disclose to another person, information he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.~~ "dishonestly making a false representation, failing to disclose information or abusing a position held, with the intention of making financial gain or causing a financial loss" as defined in the Fraud Act 2006.

~~2.1~~2.2 Frauds can take various forms, including:

(a) Fraud by false representation; by dishonestly making a false representation by making the representation to make a gain for yourself or another, or to cause loss to another or expose another to risk of loss. A representation is false if it is untrue or misleading, and the person making it knows that it is, or might be, untrue or misleading. An example of this would be an employee submitting a false expenses claim form for payment.

(b) Fraud by failing to disclose information; by dishonestly failing to disclose to another person information which you are under a legal duty to disclose and intends, by failing to disclose the information, to make a gain for themselves or another, or to cause loss to another or expose another to the risk of loss. An example of this would be an employee failing to disclose a criminal conviction that would affect their working practices.

(c) Fraud by abuse of position; by occupying a position in which you are expected to safeguard, or not to act against, the financial interests of another person, and dishonestly abusing that position, intending, by means of the abuse of that position, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. An example of this would be a Chief Financial Officer~~Director of Finance~~ diverting company monies from an employer's bank account into their own personal bank account.

~~2.2~~2.3 The Bribery Act 2010 repealed previous corruption legislation and has introduced the offences of offering and/or receiving a bribe. It also places specific responsibility on NHS Trusts to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. From July 2011 when the act came into force, the four main offences of Bribery are defined as:

~~2.2.1~~2.3.1 Offering a bribe;
~~2.2.2~~2.3.2 Receiving a bribe;
~~2.2.3~~2.3.3 Bribing a foreign public official and;
~~2.2.4~~2.3.4 Failure to prevent bribery

~~2.3~~2.4 Bribery is defined as "the offering, promising, giving, receiving, or soliciting of something of value for the purpose of influencing the action of an official in the discharge of his/her public or legal duties"~~"Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards, or other privileges"~~. Bribery occurs when an individual offers, promises or gives a financial or other advantage to another person and intends that advantage to a) induce a person to perform improperly a relevant functions of activity in order

and/or b) knows or believes that acceptance of the advantage would itself constitute the improper performance of a relevant activity or function.

2.42.5 Corruption is broadly defined as "where someone is influenced by bribery, payment or benefit in kind to unreasonably use their position to give some advantage to themselves or to another". ~~Corruption is broadly defined as the offering of the acceptance of inducements, gifts or favours, payments or benefit in kind which may influence the improper action of any person.~~; Ccorruption does not always result in loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

2.52.6 In line with their responsibilities, the Chief Executive and Chief Financial Officer~~Director of Finance~~ shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption. The Audit Committee shall oversee the function.

2.62.7 The Trust Board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist ~~as specified by the Secretary of State Directive and the NHS Standard Contract. Department of Health~~ whose role and responsibilities are determined by the NHS Counter Fraud Authority, the NHS Counter Fraud Authority NHS Anti-Fraud Manual and Service Condition 24 of the Standard NHS Contract

2.72.8 The Local Counter Fraud Specialist shall report to the Chief Financial Officer~~Director of Finance~~ and shall work with staff in the NHS Business Service Authority in accordance with NHS ~~Protect~~ Counter Fraud Authority's Anti-Fraud Manual

2.82.9 The Local Counter Fraud Specialist will provide a written report, and a work plan, at least annually, on counter fraud work within the Trust.

2.92.10 The Chief Financial Officer~~Director of Finance~~ is responsible for providing detailed procedures to enable the Trust to minimise and, where possible, to eliminate fraud and corruption. These procedures are included in the Trust's Anti-Bribery & Anti-Fraud policy (G18) ~~Trust's Anti-Bribery policy (G18)~~ which sets out action to be taken by persons detecting a suspected fraud and persons responsible for investigating it.

2.102.11 The measures that are put in place shall be sufficient to satisfy all external bodies to whom the Trust is accountable to, through:

(a) Encouraging prevention

(b) Promoting detection

(c) Ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively

2.112.12 Fraud and corruption shall be dealt with as gross misconduct.

2.122.13 It is expected that all officers shall act with the utmost integrity, ensuring adherence to all relevant regulations and procedures. It is the responsibility of the Chief Financial Officer~~Director of Finance~~ to produce and issue such procedures to the appropriate Directors and Line Managers who should ensure that all staff has access to these.

~~2.13~~2.14 The Director of Human Resources is responsible for ensuring that steps are taken at the recruitment stage to establish as far as possible the previous record of potential employees in terms of their propriety and integrity.

~~2.14~~2.15 Staff are expected to act in accordance with the Trust's SOs and the NHS Code of Business Conduct following guidance on the receipt of gifts and hospitality.

~~2.15~~2.16 Independent members are subject to the same high standards of accountability and are required to declare and register any interests which might potentially conflict with those of the Trust.

~~2.16~~2.17 The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls and evaluate the implication of fraud for their opinion on the system of risk management, control and guidance.

~~2.17~~2.18 Staff are required to raise any concerns they may have regarding suspected fraud and/or corruption by informing their line manager, Internal Audit, Chief Financial Officer~~Director of Finance~~, the Trust's Local Counter Fraud Specialist (~~George Churcher 07825 119703~~ Simon Stanyer, KPMG 07747 565380) or the NHS National Fraud and Corruption Reporting line on 0800 0284060 or www.reportnhsfraud.nhs.uk.

~~2.18~~2.19 The Chief Financial Officer~~Director of Finance~~ is responsible for ensuring that action is taken to investigate any allegations of fraud or corruption through the Local Counter Fraud Specialist. The steps to be taken are detailed in the Trust's Anti-Bribery policy (G18).

~~2.19~~2.20 Senior managers are expected to deal firmly and promptly and in accordance with the Trust's disciplinary procedure with anyone who attempts to defraud the Trust or acts in a corrupt manner.

3. SECURITY MANAGEMENT

3.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management and ensure compliance with the ~~2017/18 and 2018/~~current~~19~~ NHS Standard Contract.

3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management and in compliance with the ~~2017/18 and 2018/19~~ current NHS Standard Contract.

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

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

4.1 Preparation and Approval of Business Plans and Budgets

4.1.1 The Chief Executive will from time to time compile and submit to the Trust Board an Integrated Business Plan (IBP). In addition annual operating plans will be submitted to the Board in accordance with NHSI/E requirements which takes into account the IBP, financial targets and forecast limits of available resources. The IBP and annual operating plans will contain:

(a) A statement of the significant assumptions on which the plans are based

(b) Details of major changes in workload, delivery of services or resources required to achieve the plan

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

(a) Be in accordance with the aims and objectives set out in the IBP

(b) Be in accordance with workload and workforce plans

(c) Be produced following discussion and agreement with appropriate Budget Holders

(d) Be prepared within the limits of available funds

(e) Identify potential risks and mitigations

(f) Have due consideration of the impact on the quality and safety of patient care

4.1.3 The Chief Financial Officer~~Director of Finance~~ shall continually monitor financial performance against budget and the IBP, periodically review them, and report to the Trust Board.

4.1.4 All Budget Holders must provide financial or non-financial information as required by the Chief Financial Officer~~Director of Finance~~ to enable budgets to be compiled.

4.1.5 All Budget Holders will confirm acceptance to their allocated budgets prior to the start of the financial year (i.e. 1st April). The Trust will prepare documentation which summarises all internal financial plans by the end of April of each new financial year. The Chief Financial Officer~~Director of Finance~~ will ensure that divisions are notified in writing of their budget with:

(a) A clear definition of the functions/services for which the budget is provided

(b) The amount of the budget

(c) The planned levels of the activity/service provision

4.1.6 The Chief Financial Officer~~Director of Finance~~ has a responsibility to ensure that adequate training is delivered on an on-going basis to Budget Holders to help them manage their budgets successfully.

4.2 Budgetary Delegation

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

(a) The amount of the budget

(b) The purpose/s of each budget heading

(c) Individual and group responsibilities

(d) Authority to exercise virement

(e) Achievement of planned levels of service

(f) The provision of regular reports

4.2.2 Budgetary responsibility is delegated at the start of each financial year to the relevant Executive Director, Clinical Director or Head of Service. These are known as 'Budget Holders'.

4.2.3 In turn, an Executive Director, Clinical Director or Head of Service (Budget Holder) may make recommendations to the Chief Financial Officer~~Director of Finance~~ to delegate the management of the budget (or any part of it) to a designated 'Budget Manager'. Account shall be taken of the scope and approximate value of resources and the seniority and management potential of a prospective Budget Manager

4.2.4 If individual cost centres are delegated further it will be to a designated 'Budget Administrator'. Although management of a budget can be devolved by Budget Holders, ultimate responsibility for delivery of the annual budget lies with the Budget Holder. Therefore, the Budget Manager or Budget Administrator will be responsible for the day-to-day management of the budget.

4.2.5 The Scheme of Delegation clearly sets out the authorisation limits for these levels of management. On no account can a member of staff authorise expenditure against a cost centre for which he or she is not an authorised signatory. A list of authorised signatories is kept by the Chief Financial Officer~~Director of Finance~~.

4.2.6 The term "authorised signatories" referred to throughout these SFIs refers to Budget Administrators, Budget Managers and Budget Holders, along with the Chief Financial Officer and ~~Director of Finance~~, ~~Chief Officer for Finance and Performance,~~ Chief Executive ~~and Chairman~~ who are all authorised signatories for the Trust.

~~4.2.6~~4.2.7 Any additions to the authorised signatory list should be approved by the Budget Holder and the Chief Financial Officer

~~4.2.7~~4.2.8 The Trust Board, acting upon the advice of the Chief Financial Officer~~Director of Finance~~, will periodically review and approve the income and expenditure limits within which Budget Holders, Managers and Administrators operate. These limits will be laid down in the Scheme of Delegation.

~~4.2.8~~4.2.9 The Chief Executive, in conjunction with the Chief Financial Officer~~Director of Finance~~, will periodically re-assess all functions of the Trust that incur financial

consequences and ensure that responsibility for exercising budgetary control for each and every function is delegated to an appropriate Budget Holder.

4.3 Budgetary Control and Reporting

4.3.1 The Chief Financial Officer~~Director of Finance~~ will devise and maintain systems of budgetary control and financial reporting. These will include:

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

(i) Performance against NHSI/E risk ratings

(ii) Income and expenditure year to date, showing variances to plan, trends and forecast year end position

(iii) Statement of Financial Position (Balance Sheet) year to date, showing variances to plan and forecast year-end position

(iv) Cash flow statement year to date, showing variances to plan and forecast year-end position

(v) Contract performance year to date

(vi) Cost improvement plan savings year to date and full year values / forecast outturn with analysis of the type of i.e. recurrent or non recurrent savings

(vii) Capital project spend year to date, showing variances to plan and projected outturn against plan

~~(viii) Income and expenditure position by division year to date, showing variances to plan and forecast year end position~~

~~(ix)~~(viii) Explanations of any material variances from plan

~~(x)~~(ix) Details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer~~Director of Finance~~'s view of whether such actions are sufficient to correct the situation

(b) The issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder, covering the areas for which they are responsible

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

(d) Monitoring of management action to correct variances within agreed timeframes

(e) Arrangements for the authorisation of budget transfers in accordance with the virement rules

(f) The financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.3.2 Each Budget Holder is responsible for ensuring that:

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

(a) Ensuring expenditure is appropriately managed within budget escalating any issues and overspends through management structures

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

(c) No permanent employees are appointed outside the funded establishment without the approval of the Chief Executive on recommendation from the Director of Human Resources and the Chief Financial Officer or~~and~~ any locally or Trust-wide established control procedures (such as vacancy control panels), agreed by the Chief Executive and in line with delegated limits.

(d) No expenditure is incurred against a budget outside of their particular remit without the express consent of the delegated Budget Holder for the budget concerned

(e) The systems of budgetary control established by the Chief Financial Officer~~Director of Finance~~ are complied with fully

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the IBP, annual operating plans and a balanced budget.

4.3.4 All employees of the Trust, especially those involved with the budgetary process, have a responsibility to the Trust Board for identifying all possible opportunities to make savings or to use Trust resources more effectively. All such opportunities should be brought to the attention of the appropriate Executive Director, Clinical Director or Head of Service for consideration and possible inclusion in the plans of the division.

4.3.5 The budgetary process requires adherence to particular timescales for the performance of routines and duties. These timescales change periodically and will be issued by the Finance Department annually. The Chief Financial Officer~~Director of Finance~~ is responsible for issuing and reviewing guidance on budgetary timetables. It is the responsibility of all Executive Directors, Clinical Directors and Head of Services concerned to adhere to such timetables and to inform the Chief Financial Officer~~Director of Finance~~ of any reasons preventing the achievement of a specific deadline.

4.3.6 The Trust Board is responsible for ensuring that the Trust's financial performance is within the targets agreed by the ~~Department of Health~~ Department of Health and Social Care. In exercising this responsibility, the Trust Board will be guided by the advice of the Chief Executive and the Chief Financial Officer~~Director of Finance~~.

4.3.7 The Chief Financial Officer~~Director of Finance~~ reserves the right to have access to all Budget Holders and has the authority to require explanations on performance and spending and income trends within the remit of the Budget Holder. In normal circumstances, access will be through the relevant Executive Director and/or Divisional Manager.

4.4 Virements

4.4.1 Virement is defined as the transfer of budget sums within the areas for which a budget holder is responsible, or transfers to other budget holders i.e. any redistribution of budgeted amounts.

4.4.2 There are occasions where virement is generally appropriate, these include:

(a) Adjustments to reflect changes that could not have been foreseen at the start of the financial year

(b) Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purposese~~e~~

4.4.3 There are occasions where virement is not 'generally' appropriate:

(a) Smoothing budget statements to mask underlying issues

(b) Using fortuitous underspends to support pressures in other areas

(c) Funding additional establishment through savings in non-pay budget.

(d) Changing nurse establishments within funding baseline without the prior agreement of the Director of Nursing

~~(b)~~

4.4.4 To maintain central control of funding and recognising the need for the Trust to meet its statutory financial duties, limitations on the extent to which virement can be applied are needed. These limits provide a degree of flexibility for budget holders whilst recognising the need for overall control of spending within the Trust.

4.4.5 The following types of virement will generally not be considered unless a very strong case of need is made by the Budget Holder with agreement by the Chief Financial Officer:

(a) Virement between non recurrent and recurrent resources

(b) Virement between income and any other category

~~(b)~~(c) Virement from non pay to create additional establishment

4.4.6 The Trust Board has defined appropriate rules for virement between budgets. These rules are based upon an escalating basis of significance of the virement:

Virement	Authorisation Required from:
Re-phasing of Budgets	Chief Financial Officer
Budget moves between income, pay or non pay	Budget Holder and Deputy Director of Finance
Budget moves between pay to pay or non pay to non pay	Budget Holder and Deputy Director of Finance
CIP transactions	As above + Director of PMO
Changes to Nursing Establishment	As above + E-Rostering Manager
Changes to Medical Establishment	As above + Head of Medical Staffing

~~Virement~~	~~Authorisation required by~~
~~Budget moves between income, pay or non pay~~	~~Budget Holder and Deputy Director of Finance~~
~~Budget moves between pay to pay and non pay to non pay~~	~~Deputy Director of Finance, Associate Directors and/or Directorate Managers~~
~~Re-phasing of budgets~~	~~Budget Holder and Deputy Director of Finance~~

Table 2

~~4.4.6~~4.4.7 All virements must be communicated to the appropriate Divisional Business Advisor/Financial Manager and authorised through completion of the required virement authorisation form.

~~4.4.7~~4.4.8 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Trust Board.

~~4.4.8~~4.4.9 Any budgeted funds not required for their designated purpose/s revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

~~4.4.9~~4.4.10 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer~~Director of Finance~~.

~~4.4.10~~4.4.11 Any virement movements will be reported to the ~~Finance and~~ Performance and Finance Committee (~~FPC~~PFC) on a regular basis.

4.5 Reserves

4.5.1 The Chief Financial Officer~~Director of Finance~~, on behalf of the Chief Executive, will endeavour to create such reserves as are deemed necessary to secure the ability of the Trust to meet its financial targets. Reserves may include sums to cover future pay awards, price inflation, unforeseen contingencies, non recurrent spending and other specific items as yet not allocated to individual budgets.

4.5.2 The Chief Financial Officer~~Director of Finance~~ may exercise discretion to partly, or wholly, allocate reserves directly to the Divisions or subsequent allocation to specific budgets. In these circumstances, a clear definition of the rules governing the authority to apply the reserve/s will be required.

4.5.3 Applications to draw down reserves must follow the process specified by the Chief Financial Officer~~Director of Finance~~ and be approved by the Budget Holder and Chief Financial Officer~~Director of Finance~~.

4.6 Revenue business cases

4.6.1 Revenue business cases are required to allocate additional revenue funding from that specified in the annual budget setting process (including supporting invest to save proposals that require additional funding with a view to producing additional income/savings (CIP)).

4.6.2 If a source of funds is deemed readily available then investments of £25,000 or less can be authorised by the Chief Financial Officer~~Director of Finance~~ without the need to produce a full business case. If approved, the division will need to apply for a virement (see SFI 4.4).

4.6.3 For replacement consultant posts only, the Clinical Director and Associate Directors are responsible for approving the business case for such posts as such posts are deemed to be within the Trust's workforce plan. Any new consultant posts should follow the business case process as for any other revenue funding.

4.6.4 Any revenue business cases developed should have the support of the Divisional management team or Corporate Director as appropriate and should be in line with the Trust's priorities as outlined in the Integrated Business Plan and Annual Plan.

4.6.5 The ~~Finance and~~ Performance and Finance Committee (~~FPC~~PFC) will approve the revenue business case process.

4.6.6 All completed business cases will be reviewed by the Formal Executive Meeting (FEM)~~–~~. FEM has delegated authority from the Trust Board to approve revenue business cases of up to £250,000.

4.6.7 The FEM will report monthly to the Trust Executive Committee (TEC) to confirm decisions made at FEM and also take any business cases for revenue investment over £250,000 for final review ~~to gain~~ and recommendation for approval to the ~~Finance and~~ Performance and Finance Committee. ~~approval. TEC has delegated authority from the Trust Board to approve revenue business cases of up to £1,000,000.~~

4.6.8 Cases between £250~~1,000~~,000 and £1~~3~~,000,000 will be taken ~~by TEC~~ to the ~~Finance and~~ Performance and Finance Committee (~~FPC~~PFC) for approval. Any cases over £31,000,000 will require Trust Board approval.

4.6.9 NHS Improvement/England (NHSI/E) is also required to approve any revenue business cases which exceed £15,000,000, following Trust Board approval being given. This limit can be reduced at the discretion of the NHSI/E where a Trust is reporting a year end deficit.

4.6.10 Revenue business cases have to go through all the relevant approval groups dependent on values, so for example a case of over £15,000,000 will require approval from FEM, ~~who will then recommend to TEC,~~ who will recommend to ~~F~~PFC, who will recommend to Trust Board for approval. The case will then be recommended to NHSI/E for approval.

4.6.11 The values quoted in SFI 4.6.2 and 4.6.6 to 4.6.9 are inclusive of VAT and represents either annual expenditure or annual income level, whichever the greater. No netting off between expenditure and income should be undertaken in identifying these annual values.

4.6.12 Business cases which have both capital and revenue funding requirements should be fully completed (i.e. including all capital and revenue implications) and the capital

funding source should be confirmed (via the Capital Investment Group (CIG)) prior to the business case being presented to FEM

Business Case Approval Limits	**Incremental (additional) income or revenue (higher of) including VAT**				
	<£25k	> £25k to £250k	> £250k to £1m	> £1m to £15m	> £15m
Authority Delegated to:	Chief Financial Officer	Formal Executive Meeting (FEM)	Performance and Finance Committee (PFC)	Trust Board	NHSI/E

Table 3

~~4.6.12~~4.6.13 A benefits review will take place at a time determined by FEM at the time of approval for all approved business cases which will assess the success of the revenue business case based on Key Performance Indicators (KPIs) included within the revenue business case. Regular reports on benefits reviews undertaken will be submitted by FEM to ~~F~~PFC.

4.7 Monitoring Returns

4.7.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation in the format and timeframes required.

4.7.2 The internal monitoring of the Trust's and departmental business plans will take place through regular performance reviews at Executive level with appropriate support.

5. ANNUAL ACCOUNTS AND REPORTS

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

(a) Prepare financial returns in accordance with the accounting policies and guidance given by the ~~Department of Health~~ Department of Health and Social Care and the Treasury, the Trust's accounting policies, and generally accepted accounting practice

(b) Prepare and submit annual financial reports to the ~~Department of Health~~ Department of Health and Social Care certified in accordance with current guidelines

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

~~5.2~~ The Trust's audited annual reports and accounts, and any report of the auditor on them, must be presented to the Trust Board for approval. ~~or by the Audit Committee as delegated by the Trust Board.~~

~~5.3~~5.2

~~5.4~~5.3 The Trust's annual accounts must be audited by an auditor appointed by the Public Sector Audit Appointments body. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

~~5.5~~5.4 The Trust will publish an annual report, in accordance with guidelines on local accountability. This will be presented to the Trust Board for approval.. ~~or to the Audit Committee as delegated by the Trust Board for approval.~~ The annual report will also be presented at a public meeting. The document will comply with the ~~Department of Health~~ Department of Health and Social Care's Manual for Accounts.

6. BANK ACCOUNTS

6.1 General

6.1.1 The Chief Financial Officer~~Director of Finance~~ is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and ~~/~~directions issued from time to time by the ~~Department of Health~~ Department of Health and Social Care.

6.1.2 The Trust Board shall approve the banking arrangements.

6.1.3 The Trust operates one bank account under the Government Banking Service (GBS) with~~-~~ RBS.

6.2 Bank Accounts

6.2.1 The Chief Financial Officer~~Director of Finance~~ is responsible for:

(a) Bank accounts

(b) Establishing separate bank accounts for the Trust's non-exchequer (donated) funds

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

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

(e) Monitoring compliance with ~~Department of Health~~ Department of Health and Social Care guidance on the level of cleared funds

(f) Establishing treasury policies and procedures to ensure the effective management of cash and bank balances

6.3 Banking Procedures

6.3.1 The Chief Financial Officer~~Director of Finance~~ will prepare detailed instructions on the operation of bank accounts which must include:

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

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

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

~~6.3.3~~6.3.2 All funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer~~Director of Finance~~ shall open any bank account in the Trusts name or include the name of the Trust.

~~6.3.4~~6.3.3 The Chief Financial Officer~~Director of Finance~~ shall advise the bankers in writing of the officer(s) and or Director(s) authorised to release money from, and draw cheques on, each bank account of the Trust.

~~6.3.5~~6.3.4 All payments shall be supported by two authorised signatories on the cheque or authority to pay, as appropriate. Cheques will not be drawn for cash.

~~6.3.6~~6.3.5 All bank cheques or other orders for payment shall be ordered only upon the authority of the Chief Financial Officer~~Director of Finance~~, who shall make proper arrangements for their safe custody.

~~6.4 Tendering and Review~~

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

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

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

7.1 Income Systems

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

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

7.1.3 Any income raised from income generation and from contracts with non NHS bodies will be reinvested in service provision.

7.2 Fees and Charges

7.2.1 The Trust shall follow the ~~Department of Health~~ Department of Health and Social Care's Operating Framework and National Tariff Payment system in setting prices for NHS service agreements.

7.2.2 The Chief Financial Officer~~Director of Finance~~ is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the ~~Department of Health~~ Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the ~~Department of Health~~ Department of Health and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

7.2.4 All employees must ensure that the appropriate Trust financial procedures are followed with regards to accurately and promptly recording any money due to the Trust arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.2.5 The Chief Financial Officer~~Director of Finance~~ shall be responsible for implementing any such guidance issued by the ~~Department of Health~~ Department of Health and Social Care in relation to the costing and pricing of services, and in particular services provided to NHS commissioning bodies.

7.2.6 The preparation and signing of all tenancy agreements and licenses in respect of staff accommodation shall be the responsibility of the Chief ~~Financia~~Executive~~l~~ Officer~~Director of Finance~~.

7.2.7 Patient activity income will be subject to compliance with the latest applicable National Tariff Payment system guidance.

7.3 Debt Recovery

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

7.3.2 The Chief Financial Officer~~Director of Finance~~ shall establish procedures for the write off of debts after all reasonable steps have been taken to secure payments, including

debt recovery by external organisations. Where sums to be written off exceed £150,000, the Chief Financial Officer~~Director of Finance~~ will seek the consent of the Chief Executive and ~~the~~ items exceeding £50,000 will require consent of ~~to~~ the Trust Board.

7.3.3 Income not received should be dealt with in accordance with the Trust's Losses and Special Payments Policy. ~~Where sums to be written off exceed £50,000, the Director of Finance shall seek the consent of the Chief Executive and Trust Board.~~

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

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Chief Financial Officer~~Director of Finance~~ is responsible for:

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

(b) Ordering and securely controlling any such stationery

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

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

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

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

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

7.4.5 The opening of cash tills, telephone and coin operated machines, and the counting and recording of the takings shall be undertaken by two members of staff together. The coin box keys shall be securely held by a nominated member of staff.

7.4.6 The Chief Financial Officer~~Director of Finance~~ shall prescribe the system for the transporting of cash and other negotiable instruments. Wherever practicable, the services of a specialist security firm will be employed.

7.4.7 All unused cheques and other orders shall be subject to the same security precautions as are applied as cash. Bulk stocks of cheques shall be retained by the Trust under appropriate security arrangements and a record maintained of cheques used.

7.4.8 All cheques shall be subject to special security precautions as may be required from time to time by the Chief Financial Officer~~Director of Finance~~.

7.4.9 Staff shall be informed in writing on appointment, by the appropriate departmental or senior member of staff of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

7.4.10 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the Losses and Special Payments policy.

7.4.11 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS) or by Faster Payments and drawn in accordance with these instructions, except with the agreement of the Chief Financial Officer~~Director of Finance~~, as appropriate, who shall be satisfied about security arrangements.

7.4.12 To comply with money laundering legislation, under no circumstances will the Trust accept cash payments in excess of £10,000 in respect of any single transaction. Any attempts by an individual to effect payment above this amount shall be notified immediately to the Chief Financial Officer~~Director of Finance~~.

8. TENDERING, CONTRACTING AND PURCHASING PROCEDURES

8.1 Duty to comply with SOs and SFIs

8.1.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with these SOs and SFIs (except where SO 3.13 Suspension of SOs is applied).

Detailed below is a summary table of the process to follow dependent upon the value of the intended expenditure. Please note this is purely a summary and the full SFI detail held within this section should be read and understood but the below is given as an aid for users.VAT, apply

Value of intended expenditure or income (total contract value)	£250 to £4,999	£5,000 to £19,999	£20,000 to £49,999	£50,000 and above
	N.B. Values stated above are inclusive of VAT, apply to both capital and revenue expenditure and relate to total contract life cycle spend (i.e. total amount of expenditure being committed)			
Competitive (i.e. formal)	N/A – formal competition not required	At least 3 quotations to be obtained where practicable	At least 3 formal quotes advertised via contracts finder	At least 2 individuals/firms to be invited to tender Spend over the OJEU limit of £122,976 is to follow the OJEU advertisement and procurement process
Non-competitive (i.e. informal)	At least 3 quotations to be obtained verbally	N/A	To be followed if circumstances detailed in SFI 8.13.3 met Single quotation documentation to be completed and authorised by Chief Financial Officer	To be followed if circumstances detailed in SFI 8.5.3 & 8.5.4 met Single tender documentation to be completed and authorised by Chief Financial Officer & Chief Executive (where appropriate)

	No quotation or tender	Quotations	Tenders
Value of intended expenditure or income (total contract value)	£250 to £20,000	£20,001 to £50,000	£50,001 and above
	N.B. Values stated above are inclusive of VAT,apply to both capital and revenue expenditure and relate to total contract life cycle spend (i.e. total amount of expenditure being committed)		
Competitive (i.e. formal)	N/A	At least 3 quotations to be obtained	At least 2 individuals/firms to be invited to tender Spend over the OJEU limit of £118,133106,047 is to follow the OJEU advertisement and procurement process
Non-competitive (i.e. informal)	At least 3 quotations to be obtained	To be followed if circumstances detailed in SFI 8.13.3 met Single quotation documentation to be completed and authorised by Chief Financial OfficerAssociate Director – Procurement and Commercial Services	To be followed if circumstances detailed in SFI 8.5.3 & 8.5.4 met Single tender documentation to be completed and authorised by Chief Financial OfficerDirector of Finance & Chief Executive (where appropriate)

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8.2 EU directives governing public procurement

8.2.1 Directives by the Council of the European Union promulgated by the Department of Health Department of Health and Social Care (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs.

8.3 Reverse eAuctions

8.3.1 The Trust will seek advice from a relevant collaborative partner on the operation of Reverse eAuctions via the Supplies and Procurement Department.

8.4 Capital Investment Manual and other ~~Department of Health~~ Department of Health and Social Care guidance

8.4.1 The Trust shall comply as far as is practicable with the requirements of the ~~Department of Health~~ Department of Health and Social Care "Capital Investment Manual" and "Estate code" and "Procure 22" (normally to be considered for all schemes in excess of £1 million) in respect of capital investment and estate and property transactions.

8.4.2 In addition, "Concode (volume 1 – 3)" and "NHS Estates Agreement for the Appointment of Architects, Surveyors and Engineers for Commissions in the National Health Service" provides specific guidance relating to the procurement and execution of construction contracts and design consultant commissions.

8.4.3 In the case of management consultancy contracts the Trust shall comply as far as is practicable with ~~Department of Health~~ Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS".

8.5 Formal competitive tendering

8.5.1 The Trust shall ensure that competitive tenders are invited for:

(a) The supply of goods, materials and manufactured articles

(b) The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the ~~Department of Health~~ Department of Health and Social Care)

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals

8.5.2 Where the Trust is obligated to invite tenders for the supply of healthcare services these SFIs shall apply as far as they are applicable to the tendering procedure.

8.5.3 Formal tendering procedures **need not be applied** where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (inclusive of VAT)

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

(c) Regarding disposals as set out in SFI 8.21

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

(a) In very exceptional circumstances where the Chief Executive or their nominated officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal

tendering procedures, and the circumstances are detailed in an appropriate Trust record

(b) Where the requirement is covered by an existing contract and the requirement does not constitute a material change of contract

(c) Where there are collaborative arrangements and market testing has already formally taken place. e.g., through Crown Commercial Services

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

(e) Where specialist expertise is required and is proven to be available from only one source

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

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

(h) Where allowed and provided for in the Capital Investment Manual

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

8.5.6 Under no circumstances can procurement, with a total contract lifecycle value (i.e. minimum 3 years, if not specified), over the current minimum Official Journal of European Union (OJEU) spend threshold (currently£11~~8~~22, ~~133~~976~~106,047~~) be waivered.

8.5.7 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record (i.e. a Single Tender waiver form contained within the electronic Request for Executive Approval Form (eReaf) system), authorised by the Chief Financial Officer~~Director of Finance~~ and Chief Executive (where appropriate) and reported to the Audit Committee at each meeting.

8.5.8 Where the exceptions set out in SFI 8.5.4 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

8.5.9 The Trust does not maintain an approved supplier list, except for building and engineering works (see SFI 8.5.16) and temporary agency recruitment (see SFI 8.5.17). Firms who apply for consideration will be directed to the NHS Supplier Information Database (NHS SID) in the first instance. Suppliers not on NHS SID will be assessed for technical and financial competence during the procurement process

and the level of assessment will be comparable to the value of business being procured.

8.5.10 All suppliers must be made aware of the Trust's terms and conditions of contract.

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

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

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

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

8.5.15 An appropriate record contained within the eReaf system, should be made of the reasons for inviting a tender or quote other than from an approved procurement route /~~in the contract file should be made of the reasons for inviting a tender or quote other than from an~~ approved list.

8.5.16 The Trust will use contractors registered on Construction Line (www.constructionline.co.uk) ~~for its~~as vetted and approved contractors for capital developments or the Procure 2~~1+~~2 Framework.

8.5.17 The Trust has in place an approved supplier list for temporary agency recruitment. This list has been subject to due procurement process. Suppliers from this list must be utilised by the budget administrator/manager/holder in all cases of temporary staff recruitment via an external agency.

8.5.18 It is the budget administrators/manager/holder's responsibility to ensure full awareness of the supplier's terms and conditions of engagement before committing to recruit any temporary agency resource. Failure to understand the terms and conditions of engagement fully, could result by default, as an acceptance of the suppliers own Terms and Conditions of contract, exposing the Trust to unnecessary contractual risk and financial exposure (for example, significantly high introductory fees if the Trust proceeds to employ permanently the temporary agency resource).

8.5.19 If a budget administrator/manager/holder uses a supplier for temporary agency recruitment that is not on the approved supplier list, the use of such a supplier could lead to a contravention of Official Journal of European Union (OJEU) Procurement regulations. The noncompliance would also be a breach of these SFIs which could result in disciplinary proceedings and be reported to Audit Committee (as per SFI 1.5 and 1.6).

8.5.20 It is the responsibility of the budget administrator/manager/holder who is committing the trust to temporary resource to ensure that all relevant pre-employment checks have been completed to avoid exposing the Trust and patients to unnecessary risk. The use of suppliers for temporary agency resource who are not on the approved supplier list may not in some cases have adopted a policy of conducting these checks prior to supplying the temporary resource to the Trust.

8.5.21 Further commercial advice regarding the recruitment of temporary agency staff should be sought from the relevant category lead for agency within the Supplies and Procurement department.

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

8.5.23 Items estimated to be below the limits set in these SFIs, for which formal tendering procedures are not used, which subsequently prove to have a value above such limits shall be reported to the Chief Executive or their nominated officer, and be recorded in an appropriate Trust record.

8.6 Contracting/tendering procedure

8.6.1 For all tenders (both e-procurement and non e-procurement):

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders and that no tender will be accepted beyond this date

(b) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Terms and Conditions as are applicable

(c) Every tender for building and engineering construction works (except in some circumstances for maintenance work only where HBN00-08 guidance should be followed), shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or New Engineering Contract (NEC) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode., When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. . The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. The NEC form of contract and the Model Form of Engineering Contract should be used whenever applicable. Tendering based on other forms of contract (P22) may be used ~~only~~

~~after~~following ~~prior~~ consultation with the ~~DOH~~ Department of Health and Social Care.

~~8.6.2 In addition, for non e-Procurement tenders, the invitation to tender shall state that, no tender will be accepted unless:~~

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

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

8.7 Receipt and safe custody of tenders

8.7.1 For e-Procurement tenders:

(a) All tenders received through the e-Procurement portal will be stored within the system until the time appointed for their opening, the e-Procurement function will not allow any member of the originating department or the wider Trust to access tenders before the specified date

(b) The e-Procurement function will automatically create a log that records the date and time of receipt of each tender

8.7.2 For non e-Procurement tenders:

(a) A member of the originating department (band 5 or above) will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening

(b) The date and time of receipt of each tender shall be endorsed on the tender envelope/package

(c) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender. Any person directly involved in the tender process or subsequent evaluation should be the person responsible for the receipt and safe custody and tenders

8.8 Opening tenders and register of tenders

8.8.1 For e-Procurement tenders:

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, an authorised person within the originating department (band 5 or above) who was duly named during the tendering process, will access the e-procurement system and authorise the electronic opening of all submitted tenders

(b) The e-Procurement system will automatically register the details of opening i.e. date, time, authorised person

(c) The e-Procurement system will retain a log for each set of competitive tender invitations dispatched:

(i) The name of the individuals invited

(ii) The names of firms individuals from which tenders have been received

(iii) The price shown on each tender

(d) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, should be dealt with in the same way as late tenders (see SFI 8.10).

8.8.2 For non e-Procurement tenders:

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, an authorised person within the originating department (band 5 or above) who was duly named during the tendering process, will open all tenders received

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

(c) A register shall be maintained to show for each set of competitive tender invitations despatched:

(i) The name of all firms individuals invited

(ii) The names of firms individuals from which tenders have been received

(iii) The date the tenders were opened

(iv) The persons present at the opening

(v) The price shown on each tender

(vi) A note where price alterations have been made on the tender

(d) Each entry to this register shall be signed by those present

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

(f) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (see SFI 9.10).

(g) The ‘originating’ Department will be taken to mean the Department sponsoring or commissioning the tender. Any person directly involved in the tender process or subsequent evaluation should be the person responsible for the opening or registration of tenders

8.9 Admissibility

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

8.9.2 Where only one tender is sought and/or received, the Chief Executive or their nominated officer and Chief Financial Officer~~Director of Finance~~ shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.10 Late tenders

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

8.10.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not been received by the person carrying out the tender process or if the process of evaluation and adjudication has not started.

8.10.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody either by the duly authorised person within the originating department or within the relevant portal of the e-procurement system.

8.11 Acceptance of formal tenders

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

8.11.2 The lowest acceptable tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons, which may include technical suitability, adherence to the specification, service record of the proposed successful supplier and other non-financial factors that have a bearing on the total cost and are relevant to the procurement in question, shall be recorded in either the contract file, or other appropriate record.

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

(a) Experience and qualifications of team members

(b) Understanding of client's needs

(c) Feasibility and credibility of proposed approach

(d) Ability to complete the project on time

8.11.4 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

8.11.5 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SFIs except with the authorisation of the Chief Executive or their nominated officer

8.11.6 The use of these procedures must demonstrate that the award of the contract was:

(a) Not in excess of the going market rate/price current at the time the contract was awarded

(b) That best value for money was achieved.

8.11.7 All tenders should be treated as confidential and should be retained for inspection. Records may be kept electronically in accordance with the HSC 1999/053.

8.12 Tender reports to the Trust Board

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

8.13 Quotations: Competitive and non-competitive

8.13.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £20,000 but not exceed £50,000 (inclusive of VAT).

8.13.2 For competitive quotations, quotations should be :

(a) Obtained from at least 3 firms/individuals based on specifications or Terms of Reference prepared by, or on behalf of, the Trust (where this number of suppliers exist for the requirement)

(b) In writing unless carried out using the e-procurement system, or unless the Chief Executive or their nominated officer determines that it is impractical to do so, in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record

(c) Treated as confidential and be retained for inspection

(d) Evaluated by the nominated person from the originating department and the quote which gives the best value for money should be selected

(e) If the selected quote is not the lowest quotation, if payment is to be made by the Trust or the highest, if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record

8.13.3 For non-competitive quotations, quotations in writing may be obtained in the following circumstances:

(a) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion

of the responsible officer, possible or desirable to obtain competitive quotations

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

(c) Miscellaneous services, supplies and disposals

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

8.13.4 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SFIs except with the authorisation of either the Chief Executive, or their nominated officer, or the Chief Financial Officer~~Director of Finance~~.

8.14 Authorisation of tenders and competitive quotations

8.14.1 Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows. These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Contract value (Inclusive of VAT)	**Authorisation by**
£0 - £50,000	Budget Holder
£50,001 - £100,000	Director of Finance
£100,001 to £500,000	Chief Financial Officer~~Chief Officer – Finance and Performance~~
£500,001 to £1,000,000	Chief Executive
£1,000,001 to £3,000,000	~~Finance and~~ Performance and Finance Committee
£3,000,001 and above	Trust Board

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

8.14.3 The ~~Associate~~ Director of – Procurement ~~and Commercial Services~~ will report proposed procurements over the value of £1m to the Performance and Finance Committee prior to the award of any contract, and also provide a contract award report for all procurements over a value of £500,000 to the Chief Executive Officer on a monthly basis.~~the current OJEU limit (currently£118,133106,047) to the Chief Financial OfficerDirector of Finance and Chief Officer – Finance and Performance prior to the award of any contract~~.

8.15 Instances where formal competitive tendering or competition quotation is not required

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

(a) The Trust shall use the "nominated national NHS Logistics provider" for procurement of all goods and services unless the Chief Executive or their nominated officer deems it inappropriate. The decision to use an alternative source must be documented

(b) If the Trust does not use "nominated national NHS logistics provider" – where tenders and quotations are not required, because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer~~Director of Finance~~

8.16 Procurement processes for pharmacy medicines

8.16.1 Where a Commercial Medicines Unit (CMU) hospital framework contract exists, the Trust will purchase medicines under this contract.

8.16.2 The CMU is part of the Medicine, Pharmacy and Industry Group of the ~~Department of Health~~ Department of Health and Social Care. The focus of the work of the CMU is on strategic supply management and procurement of medicines for use in secondary care. The CMU works in partnership with hospital procurement colleagues across the NHS in England; this includes leading a selective competitive tendering work plan for the implementation of hospital framework contracts.

8.16.3 Where no CMU contract exists, and where applicable, the Trust will comply with the quotation, tendering and contract procedures detailed in SFI 18 and support will be provided by the Supplies and Procurement Department accordingly. However, for many medicines there is only one supplier and therefore the conditions where formal tendering procedures may be waived (detailed in SFI 8.5.4) are applicable.

8.17 Private Finance for capital procurement

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

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

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

(c) The proposal must be specifically agreed in accordance with the delegated authorisation limits specified in the Scheme of Delegation

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

(e) Any schemes involving PFI (new schemes or contract variations), irrespective of value, will also require discussion with the NHSI/E~~i~~ to agree the approval requirements.

8.18 Compliance requirements for all contracts

8.18.1 The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's SOs and SFIs

(b) EU Directives and other statutory provisions

(c) Any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants

(d) Such of the NHS Standard Terms and Conditions as are applicable

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance

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

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

8.18.2 The Chief Executive Officer delegates the responsibility of authorising/signing of all commercial contracts to the Director of Procurement, with the exception of building and works contracts which is delegated to the Director of Estates, Facilities and PFI'. The conditions set out in 18.18.1 must be satisfied.

8.19 Personnel and Agency or Temporary Staff Contracts

8.19.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

8.20 Healthcare Services Agreements

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

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

8.21 Disposals

8.21.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

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

(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the ~~supplies~~ Procurement policy (SP01) of the Trust

(c) Items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis

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

(e) Land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance

8.22 In-house services

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

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

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist

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

(c) Evaluation team, comprising normally a specialist officer, a Supplies and Procurement officer and a Chief Financial Officer~~Director of Finance~~ representative. For services having a likely annual expenditure exceeding £100,000, a Non-executive Director~~non-officer member~~ should be a member of the evaluation team

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

8.22.4 The evaluation team shall make recommendations to the Trust Board.

8.22.5 If in-house services are outsourced, the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.23 Applicability of SFIs on tendering and contracting to funds held in trust

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

8.24 Use of local and smaller suppliers

8.24.1 The Trust will strive to ensure that local and smaller suppliers are not discriminated against in the procurement process and specifications.

8.25 Delegated Orders

The Estates, Facilities and PFI Division have delegated authority in regard to the raising of purchase orders in relation to MTC related purchase orders and emergency orders only. (These can be emergency orders required at any time, but should not be confused with urgent orders). As outlined in section 11.5.1 all emergency orders must subsequently be confirmed by an official purchase order and clearly marked "Confirmation Order".

It should also be noted that a fully authorised electronic Request for Executive Approval Form (eReaf) is still required for all MTC related purchase order and emergency order expenditure exceeding £20,000 (including VAT).

9. NHS SERVICE AGREEMENTS CONTRACTING FOR PROVISION OF SERVICES

9.1 Contractual agreements

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring contracts are suitably negotiated with commissioners for the provision of services to patients in accordance with the Integrated Business Plan and subsequent Annual Business Plan, and for establishing the arrangements for providing extra-contractual services.

9.1.2 These contracts are not legally binding.

9.1.3 In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer~~Director of Finance~~ regarding:

(a) Costing and pricing of services

(b) National Tariff Payment system

(c) Payment terms and conditions

(d) Penalty and fine implications

(e) Billing systems and cash flow management

(f) Any other matters of a financial nature

(g) The contract negotiation process and timetable

(h) The provision of contract data

~~(i) The pricing of services~~

~~(j)~~(i) Contract management and monitoring arrangements

~~(k)~~(j) Amendments to contracts and extra-contractual arrangements

~~(l)~~(k) Targets and performance/quality standards specified in the contract

(l) Any other matters relating to contracts of a legal or non-financial nature

(m) Any other / new innovative payment methodologies

9.1.4 Contracts should be so devised as to minimise the risk whilst maximising the Trust's opportunity to generate income.

9.1.5 Any pricing of contracts at marginal cost must be undertaken by the Chief Financial Officer~~Director of Finance~~ and where material reported to the Trust Board.

9.1.6 Contracts with NHS commissioning bodies require the signature of the Chief Executive or the Chief Financial Officer~~Director of Finance~~.

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

9.2 Reports to Trust Board on contractual agreements

9.2.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Trust Board detailing actual and forecast income from the contractual agreements. This will include information on costing arrangements, in line with the National Tariff Payment system. Where specific services are outside the scope of National Tariff Payment system, all parties should agree a common currency for application across the range of contractual agreements.

9.2.2 The report should also include information regarding the risks and mitigations in place relating to the contract.

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

10.1 Nominations and Remuneration ~~Remuneration and Nominations~~ Committee

10.1.1 In accordance with SOs the Trust Board shall establish a Nominations and Remuneration ~~and Nominations~~ Committee, with clearly defined Terms of Reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

10.1.2 The Committee will:

(a) Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.) ~~and the Chief Executive. For those other senior posts reporting directly to the Chief Executive, the decision on remuneration and terms of service remains with the Chief Executive/Medical Director or Executive Director lead.~~ This will include:

(i) All aspects of salary (including any performance-related elements/bonuses)

(ii) Provisions for other benefits, including pensions and cars

(iii) Arrangements for termination of employment and other contractual terms

(b) Monitor and evaluate the performance of individual Directors (with the advice of the Chief Executive)

(c) Advise on and oversee appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

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

10.1.4 The Trust Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

~~10.1.5~~ The Trust will pay allowances to the Chairman and Non-Executive ~~Chairman and non-officer~~ members of the Trust Board in accordance with instructions issued by the Secretary of State for Health. ~~Once authorised as a Foundation Trust the Membership Council shall establish a remuneration committee with responsibility for reviewing the pay and allowances to the Chairman and Non-Executive Directors in accordance with the Core constitution of the Trust. Pay and allowances will be made in accordance with those industry averages, benchmarked at the point of authorisation.~~

~~10.1.6~~10.1.5

10.2 Funded Establishment

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

10.3 Staff Appointments

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

(a) Unless authorised to do so by the Chief Executive ~~or~~ and Director of Human Resources ; and

(b) And is ~~Within~~within the limit of their approved budget and funded establishment, and

(c) And ~~It~~ is in accordance with any local or Trust-wide controls placed on recruitment to vacant positions, such as vacancy control panels

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

10.3.3 A manager may only action such a change against those cost centres/budgets for which he/she has formal responsibility. ~~The Chief Financial Officer~~Director of Finance ~~is to keep an up to date list of authorised signatories by cost centre/budget code.~~

10.3.4 Advertisements for all posts must be placed via the Human Resources Directorate

10.4 Processing Payroll

10.4.1 The Chief Financial Officer~~Director of Finance~~ is responsible for:

(a) Performance managing the outsourced payroll provision to ensure it is in line with the contract and service continuity in maintained

(b) Where necessary reporting any variations to the contract or significant areas of risk in relation to the service to the Trust Board

(c) Specifying timetables for submission of properly authorised time records and other notifications

(d) The final determination of pay and allowances

(e) Making payment on agreed dates

(f) Agreeing method of payment

10.4.2 The Chief Financial Officer~~Director of Finance~~ will issue instructions regarding:

(a) Verification and documentation of data

(b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances

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

(d) Security and confidentiality of payroll information

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

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

(g) Methods of payment available to various categories of employee and officers. This will be by bank credit direct to a bank or other financial institution nominated by the employee

(h) Procedures for payment by cheque or bank credit to employees and officers

(i) Procedures for the recall of cheques and bank credits

(j) Pay advances and their recovery

(k) Maintenance of regular and independent reconciliation of pay control accounts

(l) Separation of duties of preparing records and handling cash

(m) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust

10.4.3 Appropriately nominated managers, including HR representatives have delegated responsibility for:

(a) Submitting time records, and other notifications in accordance with agreed timetables

(b) Completing time records and other notifications in accordance with the Chief Financial Officer~~Director of Finance~~'s instructions and in the form prescribed by the Chief Financial Officer~~Director of Finance~~

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the appropriate Director or Budget Holder and payroll must be informed immediately

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

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to the Human Resources Director for:

(a) Ensuring that all employees are issued with a Contract of Employment which complies with employment legislation

(b) Ensuring controls are in place for actioning variations to, or termination of, contracts of employment. The transacting of this responsibility has been delegated to the line manager

(c) Any pay rates outside national terms and conditions will need prior agreement by the Chief Financial Officer and the Human Resources Director; this will include changes to bank rates as well as substantive posts.

(d)
The Human Resources Director will maintain a schedule of all pay rates outside the national terms and conditions and will notify payroll of any changes

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Holders prior to the start of the financial year to which the budget relates.

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

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

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

The limits are:

Authority Delegated To	Requisition of Goods and Services	Authorisation of Non Purchase Order Invoices*
Budget Administrators	£0 to £5,000	£0 to £5,000
Budget Managers	£0 to £20,000	£0 to £20,000
Budget Holders	£0 to £20,000	£0 to £20,000
Director of Finance	£20,001 to £100,000	£20,001 to £100,000
Chief Financial Officer	£100,001 to £250,000	£100,001 to £250,000
Chief Executive	£250,001 to £500,000	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,000,000	£500,001 to £1,000,000
Trust Board	£1,000,001 and above	£1,000,001 and above

Table 6

* As per the agreed Non PO lists (section 11.2.1)

~~Authority Delegated To~~	~~Current~~	
~~Budget Administrators~~	~~£0 to £5,000~~	
~~Budget Managers~~	~~£0 to £25,000~~	
~~Budget Holders~~	~~£0 to £50,000~~	
~~Director of Finance~~	~~£50,001 to £100,000~~	
~~Chief Officer – Finance and Performance~~	~~£100,001 to £500,000~~	
~~Chief Executive~~	~~£500,001 to £1,000,000~~	
~~Finance and Performance Committee~~	~~£1,000,001 to £3,000,000~~	
~~Trust Board~~	~~£3,000,001 and above~~	

~~*Table 46*~~

The authorisation levels for pharmacy drugs requisitions are separately agreed as set out in the table below. Requisitions up to a value of £170,000 are authorised within the Pharmacy team.

Authority Delegated To	Requisition of Goods and Services (Drugs and Pharmacy Consumables)
Senior Assistant Technical Officer (ATO) Procurement and Senior Pharmacy Technician	£0 to £35,000
Lead Procurement Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Pharmacy Supply Chain Manager (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b).	£35,001 to £120,000
Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c).	£120,001 to £170,000
Chief Financial Officer	£170,001 to £250,000
Chief Executive	£250,001 to £500,000
Performance and Finance Committee	£500,001 to £1,000,000
Trust Board	£1,000,001 and above

Table 7

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

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

11.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Supplies and Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer~~Director of Finance~~ (and/or the Chief Executive) shall be consulted.

The Supplies and Procurement Department, with input from the Finance Department, will be responsible for maintaining the list detailing the areas of expenditure that do not require a Purchase Order. This list will be known as the 'Agreed Non Purchase Order List' and will list specific suppliers. Any suppliers contained within the Agreed Non Purchase List will not require a purchase order and will therefore be exempt from the Trusts requisition approval process.

11.2.2 Under no circumstances should a requisition be split in such a way to circumvent particular spending limits attached as per the Scheme of Delegation.

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

11.2.4 The Chief Financial Officer~~Director of Finance~~ will:

(a) Advise the Trust Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFIs and regularly reviewed

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

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

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

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices against specific cost centre codes

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

(iii) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time worked, 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

(iv) Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained

(v) The account is arithmetically correct

(vi) The account is in order for payment

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

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

(e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 11.3.

11.3 Prepayments

11.3.1 Prepayments for goods and services where the Trust is paying in advance of receipt of the goods or services, excluding payments for training courses,

subscriptions and membership fees up to the value of £5,000 (inclusive of VAT) are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages and with the explicit approval of the Chief Financial Officer~~Director of Finance~~

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

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

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

11.4 Official purchase orders

11.4.1 Official purchase orders must:

(a) Be consecutively numbered

(b) Be in a form approved by the Chief Financial Officer~~Director of Finance~~

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

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

11.5 Duties of Managers and Officers

11.5.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer~~Director of Finance~~ and that:

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

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

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

(d) In accordance with the Trust's Standards of Business Conduct Policy, no order shall be issued for any item or items to any firm which has made an offer of gifts (see SFI 19), reward or benefit to Directors or employees, other than:

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

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

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

(f) All goods, services, or works are ordered on an official purchase order except for purchases from petty cash or with explicit approval of the Chief Financial Officer~~Director of Finance~~

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

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds and should be placed for the value for the life of the contract.

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

~~(j) Changes to the list of employees and officers authorised to certify invoices should be approved by the Divisional Business Advisor and Chief Financial Officer~~~~Director of Finance~~

~~(k)~~(j) Purchases from petty cash are restricted to a maximum value of £50 and by type of purchase in accordance with instructions issued by the Chief Financial Officer~~Director of Finance~~

~~(l)~~(k) Petty cash records are maintained in a form as determined by the Chief Financial Officer~~Director of Finance~~

11.5.2 Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, PFI and P22 (including NEC contracts) and Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

11.6.1 Payments to local authorities and voluntary organisations, made under the powers of section 28A of the NHS Act, for the provision of social care for people who otherwise would be the responsibility of the NHS, shall comply with procedures laid down by the Chief Financial Officer~~Director of Finance~~ which shall be in accordance with these Acts.

11.6.2 Where NHS Trusts are proposing to enter into partnership arrangements e.g. joint ventures, joint arrangements or special vehicles. NHSI/E will reserve the right to

review these on a case by case basis and these schemes may require NHSI/E approval to proceed.

11.7 Leases

11.7.1 The Chief Financial Officer~~Director of Finance~~ must ensure that any lease entered into on behalf of the Trust represents value for money.

11.7.2 A commercial lease is a legally binding contract made a landlord and a business tenant. The lease gives a tenant the right to use certain property for a business or commercial activity for a period of time (minimum 6 months) in exchange for consideration (i.e. money) paid to the landlord. A commercial lease offers exclusive possession of a defined area (demise), with the main legislation being the Landlord and Tenant Act 1954. ~~A lease is generally defined as a contract renting land, buildings, etc., to another or a contract or instrument conveying property to another for a specified period. It will not be a flexible arrangement and will be for a long time period (i.e. more than 12 months). The agreement will usually be written and be predetermined and cannot be broken without breaking the lease often incurring penalties.~~

11.7.3 A licence to occupy is a legal agreement between the licensor (the party who owns the property/land) and the licensee (the party seeking to occupy the property/land), giving the licensee the right to occupy a designated area of the property for a defined length of time (i.e. there is no minimum of maximum period but is usual for licences to be for 1 day to 6 months or more). Licences do not offer exclusive possession but rather the designated area can be relocated. ~~A rental agreement differs to a lease as it will generally be an agreement where a payment is made for the temporary use of a good or property owned by another person or company. It will often be flexible and for the short term (i.e. a period of less than 12 months). The agreement may be predetermined but terms can be changed and the agreement can be cancelled at any time with no or low value penalty.~~

11.7.4 ***Contracts for goods and services can also contain leases. These contracts, mainly for equipment or vehicles, will contain a lease if the Trust has the right to obtain substantially all of the economic benefits from use of a an asset, for example by having exclusive use of the asset over the period of the lease, and the Trust has the right to direct the use of the identified asset. In effect, the Trust decides how the asset will be used and for what purpose.***

11.7.4 All leases and contracts for goods and equipment must be forwarded to the Supplies and Procurement Department to validate the legal content of the lease/contract and for inclusion on the goods and equipment Lease Contracts Register.

11.7.5 All leases and contracts for premises must be forwarded to the Estates, Facilities and PFI Department to validate the legal content of the lease/contract and for inclusion on the premises Lease Contracts Register.

~~11.7.4~~11.7.6

~~11.7.5~~11.7.7 Further guidance must be obtained from the Finance Department regarding the accounting treatment of leases and the definition of a finance lease and an operating lease.

12 EXTERNAL BORROWING ~~AND INVESTMENTS~~

12.1 Borrowings

12.1.1 The Chief Financial Officer~~Director of Finance~~ will advise the Trust Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the ~~Department of Health~~ Department of Health and Social Care . The Chief Financial Officer~~Director of Finance~~ is also responsible for reporting periodically to the Board concerning the PDC debt and all loans~~ and overdrafts.~~.

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

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

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

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

12.1.6 All long-term borrowing must be consistent with the plans outlined in the Integrated Business Plan ~~Long-Term Financial Model~~ and be approved by the Trust Board.

~~12.2 Investments~~

~~12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Trust Board.~~

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

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

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

13.1 Capital Investment

13.1.1 The Chief Executive:

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

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

(c) Shall ensure that the capital investment is not undertaken without confirmation of purchaser/s support and the availability of resources to finance all revenue consequences, including capital charges. Any resource requirements outside of agreed budgets will be taken through the required authorisation process

(d) That a Capital Investment Programme, produced on an annual basis, is submitted to and approved by the Trust Board prior to the start of the financial year

13.1.2 The approval of a capital programme shall not constitute approval for expenditure on any scheme, i.e. a completed capital bid and, where applicable, capital business case will still be required.

13.1.3 For all capital expenditure proposals the Chief Executive shall ensure that:

(a) A capital bid is prepared and approved through the agreed process

(b) All proposals to lease, hire or rent ~~fixed~~ tangible and intangible assets have been subject to appraisal of their impact on the Trust's ability to achieve its financial targets and, where appropriate, subject to legal advice from the Trust's legal advisor on the terms of the proposed contract

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

(a) Specific authority to commit expenditure

(b) Authority to proceed to tender

(c) Approval to accept a successful tender

13.1.5 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's SOs and SFIs.

13.1.6 The Chief Financial Officer~~Director of Finance~~ shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

13.2 **Delegation and reporting**

13.2.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

13.2.2 Expenditure on ~~fixed assets~~ tangible and intangible assets for the Trust must follow the correct delegation and reporting lines specifically designed for approval of capital expenditure detailed in the Scheme of Delegation. Accounting for ~~fixed~~ tangible and intangible assets must comply with the ~~NHS Manual for Accounts~~DHSC Group Accounting Manual

13.2.2 A separate capital budget must be prepared for each capital scheme.

13.2.3 Each capital allocation is made on an expenditure ~~cash~~ basis for a specific financial year. Any proposed/anticipated slippage or variation in cost on a capital scheme must be reported to the ~~Director of Finance~~Chief Financial Officer at the earliest opportunity.

13.2.4 Any proposed advancement of all, or part of, a capital scheme must receive the authorisation of the Chief Financial Officer~~Director of Finance~~ prior to its execution. The Chief Financial Officer~~Director of Finance~~ may, in consultation with the responsible Director ~~of Corporate Services~~, approve variations to schemes included within the capital programme as approved by the Trust Board.

13.2.5 Progress on each capital scheme should be reviewed at least monthly and a projection to the year end updated. Any significant changes must be notified to the Trust Board at the earliest opportunity.

13.2.6 The Chief Financial Officer~~Director of Finance~~ will specify the process and timetable to be followed by the Trust for compiling the annual and future capital plans for the Trust.

13.2.7 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estatecode”.

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

13.2.9 The Chief Financial Officer~~Director of Finance~~ shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.2.10 The relevant capital project Director ~~Corporate Services~~ is responsible for the selection of architects, quantity surveyors, consultant engineers, IT engineers, other professional advisors and service providers within procurement and EU regulations.

13.3 Capital charges

13.3.1 Prior to the commencement of a financial year, at a time determined by the Chief Financial Officer~~Director of Finance~~, an estimate of capital values and capital charges incurred by the Trust for the ensuing year will be calculated. This will be

based on the current asset register and will take account of known future purchases, sales, revaluations and any other anticipated transactions.

13.3.2 During the financial year the capital charges will be calculated on a monthly basis. Projections for the remainder of the financial year will be updated taking into account any revised expectation of the timing and value of transactions on the asset register.

13.4 Capital definition and criteria

13.4.1 Capital expenditure is defined as expenditure on a tangible or intangible productive resource with an expected life in excess of one year.

13.4.2 The capitalisation limit is expenditure of £5,000 (inclusive of VAT) or more on:

(a) A discrete asset

(b) A collection of assets which individually may be valued at less than £5,000 but which together form a single collective asset because the items fulfil all of the following criteria:

(i) The items are functionally interdependent

(ii) The items are acquired at about the same date and are planned for disposal at about the same date

(iii) The items are under single managerial control

~~(iii)~~(iv) The items have an individual value of £250 or more

(c) At the Trust discretion, a collection of assets which individually may be valued at less than £5,000 but which form part of the initial equipping and setting up of a cost of a new building

13.4.3 Capital budgets must not be used to cover purchases that do not conform to the current capital definition as specified by the ~~Department of Health~~ Department of Health and Social Care.

13.4.4 Major expenditure on maintaining the condition of an asset will normally be treated as a revenue item except that any proportion relating to an enhancement to the asset will be treated as capital.

13.4.5 For land and building payments the amount capitalised can include lump sum payments for related rights (including capitalised rents) and payments made under the Land Compensation Act 1973.

~~13.4.6 Fixed assets should not ordinarily be purchased from revenue funds, however, there may be instances where this is required but they must be approved by the Chief Financial OfficerDirector of Finance.~~

~~13.4.7~~13.4.6 Bids for capital spend should be made following the process as specified by the Chief Financial Officer~~Director of Finance~~. Capital bids will be classified as either investment capital or ~~maintenance~~ replacement capital, these are defined as:

(a) Investment capital - this is capital spend for new assets where it likely that the Trust will incur additional revenue consequences for example. staffing, consumables etc. A supporting case, relevant to the level of investment is required for investment capital funding – see 13.5.2

(b) ~~Maintenance~~ Replacement capital – this is capital spend which is replacing an existing asset that the Trust already holds, it is unlikely that a result of this additional capital spend, additional revenue consequences will be incurred. Business cases may be required at the discretion of the Chief Financial Officer~~Director of Finance~~

13.5 Capital business cases

13.5.1 A supporting case, relevant to the level of investment, is required for all new capital investment, investment capital, if it is not relating to the replacement of an existing asset

13.5.2 The annual budget will detail the Capital schemes for the coming year. A summary of the internal capital approval limits for schemes included in the annual plan is ~~shown~~ as below:

	~~Investment Value £~~	~~Incremental (additional) income or revenue (higher of) included within ALL Capital bids~~			
		~~<£25k~~	~~£25k - <£500250k~~	~~£500k1m - <£13m~~	~~£13m - <£15m~~
~~Investment capital~~	~~<£100k~~	~~DOFChief Financial Officer~~	~~Business case to Exec Team~~	~~Business case to FPC~~	~~Business case to Trust Board~~
	~~£100k - <£1m~~	~~Statement of Need to CIG~~	~~Business case to Exec Team~~	~~Business case to FPC~~	~~Business case Trust Board~~
	~~£1m - <£3m~~	~~Business case to TEC and FPC~~	~~Business case to TEC and FPC~~	~~Business case to TEC and FPC~~	~~Business case to Trust Board~~
	~~£3m - <£15m~~	~~Business case to Trust Board~~	~~Business case to Trust Board~~	~~Business case to Trust Board~~	~~Business case to Trust Board~~
~~Maintenance Capital~~	~~ALL~~	~~No case required~~	~~Business case to Exec Team~~	~~Business case to FPC~~	~~Business case to Trust Board~~

Capital Approval Limits	Investment Value £	Incremental (additional) income or revenue (higher of) included within ALL Capital bids			
		<£25k	£25k-<£500k	£500k - <£1m	£1m - <£15m
Investment capital	<£100k	Chief Financial Officer	Business case to Exec Team	Business case to PFC	Business case to Trust Board
	£100k - <£1m	Statement of Need to CIG	Business case to Exec Team	Business case to PFC	Business case Trust Board
	£1m - <£3m	Business case to PFC	Business case to PFC	Business case to PFC	Business case to Trust Board
	£3m - <£15m	Business case to Trust Board	Business case to Trust Board	Business case to Trust Board	Business case to Trust Board
Maintenance Capital	ALL	No case required	Business case to Exec Team	Business case to PFC	Business case to Trust Board

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Schemes not identified in the annual plan will require FPCExecutive Team sign off, unless expressly agreed as part of the business case process or coveredagreed by the Trust Board.

13.5.3 The Finance and Performance and Finance Committee (FPFC) will approve the capital business case process.

13.5.4 The Trust Board will approve the capital programme as part of the annual plan. The Trust's Capital Investment Group (CIG) has delegated authority from the Trust Board to approve capital investment cases up to £1,000,000 as identified in the programme approval table at 13.5.2.

13.5.5 NHSI/E is also required to approve any individual capital investments which exceed £15,000,000, following Trust Board approval being given. The limit can be reduced at the discretion of NHSI/E where a Trust is reporting a year end deficit. A summary of the external business case approval limits is shown below. The approval process for investments below the values quoted but falling within the exceptions criteria will be agreed with NHSI/E on an individual basis.

Investment value	Approval body	Key stage documentation	Self –assessment Business case core checklist required	Indicative Review Timescales*
Up to £15m	Internal	Trust's internal governance process	No	Internal
£15m to £30m	NHSI/E~~i~~ and DH	OBC and FBC required (SOC also required for any scheme requiring DH finance)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.~~Yes~~	8 weeks
£30m to £50m	NHSI/E~~i~~ Resources Committee and DH	SOC,OBC and FBC required (or SOC, ABC, CBC or Lift stage 1 and 2 equivalent for PFI/PF2 or LIFT)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.	8 - 12 weeks
Over £50m	NHSI/E~~i~~ Resources Committee and Board, DH and HMT	SOC,OBC and FBC required (or SOC, ABC, CBC or Lift stage 1 and 2 equivalent for PFI/PF2 or LIFT)	Yes, plus the clinical quality checklist for all business cases with a patient facing or business case aspect.	8 - 12 weeks Plus

Table 9~~8~~

13.5.6 Capital business cases have to go through all the relevant approval groups dependent on values, so for example, a case of over £15,000,000 will require approval from CIG, who will then recommend to ~~F~~PFC, who will recommend to Trust Board for approval. The case will then be recommended to NHSI/E for approval.

13.5.7 The values quoted in SFI 13.8 are inclusive of VAT.

13.5.8 For capital schemes relating to I.T, leased equipment, leased property, managed equipment and managed service schemes, the delegated limits apply to whole life costs, not just the capital cost. Schemes with whole life costs in excess of NHS Trust delegated limits will require NHSI/E approval in line with the delegated limits.13.5.9 For leased property; the limits apply to the whole-life cost of the transaction, rather than just capital cost.

13.5.9 Total capital cost to the private sector (i.e. Private Finance Initiatives (PFI)) includes the cost of construction, equipment, professional fees, rolled-up interest and financing costs such as bank arrangements fees, bank due diligence fees, banks lawyers' fees, and third party equity costs plus irrecoverable VAT. Any capital cost that will be incurred directly by the NHS in progressing the schemes must also be

included. Typical examples include land purchased from outside the NHS, equipment and enabling works.

13.5.10 Where NHS Trusts are requesting transfers of assets and/or services between organisations NHS Trusts are asked to contact the relevant NHSI/E Director of Delivery and Development and/or Business Support teams who will advise on how to take these forward. Asset transfers with a value in excess of NHS Trust delegated limits will require a business case and NHSI/E approval in line with the delegated limits detailed in SFI 13.5.56.

13.6 Private Finance Initiatives (PFI)

13.6.1 Any schemes involving PFI (new schemes or contract variations), irrespective of value, will also require discussion with the NHSI/Ei to agree the approval requirements.

13.6.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its allocations, the following procedures shall apply:

(a) The Chief Financial OfficerDirector of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health Department of Health and Social Care or in line with any current guidelines

(c) The proposal must be specifically agreed by the Trust Board (except for additional capital spending to existing PFI contracts which will follow the Trust's authorisation thresholds that are in place for non PFI capital)

(d) The proposed capital spend must be approved in accordance with the Trust's business planning and capital approval thresholds that are in place for procuring assets through the non PFI route

13.7 Asset Registers

13.7.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial OfficerDirector of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a rolling programme detailed within financial procedures for fixed tangible and intangible assets.

13.7.2 The Trust shall maintain an asset register recording fixed tangible and intangible assets.

13.7.3 Additions to the fixed tangible and intangible asset register must be clearly identified to an appropriate asset manager and be validated by reference to:

(a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) Lease agreements in respect of assets held under a ~~finance lease and capitalised~~right of use asset.

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

13.7.5 The Chief Financial Officer~~Director of Finance~~ shall approve procedures for reconciling balances on ~~fixed assets accounts~~ the relevant general ledger ~~in ledgers~~ against balances on ~~fixed~~ the asset registers.

13.7.6 The carrying value of each asset shall be assessed and impaired or revalued to current values in accordance with the Trust's Accounting Policies and relevant accounting standards.

13.7.7 The value of each asset shall be depreciated using methods and rates as specified in the Trust's Accounting Policies and relevant accounting standards.

13.8 Security of Assets

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

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

(a) Recording managerial responsibility for each asset

(b) Identification of additions and disposals

(c) Identification of all repairs and maintenance expenses

(d) Physical security of assets

(e) Verification of the existence of, condition of, and title to, assets recorded

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

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

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

13.8.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Trust Board members and senior employees in

all disciplines to apply such appropriate routine security practices as may be determined by the Trust Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

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

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

13.8.7 All budget and department managers are responsible for confirming the accuracy of the asset register of all assets of the Trust within their area of responsibility.

14 STORES AND RECEIPT OF GOODS

14.1 General position

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

(a) Kept to a minimum

(b) Subjected to minimum annual stock take

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

14.2 Control of stores, stocktaking, condemnations and disposal

14.2.1 Subject to the responsibility of the Chief Financial Officer~~Director of Finance~~ for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer~~Director of Finance~~. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer, the control of theatre stocks shall be the responsibility of the designated theatres manager and the control of any fuel, oil and coal of a designated estates manager.

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

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

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

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

14.2.6 The designated Manager shall be responsible for a system approved by the Chief Financial Officer~~Director of Finance~~ for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer~~Director of Finance~~ any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.3 Goods supplied by NHS Supply Chain

14.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before

forwarding this to the Chief Financial Officer~~Director of Finance~~ who shall satisfy himself that the goods have been received before accepting the recharge.

14.4 Consignment stock

14.4.1 Consignment stocks are those items that remain the property of the supplier until used, but remain on the Trust's site for practical reasons.

14.4.2 Any consignment stock held must have been approved in accordance with the delegation of authority and must be kept to an agreed minimum level. Consignment stock must not be included in the Trust's stock value but separate records must be kept

14.4.3 It is the responsibility of the ~~Directorate~~ authorised senior manager / Associate Director to ensure that SFI 14.4 is followed.

14.4.4 Any documentation that sets out the terms and conditions of the consignment stock arrangements must be approved by the Trust's Supplies and Procurement Department.

15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

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

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

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer~~Director of Finance~~

(b) Recorded by the Condemning Officer (Budget Manager) in a form approved by the Chief Financial Officer~~Director of Finance~~ which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer~~Director of Finance~~. For any ~~fixed~~ tangible and intangible asset disposals this should be accompanied by a completed asset disposal form.

15.1.4 The Condemning Officer (Budget Manager) shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer~~Director of Finance~~ who will take the appropriate action.

15.1.5 A business case will need to be submitted to NHSI/E where disposal proceeds are above the Trust's delegated limits. The business case will need to make the case for both the disposal and the retention of proceeds. The Trust will retain and reinvest the proceeds subject to business case approval by NHSI/E. As a minimum the disposal and retention business case will need to give indication of what the retained receipts will be used for example reinvested in healthcare buildings/infrastructure. The authorisation limits applicable to capital disposals are in line with those for capital investment as detailed in SFI 13.5.

15.2 Losses and Special Payments

15.2.1 The Chief Financial Officer~~Director of Finance~~ must prepare procedural instructions on the recording of and accounting for losses and special payments.

15.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department who must immediately inform the Chief Executive and the Chief Financial Officer~~Director of Finance~~ or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer~~Director of Finance~~ and/or the Chief Executive.

15.2.3 If any level of theft or criminal damage is suspected the Chief Financial Officer~~Director of Finance~~ must immediately inform the police and Security Management Director

15.2.4 For losses or special payments caused or apparently caused by theft, fraud (see SFI 2), criminal damage (including arson), and neglect of duty or gross carelessness (except if trivial /immaterial) the Chief Financial Officer~~Director of Finance~~ must immediately notify the Trust Board and the External Auditor.

15.2.5 In all cases of alleged fraud or corruption NHS ~~Protect~~ Counter Fraud Authority must be informed in accordance with the Secretary of State directions.

15.2.6 Within limits delegated to it by the ~~Department of Health~~ Department of Health and Social Care, the Trust Board shall approve the writing-off of losses and special payments.

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

15.2.8 For any loss, the Chief Financial Officer~~Director of Finance~~ should consider whether any insurance claim can be made against insurers.

15.2.9 The Chief Financial Officer~~Director of Finance~~ shall maintain a Losses and Special Payments Register and the Audit Committee may at any time request to see this register.

15.2.10 All losses and special payments must be reported to the Audit Committee at every meeting ~~who will prospectively approve all such payments valued at £25,000 and above~~.

15.2.11 The Scheme of Delegation details the financial limits in respect of losses and special payments.

16. INFORMATION TECHNOLOGY (IT)

16.1 Responsibilities and duties of the Director of IM&T

16.1.1 The Director of IM&T, who is responsible for the security of the computerised financial data of the Trust, shall:

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

(b) Ensure the safe environment of the system, its security, privacy, data back-ups and protection against viruses,

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

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

16.1.2 The Chief Financial Officer~~Director of Finance~~ shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation following Information Technology Infrastructure Library (ITIL) procedures. Information and guidance on these procedures can be obtained from the ICT Service Delivery Manager. Where this is undertaken by another organisation, Trust ITIL procedures must be followed by them prior to implementation and assurances of adequacy obtained.

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

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

16.2.1 The Director of IM&T manages the Information Technology (IT) function.

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

(a) Details of the outline design of the system

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

16.2.3 The Director of IM&T shall ensure that all computer software held by the Trust is properly licensed and operated in accordance with the terms of the license.

16.3 Contracts for Computer Services with other healthcare bodies or outside agencies

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

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

16.4 Risk Assessment

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

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

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

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

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

(c) ~~Director of~~ Finance staff have access to such data

(d) Such computer audit reviews, as are considered necessary, are being carried out

16.5.2 Any changes to such systems must be notified to and approved by the Chief Financial Officer~~Director of Finance~~.

17. PATIENTS' PROPERTY

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

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

(a) Notices and information booklets (notices are subject to sensitivity guidance)

(b) Hospital admission documentation and property records

(c) The oral advice of administrative and nursing staff responsible for admissions

(d) Trust website

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

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

17.1.5 Property handed over for safe custody shall be placed into the care of the Chief Financial Officer~~Director of Finance~~, or his nominee, except where there are no administrative staff present, in which case the property shall be placed into the care of the most senior member of the nursing staff on duty. A member of staff receiving patients' property handed over to him/her by other staff shall sign for its receipt.

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

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

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

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

18. FUNDS HELD ON TRUST (DONATED /CHARITABLE FUNDS)

18.1 UHNM Charity

18.1.1 UHNM Charity was set up by the ~~Department of Health~~ Department of Health and Social Care as the official Charity for the Trust to receives all voluntary income (donated funds) given in support of UHNM NHS Trust (its hospitals, divisions and research etc.)

18.1.2 Donated funds include legacies, donations, grants, trading and money from fundraising activities (including gaming). These may be received from patients, families, members of the public, community groups, grant making trusts and foundations, and businesses, the donated funds are held, on trust, in separate charitable funds that meets the wishes of the donor.

18.1.3 As established by the Secretary of State for Health, UHNM Charity is managed by the ~~NHS~~ UHNM Trust Board as a Corporate Trustee.

18.2 Corporate Trustee

18.2.1. SOs outline the Trust's responsibilities as a corporate trustee (all voting members of the Trust Board are defined as Trustees) for the management of funds it holds on trust, along with SFIs that defines the need for compliance with Charities Commission latest guidance and best practice.

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

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

18.3 Accountability to Charity Commission and Secretary of State for Health

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

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

18.4 Applicability of Standing Financial Instructions to funds held on Trust

18.4.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

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

18.4.3 The Trust Board, through delegation to a Sub-Committee, shall approve and monitor spend against an annual budget for the charitable fund.

18.4.4 A schedule of the balances of all general and specific funds will be regularly maintained and periodically published to all appropriate responsible officers. Details of any current proposals for deployment of fund balances will be included in the schedule.

18.4.5 The Charity's audited annual reports and accounts, and any report of the auditor on them, must be presented to the Trust Board in its capacity as the Corporate Trustee for approval.

18.4.65 The Chief Executive will, in respect of each separate specific fund, nominate an appropriate Director, Consultant or Manager to exercise first level authorisation up to the prescribed limit. For expenditure above this level the authorisation of appropriate managers, Executive Directors, Chief Financial Officer~~Director of Finance~~ or Chief Executive will be required. The limits for authorisation are specified within the Scheme of Delegation.

18.4.76 Further details regarding donated funds held on trust, including the responsibility staff have when receiving a donation, are detailed in policy F06 ~~Charitable Funds~~UHNM Charity Policy.

19 HOSPITALITY AND GIFTS (RECEIVING)

19.1 General

19.1.1 The Chief Financial Officer~~Chief Officer – Finance and Performance~~ shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff, as set out in Policy on Standards of Business Conduct (G16). This policy is deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs.

20. RETENTION OF DOCUMENTS

20.1.1 All NHS records are public records under the terms of the Public Records Act 1958 Sections 3 (1) – (2).

20.1.2 The Trust has a duty under the Public Records Act along with the Records Management Code of Practice for Health and Social Care 2016 to ensure the safekeeping and eventual disposal of all types of document. ~~and t~~The requirements of all staff members are set out in the Trust's Data Protection Security and Confidentiality Policy (IG10) and Corporate Records Management Policy (G11). These~~is~~ policies~~y~~ are~~is~~ deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs

20.1.3 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with ~~Department of Health~~ Department of Health and Social Care guidelines.

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

20.1.5 Records held in accordance with latest ~~Department of Health~~ Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

20.1.6 Where records are required to be stored off-site the Trust will use approved suppliers. Detail available from the Information Governance Team.

21. RISK MANAGEMENT AND INSURANCE

21.1 Risk Management Policy

21.1.1 The Chief Executive shall ensure that the Trust has a Risk Management Policy that meets legal, regulatory and best practice standards, which must be approved and monitored by the Trust Board.

21.1.2 The Trust's Risk Management Policy (RM01) is deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs

21.1.3 Compliance with the Risk Management Policy (RM01) supports the Trust's Annual Governance Statement included within the Annual Report and Accounts.

21.2 Insurance: Risk Pooling Schemes administered by NHSLA

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

21.3 Insurance Arrangements with Commercial Insurers

21.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust's may enter into commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

(b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into

(c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer~~Chief Officer – Finance and Performance~~ should consult the ~~Department of Health~~ Department of Health and Social Care

21.4 Trust Board Procedures for Insurance Cover

21.4.1 Where the Trust Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer~~Chief Officer – Finance and Procurement~~ shall ensure that the arrangements entered into are appropriate and necessary. The Chief Financial Officer ~~Chief Officer – Finance and Performance~~ shall ensure that documented procedures cover these arrangements.

21.4.2 Where the Trust Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes,

the Chief Financial Officer ~~Chief Officer – Finance and Performance~~ shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer ~~Chief Officer – Finance and Performance~~ will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer ~~Chief Officer – Finance and Performance~~ should ensure documented procedures also cover the management of claims and payments below the deductible limit in each case.

Overseas

University Hospitals of North Midlands NHS Trust

Policy No. F02
Trust Policy for Scheme of Reservation and Delegation of Powers

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

Version:	~~3~~5
Ratified By:	**Trust Audit Committee** and Trust Board
Date Ratified:	~~April 2017~~February 2020
Date of Issue via Intranet:	~~May 2017~~February 2020
Date of Review:	~~April 2020~~February 2022
Trust Contact:	~~Assistant Director of Finance – Chief Accountant~~Strategic Director of Finance
Executive Lead:	~~Director of Finance~~ Chief Financial Officer

Version Control Schedule

Final Version	Issue Date	Comments
1	December 2014	Document issued to create a standalone policy, previously integrated with F01. Document updated to reflect current practices and adherence to current Department of Health guidelines
2	January 2017	Approved by Audit Committee 27 January 2017
3	April 2017	Approved by Audit Committee 28 April 2017
4	January 2020	Approved by Audit Committee 23 January 2020
5	February 2020	Approved by Trust Board 05 February 2020

University Hospitals of North Midlands NHS
NHS Trust

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the “right and freedom” of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

CONTENTS

1. INTRODUCTION

1.1 Standing Order (SO) 4 "Arrangements for the exercise of Trust functions by delegation" states that subject to such directions as may be given by the Secretary of State, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of SO 4, or by an officer of the Trust, or by another body as defined in SO 4.1.2, in each case subject to such restrictions and conditions as the Trust thinks fit.

1.2 The purpose of this policy is to set out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. The Trust Board remains accountable for all of its functions; even those delegated to the Chairman, individual directors or officers and therefore, expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2. STATEMENT

2.1 To provide details of the powers reserved by the Trust Board and the powers delegated to other officers of the Trust.

3. SCOPE

3.1 This policy applies to all areas of the Trust and all individuals employed by the Trust including contractors, voluntary workers, students, locum and agency staff and those holding honorary contracts.

4. DEFINITIONS

4.1 Detailed below is a list of terms used in this document and a definition of their meaning.

Term	Definition
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, wherever possible, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority to manage finances (Income and expenditure to a limit of £50,000) for a
Departmental Manager	Director or Employee at Band 8a or above responsible for authorisation in line with Human Resources policies

Term	Definition
	specific area of the organisation
Chairman	The person appointed to lead the Trust Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole
Chief Executive	Chief officer of the Trust
~~Chief Officer for Finance and Performance~~ Chief Financial Officer	Chief Financial Officer of the Trust
Director of Finance	Financial Director for the Trust with powers delegated from the ~~Chief Officer for Finance and Performance~~Chief Financial Officer
He/she or his/her	Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes
Scheme of Reservation and Delegation of Powers. Policy number F02	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. . Referred to as 'the Scheme of Delegation' within this document.
Standing Financial Instructions (SFIs). Policy number F01	Document detailing the financial responsibilities, policies and procedures adopted by the Trust. . Referred to as 'the SFIs' within this document.
Standing Orders. Policy number G19~~Trust~~	Document which sets out the regulation of the Trust proceedings and business. Referred to as the SOs in this document.~~University Hospital of North Midlands NHS Trust~~
Trust	University Hospital of North Midlands NHS Trust
Trust Board	Board of the Trust

Table 1

4.2 Wherever the title Chief Executive, ~~Director of Finance~~Chief Financial Officer or other nominated officer is used in this Scheme of Reservation and Delegation of Powers, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

4.3 Wherever the term "employee" and the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

5. ROLES AND RESPONSIBILITIES

5.1 Role of Chief Executive

5.1.1 All powers of the Trust which have not been retained as reserved by the Trust Board or delegated to an Executive Committee or Sub-Committee shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other Directors and Officers.

5.1.2 All powers delegated by the Chief Executive can be reassumed by him/her should the need arise. As Accounting Officer the Chief Executive is accountable for the funds entrusted to the Trust.

5.2 Role of all Directors and Officers

5.2.1 Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a matter in which their judgment was likely to be cause for public concern.

5.2.2 This policy shows only the "top level" of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other procedures within the Trust.

5.2.3 In the absence of a Director or Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officers deputy unless alternative arrangements have been requested by the Trust Board.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

6.1 Training or support on the use of this policy can be obtained from the Assistant Director of Finance – ~~Chief Accountant~~Financial Controller.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

7.1.1 In accordance with SOs, the Trust Board shall formally establish a committee of independent members, as an Audit Committee, with formal Terms of Reference, which includes ensuring compliance with the Scheme of Reservation and Delegation of Powers.

As well as ensuring policy compliance through the Trust's own internal systems and controls, this policy is also audited as part of the key financial systems and controls annual audit and any such breaches are reported to audit committee

7.1.2 Failure to comply with this policy will be recorded by the Chief Financial Officer. Failure to comply with the policy is a disciplinary matter, which may be reported to the Audit Committee, and could result in dismissal.

7.1.3 All members of the Trust Board and employees have a duty to disclose any non-compliance with this policy to the ~~Director of Finance~~ Chief Financial Officer as soon as possible.

7.2 Review

7.2.1 ~~This policy will be reviewed 1 year post ratification of version 1, and every 3 years thereafter unless changes in national legislation override this or there has been a specific request to review earlier.~~This policy will be reviewed two years post ratification, unless changes in national legislation override this or there has been a specific request to review earlier.

8. REFERENCES

~~Trust's~~ Standing Orders – G19
~~Trust's~~ Standing Financial Instructions - F01
F02 Trust Policy for Scheme of Reservation and Delegation of Powers ~~Policy for the Standing Financial~~

Appendix A – RESERVATION OF POWERS TO THE TRUST BOARD

1. GENERAL

1.1 The Code of Accountability which has been adopted by the Trust requires the Trust Board to determine those matters on which decisions are reserved unto itself. These reserved powers are set out in 1.2 – 1.9 below.

1.2 General Enabling Provision

1.2.1 The Trust Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

1.3 Regulation and Control

1.3.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Trust Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

1.3.2 Suspend SOs.

1.3.3 Vary or amend the SOs.

1.3.4 Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 4.2.

1.3.5 Approve a scheme of delegation of powers from the Trust Board to Committees.

1.3.6 Require and receive the declaration of Trust Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.

1.3.7 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

1.3.8 Disciplining Directors who are in breach of statutory requirements or SOs.

1.3.9 Approve arrangements for dealing with complaints.

1.3.10 Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.

1.3.11 Receive reports from Committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on.

1.3.12 Confirm the recommendations of the Trust's Committees where the Committees do not have executive powers.

1.3.13 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

1.3.14 Establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board.

1.3.15 Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

1.3.16 Authorise use of the seal.

1.3.17 Ratify or otherwise instances of failure to comply with SOs brought to the Chief Executive's attention in accordance with SO 4.6.

1.3.18 Approval of disciplinary procedure for Directors and Officers of the Trust.

1.4 Appointments and dismissals

1.4.1 Appoint and dismiss Committees (and individual members) that are directly accountable to the Trust Board.

1.4.2 Appoint the Vice Chairman of the Board.

1.4.3 Appoint, appraise, discipline and dismiss Executive Directors.

1.4.4 Confirm appointment of Members of any Committee of the Trust as representatives on outside bodies.

1.4.5 Appoint, appraise, discipline and dismiss the Associate Director of Governance.

1.4.6 Approve proposals from the Remuneration and Nominations Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration and Nominations Committee.

1.5 Policy determination

1.5.1 The approval of management policies including Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.

1.6 Strategy and Business Plans and Budgets

1.6.1 Define the strategic aims and objectives of the Trust.

1.6.2 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.

1.6.3 Approve and monitor the Trust's policies and procedures for the management of risk.

1.6.4 Approve the Capital Programme.

1.6.5 Approve annually plans in respect of health investment & services provision and the application of available financial resources.

1.6.6 Approve annually Trust's proposed organisational development proposals.

1.6.7 Ratify proposals for acquisitions and disposals.

1.6.8 Approve PFI proposals for new PFI schemes.

1.6.9 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature as per scheme of delegation approved limits.

1.6.10 Approve proposals for action on litigation against or on behalf of the Trust.

1.6.11 Review use of NHS Litigation Authority (NHSLA) risk pooling schemes (LPST/CNST/RPST).

1.7 Direct Operational Decisions

1.7.1 Acquisition, disposal or change of use of land and/or buildings.

1.7.2 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross (i.e. including VAT) annual income or expenditure (that is before any set off) of £500,000.

1.7.3 Approval of individual compensation payments over £25,000.

1.7.4 Agree action on litigation against or on behalf of the Trust.

1.8 Financial and Performance Reporting Arrangements

1.8.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors, Committees and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Trust Board.

1.8.2 Approve the opening and closing of bank accounts.

1.8.3 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

1.8.4 Receipt and approval of the Trust's Annual Report including the annual accounts.

1.9 Audit Arrangements

1.9.1 Receipt of the annual management letter received from the external auditor and agreement of action on the recommendations, where appropriate, of the Audit Committee.

1.9.2 Receipt of the annual report received from the internal auditor and agreement of action on the recommendations, where appropriate, of the Audit Committee.

1.9.3 Ratify the approval of the appointment or dismissal of the external auditor.

1.9.4 Approval of external auditor's arrangements for the separate audit of funds held on Trust.

Appendix B – RESERVATION OF POWERS TO THE COMMITTEES OF THE TRUST BOARD

1. Delegation to Committees

1.1 The Trust Board may determine that certain powers shall be exercised by Standing Committees. The composition and Terms of Reference of such committees shall be that determined by the Trust Board from time to time taking into account where necessary the requirements of ~~Department of Health~~ Department of Health and Social Care, NHS Improvement and/or the Charity Commission. The Trust Board shall determine the reporting requirements in respect of these committees. In accordance with SO 4.3 committees may not delegate executive powers to their sub groups unless expressly authorised by the Trust Board.

2. Audit Committee

2.1 The Audit Committee will support the Trust Board in their responsibilities for issues of risk control and governance by reviewing the comprehensiveness of assurances in meeting the Trust Board and Accounting Officer's assurance needs and review the reliability and integrity of these assurances.

2.2 The Committee will advise the Trust Board and Accounting Officer on:

(a) The strategic processes for risk, control and governance and the Annual Governance Statement

(b) The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors

(c) The planned activity and results of both internal and external audit including Counter Fraud arrangements

(d) Adequacy of management response to issues identified by audit activity, including external audit's management letter

(e) Assurances relating to the corporate governance requirements for the organisation

(f) (Where appropriate) proposals for tendering for either internal or external audit services, or for purchase of non-audit services from contractors who provide audit services

(g) Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations

3. Nominations and Remuneration ~~and Nominations~~ Committee

3.1 The Committee will:

(a) Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e.: Trust Board voting and no-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework. ~~and the Chief Executive. For those senior posts reporting directly to the Chief Executive, the decision on remuneration and terms of service~~

~~remains with the executive/Medical Director or Executive Director lead~~. This will include:

(i) All aspects of salary (including any performance-related elements/bonuses)

(ii) Provisions for other benefits, including pensions and cars

(iii) Arrangements for termination of employment and other contractual terms

(b) Monitor and evaluate the performance of individual Directors (with the advice of the Chief Executive)

(c) Advise on and oversee appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

3.2 The Committee Chairman shall make recommendations to the Trust Board regarding the Composition of the Trust Board to ensure there are robust processes in place to review the role and performance of Non-Executive Directors and the Chairman, and to advise the Chairman regarding the filling of Non-Executive Vacancies.

3.3 The Committee is also responsible for reviewing and advising the Trust Board on the appointment process for Non-Executive Directors.

4. Quality ~~and Assurance~~Governance Committee

4.1 The Quality ~~Assurance~~ Governance Committee will assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

4.2 The primary duties of the Committee are:

(a) To provide assurance to the Trust Board, of the level, adequacy and maintenance of integrated governance, risk management and internal control across quality and research governance activities

(b) In respect of this Committee, quality is defined as made up of three elements; patient safety, clinical best practice and patient experience.

5. Performance and Finance ~~and Efficiency~~ Committee

5.1 The Performance and Finance ~~and Efficiency~~ Committee will oversee all aspects of the Trust's financial, workforce and performance management arrangements, and provide robust assurance in these areas to the Trust Board. The Trust Board will continue to have primary responsibility for the financial, organisational development and business performance of the Trust and all Trust Board Directors will continue to be accountable in this respect.

5.2 The Committee will:

(a) Consider financial, operational and workforce strategies, prior to submission to the Trust Board for approval

(b) Approve business cases in accordance with delegated authority from the

Trust Board
(c) Review progress against the delivery of business plans
(d) Oversee financial, operational and workforce related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis
(e) Escalation of matters to Trust Board as agreed by the Committee
~~(a) Oversee the development and maintenance of the Trust's medium and long term financial strategy/integrated business plan~~

~~(b) Review and monitor short and long term financial plans and their link to operational performance~~

~~(c) Oversee financial risk evaluation, measurement and management~~

~~(d) Review the risk mitigation plan from the Corporate Risk Register that has been assigned to the Committee~~

~~(e) Escalation to Trust Board as deemed appropriate by the Chair of the Committee~~

6. ~~Professional Standards and Conduct Committee~~Transformation and People Committee

6.1 The Committee will ~~review the management and governance arrangements in respect of managing concerns about the professional standards and clinical conduct of Trust employees, including conduct which is potentially damaging to the Trust's reputation~~ assure the Trust Board in relation to the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

6.2 The Committee will:

(a) ~~Provide~~ Ensure that strategic transformation, workforce and organisational development matters are considered and planned into Trust Strategy and service delivery ~~assurance to the Trust Board and, in the case of medical staff, will ensure compliance with Maintaining High Professional Standards, that appropriate and timely management processes are in place~~
(b) Approve new Workforce / Organisational Development projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce
(c) Approve the development implementation and evaluation of Leadership and Management Development, Talent Management & Succession Planning, Wellbeing Plans and Apprenticeship and Widening participation activity.
~~(a)~~(d) Approve mandated workforce reporting returns including workforce equality, revalidation and Safe Staffing reports

7. ~~Charity~~ Trustee Committee

7.1 The Committee will:

(a) Be responsible for all aspects of the management of the investment of funds held in the Trust (i.e. Charitable Funds) and for the effective utilisation of those funds

(b) Ensure Charities Commission requirements are fulfilled

(c) Provide assurance to the Trust Board that systems have been established to manage the funds ensuring that the identification, assessment and management of risk is linked to the achievement of the charity's operational objectives.

8. Trust Executive Committee

8.1 The Committee will execute actions delegated from the Trust Board and to support the operational management of the Trust in accordance with the Trust's Standing Orders and the Standing Financial Instructions.

8.2 The Committee:

(a) Is the executive arm of the Trust through which all officer-led Forum/Steering Groups within the Trust report

(b) Is the Trust's nominated risk committee

(c) Will advise the Chief Executive on key issues, which affect the delivery of services within the Trust to reach clear executive decision and action

Appendix C - SCHEME OF DELEGATION

1. General

1.1.1 The Scheme of Delegation has been designed to be a comprehensive response to the range of delegated matters identified in nationally promulgated guidance to the NHS and in the Trust's own SFIs and SOs.

1.1.2 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted within the written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate.

1.1.3 Certain matters needing to be covered in the Scheme of Delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are included in the Detailed Scheme of Delegation (section 5).

1.1.4 This Scheme of Delegation covers only matters delegated by the Trust Board to Directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within his/her directorate. He/she must produce a scheme of delegation for matters within his/her directorate, which must receive the written approval of the Chief Executive. In particular the Scheme of Delegation should include how the directorate budget and procedures for approval of expenditure are delegated.

2. Duties delegated as per the Accounting Officer Memorandum

2.1 The Accounting Officer Memorandum is strictly applicable to NHS bodies accountable to the Secretary of State.

2.2 Chief Executive

2.2.1 Duties delegated:

(a) Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources

(b) Sign a statement in the accounts outlining responsibilities as the Accountable Officer

(c) Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:

(i) Have a clear view of their objectives and the means to assess achievements in relation to those objectives

(ii) Be assigned well defined responsibilities for making best use of resources

(iii) Have the information, training and access to the expert advice they need to exercise their responsibilities effectively

(d) Achieve value for money from the resources available to the Trust and avoid

waste and extravagance in the organisation's activities

(e) Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the External Auditors

(f) Primary duty to see that ~~Director of Finance~~ Chief Financial Officer discharges this function.

(g) Ensuring that expenditure by the Trust complies with Parliamentary requirements.

(h) If the Chief Executive considers the Trust Board or Chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chairman and the Trust Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary NHS Improvement (NHSI/E) and ~~Department of Health~~ Department of Health and Social Care

(i) If the Board or Chairman is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Trust Board. If the outcome is that the Chief Executive is overruled it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS Improvement (~~NHSI~~ NHSI/E) and the ~~Department of Health~~ Department of Health and Social Care. In such cases, and in those described in paragraph 19 of the Accountable Officer Memorandum, the Chief Executive should, as a Member of the Trust Board, vote against the course of action rather than merely abstain from voting.

2.3 Chief Executive and Chief ~~Officer for Finance~~ Financial ~~and Performance~~ Officer

2.3.1 Duties delegated:

(a) Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs

(b) Sign the accounts on behalf of the Trust Board

(c) Chief Executive, supported by Chief Financial Officer, to ensure appropriate advice is given to the Trust Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness

2.4 ~~Director of Finance~~Chief Financial Officer

2.4.1 Duties delegated:

(a) Operational responsibility for effective and sound financial management and information

2.5 Chairman and Associate Director of ~~Corporate Affairs~~Governance

2.4.1 Duties delegated:

(a) Implement requirements of Corporate Governance

3. Duties delegated from the Code of Conduct and Accountability

3.1 The Codes of Conduct and Accountability represent standard good practice within the NHS and are applicable to the behaviour or Directors and officers of the Trust.

3.2 Trust Board

3.2.1 Duties delegated:

(a) Approve procedure for declaration of hospitality and sponsorship

(b) Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns

(c) Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities

(d) The Board has six key functions for which it is held accountable by the ~~Department of Health~~ Department of Health and Social Care on behalf of the Secretary of State:

(i) To ensure effective financial stewardship through value for money, financial control and financial planning and strategy

(ii) To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation

(iii) To appoint, appraise and remunerate senior executives

(iv) To ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them

(v) To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary

(vi) To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs

(e) It is the Trust Board's duty to:

(i) Act within statutory financial and other constraints

(ii) Be clear what decisions and information are appropriate to the Board and draw up, approve, implement and communicate SOs, a schedule of decisions reserved to the Board and SFIs to reflect these

(iii) Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account

(iv) Establish performance and quality measures that maintain the effective use of resources and provide value for money

(v) Specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities

(vi) Establish Audit and Remuneration Committees on the basis of formally agreed Terms of Reference that set out the membership of the Sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board

(f) NHS Trust Boards must comply with legislation and guidance issued by the ~~Department of Health~~ Department of Health and Social Care on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money

3.3 All Trust Board Members

3.3.1 All Trust Board Members must subscribe to the Code of Conduct and share corporate responsibility for all decisions of the Trust Board

3.4 Chairman

3.4.1 It is the Chairman's duty to:

(a) Provide leadership to the Trust Board

(b) Enable all Trust Board members to make a full contribution to the Trust Board's affairs and ensure that the Trust Board acts as a team

(c) Ensure that key and appropriate issues are discussed by the Trust Board in a timely manner

(d) Ensure the Trust Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions

(e) Lead Non-Executive Trust Board members through a formally-appointed Remuneration Committee of the main Trust Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members

(f) Appoint Non-Executive Trust Board members to an Audit Committee of the main Board

(g) Advise the Secretary of State on the performance of Non-Executive Trust Board members

(h) Chair the Membership Council/Shadow Membership council when established

3.5 Chief Executive

3.5.1 The Chief Executive is accountable to the Chairman and Non-Executive members of the Trust Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship

3.5.2 The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board

3.5.3 The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum

3.6 Non-Executive Directors

3.6.1 Non-Executive Directors are appointed by Appointments Commission to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability through the ~~Department of Health~~ Department of Health and Social Care to Ministers and to the local community

3.7 Chairman and Directors

3.7.1 It is the duty of the Chairman and all Directors to declare any conflicts of interest.

4. Duties delegated from the Trust's Standing Orders (SOs)

4.1 Detailed below is a summary of the items held within the SFIs which are delegated and details are provided as to who these matters are delegated to. The below is not intended to replace the detail included within the SFIs and is to be read alongside the SFIs.

SO Ref.	Authority delegated to	Duties delegated
4.1	Chairman	Final authority in interpretation of SOs
1.4	Trust Board	Appointment of Vice Chairman/Senior Independent Director (If either appointed)
2.1	Chairman	Call meetings
2.9	Chairman	Chair all Trust Board meetings and associated responsibilities
2.10	Chairman	Give final ruling in questions of order, relevancy and regularity of meetings
2.12	Chairman	Having a second or casting vote
2.13	Trust Board	Suspension of SOs
2.13	Audit Committee	Audit Committee to review every decision to suspend SOs (power to suspend SOs is reserved to the Trust Board)
2.14	Trust Board	Variation or amendment of SOs
3.5	Trust Board	Formal delegation of powers to Sub-Committees or joint committees and approval of their constitution and Terms of Reference. (Constitution and Terms of Reference of Sub Committees may be approved by the Chief Executive)
4.2	Chairman & Chief Executive	The powers which the Trust Board has retained to itself within these SOs may in emergency be exercised by the Chairman and Chief Executive after having consulted with at least two Non-Executive members
4.4.2	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion
4.6	All Staff	Disclosure of non-compliance with SOs to the Chief Executive as soon as possible
5.1.2	Trust Board	Declare relevant and material interests
5.2	Chief Executive	Maintain Register(s) of Interests.
5.4.1	All Staff	Comply with national guidance contained in NHS England's "Managing Conflicts of Interest in the NHS" ~~Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff"~~
5.4.4	All Staff	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Trust Board)
6.1/6.3	Chief Executive	Keep seal in safe place and maintain a register of sealing
6.4	Chief Executive and Executive Director	Approve and sign all documents which will be necessary in legal proceedings

5. Duties delegated from the Trust's Standing Financial Instructions (SFIs)

5.1 Detailed below is a summary of the items held within the SFIs which are delegated and details are provided as to who these matters are delegated to. The below is not intended to replace the detail included within the SFIs and is to be read alongside the SFIs.

SFI Ref.	Authority delegated to	Duties delegated
1.3	~~Director of Finance~~Chief Financial Officer	Approval of all financial procedures
1.4	~~Director of Finance~~Chief Financial Officer	Advice on interpretation or application of SFIs
1.7	All members of the Trust Board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the ~~Director of Finance~~ Chief Financial Officer as soon as possible
5.2.2	Chief Executive	Responsible as the Accountable Officer to ensure that the Trust Board meets its obligations to perform its functions within the available financial resources and has overall responsibility for the System of Internal Control
5.2.1 & 5.3.1	Chief Executive & ~~Director of Finance~~Chief Financial Officer	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities
5.2.3	Chief Executive	To ensure all Board members and officers, present and future, are notified of and understand Standing Financial Instructions.
5.3.2	~~Director of Finance~~Chief Financial Officer	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action. b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared, documented and maintained. c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position. d) Providing financial advice to members of Trust Board and staff. e) Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
5.5.1	All Trust Board members and employees	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
5.6.1	Chief Executive	Ensure that any contractor or employees of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of the SFIs and their requirement to comply.
Appx A – 1.1	Audit Committee	Provide independent and objective view on internal control and probity.
Appx A – 1.1.6	Chairman of Audit Committee	Raise the matter at the Trust Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts

Appx A – 1.2.1	~~Director of Finance~~Chief Financial Officer	Ensure an adequate Internal Audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an Internal Audit service provider is changed.)
Appx A –	~~Director of Finance~~Chief Financial Officer	Decide at what stage to involve police in cases of

SFI Ref.	**Authority delegated to**	**Duties delegated**
1.2.2 (c)		misappropriation and other irregularities not involving fraud or corruption
Appx A – 1.2.4	Head of Internal Audit	Review, appraise and report in accordance with recognised professional best practice
Appx A – 1.3.1	Audit Committee	Ensure cost-effective External Audit service
Appx A – 2.6	Chief Executive & ~~Director of Finance~~Chief Financial Officer	Monitor and ensure compliance with Directions issued by the Secretary of State on Fraud and Corruption
Appx A – 2.7	Trust Board	Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist
Appx A – 3.1 & 3.2	Chief Executive	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist
Appx A – 4.1.1	Chief Executive	Compile and submit to the Trust Board an Integrated Business Plan (IBP) which takes into account financial targets and forecast limits of available resources. The Business Plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan
Appx A – 4.1.2	~~Director of Finance~~Chief Financial Officer	Submit budgets to the Trust Board for approval
Appx A – 4.1.3	~~Director of Finance~~Chief Financial Officer	Monitor performance against budget
Appx A – 4.1.6	~~Director of Finance~~Chief Financial Officer	Ensure adequate training is delivered on an on-going basis to budget holders
Appx A – 4.2.1	Chief Executive	Delegate budget to budget holders.
Appx A – 4.3.1	~~Director of Finance~~Chief Financial Officer	Devise and maintain systems of budgetary control
Appx A – 4.4.8	Chief Executive & Budget Holders	Must not exceed the budgetary total or virement limits set by the Trust Board

Appx A – 4.3.2	Budget Holders	Ensure that: (a) ~~No overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Trust Board~~. Expenditure is appropriately managed within budget escalating any issues and overspends through management structures, (b) Approved budget is not used for any other than specified purpose subject to rules of virement (c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment (d) No spend is incurred against a budget outside of the Budget Holders remit (e) Systems of budgetary control are complied with fully
Appx A – 4.3.3	Chief Executive	Identify and implement cost improvements and income generation activities in line with the IBP
Appx A – 4.7.1	Chief Executive	Submit monitoring returns
Appx A –	~~Director of Finance~~Chief Financial Officer	Prepare annual reports and accounts

SFI Ref.	**Authority delegated to**	**Duties delegated**
5.1		
Appx A – 6.1 – 6.3	~~Director of Finance~~Chief Financial Officer	Manage banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories
Appx A – 7	~~Director of Finance~~Chief Financial Officer	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash
Appx A – 7.2.4	All employees	Duty to follow Trust's financial procedures with regards to accurately and promptly recording money due from transactions which they initiate/deal with
Appx A – 8.5.4 (a)	Chief Executive	Can waive formal tendering procedures if Chief Executive decides such procedures would not be practicable or estimated expenditure/income would not warrant formal tendering procedures
Appx A – 8.5.7	~~Director of Finance~~Chief Financial Officer	Authorise waivers of tendering procedures
Appx A – 8.9.2	Chief Executive and Director of Finance	Where one tender is received will assess for value for money and fair price
Appx A – 8.11.5	Chief Executive	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive

Appx A – 8.5.14	Chief Executive	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote
Appx A – 8.13.4	Chief Executive or ~~Director of Finance~~Chief Financial Officer	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive
Appx A – 8.17.1 (a)	Chief Executive	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector
Appx A – 8.~~17.1 (g)~~18.2	Chief Executive	The Chief Executive shall nominate an officer who shall oversee and manage all contracts on behalf of the Trust
Appx A – 8.1~~9~~8.1	Chief Executive	Nominate officers, with delegated authority, to enter into contracts of employment, regarding staff, agency staff, temporary staff service contracts
Appx A – 8.~~21~~22.1	Chief Executive	Ensure that best value for money can be demonstrated for all services provided on an in-house basis
Appx A – 8.2~~1~~.5	Chief Executive	If in-house services are outsourced, the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust
Appx A – 9.1.1	Chief Executive	Responsible for negotiating contracts with commissioners for the provision of services to patients
Appx A – 9.2.1	Chief Executive	Ensure that regular reports are provided to the Trust Board detailing actual and forecast income from Service

SFI Ref.	**Authority delegated to**	**Duties delegated**
		Level Agreements.
Appx A – 10.1.1	Trust Board	Establish a ~~Remuneration and~~ Nominations and Remuneration Committee
Appx A – 10.1.2 (a)	~~Remuneration and~~ Nominations and Remuneration Committee	Advise the Trust Board and make recommendations on the remuneration and terms of service for the Chief Executive, other officer members and senior employees, ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements
Appx A – 10.1.2 (~~c~~b)	Nominations and Remuneration Committee~~Remuneration and Nominations Committee~~	Monitor and evaluate the performance of individual ~~officer members (and other senior employees)~~Directors
Appx A – 10.1.2 (~~d~~c)	Nominations and Remuneration Committee~~Remuneration and Nominations Committee~~	Advise and oversee appropriate contractual arrangements for senior employees when required.~~, including proper calculation and scrutiny of termination payments~~.
Appx A – 10.1.4	Trust Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Nominations and Remuneration Committee
Appx A – 10.3.1	Chief Executive	Give authorisation to Trust Board members and employees to engage, re-engage or re-grade employees, either permanently or temporarily, and hire agency staff

Appx A – 10.4.1	~~Director of Finance~~Chief Financial Officer	Responsible for processing of payroll including performance managing the outsourced provision of services to ensure it is in line with the contract, where necessary report any variations to the contract to Trust Board, specify timetables for submission of properly authorised time records and other notifications, final determination of pay and allowances, making payments on agreed dates, agreeing method of payment and issuing instructions regarding payroll
Appx A - 10.4.3	Nominated Managers	Submit time records in line with timetable, complete time records and other notifications in required form and submit termination forms in prescribed form and on time.
Appx A – 10.4.4	~~Director of Finance~~Chief Financial Officer	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
Appx A – 10.5.1	Human Resources Director	Ensure that all employees are issued with a Contract of Employment which complies with employment legislation and deal with variations to, or termination of, contracts of employment.
Appx A – 11.1.1	Chief Executive	Determine the level of delegation of non-pay expenditure to Budget Holders, including a list of employees authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level
Appx A – 11.1.3	Chief Executive	Set out procedures on the seeking of professional advice regarding the supply of goods and services
Appx A – 11.2.1	Requisitioner	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money

SFI Ref.	**Authority delegated to**	**Duties delegated**
		for the Trust. In so doing, the advice of the Trust's Supplies and Procurement Department shall be sought
Appx A – 11.2.4	~~Director of Finance~~Chief Financial Officer	Advise the Trust Board regarding setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained, prepare procedural instructions on the obtaining of goods/services incorporating the thresholds, responsible for the prompt payment of all properly authorised accounts and claims, responsible for designing and maintaining a system of verification, recording and payment of all amounts payable and be responsible for ensuring that payment is only made when goods/services have been received
Appx A – 11.3.1 (a) – (c)	~~Director of Finance~~Chief Financial Officer	Approve proposed prepayment arrangements for goods/services excluding training courses/subscriptions/membership fees up to £5,000
Appx A – 11.3.1 (d)	Budget Holder	Ensure that all items due under a prepayment contract are received
Appx A – 11.4.1	Chief Executive	Authorise who may use and be issued with official purchase orders
Appx A – 11.5.1	Managers and officers	Ensure that they comply fully with the guidance and limits specified by the ~~Director of Finance~~ Chief Financial Officer in relation to non-pay

		expenditure
Appx A – 11.5.2	Chief Executive and ~~Director of Finance~~Chief Financial Officer	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, PFI and ~~P21+~~P22 (including NEC~~3~~ contracts)~~(to be shortly superseded by P22)~~ and Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of the relevant Director.
Appx A – 11.6.1	~~Director of Finance~~Chief Financial Officer	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
Appx A – 11.7.1	~~Director of Finance~~Chief Financial Officer	Ensure that any lease entered into on behalf of the Trust represents value for money
Appx A – 12.1.1	~~Director of Finance~~Chief Financial Officer	Advise the Trust Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning the PDC debt and all loans ~~and overdrafts~~.
Appx A – 12.1.2	Trust Board	Approve a list of employees authorised to make short term borrowings on behalf of the Trust (this must include the Chief Executive and Chief Financial Officer)
Appx A – 12.1.3	~~Director of Finance~~Chief Financial Officer	Prepare detailed procedural instructions concerning applications for loans. ~~and overdrafts~~
Appx A – 12.1.5	Chief Executive or ~~Director of Finance~~Chief Financial Officer	Be on an authorising panel, comprising one other member, for short term borrowing approval
~~Appx A – 12.2.2~~	~~Director of Finance~~	~~Advise the Trust Board on investments and report, periodically, on performance of investments~~
~~Appx A – 12.2.3~~	~~Director of Finance~~	~~Prepare detailed procedural instructions on the operation of investments held~~
Appx A – 13.1.1	Chief Executive	Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities,

SFI Ref.	**Authority delegated to**	**Duties delegated**
		responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost, ensuring that capital investment is not undertaken without availability of resources to finance all revenue consequences and that a Capital Investment Programme is produced on an annual basis which is submitted and approved by Trust Board
Appx A – 13.1.4	Chief Executive	Issue managers responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender
Appx A – 13.1.5	Chief Executive	Issue a scheme of delegation for capital investment management
Appx A – 13.1.6	~~Director of Finance~~Chief Financial Officer	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes

Appx A – 13.2.8	Chief Executive	For capital schemes that stipulate stage payments will issue procedures for their management
Appx A – 13.2.9	~~Director of Finance~~Chief Financial Officer	Assess the requirement for the operation of the construction industry taxation deduction scheme
Appx A – 13.2.10	~~Director of Finance~~Chief Financial Officer	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure
Appx A – 13.6.1 (a)	~~Director of Finance~~Chief Financial Officer	Demonstrate that the use of Private Finance Initiatives (PFI) represents value for money and genuinely transfers significant risk to the private sector
Appx A – 13.6.1 (c)	Trust Board	Proposal to use PFI must be specifically agreed by the Trust Board (except for ~~variations~~ additional capital spending to existing PFI contracts which will follow the Trust's authorisation thresholds that are in place ~~for non-pay spend for~~ non PFI capital~~spending~~)
Appx A – 13.7.1	Chief Executive	Responsible for maintenance of asset registers (on advice from Chief Financial Officer)
Appx A – 13.7.5	~~Director of Finance~~Chief Financial Officer	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers
Appx A – 13.8.1	Chief Executive	Overall control of security of fixed assets
Appx A – 13.8.2	~~Director of Finance~~Chief Financial Officer	Approval of ~~fixed~~ asset control procedures
Appx A – 13.8.4 & 13.8.5	Trust Board members and all senior staff	Responsibility for security of Trust assets including notifying discrepancies to Chief Financial Officer, and reporting losses in accordance with Trust procedure
Appx A – 14.2.1	Chief Executive	Delegate overall responsibility for control of stores
Appx A – 14.2.1	~~Director of Finance~~Chief Financial Officer	Responsible for systems of control over stores
Appx A – 14.2.1	Designated Pharmaceutical Officer	Responsible for control of pharmaceutical stocks
Appx A – 14.2.1	Designated Estates Officer	Responsible for control of stocks of fuel oil and coal
Appx A 14.2.1	~~d~~Designated theatres manager	Responsible for control of theatres stocks
Appx A – 14.2.3	Chief Financial Officer~~Chief Financial Officer~~	Set out procedures and systems to regulate the stores including receipt of goods, issues and returns to stores

SFI Ref.	**Authority delegated to**	**Duties delegated**
		and losses
Appx A – 14.2.4	~~Director of Finance~~Chief Financial Officer	Agree stocktaking arrangements

Appx A – 14.2.5	~~Director of Finance~~Chief Financial Officer	Approve alternative arrangements where a complete system of stores control is not justified
Appx A – 14.2.6	~~Director of Finance~~Chief Financial Officer	Approve system for review of slow moving and obsolete stock items and for condemnation, disposal and replacement of all unserviceable items
Appx A – 14.3.1	Chief Executive	For goods supplied via the ~~NHS Logistics~~'Supply chain central warehouses' identify persons authorised to requisition and accept goods from stores
Appx A – 15.1.1	~~Director of Finance~~Chief Financial Officer	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers
Appx A – 15.2.1 & 15.2.3	~~Director of Finance~~Chief Financial Officer	Prepare procedures for recording and accounting for losses and special payments and informing Police and Security Management Director in cases of suspected theft or criminal damage
Appx A – 15.2.2	All staff	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and ~~Director of Finance~~Chief Financial Officer
Appx A – 15.2.4	~~Director of Finance~~Chief Financial Officer	Immediately notify Trust Board and External Auditor for losses caused or apparently caused by theft, fraud, criminal damage, neglect of duty or gross carelessness (unless trivial/immaterial)
Appx A – 15.2.5	~~Director of Finance~~Chief Financial Officer	In cases of fraud and corruption inform NHS ~~Protect~~ Counter Fraud Authority
Appx A – 15.2.6	Trust Board	Approve write off of losses and special payments (within limits delegated by ~~Department of Health~~ Department of Health and Social Care)
Appx A – 15.2.8	~~Director of Finance~~Chief Financial Officer	For any loss, consider whether any insurance claim can be made against insurers
Appx A – 15.2.9	~~Director of Finance~~Chief Financial Officer	Maintain losses and special payments register
Appx A – 16.1.2	~~Director of Finance~~Chief Financial Officer	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation
Appx A – 16.3.2	~~Director of Finance~~Chief Financial Officer	Where another health organisation or any other agency provides a computer service for financial applications periodically seek assurances that adequate controls are in operation
Appx A – 16.4.1	Director of IT	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place
Appx A – 16.5.1	~~Director of Finance~~Chief Financial Officer	Where computer systems have an impact on corporate financial systems satisfy themselves that systems acquisition, development and maintenance are in line with corporate policies, data produced for use with financial systems is adequate, accurate, complete and timely, and that a management trail exists, Director of

SFI Ref.	Authority delegated to	Duties delegated
		Finance staff have access to such data and such computer audit reviews are being carried out as are considered necessary.
Appx A – 17.1.2	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission
Appx A – 17.1.4	~~Director of Finance~~Chief Financial Officer	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients
Appx A – 17.1.8	Departmental managers	Inform staff of their responsibilities and duties for the administration of the property of patients
Appx A – 18.2~~1~~.3	~~Director of Finance~~Chief Financial Officer	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately
Appx A – 19.1.1	~~Director of Finance~~Chief Financial Officer	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
Appx A – 20.1.3	Chief Executive	Maintaining archives for all records required to be retained in accordance with ~~Department of Health~~ Department of Health and Social Care guidance.
Appx A – 21.1.1	Chief Executive	Ensure that the Trust has a risk management programme
Appx A – 21.1.1	Trust Board	Approve and monitor risk management programme
Appx A – 21.2.1	Trust Board	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority provider or to self-insure for some or all of the risks covered by the risk pooling schemes
Appx A – 21.4.1	~~Director of Finance~~Chief Financial Officer	Where the Trust Board decides to use the risk pooling schemes administered by the NHS Litigation Authority, shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme and ensure that documented procedures cover these arrangements.
Appx A – 21.4.2	~~Director of Finance~~Chief Financial Officer	Where the Trust Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision
Appx A – 21.4.2	~~Director of Finance~~Chief Financial Officer	Draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed
Appx A – 21.4.3	~~Director of Finance~~Chief Financial Officer	Ensure documented procedures cover management of claims and payments below the deductible limit.

6. Detailed scheme of delegation

6.1 Detailed below is a summary of the delegated limits as per the Standing Financial Instructions (SFIs). The below is not intended to replace the detail included within the SFIs and is to be read alongside the SFIs.

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
Appx A - 4.2		**Budgetary Delegation** Responsibility for management of:
	Chief Executive	Total of operational and corporate budgets
	Budget Holder (Executive Director, Clinical Director or Head of Service)	Total of budgets at other specified level (e.g. for the totality of services covered by the Division)
	Budget Manager	At individual budget level (e.g. department/function or collective specialty group)
	Budget Administrator	At individual cost centre/s level
Appx A - 4.4		**Virements** Types of virement:
	Budget Holder and Deputy Director of Finance ~~Director of Finance~~	Budget moves between income, pay or non-pay
	~~Associate Directors and/or Directorate Managers~~ Budget Holder and Deputy Director of Finance	Budget moves between pay to pay and non-pay to non-pay
	~~Budget Holder and Director of Finance~~Chief Financial Officer	Re-phasing of budgets

Appx A - 4.6		**Revenue business cases**
	~~Director of Finance~~Chief Financial Officer	If source of funds deemed readily available and investment < £25,000
	Clinical Director and Associate Directors	Replacement consultant posts
		Revenue business cases with investment of:
	Formal Executive Team	~~£0 (if source of funds not deemed readily available)/£~~25,001 to £250,000
	~~Trust Executive~~ Performance and Finance Committee~~Committee (TEC)~~	£250,001 to ~~£~~1,000,000

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
	~~Finance and Efficiency Committee (FEC)~~	~~£1,000,001 to £3,000,000~~
	Trust Board	£~~3~~1,000,001 to £15,000,000
	NHS Improvement (~~NHSI~~ NHSI/E)	£15,000,001 and above
Appx A - 7		**Income, fees and charges**
	~~Director of Finance~~Chief Financial Officer	For setting income, fees and charges relating to: Private patients, overseas visitors, income generating activities and all other patient and non patient related services
	Chief Executive and ~~Director of Finance~~Chief Financial Officer	For prices of all NHS contracts
Appx A - 7.2.3		**Authorisation of sponsorship deals:**
	Chief Executive or ~~Director of Finance~~ Chief Financial Officer ~~or Medical Director~~	For the Trust
	Charitable Funds Committee	For the Charitable fund

Appx A - 8		**Tendering, contracting and purchasing procedures** Values stated below are inclusive of VAT and apply to both capital and revenue expenditure
	Budget Holder/Manager or ~~Associate Director of Procurement & Commercial Services~~ Director of Procurement	£0 to £~~1,000~~4,999 -"verbal" informal quotes should be obtained wherever practicable. £~~5~~1,00~~0~~1 - £19~~2~~4,999 – "formal quotes" should be obtained from a minimum of three (3) suppliers where practicable. £2~~0~~5,000 to £49,999 – "formal quotes" should be obtained from a minimum of three (3) suppliers and the opportunity advertised through "contracts finder" £50,000 to £122~~0~~6,976~~047~~ – "formal tenders" should be obtained and the opportunity

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
		advertised through "contracts finder" £122~~0~~6,~~047~~ 976 and above – "formal tenders" should be obtained and there is a legal requirement to advertise the contract through the Official Journal of Europe (OJEU).
	~~Associate Director of Procurement & Commercial Services~~ Chief Financial Officer	Waivering of Quotations subject to SFIs
	Chief Executive or ~~Director of Finance~~ Chief Financial Officer~~or Chairman~~	Waivering of Tenders subject to SFIs
	Band 5 level or above within originating department	Opening tenders and opening quotations
Appx A - 10		**Human Resources and pay**
	~~Associate Director~~Chief Financial Officer and Director of Human Resources	Granting additional increments to staff within budgets

	~~Departmental Manager and~~ Chief Executive and Director of Human Resources ~~or nominated officer~~ Budget Manager or Budget Holder	~~All requests for~~Authorisation of upgrading or re-grading staff ~~shall be dealt with~~ in accordance with Trust procedure Regarding pay documentation, authorise standing data forms effecting pay, new starters, variations and leavers, time and attendance submissions, travel and subsistence expenses and authorise with-holding of annual increments in line with appraisal policy
Appx A - 10	~~Budget Holder and Associate Director~~ Budget Holder	**Authorised ~~car and~~ mobile phone users** ~~Requests for new posts to be authorised as car users~~ Requests for new posts to be authorised as requiring a Trust mobile phone ~~users~~
10		**Staff Retirement Policy**

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
	Departmental Manager	Authorisation for flexible retirement including retire and return
Appx A - 10	Director of Human Resources or Chief Executive and ~~Director of Finance~~ Chief Financial Officer Nominations and Remuneration Committee and NHSI/E NHSI/E	**Redundancy** Approval of redundancy payments: £0 to £10,000 £10,000 and above Redundancy Payment to a Director
Appx A - 10	~~Departmental~~ Budget Manager	**Ill health retirements** Decision to pursue retirement on the grounds of ill-health
Appx A - 10	~~Remuneration and~~ Nominations and	**Dismissals** Dismissal of: a) Executive Director

	Remuneration Committee Medical Director and Chief Executive ~~Directorate or~~ Departmental Manager	b) Senior medical staff c) All other staff
Appx A - 10.2	Chief Executive on recommendation from Director of Human Resources and Chief Financial Officer	**Engagement of staff not in the establishment** Approval of engagement of staff that are not in the permanent establishment (regardless of value)
Appx A - 10.3	Budget Manager, Budget Holder, HR Manager and Divisional Business Advisor Executive Director following approval by Budget Holder	**Engagement of permanent staff in the establishment** Approval to appoint to agreed establishment (other than senior medical staff) if the post is or will be vacant and the post is funded recurrently and budget is available Approval to appoint where, exceptionally, the post is not on the agreed establishment, providing that the appointment is vital for the service and a source of recurrent funding

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
		has been identified and is available. The post must be established in the budget in accordance with the virement rules set out in SFIs at 4.4.6
	Chief Executive and ~~Director of Finance~~ Chief Financial Officer following approval by appropriate Executive Director and appropriate Budget Holder	Approval to satisfactorily appoint senior medical staff (Consultant Staff Grade, Associate Specialist, Hospital Practitioner and Trust Doctor) to agreed establishment providing that the post is or will be vacant and the post is funded and supporting costs are funded recurrently and budget is available
Appx A - 10.3.1		**Engagement of temporary staff and renewal of fixed term contracts**

	Budget Holder	Engagement of temporary staff (excluding senior medical staff and NHSP/nurse agency) where the cover is vital for the service, is for a vacant post (which is funded recurrently and budget is available and can accommodate these costs)
	Budget Holder and relevant Executive Director	Engagement of temporary staff where the cover is vital for service and the cover is for a vacant post which is funded recurrently and budget is not available or cannot accommodate these costs
	Budget Holder and relevant Executive Director	Where in exceptional circumstances it is necessary to engage temporary staff in an emergency situation, the above approvals must be sought retrospectively. This must include securing the alternative sources of funding where appropriate (for example on-call Managers).
Appx A - 11		**Non-Pay Expenditure** This includes committing the Trust to expenditure by~~,~~ raising purchase orders and the payment of goods or services The values detailed below are gross values (i.e. the total cost inclusive of VAT) The values detailed below are relevant to **all non-pay costs (excluding pharmacy drugs)**:
	Budget Administrators	£0 to £5,000
	Budget Managers	£0 to £~~25~~20,000

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
	Budget Holders	£0 to £~~25~~0,000
	Director of Finance	£~~25~~0,001 to £100,000
	~~Chief Officer – Finance~~Chief Financial Officer ~~and Performance~~	£100,001 to £~~2550~~0,000
	Chief Executive	£~~2550~~0,001 to £~~51,0~~00,000
	Performance and Finance ~~and Performance~~ Committee	£~~1,05~~00,001 to £~~13~~,000,000

	Trust Board	£~~3~~1,000,001 and above NB – Requisitions require authorisation of **all** of the above up to the financial limit ~~N.B. For approvals over £50,000 where Director of Finance, Chief Officer – Finance and Performance, Chief Executive, Finance and Performance Committee or Trust Board authorisation is required, the spend has to previously be authorised by the budget Holder. So for e.g. spend of £3,000,001 will have to be authorised by the Budget Holder, Director of Finance, Chief Officer – Finance and Performance, Chief Executive, Finance and Performance Committee and Trust Board (in that order).~~ The values detailed below are relevant to **all pharmacy drug costs** and values are inclusive of VAT:
	Senior Assistant Technical Officer (ATO) Procurement and Senior Pharmacy Technician ~~Stock Control or Procurement and Stock Control Technician~~	£0 to £35,000 £ 35,001 to £120,000
	Lead Procurement Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Pharmacy Supply Chain Manager (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b).	
	Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c).	
	~~Senior Procurement Technician or Chief~~	£120,001 to £170,000 ~~£0 to £60,000~~

	~~Clinical Information Technician or Chief Technician Procurement or High Cost Medicines & Homecare Pharmacist~~	

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	~~Pharmacy Directorate Manager, Deputy Clinical Director of Pharmacy or Clinical Director of Pharmacy~~	~~£0 - £90,000~~
	~~Director of Finance~~	~~£90,001 to £100,000~~
	~~Chief Officer – Finance and Performance~~Chief Financial Officer	£17~~000~~,001 to £25~~0~~0,000
	Chief Executive	£25~~0~~0,001 to £~~1,5~~1,500,000
	~~Finance~~ Performance and ~~Performance~~Finance Committee	£5~~1,0~~1,000,001 to £1~~3~~3,000,000
	Trust Board	£1~~3~~3,000,001 and above NB – Requisitions require authorisation of **all** of the above up to the financial limit ~~N.B. For approvals over £90,000 where Director of Finance, Chief Officer – Finance and Performance, Chief Executive, or Trust Board authorisation is required, the spend has to be previously authorised by the relevant officers detailed above. So for e.g. spend of £750,000 will have to be authorised by the Senior Procurement or Pharmacist Directorate Manager or Clinical Director, Director of Finance, Chief Officer – Finance and Performance and Chief Executive (in that order).~~
Appx A - 11.5.1		**Agreements and licenses relating to accommodation at the Trust**

	Director of Estates, Facilities & PFI, and ~~Director of Finance~~Chief Financial Officer Director of Estates, Facilities & PFI, ~~Director of Finance~~ Chief Financial Officer or Chief Executive	Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff and extensions to lease agreements Letting of premises to outside organisations
Appx A - 11.5.1	Petty cash holder ~~Director of Finance~~Chief Financial Officer	**Petty cash disbursements** Expenditure up to £50 per item Expenditure over £50 per item
Appx A - 11.7		**Leases**

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
	~~Director of Finance~~Chief Executive or any Executive Director ~~Director of Finance and Chief Executive~~ Any two Executive Directors	Granting and terminating of leases ~~with annual rent of:~~ ~~£0 to £100,000~~ where a legal document ~~£100,000 and above~~ where the document requires sealing ~~The values above are gross values (i.e. total rent inclusive of VAT)~~
Appx A- 13		**Capital Investment** This includes committing the Trust to capital spend, raising purchase requisitions and the payments for capital spend All capital spend must be approved as part of the Trust's annual capital programme For all capital expenditure proposals a capital bid must be prepared A capital business case is required for all new capital investment if it is not relating to the replacement of an existing asset The approval limits for capital only business cases are detailed below (these values are

		gross values i.e. the total cost inclusive of VAT and are for all capital business cases regardless of funding source (i.e. are for both non PFI and PFI funded capital):
	Capital Investment Group (CIG)	£0 to £1,000,000
	~~Finance and Efficiency~~Performance and Finance Committee (~~F~~PF~~E~~C)	£1,000,001 to £3,000,000
	Trust Board	£3,000,001 to £15,000,000
	NHS Improvement (~~NHSI~~ NHSI/E) and DH	£15,000,001 and above
Appx A - 15.1		**Disposals and condemnations** The person responsible for condemning items at the Trust is dependent on the item as detailed below:
	Director of Estates,	For electrical items

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
	Facilities & PFI	
	Associate Director ~~or Head of Division~~	For furniture items
	Medical Director	For medical items
		Authorisation for method of disposal (excluding land and buildings):
	Associate Director ~~or Head of~~ ~~Division~~ and ~~Associate Director of Procurement & Commercial Services~~ Director of Procurement	£0 to £10,000
	~~Associate Director of Procurement & Commercial Services~~ Director of Procurement and Director of Finance	£10,001 to £500,000

	~~Associate Director of Procurement & Commercial Services~~ Director of Procurement and ~~Director of Finance~~ Chief Financial Officer and Trust Board	£500,000 and above
	~~Director of Finance~~ Chief Financial Officer and Chief Executive and Trust Board and NHS(~~NHSI~~NHSI/E) where appropriate	Disposal of land or buildings
Appx A - 15.2		**Losses and special payments** Limits and authorisation levels are dependent on the type of loss and special payment. All losses and special payments must be reported to the Audit Committee at every meeting and Audit Committee will prospectively approve all such payments valued at £25,000 and above **Losses and special payments of:** (a) Losses of cash:
	~~Director of Finance~~Chief Financial Officer	£0 to £50,000

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
	Chief Executive and ~~Director of Finance~~Chief Financial Officer	£50,001 to £250,000
	Chief Executive and ~~Director of Finance~~ Chief Financial Officer and Trust Board	£250,001 and above
Appx A - 15.2.3 & 15.2.4		**Reporting of losses and special payments**
	~~Director of Finance~~Chief Financial Officer	Where the theft/fraud relating to a loss/special payment is suspected inform the police and Security Management Director

	~~Director of Finance~~Chief Financial Officer	For losses/special payments caused or apparently caused by theft, fraud, criminal damage (including arson), neglect of duty or gross carelessness (except if trivial /immaterial) immediately notify the Trust Board and the External Auditor
Appx A - 18		**Funds held on trust (donated / charitable funds)** This relates to any expenditure relating to Charitable Funds. The values detailed below are gross values (i.e. the total cost including VAT where applicable for the Charity).
	Fund Manager and Directorate or Departmental Manager and Charity Manager	£0 to £5,000
	Fund Manager and Directorate or Departmental Manager and Charity Manager and ~~Director of Finance~~ Chief Financial Officer	£5,001 to £25,000
	Fund Manager and Directorate or Departmental Manager and Charity Manager and ~~Director of Finance~~ Chief Financial Officer and Chairman of Charitable Funds Committee	£25,001 and above
Appx A - 19.4.4 Policy G16 Standards of Business Conduct		**Receiving hospitality** This applies to both individual and collective

SFI Ref./ Other Ref.	**Authority delegated to**	**Duties delegated**
		hospitality receipt items
	Associate Director of ~~Corporate Affairs~~Governance	Any employee of the Trust receiving hospitality of in excess of £25 per item received is to declare this in the Hospitality Register maintained by the Associate Director of ~~Corporate Affairs~~Governance
Appx A - 20.1.3	Chief Executive	Responsibility for retention of records

Annual leave and Public Holiday Leave Policy (Except Medical Staff) HR52	Departmental Manager	**Annual, Public Holiday Leave** Approval of annual leave and approval of carry forward up to a maximum of 5 days or up to statutory entitlement in the case of individuals unable to take leave due to sickness
HR15 Career Grade Doctors Annual Leave Policy	Clinical Director or Clinical Lead	**Annual, Public Holiday Leave (Medical Staff)** Approval of medical staff leave of absence (paid)
HR55 Junior Doctors Annual Leave Policy	Rota Co-coordinator/Directorate Manager/ Consultant (for Specialist Registrars only)	Approval of medical staff leave of absence (unpaid)
HR~~14 Attendance Management Policy (All Staff)~~52 Annual, Public Holiday and Other Leave Policy	Departmental Manager	Approval of compassionate leave up to one working week or, in exceptional circumstances, up to two working weeks Approval of emergency leave (in line with the categories as set out in HR52) arrangements (up to 3 days). Any additional leave required above the 3 working days may be taken at manager's discretion Approval of short term carer/domestic need up to 5 days (on a time owing basis, subject to payback)
HR40 Study leave/professional leave for career grade doctors	Clinical Director (or delegated individual)/Departmental Manager/ Budget Holder	**Study leave** Approval of study leave: N.B. Any study leave which is to take place outside the UK is to be approved by those

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Clinical Director (or Medical Director in absence) and Budget Holder	individuals noted below and the Chief Financial Officer. (see policy for guidance on approval levels)
HR49 Learning and Education Policy For all Trust Staff	Departmental Manager or Budget Holder	a) For non-medical/non clinical staff
	Budget Holder and Clinical Director	b) For medical staff (excluding Clinical Directors)
	Departmental Manager or Budget Holder	c) For nursing/midwifery staff
	Departmental Manager or Budget Holder	d) For Clinical Directors
HR11 Paternity and Maternity Leave Policy	Departmental Manager	**Maternity and Paternity Leave** Approval of unpaid parental leave Maternity leave – paid and unpaid
F14 Trust Removal Expenses Policy		**Relocation expenses** Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing approval is sought prior to the offer being made in writing to the candidate)
	Budget Holder and Director of Human Resources	Up to £8,000
	Budget Holder and Director of Human Resources and Chief Executive	£8,001 and above
	Chief Executive and Medical Director	**Research Projects** Authorisation of research projects
	Chief Executive and Medical Director and	**Clinical Trials** Authorisation of clinical trials

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Chief Operating Officer	
	Chief Executive	**Patients and Relatives Complaints** Overall responsibility for ensuring that all complaints are dealt with effectively.
	Director of Communications and Executive Director/Executive Director On-Call Director of Communications or Chief Executive or Executive Director/ Executive Director On-Call	**Relationship with the press** Non-emergency general enquiries within or outside hours Emergency within or outside hours
Nurse/Midwives/ Health Visitors Act Midwives Rules / Code of Practice UKCC Code of Professional Conduct	Chief Executive and Chief Nurse	**Extended Role Activities** Approval of Nurses to undertake duties/procedures which can properly be described as beyond the normal scope of Nursing Practice.
	Chief Operating Officer Chief Operating Officer and Chief Executive On Call Manager or Chief Executive	**Patient services** Variation of operating and clinic sessions within existing numbers: d) Temporary variations e) Permanent variations All proposed changes in bed allocation and use for both temporary and permanent changes
	Director of Human Resources	Facilities for staff not employed by the Trust to gain practical experience - Professional Recognition, Honorary Contracts, and Insurance of Medical Staff
	Director of Estates, Facilities & PFI	Review of fire precautions

SFI Ref./ Other Ref.	Authority delegated to	Duties delegated
	Chief Nurse	Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations
	Medical Director	Review of Medicines Inspectorate Regulations
	Director of Estates, Facilities & PFI	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal
	Director of IT	Review of Trust's compliance with the Data Protection Act
	~~Director of Finance~~Chief Financial Officer	Monitor proposals for contractual arrangements between the Trust and outside bodies
	~~Associate Director of Corporate Affairs~~Director of IM&T	Review the Trust's compliance with the Freedom of Information Act
	~~Director of Finance~~Chief Financial Officer	Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" as per Caldicott, the IG Toolkit and future guidance from the General Data Protection Regulation.
SO 5.2 and Policy G16 Standards of Business Conduct	Associate Director of ~~Corporate Affairs~~Governance	The keeping of a Declaration of Interests Register
SO 6.2	Chairman and Chief Executive	Attestation of sealing's in accordance with Standing Orders
SO 6.3	Associate Director of ~~Corporate Affairs~~Governance	The keeping of a register of sealing

F01 Standing Financial Instructions - changes log - relating to V1 200108 for EDs 15/01/20

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
	Generic Changes							
1		All		Director of Finance	Chief Financial Officer		Updated Reference	
2		All		Chief Officer for Finance and Performance	Chief Financial Officer		Updated Reference	
3		All		Associate Director of Procurement & Commercial Services	Director of Procurement		Updated Reference	
4		All		NHSI	NHSI/E		Updated Reference	
5		All		NHS Protect	NHS Counter Fraud Authority		Updated Reference	
6		All		Department of Health (DoH)	Department of Health and Social Care (DHSC)		Updated Reference	
7		All		Finance and Performance Committee (FPC)	Performance and Finance Committee (PFC)		Updated Reference	
	Main Section							
8	8	4. Definitions	Table 1		Departmental Manager - Director or Employee at Band 8a or above responsible for authorisation in line with Human Resources policies	Clarification of role referred to in this policy.	New Entry	
9	8	4. Definitions	Table 1	Scheme of Delegation and Reservation of Powers	Policy number F02. Referred to as 'the Scheme of Delegation' within this document		Additional Information	
10	8	4. Definitions	Table 1	Standing Financial Instructions	Policy number F01. Referred to as 'the SFIs' within this document		Additional Information	
11	10	5 Roles and Responsibiities	5.3.3	The Chief Financial Officer will maintain a register of the required readers of the SFIs.	The Chief Financial Officer will maintain a register of the required readers of the SFIs. . These readers will predominantly be any authorised signatory for the Trust.		Clarification of requirement	MO/Fin
12	11	5 Roles and Responsibiities	5.6.1		Standing Orders. Policy number G19 Document which sets out the regulation of the Trust proceedings and business. Referred to as the SOs in this document.	Information re document referred to in this policy.	New Entry	
13	12	8 References		Trust's Scheme of Delegation	Trust Policy for Scheme of Reservation and Delegation of Powers - F02		Updated Reference	
	Appendix A							
14	13	1. Audit	1.1.4	NHS Audit Committee Handbook 2015	NHS Audit Committee Handbook 2018		Updated Reference	

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
15	14	1. Audit	1.2.1	Audit Committee shall be involved in the selection process when/if an Internal Audit service provider **is changed**.	Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is **re-appointed, extended or changed**.	Clarification	Clarification of requirement	MO/Fin
16	15	1. Audit	1.2.8	The reporting system shall be reviewed at least every three years			Removed as outdated / not required	
17	16	1. Audit	1.3.2		It is the responsibility of the Chief Financial Officer to ensure an adequate External Audit service is provided and the Audit Committee shall be involved in the selection process when/if an External Audit service provider is re-appointed, extended or changed.	Information re requirement of committee	New Entry	
18	17	2. Fraud and Bribery	2.1	Fraud is defined as any person who dishonestly makes a false representation to make a gain for himself/herself or another or dishonestly fails to disclose to another person, information he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.	Fraud is defined as "dishonestly making a false representation, failing to disclose information or abusing a position held, with the intention of making financial gain or causing a financial loss" as defined in the Fraud Act 2006	As per the definition in Trust Policy G18	Updated Reference	NH
19	17	2. Fraud and Bribery	2.4	Bribery is defined as "Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards, or other privileges".	Bribery is defined as "the offering, promising, giving, receiving, or soliciting of something of value for the purpose of influencing the action of an official in the discharge of his/her public or legal duties".	As per the definition in Trust Policy G18	Updated Reference	NH
20	18	2. Fraud and Bribery	2.5	Corruption is broadly defined as the offering of the acceptance of inducements, gifts or favours, payments or benefit in kind which may influence the improper action of any person	Corruption is broadly defined as "where someone is influenced by bribery, payment or benefit in kind to unreasonably use their position to give some advantage to themselves or to another".	As per the definition in Trust Policy G18	Updated Reference	NH
21	18	2. Fraud and Bribery	2.7	The Trust Board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Secretary of State Directive and the NHS Standard Contract. Department of Health	The Trust Board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist whose role and responsibilities are determined by the NHS Counter Fraud Authority, the NHS Counter Fraud Authority NHS Anti-Fraud Manual and Service Condition 24 of the Standard NHS Contract	Included additional info to reflect that within G18	Updated Reference	NH
22	18	2. Fraud and Bribery	2.10	Trust's Anti-Bribery policy (G18)	Trust's Anti-Bribery & Anti-Fraud policy (G18)	included Anti-Fraud into the title of G18	Updated Reference	NH
23	19	2. Fraud and Bribery	2.18	George Churcher 07825 119703	Simon Stanyer, KPMG 07747 565380		Updated Reference	

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
24	20	3. Security Management		2017/18 and 2018/19 NHS Standard Contract	Current NHS Standard Contract		Updated Reference	
25	22	4. Allocations, Business Planning …	4.2.6	and Chairman	Removed as not required as an authorised signatory		Removed as outdated / not required	
26	26	4. Allocations, Business Planning …	4.2.7		Any additions to the authorised signatory list should be approved by the Budget Holder and the Chief Financial Officer	New Entry to clarify authorisation requirement	New Entry	
27	23	4. Allocations, Business Planning …	4.3.1 (vi)	Cost improvement plan savings year to date and full year values with analysis of the type of i.e. recurrent or non recurrent savings	Cost improvement plan savings year to date and full year values **/ forecast outturn** with analysis of the type of i.e. recurrent or non recurrent savings	Additional information required	Clarification of requirement	MO/Fin
28	23	4. Allocations, Business Planning …	4.3.1 (viii)	Income and expenditure position by division year to date, showing variances to plan and forecast year end position		Removed as does not form part of the board report	Removed as outdated / not required	
29	24	4. Allocations, Business Planning …	4.3.2 (a)	Any likely overspending or reduction in income that cannot be met by virement is not incurred without prior consent of the Trust Board	Ensuring expenditure is appropriately managed within budget escalating any issues and overspends through management structures	Clarification	Clarification of requirement	MO/Fin
30	24	4. Allocations, Business Planning …	4.3.2 (c)	No permanent employees are appointed outside the funded establishment without the approval of the Chief Executive and any locally or Trust-wide established control procedures (such as vacancy control panels), agreed by the Chief Executive and in line with delegated limits.	No permanent employees are appointed outside the funded establishment without the approval of the Chief Executive **on recommendation from the Director of Human Resources and the Chief Financial Officer** or any locally or Trust-wide established control procedures (such as vacancy control panels), agreed by the Chief Executive and in line with delegated limits.	Clarification	Clarification of requirement	CS
31	25	4. Allocations, Business Planning …	4.4.3 (c)		Funding additional establishment through savings in non-pay budget.	New Entry as not an allowed virement	New Entry	
32	25	4. Allocations, Business Planning …	4.4.3 (d)		Changing nurse establishments within funding baseline without the prior agreement of the Director of Nursing	New Entry as a virement control	New Entry	
33	25	4. Allocations, Business Planning …	4.4.5	virement will generally not be considered unless a very strong case of need is made by the Budget Holder	virement will generally not be considered unless a very strong case of need is made by the Budget Holder **with agreement by the Chief Financial Officer**	Clarification on authorisation required	Clarification of requirement	MO/Fin
34	25	4. Allocations, Business Planning …	4.4.5 (c)		Virement from non pay to create additional establishment	New entry where virements are not acceptable	New Entry	
35	25	4. Allocations, Business Planning …	4.4.6	Old virement table	Updated virement table	Clarification of roles and linkage with other systems	Clarification of requirement	DD

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
36	27	4. Allocations, Business Planning …	4.6.7	The FEM will report monthly to the Trust Executive Committee (TEC) to confirm decisions made at FEM and also take any business cases for revenue investment over £250,000 for approval. **TEC has delegated authority from the Trust Board to approve revenue business cases of up to £1,000,000**,	The FEM will report monthly to the Trust Executive Committee (TEC) to confirm decisions made at FEM and also take any business cases for revenue investment over £250,000 for final review and recommendation for approval **to the Performance and Finance Committee.**	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	MO/Fin
37		4. Allocations, Business Planning …	4.6.8	Cases between **£1.000,000 and £3,000,000** will be taken to the Finance and Performance Committee (FPC) for approval. Any cases over **£3,000,000** will require Trust Board approval.	Cases between **£250,000 and £1,000,000** will be taken to the Performance and Finance Committee (PFC) for approval. Any cases over **£1,000,000** will require Trust Board approval.	Change of authorisation limits for trust committees	Change of Authorisation	MO/Fin
38	27	4. Allocations, Business Planning …	4.6.9	(NHSI/E) is also required to approve any revenue business cases which exceed **£5,000,000**	(NHSI/E) is also required to approve any revenue business cases which exceed **£15,000,000**	NHSI limit update	Updated Reference	
39	27	4. Allocations, Business Planning …	4.6.10	Revenue business cases have to go through all the relevant approval groups dependent on values, so for example a case of over £5,000,000 will require approval from FEM, **who will recommend to TEC**, who will recommend to FPC, who will recommend to Trust Board for approval. The case will then be recommended to NHSI for approval.	Revenue business cases have to go through all the relevant approval groups dependent on values, so for example a case of over £5,000,000 will require approval from FEM, who will recommend to PFC, who will recommend to Trust Board for approval. The case will then be recommended to NHSI for approval.	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	MO/Fin
40	27	4. Allocations, Business Planning …	4.6.11	The values quoted in SFI 4.6.2 and 4.6.6 to 4.6.9 are inclusive of VAT and represents either annual expenditure or annual income level.	The values quoted in SFI 4.6.2 and 4.6.6 to 4.6.9 are inclusive of VAT and represents either annual expenditure or annual income level, **whichever the greater**.	Clarification	Clarification of requirement	MO/Fin
41	27	4. Allocations, Business Planning …	4.6.12		Business Case Authorisation table	New table to show limits	New Entry	
42	28	4. Allocations, Business Planning …	4.6.13	A benefits review will take place at a time determined by FEM for all approved business cases	A benefits review will take place at a time determined by FEM **at the time of approval** for all approved business cases	Clarification	Clarification of requirement	MO/Fin
43	29	5. Annual Accounts and Reports	5.2	The Trust's audited annual accounts, and any report of the auditor on them, must be presented to the Trust Board for approval. **Or by the Audit Committee as delegated by the Trust Board**	The Trust's audited annual **reports and** accounts, and any report of the auditor on them, must be presented to the Trust Board for approval	removes AC delegatged authority - core board duty	Clarification of requirement	MO/Fin
44	29	5. Annual Accounts and Reports	5.4	The Trust will publish an annual report, in accordance with guidelines on local accountability. This will be presented to the Trust Board for approval. **Or to the Audit Committee as delegated by the Trust Board for approval.**	The Trust will publish an annual report, in accordance with guidelines on local accountability. This will be presented to the Trust Board for approval.	removes AC delegatged authority - core board duty	Clarification of requirement	MO/Fin

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
45	30	6. Bank Accounts	6.3.2	The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.		Remove no longer relevant as only use RBS with government defined T&Cs	Removed as outdated / not required	SB
46	30	6. Bank Accounts	6.3.2	All funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer shall open any bank account in the name of the Trust.	All funds shall be held in accounts in the name of the Trust. No officer other than the Chief Financial Officer shall open any bank account in **the Trusts name or include the** name of the Trust.	Clarification	Clarification of requirement	MO/Fin
47	31	6. Bank Accounts	6.4	Tendering and Review		Remove no longer relevant as only use RBS with government defined T&Cs	Removed as outdated / not required	
48	31	6. Bank Accounts	6.4.1	The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.		Remove no longer relevant as only use RBS with government defined T&Cs	Removed as outdated / not required	
49	31	6. Bank Accounts	6.4.2	Competitive Tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Trust Board. This review is not necessary for Government Banking Service (GBS) accounts.		Remove no longer relevant as only use RBS with government defined T&Cs	Removed as outdated / not required	
50	32	7. Income, fees and charges ….	7.2.6	The preparation and signing of all tenancy agreements and licenses in respect of staff accommodation shall be the responsibility of the **Chief Financial Officer**	The preparation and signing of all tenancy agreements and licenses in respect of staff accommodation shall be the responsibility of the **Chief Executive Officer**	Reflects policy EF07 and system in place	Updated Reference	AC
51	32	7. Income, fees and charges ….	7.3.2 Debt recovery	Where sums to be written off exceed **£150,000, the Chief Financial Officer will seek the consent of the Chief Executive and the Trust Board**.	Where sums to be written off exceed **£1,000, the Chief Financial Officer will seek the consent of the Chief Executive and items exceeding £50,000 will require consent of the Trust Board**.	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	MO/Fin
52	33	7. Income, fees and charges ….	7.3.3	Where sums to be written off exceed £50,000 the Director of Finance shall seek consent of the Chief Executive and the Trust Board.		Removed as covered in 7.3.2	Removed as outdated / not required	
53	33	7. Income, fees and charges ….	7.4.4	The holders of safe keys shall not accept **unofficial** funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers.	The holders of safe keys shall not accept **patient or other** unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers.	Clarification of requirement that only patient monies can be accepted for safe keeping in general, but donations may also be held.	Clarification of requirement	MO/Fin
54	35-49	8. Tendering, Contracting and Purchasing Procedures	throughout	OJEU limit £106,047	OJEU Limit £108,133		Updated Reference	

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
55	35-49	8. Tendering, Contracting and Purchasing Procedures	throughout	Associate Director of Procurement & Commercial Services	Director of Procurement		Updated Reference	
56	35	8. Tendering, Contracting and Purchasing Procedures	8.1.2 - quotations £20k to £50k	Single quotation documentation to be completed and authorised by Associate Director, Procurement and Commercial Services	Single quotation documentation to be completed and authorised by Chief Financial Officer	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	MO/Fin
57	35	8. Tendering, Contracting and Purchasing Procedures	8.1.2 - quotations £20k to £50k	Old purchasing requirements table	Updated purchasing requirements table including OJEU limit of £122,976 applicable from 01/01/20	Table updated to relect no quotations or tenders up to £20,000	Clarification of requirement	NJJ
58	38	8. Tendering, Contracting and Purchasing Procedures	8.5.7	Single Tender waiver form	Single Tender waiver form **contained within the eReaf system**	Formalises Reaf system into Trust SFIs	Updated Reference	NJJ
59	39	8. Tendering, Contracting and Purchasing Procedures	8.5.15	An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.	An appropriate record, **contained within the eREAF system**, should be made of the reasons for inviting a tender or quote other than from an **approved procurement route** / approved list	strengthened wording And formalisation of Reaf system	Clarification of requirement	NJJ
60	39	8. Tendering, Contracting and Purchasing Procedures	8.5.16	The Trust will use Construction Line (www.constructionline.co.uk) for its approved contractors for capital developments or the **Procure 21+** Framework.	The Trust will use contractors registered on Construction Line (www.constructionline.co.uk) **as vetted and approved contractors** for capital developments or the **Procure 22** Framework.	Strengthened wording and updated framework	Updated Reference	AC
61	40	8. Tendering, Contracting and Purchasing Procedures	8.6.1 (c)	Tendering based on other forms of contract may be used only after prior consultation with the Department of Health and Social Care.	Tendering based on other forms of contract **(P22)** may be used following consultation with the Department of Health and Social Care.	Strengthened wording and updated framework	Updated Reference	AC
62	41	8. Tendering, Contracting and Purchasing Procedures	8.6.2	Section on non E-procurement Tenders		E procurement is always used	Removed as outdated / not required	AC
63	45	8. Tendering, Contracting and Purchasing Procedures	8.14.3	The Director of Procurement will report proposed procurements over the current OJEU limit **(currently £118,133) to the Chief Financial Officer prior to the award of any contract.**	The Director of Procurement will report proposed procurements over the **value of £1m to the Performance and Finance Committee** prior to the award of any contract, and also provide a contract award report for all procurements over a value of **£500,000 to the Chief Executive Officer on a monthly basis**.	Reflects current practice	Clarification of requirement	NJJ

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
64	46	8. Tendering, Contracting and Purchasing Procedures	8.16.3	Where no CMU contract exists, and where applicable, the Trust will comply with the quotation, tendering and contract procedures detailed in SFI 18.	Where no CMU contract exists, and where applicable, the Trust will comply with the quotation, tendering and contract procedures detailed in SFI 18 **and support will be provided by the Supplies and Procurement Department accordingly.**	Additional information to reflect current practice	Clarification of requirement	NJJ/ST
65	47	8. Tendering, Contracting and Purchasing Procedures	8.18.2		The Chief Executive Officer delegates the responsibility of authorising/signing of all commercial contracts to the Director of Procurement, with the exception of building and works contracts which is delegated to the Director of Estates, Facilities and PFI' The conditions set out in 18.18.1 must be satisfied.	New Entry to reflect current practice	New Entry	NJJ
66	48	8. Tendering, Contracting and Purchasing Procedures	8.21.1 (b)	supplies policy	Procurement Policy (SP01)	updated reference	Updated Reference	NJJ
67	48	8. Tendering, Contracting and Purchasing Procedures	8.22.2 (c)	non-officer member	Non-Executive director	updated reference	Updated Reference	
68	49	8. Tendering, Contracting and Purchasing Procedures	8.25		The Estates, Facilities and PFI Division have delegated authority in regard to the raising of purchase orders in relation to MTC related purchase orders and emergency orders only. (These can be emergency orders required at any time, but should not be confused with urgent orders). As outlined in section 11.5.1 all emergency orders must subsequently be confirmed by an official purchase order and clearly marked "Confirmation Order".	Setting out delegated ordering arrangmements in place with Estates, Facilities and PFI division	New Entry	NJJ
69	49	8. Tendering, Contracting and Purchasing Procedures	8.25		It should also be noted that a fully authorised electronic Request for Executive Approval Form (eReaf) is still required for all MTC related purchase order and emergency order expenditure exceeding £20,000 (including VAT).	Setting out delegated ordering arrangmements in place with Estates, Facilities and PFI division	New Entry	NJJ
70	50	9.NHS Contracts	9.1.3 (i)	pricing of services		Deleted point as duplicate of point 9.3.1 (a)	Removed as outdated / not required	CR
71	50	9. NHS contracts	9.1.3 (i)	Contract monitoring arrangements	Contract management and monitoring arrangements	monitoring implies no active management. NHS Standard contract requires contract management	Clarification of requirement	CR

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
72	50	9. NHS contracts	9.1.3 (m)		Any other / new innovative payment methodologies	New Entry	New Entry	CR
73	52	10. Terms of Service Allowances ….	10.1	**Remuneration and Nominations Committee**	**Nominations and Remuneration Committee**	Title updated	Updated Reference	NH
74	52	10. Terms of Service Allowances ….	10.1.2 (a)	Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and non-voting members) and the Chief Executive. For those senior posts reporting directly to the Chief Executive, **the decision on remuneration and terms of service remains with the Chief Executive/Medical Director or Executive Director lead.** This will include	Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and non-voting members) , the Chief Executive **and posts assigned to the Very Senior Manager framework**. This will include	Changed to reflect duties within NRC ToR	Updated Reference	NH
75	52	10. Terms of Service Allowances ….	10.1.5	Chairman and non-officer	Chairman and Non-Executive	Changed to Non-Exec member rather than officer	Updated Reference	NH
76	52	10. Terms of Service Allowances ….	10.1.5	Once authorised as a Foundation Trust the Membership Council shall establish a remuneration committee with responsibility for reviewing the pay and allowances to the Chairman and Non-Executive Directors in accordance with the Core constitution of the Trust. Pay and allowances will be made in accordance with those industry averages, benchmarked at the point of authorisation.		Removed as no longer a Trust goal / NHSI/E requirement	Removed as outdated / not required	NH
77	53	10. Terms of Service Allowances ….	10.3.1 (a)	Unless authorised to do so by the Chief Executive **or** Director of Human Resources	Unless authorised to do so by the Chief Executive **and** Director of Human Resources	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	CS/ RV
78	53	10. Terms of Service Allowances ….	10.3.3	The Chief Financial Officer is to keep an up to date list of authorised signatories by cost centre/budget code.		This is to be removed as covered in point 4.2.5	Removed as outdated / not required	
79	55	10. Terms of Service Allowances ….	10.5.1 (c)		Any pay rates outside national terms and conditions will need prior agreement by the Chief Financial Officer and the Human Resources Director, this will include changes to bank rates as well as substantive posts.	Updated requirement	New entry	CS/ RV
80	55	10. Terms of Service Allowances ….	10.5.1 (d)		The Human Resources Director will maintain a schedule of all pay rates outside the national terms and conditions and will notify payroll of any changes	Updated requirement	New entry	CS/ RV

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
81	56	11. Non Pay Expenditure	11.1.2	Old requisition and invoice authorisation table	Updated requisition and invoice authorisation table	Inclusion of requisition limits to reflect Reaf Process / reduced limits and updated authorisation limits for Non PO spend as per table	Change of Authorisation	SP/DD
82	56	11. Non Pay Expenditure	11.1.2		The authorisation levels for pharmacy drugs requisitions are separately agreed as set out in the table below. Requisitions up to a value of £170,000 are authorised within the Pharmacy team.	Additional note to clarify the requirement for pharmacy drugs	Change of Authorisation	ST
83	56	11. Non Pay Expenditure	11.1.2		New table - Pharmacy drugs requisition limits	New table to show limiits for pharmacy drug procurement	Change of Authorisation	ST
84	57	11. Non Pay Expenditure	11.2.1		The Supplies and Procurement Department, with input from the Finance Department, will be responsible for maintaining the list detailing the areas of expenditure that do not require a Purchase Order. This list will be known as the 'Agreed Non Purchase Order List'. Any areas of expenditure contained within the Agreed Non Purchase List will not require a purchase order and will therefore be exempt from the Trusts requisition approval process.	Reflects practical requirement and procurement role	New entry	
85	59	11. Non Pay Expenditure	11.5.1 (g)	Verbal orders must only be issued very exceptionally, by an employee designated by the Chief Executive and only in cases of emergency **or urgent necessity**	Verbal orders must only be issued very exceptionally, by an employee designated by the Chief Executive and only in cases of emergency	Restricts to emergency only	Change of Authorisation	NJJ
86	59	11. Non Pay Expenditure	11.5.1 (h)	Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds.	Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds **and should be placed for the value for the life of the contract**.	Clarification of requirement	Clarification of requirement	NJJ
87	60	11. Non Pay Expenditure	11.5.1 (j)	Changes to the list of employees and officers authorised to certify invoices should be approved by the Divisional Business Advisor and Chief Financial Officer		Removed as covered in 4.2.7	Removed as outdated / not required	DD
88	60	11. Non Pay Expenditure	11.7.2	A lease is generally defined as a contract renting land, buildings, etc., to another or a contract or instrument conveying property to another for a specified period. It will not be a flexible arrangement and will be for a long time period (i.e. more than 12 months). The agreement will usually be written and be predetermined and cannot be broken without breaking the lease often incurring penalties	A commercial lease is a legally binding contract made a landlord and a business tenant. The lease gives a tenant the right to use certain property for a business or commercial activity for a period of time (minimum 6 months) in exchange for consideration (ie money) paid to the landlord. A commercial lease offers exclusive possession of a defined area (demise), with the main legislation being the Landlord and Tenant Act 1954.	Updated definition of subject	Updated Reference	AC

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
89	60	11. Non Pay Expenditure	11.7.3	A rental agreement differs to a lease as it will generally be an agreement where a payment is made for the temporary use of a good or property owned by another person or company. It will often be flexible and for the short term (i.e. a period of less than 12 months). The agreement may be predetermined but terms can be changed and the agreement can be cancelled at any time with no or low value penalty.	A licence to occupy is a legal agreement between the licensor (the party who owns the property/land) and the licensee (the party seeking to occupy the property/land), giving the licensee the right to occupy a designated area of the property for a defined length of time (ie there is no minimum of maximum period but is usual for licences to be for 1 day to 6 months or more). Licences do not offer exclusive possession but rather the designated area can be relocated.	Updated definition of subject	Updated Reference	AC
90	61	11. Non Pay Expenditure	11.7.4		Contracts for goods and services can also contain a leases. These contracts, mainly for equipment or vehicles, will contain a lease if the Trust has the right to obtain substantially all of the economic benefits from use of a an asset, for example by having exclusive use of the asset over the period of the lease, and the Trust has the right to direct the use of the identified asset. In effect, the Trust decides how the asset will be used and for what purpose.	Updated definition of subject	Updated Reference	SB
91	61	11. Non Pay Expenditure	11.7.4	All leases and contracts must be forwarded to the Supplies and Procurement Department to validate the legal content of the lease/contract and for inclusion on the Lease Contracts Register .	All leases and contracts for **goods and equipment** must be forwarded to the Supplies and Procurement Department to validate the legal content of the lease/contract and for inclusion on the **goods and equipment** Lease Contracts Register .	Clarify requirement of two specific lease registers to be held within the Trust	Clarification of requirement	MO/Fin
92	61	11. Non Pay Expenditure	11.7.5		All leases and contracts for premises must be forwarded to the Estates, Facilities and PFI Department to validate the legal content of the lease/contract and for inclusion on the premises Lease Contracts Register .	Clarify requirement of two specific lease registers to be held within the Trust	Clarification of requirement	MO/Fin
93	62	12. External Borrowing and Investments	12	External Borrowing and Investments		The Trust does not have the authority to make investments (except Charity - S18)	Change of Authorisation	MO/Fin
94	62	12. External Borrowing and Investments	12.1.1 and 12.1.3	Loans and Overdrafts	Loans	the Trust does not have the authority to arrange overdrafts	Change of Authorisation	MO/Fin
95	62	12. External Borrowing and Investments	12.2	Detailed investment section		Removed as the Trust does not have the authority to make investments (except Charity - S18)	Change of Authorisation	MO/Fin

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
96	63-71	13. Capital Investment, Private Financing …	throughout	Director of Corporate Services	Director of Estates, Facilities and PFI		Updated Reference	
97	64	13. Capital Investment, Private Financing …	13.2.1	NHS Manual for Accounts	DHSC Group Accounting Manual		Updated Reference	
98	64	13. Capital Investment, Private Financing …	13.2.4	capital allocation is made on a **cash** basis	capital allocation is made on an **expenditure** basis	Reflects requirement	Clarification of requirement	DR
99	64	13. Capital Investment, Private Financing …	13.2.5	may, in consultation with the Director of Corporate Services	may, in consultation with the ressponsible Director	Capital spend sits with several directors	Change of Authorisation	DR
100	64	13. Capital Investment, Private Financing …	13.2.9	Inland Revenue	HMRC		Updated Reference	DR
101	64	13. Capital Investment, Private Financing …	13.2.10	The **Director of Corporate Services** is responsible for the selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations.	The **relevant capital project Director** is responsible for the selection of architects, quantity surveyors, consultant engineers, **IT engineers,** other professional advisors and **service providers** within **procurement** and EU regulations.	Capital spend sits with several directors and is wider than Estates projects	Change of Authorisation	DR
102	65	13. Capital Investment, Private Financing …	13.4.1	expenditure on a tangible productive resource	expenditure on a tangible or intangible productive resource	Reflects capitalisation of intangible assets	Clarification of requirement	DR
103	65	13. Capital Investment, Private Financing …	13.4.2 (iv)		The items have an individual value of £250 or more	New entry to reflect accounting policy	New Entry	DR
104	65	13. Capital Investment, Private Financing …	13.4.6	Fixed assets should not ordinarily be purchased from revenue funds, however, there may be instances where this is required but they must be approved by the Chief Financial Officer.		Removed to reflect accounting policy	Clarification of requirement	DR
105	65	13. Capital Investment, Private Financing …	13.4.6	maintenance capital	replacement capital	consistent terminology	Clarification of requirement	DR

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
106	66	13. Capital Investment, Private Financing …	13.5.2	A summary of the internal capital approval limits is as below	**The annual budget will detail the Capital schemes for the coming year.** A summary of the internal capital approval limits **for schemes included in the annual plan** is as below	Reflects current practice	Clarification of requirement	DR
107	66-67	13. Capital Investment, Private Financing …	13.5.2	Old Capital Business Case Table	Updated Capital Business Case Table	Table updated to reflect authorisation limits change for business cases at section 4.6	Change of Authorisation	DR
108	66	13. Capital Investment, Private Financing …	13.5.2		Schemes not identified in the annual plan will require Executive Team sign off, unless agreed as part of the business case process or agreed by the Trust Board.	New entry	Clarification of requirement	DR
109	67	13. Capital Investment, Private Financing …	13.5.4	The Trust's Capital Investment Group (CIG) has delegated authority from the Trust Board to approve capital investment cases up to £1,000,000	**The Trust Board will approve the capital programme as part of the annual plan.** The Trust's Capital Investment Group (CIG) has delegated authority from the Trust Board to approve capital investment cases up to £1,000,000 **as identified in the programme approval table at 13.5.2**	Reflects current practice and revised approval levels in the table	Clarification of requirement	DR
110	68	13. Capital Investment, Private Financing …	13.5.5	Old NHSI Approval table	Updated NHSI/E Approval table	Table updated to refect more detailed NHSE/I Requirements	Updated Reference	
111	69-70	13. Capital Investment, Private Financing …	13.7	fixed assets	tangible and intangible assets	update of terminology	Updated Reference	DR
112	70	13. Capital Investment, Private Financing …	13.7.3 (c)	Lease agreements in respect of assets held under a **finance lease and capitalised**	Lease agreements in respect of assets held under a **right of use asset**.	update of terminology	Updated Reference	DR
113	70	13. Capital Investment, Private Financing …	13.7.5	The Chief Financial Officer shall approve procedures for reconciling balances on **tangible and intangible assets accounts in ledgers** against balances on **tangible and intangible** asset registers	The Chief Financial Officer shall approve procedures for reconciling balances on **the relevant general ledger** against balances on **the** asset registers	Clarification	Clarification of requirement	DR
114	72	14. Stores and Receipt of Goods	14.2.1	The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer and the control of any fuel, oil and coal of a designated estates manager.	The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer, **the control of theatre stocks shall be the responsibility of the designated theatres manager** and the control of any fuel, oil and coal of a designated estates manager.	Updated to reflect the role of the Theatre manager	Clarification of requirement	MO/Fin

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
115	72	14. Stores and Receipt of Goods	14.2.2	health service property	NHS property		Updated Reference	
116	73	14. Stores and Receipt of Goods	14.4.3	It is the responsibility of the **Directorate manager** to ensure that SFI 14.4 is followed	It is the responsibility of the **authorised senior manager / Associate Director** to ensure that SFI 14.4 is followed.	Aligns with Inventory Policy no FA02	Clarification of requirement	DR
117	74	15. Disposals and condemnations ….	15.1.2	When it is decided to dispose of a Trust asset, the **Head of Department** or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate	When it is decided to dispose of a Trust asset, the **Budget Manager** or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice **from the Procurement department** where appropriate	Reflects authorised signatory responsibilities	Clarification of requirement	NJJ
118	74	15. Disposals and condemnations ….	15.1.3 & 15.1.4	Condemning Officer	Condemning Officer (Budget Manager)	Reflects authorised signatory responsibilities	Clarification of requirement	PB/DR
119	75	15. Disposals and condemnations ….	15.2.10	All losses and special payments must be reported to the Audit Committee at every meeting **who will prospectively approve all such payments valued at £25,000 and above .**	All losses and special payments must be reported to the Audit Committee at every meeting .	MO can approve to £50k then to Trust Board as per section 7.3	Change of Authorisation	SB
120	78	17. Patients' Property	17.1.3	Health Service premises	Trust premises		Updated Reference	
121	80-81	18. funds Held on Trust		Donated Funds	Donated / charitable Funds		Updated Reference	
122	80	18. funds Held on Trust	18.1.3	NHS Board	UHNM Trust Board		Updated Reference	
123	81	18. funds Held on Trust	18.4.5	New entry	The Charity's audited annual reports and accounts, and any report of the auditor on them, must be presented to the Trust Board Board in its capacity as the Corporate Trustee for approval.	aligns with 5.2	Change of Authorisation	MO/Fin
124	81	18. funds Held on Trust	18.4.7	F06 Charitable Funds	F06 UHNM Charity Policy		Updated Reference	
125	82	20. Retention of Documents	20.1.2	The Trust has a duty under the Public Records Act to ensure the safekeeping and eventual disposal of all types of document.	The Trust has a duty under the Public Records Act **along with the Records Management Code of Practice for Health and Social Care 2016** to ensure the safekeeping and eventual disposal of all types of document.		Updated Reference	LC
126	80	20. Retention of Documents	20.1.2	The requirements of all staff members are set out in the **Trust's Data Protection Policy (IG10)**. This policy is deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs	The requirements of all staff members are set out in the **Trust's Data Protection Security and Confidentiality Policy (IG10) and Corporate Records Management Policy (G11).** These policies are deemed to be an integral part of these SFIs and should be referred to in conjunction with these SFIs		Updated Reference	LC

No	Page	Section	Sub Section	From	To	Rationale	Category	Lead
127	82	20. Retention of Documents	20.1.6		20.1.6 Where records are required to be stored off-site the Trust will use approved suppliers. Detail available from the Information Governance Team.	Reflects current practice	Clarification of requirement	NH

F02 Scheme of Reservation and Delegation of Powers - changes log - relating to V1 200108 for EDs 15/01/20

No	Page	Section	From	To	Rationale	Category	Lead
10	6	4. Definitions - Table 1	New Entry	Departmental Manager - Director or Employee at Band 8a or above responsible for authorisation in line with Human Resources policies	Clarification of role referred to in this policy.	New Entry	CS
11	7	4. Definitions - Table 1	Scheme of Delegation and Reservation of Powers	Policy number F02. Referred to as 'the Scheme of Delegation' within this document		Additional Information	
12	7	4. Definitions - Table 1	Standing Financial Instructions	Policy number F01. Referred to as 'the SFIs' within this document		Additional Information	
13	7	4. Definitions - Table 1		Standing Orders. Policy number G19 Document which sets out the regulation of the Trust proceedings and business. Referred to as the SOs in this document.	Information re document referred to in this policy.	New Entry	
14	8	6. Training and Education	Assistant Director of Finance – Chief Accountant.	Assistant Director of Finance – Financial Controller.	Updated title	Updated Reference	fin
15	8	7. Monitoring and Review Arrangements - 7.2 Review	This policy will be reviewed 1 year post ratification of version 1, and every 3 years thereafter unless changes in national legislation override this or there has been a specific request to review earlier.	This policy will be reviewed two years post ratification, unless changes in national legislation override this or there has been a specific request to review earlier.	To align with SFIs	Clarification of requirement	NH
		Appendix A					
		No changes					
		Appendix B					
16	12	3.1(a) - Remuneration and Nominations Committee	Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e.: Trust Board voting and no-voting members) and the Chief Executive. **For those senior posts reporting directly to the Chief Executive, the decision on remuneration and terms of service remains with ...**	Advise the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e.: Trust Board voting and no-voting members) , the Chief Executive **and posts assigned to the Very Senior Manager framework.**	Changed to reflect main duties as in ToR	Clarification of requirement	NH
17	13	4	Quality and Assurance Committee	Quality Governance Committee	Title updated	Updated Reference	NH
18	13	5.2 - Performance and Finance Committee	*points (a) to (e)*	*points (a) to (e)*	Duties updated to reflect FPC ToR	Clarification of requirement	NH
19	14	6	Professional Standards Committee	Transformation and People Committee	Changed to reflect role of renewed Boardf sub-Committee	Change of Authorisation	NH
20	14	7	Charity Committee	Trustee Committee	Title updated	Updated Reference	NH

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		Appendix C - Section 4					
21	21	SO Ref 5.4.1	Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff"	Comply with national guidance contained in NHS England's "Managing Conflicts of Interest in the NHS"	Changed to reflect more recent guidance	Updated Reference	NH
		Appendix C - Section 5					
22	24	SFI Ref - Appx A - 4.3.2	(a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Trust Board	(a) Expenditure is appropriately managed within budget escalating any issues and overspends through management structures,	Changed to reflect SFI update	Clarification of requirement	MO/Fin
23	25	SFI Ref - Appx A - 8.17.1 (g)	8.17.1(g)	8.18.2	Corrected SFI reference (not an SFI change)	Updated Reference	
24	25	SFI Ref - Appx A - 8.18.1	8.18.1	8.19.1	Corrected SFI reference (not an SFI change)	Updated Reference	
25	25	SFI Ref - Appx A - 8.21.1	8.21.1	8.22.1	Corrected SFI reference (not an SFI change)	Updated Reference	
26	25	SFI Ref - Appx A - 8.21.5	8.21.5	8.22.5	Corrected SFI reference (not an SFI change)	Updated Reference	
27	25	SFI Ref - Appx A - 10.1.2(c)	10.1.2 (c)	10.1.2 (b)	Corrected SFI reference (not an SFI change)	Updated Reference	
28	25	SFI Ref - Appx A - 10.1.2 (b)	Monitor and evaluate the performance of individual officer members (and other senior employees)	Monitor and evaluate the performance of individual Directors	Corrected SFI reference (not an SFI change)	Updated Reference	
29	25	SFI Ref - Appx A - 10.1.2(d)	10.1.2 (d)	10.1.2 (c)	Corrected SFI reference (not an SFI change)	Updated Reference	
30	25	SFI Ref - Appx A - 10.1.2(c)	Advise and oversee appropriate contractual arrangements for senior employees, including proper calculation and scrutiny of termination payments.	Advise and oversee appropriate contractual arrangements for senior employees when required.	Corrected SFI reference (not an SFI change)	Updated Reference	
31	27	SFI Ref - Appx A - 11.5.2	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, **PFI and P21+ (including NEC3 contracts)(to be shortly superseded by P22)** and Health Building Note 00-08.	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, **PFI and P22 (including NEC contracts)** and Health Building Note 00-08	Corrected SFI reference (not an SFI change)	Updated Reference	
32	27	SFI Ref - Appx A - 12.1.1 and 12.1.3	Loans and Overdrafts	Loans	the Trust does not have the authority to arrange overdrafts	Change of Authorisation	MO / Fin
33	27	SFI Ref - Appx A - 12.2.2	Advise the Trust Board on investments and report, periodically, on performance of investments		Removed as the Trust does not have the authority to make investments (except Charity - S18)	Change of Authorisation	MO / Fin

No	Page	Section	From	To	Rationale	Category	Lead
34	27	SFI Ref - Appx A - 12.2.3	Prepare detailed procedural instructions on the operation of investments held		Removed as the Trust does not have the authority to make investments (except Charity - S18)	Change of Authorisation	MO / Fin
35	28	SFI Ref - Appx A - 13.6.1 (c)	(except for variations to existing PFI contracts which will follow the Trust's authorisation thresholds that are in place for non-pay spend for non PFI spending)	(except for additional capital spending to existing PFI contracts which will follow the Trust's authorisation thresholds that are in place non PFI capital)	Corrected SFI reference (not an SFI change)	Updated Reference	
36	28	SFI Ref - Appx A - 13.8.2	Approval of fixed asset control procedures	Approval of asset control procedures	Corrected SFI reference (not an SFI change)	Updated Reference	
37	28	SFI Ref - Appx A - 14.2.1		Designated theatres manager - Responsible for control of theatres stocks	Updated to reflect the role of the Theatre manager	Clarification of requirement	MO / Fin
38	29	SFI Ref - Appx A - 14.3.1	NHS Logistics'	NHS Supply chain central warehouses	Corrected SFI reference (not an SFI change)	Updated Reference	
39	30	SFI Ref - Appx A - 18.1.3	18.1.3	18.2.3	Corrected SFI reference (not an SFI change)	Updated Reference	
		Appendix C - Section 6					
40	31-46	SFI Ref - Appx A / xxx		Appx Reference in section	Corrected SFI reference (not an SFI change)	Updated Reference	
41	31	SFI Ref - Appx A - 4.4	Previous virement authorisations	Revised virement authorisations	Changed to reflect SFI update	Clarification of requirement	MO / Fin
42	32	SFI Ref - Appx A - 4.6	Previous business case authorisations	Revised business authorisations - set out in table 3 at 4.6.12	Changed to reflect SFI update	Clarification of requirement	MO / Fin
43	32	SFI Ref - Appx A - 7	Private patients, overseas visitors, income generating activities and other patient related services	Private patients, overseas visitors, income generating activities and all other patient and non patient related services	Corrected SFI reference 7.2.2 (not an SFI change)	Updated Reference	
44	32	SFI Ref - Appx A - 7	Chief Executive and Chief Financial Officer Responsible for setting prices of all NHS contracts	Chief Financial Officer Responsible for setting prices of all NHS contracts	Corrected SFI reference 7.2.5 (not an SFI change)	Updated Reference	
45	32	SFI Ref - Appx A - 7	Chief Executive and Chief Financial Officer Responsible for setting prices of all NHS contracts	Chief Financial Officer Responsible for setting prices of all NHS contracts	Corrected SFI reference 7.2.5 (not an SFI change)	Updated Reference	
46	32	SFI Ref - Appx A - 7	Chief Executive or Chief Financial Officer or Medical Director Responsible for authorisation of sponsorship deals for the Trust	Chief Executive or Chief Financial Officer Responsible for authorisation of sponsorship deals for the Trust	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	MO / Fin
47	33	SFI Ref - Appx A - 8	OJEU Limit £106,047	OJEU Limit £122,976	OJEU Limit £122,976 - applicable from 01/01/20	Updated Reference	
48	33	SFI Ref - Appx A - 8	Director of Procurement - waivering of quotations	Chief Financial Officer - waivering of quotations	Requirement as set out in table 4 of SFIs at 8.1.2	Change of Authorisation	MO / Fin
49	33	SFI Ref - Appx A - 8	Chief Executive or Chief Financial Officer or Chairman - waivering of formal tenders	Chief Executive and Chief Financial Officer - waivering of formal tenders	Corrected SFI reference 8.5.7 (not an SFI change)	Updated Reference	

No	Page	Section	From	To	Rationale	Category	Lead
50	33	SFI Ref - Appx A - 10	Associate Director and Director of Human Resources - granting additional increments to staff	Chief Financial Officer and Director of Human Resources - granting additional increments to staff	Change of authorisation limits for trust Executives and Committees - aligns with SFI 10.5.1 (c)	Change of Authorisation	MO / Fin
51	34	SFI Ref - Appx A - 10	Departmental Manager and Director of Human Resources or nominated officer - requests for upgrading or re-grading of staff	Chief Executive and Director of Human Resources - authorisation of re-grading of staff	Change of authorisation limits for trust Executives and Committees - aligns with SFI 10.3.1	Change of Authorisation	MO / Fin
52	34	SFI Ref - Appx A - 10	Requests for new posts to be authorised as car users		Removed as mileage is authorised via expenses / Easy system. There is no initial authorisation of car users.	Removed as outdated / not required	MO / Fin
53	34	SFI Ref - Appx A - 10	Requests for new posts to be authorised as mobile phone users	Requests for new posts to be authorised as requiring a Trust mobile phone	Removed as any phone costs claimed are authorised via expenses / Easy system. There is an approval process for issue of Trust mobile phones.	Clarification of requirement	MO / Fin
54	34	SFI Ref - Appx A - 10	Redundancy Payments > £10,000 - Nominations and Remuneration Committee	Redundancy Payments > £10,000 - Nominations and Remuneration Committee **and NHSI/E**	Required approval by NHSI/E clarified for redundancy payments	Clarification of requirement	JH
55	34	SFI Ref - Appx A - 10		Redundancy Payments to a Director - **NHSI/E**	Required approval by NHSI/E clarified for redundancy payments	Clarification of requirement	JH
56	35	SFI Ref - Appx A - 10	Directorate or Departmental Manager - authorisation of staff dismissal	Departmental Manager - authorisation of staff dismissal	As per the description added to definitions for Departmental Manager	Change of Authorisation	CS
57	35	SFI Ref - Appx A - 10.2	Chief Executive - engagement of staff not in establishment	Chief Executive **on recommendation of the Director of Human Resources and Chief Finance Officer**- engagement of staff not in establishment	Change of authorisation limits for trust Executives and Committees	Change of Authorisation	CS
58	35	SFI Ref - Appx A - 10.3	Approval to appoint where, exceptionally, the post is not on the agreed establishment, providing that the appointment is vital for the service and a source of recurrent funding has been identified and is available	Approval to appoint where, exceptionally, the post is not on the agreed establishment, providing that the appointment is vital for the service and a source of recurrent funding has been identified and is available. **The post must be established in the budget in accordance with the virement rules set out in SFIs at 4.4.6.**	Reflects requirement	Clarification of requirement	MO / Fin
59	36	SFI Ref - Appx A - 11	Non Pay Expenditure previous levels	Non Pay Levels to reflect SFI Limits shown in table 6 section 11.1.2	Inclusion of requisition limits to reflect Reaf Process / reduced limits and updated authorisation limits for Non PO spend as per table	Change of Authorisation	MO
60	37	SFI Ref - Appx A - 11	N.B. For approvals over £50,000 where Director of Finance, Chief Officer – Finance etc …	NB – Requisitions require authorisation of **all** of the above up to the financial limit	Simplifed Explanation	Clarification of requirement	MO / Fin
61	37	SFI Ref - Appx A - 11	Senior Assistant Technical Offficer (ATO) Procurement and **Stock Control or Procurement and Stock Control Technician**	Senior Assistant Technical Offficer (ATO) Procurement and **Senior Pharmacy Technician**	Reflects requirement for pharmacy orders up to £35k	Change of Authorisation	ST/MO

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62	37-38	SFI Ref - Appx A - 11	Removes previous authorisation levels for pharmacy orders	Lead Procurement Technician (Band 6) or Chief Clinical Information Technician (Band 7) or Pharmacy Supply Chain Manager (Band 7) or High Cost and Homecare Pharmacist (Band 8a) or Clinical Commissioning and Medicines Value Lead (Band 8b).	Reflects requirement for pharmacy orders up to £120k	Change of Authorisation	ST/MO
63	38	SFI Ref - Appx A - 11	Removes previous authorisation levels for pharmacy orders	Clinical Director of Pharmacy or Deputy / Principal Pharmacist (8c).	Reflects requirement for pharmacy orders up to £170k	Change of Authorisation	ST/MO
64	38	SFI Ref - Appx A - 11	Chief Financial Officer £100,001 to £500,000	Chief Financial Officer £170,001 to £250,000	Reflects updated requirement for Pharmacy Orders	Change of Authorisation	ST/MO
65	38	SFI Ref - Appx A - 11	Pharmacy Expenditure previous levels	Non Pay Levels £250,001 and abbove to reflect SFI Limits shown in table 6 section 11.1.2	Inclusion of requisition limits to reflect Reaf Process / reduced limits and updated authorisation limits for Non PO spend as per table	Change of Authorisation	MO / Fin
66	39	SFI Ref - Appx A - 11.7	Granting and terminating leases with expenditure of: £0-£100,000 CFO, £100,000+ CFO and CEO	Granting and terminating of leases where a legal document - Chief Executive or any Executive Director - where the document requires sealing - Any two Executive Directors	Reflects current practice for signture of property leases	Change of Authorisation	AM/NH
67	40	SFI Ref - Appx A - 15.1	Disposals and Condemnations - Head of Division		Removed as not an authorised signatory	Clarification of requirement	MO / Fin
68	42	SFI Ref - Appx A - 18		Charity Manager	Included as a signatory to reflect current practice	Clarification of requirement	SR
69	42&46	SFI Ref - Appx A - 19.4.4 and SO ref 5.2			Policy G16 Standards of Business Conduct	Updated Reference	NH
70	43	Policy HR15	**Clinical Director** - approval of Medical Staff leave of absence	**Clinical Director or Clinical Lead** - approval of Medical Staff leave of absence	Align with HR15	Updated Reference	CS
71	43	Policy HR52	Approval of emergency leave arrangements (up to 3 days). Any additional leave required above the 3 working days may be taken at manager's discretion	Approval of emergency leave **(in line with the categories as set out in HR52)** arrangements (up to 3 days). Any additional leave required above the 3 working days may be taken at manager's discretion	Align with HR52	Updated Reference	CS
72	43	Policy HR52	Approval of short term carer/domestic need up to 5 days (subject to payback)	Approval of short term carer/domestic need up to 5 days (**on a time owing basis,** subject to payback)	Align with HR52	Updated Reference	CS
73	44	Policy F14	Trust Removal Expenses Policy	F14 Trust Removal Expenses Policy		Updated Reference	
74	46	FOI responsible Officer		Director of IM&T		Updated Reference	NH

Trust Board

2019/20 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		3	8	5	10	14	4	9	6	11	8	5	11
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES													
Chief Executives Report	Chief Executive												
Patient Story	Chief Nurse												
Quality Assurance Committee Assurance Report	Associate Director of Corporate Governance												
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer												
Patient Safety Report	Chief Nurse		Q4			Q1			Q2			Q3	
Care Quality Commission Action Plan	Chief Nurse												
Revised Patient Care Improvement Strategy	Chief Nurse												
Bi Annual Nurse Staffing Assurance Report	Chief Nurse												
Quality Account	Chief Nurse												
Patient Experience Report	Chief Nurse			Q4			Q1			Q2			Q3
7 Day Services Board Assurance Report	Medical Director												
NHS Resolution Maternity Incentive Scheme	Chief Nurse												
Winter Plan	Chief Operating Officer												
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI												
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS													
Integrated Performance Report	Various												
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH													
Gender Pay Gap Report	Director of Human Resources												
Research and Development Update	Medical Director												
People Strategy Progress Report	Director of Human Resources												

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		3	8	5	10	14	4	9	6	11	8	5	11
Revalidation	Medical Director												
Workforce Disability Equality Report	Director of Human Resources												
Workforce Race Equality Standards Report	Director of Human Resources												
Staff Survey Report	Director of Human Resources												
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND													
Sustainability and Transformation Partnership Update	Director of Strategy			→									
ENSURE EFFICIENT USE OF RESOURCES													
Finance and Performance Committee Assurance Report	Associate Director of Corporate Governance												
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £3,000,001 and above	Director of Strategy												
IM&T Strategy Progress Report	Director of IM&T								→				
Going Concern	Chief Finance Officer												
Estates Strategy Progress Report	Director of Estates, Facilities & PFI												
Annual Plan 2020/21	Director of Strategy												
Financial Plan 2020/21	Chief Finance Officer												
Capital Programme 2020/21	Chief Finance Officer												
GOVERNANCE													
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance												
Professional Standards and Conduct Committee Assurance Report	Associate Director of Corporate Governance												
Audit Committee Assurance Report	Associate Director of Corporate Governance												
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3	
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3	
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance												
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance												
G6 Self-Certification	Chief Executive												
FT4 Self-Certification	Chief Executive												
Board Development Programme	Associate Director of Corporate Governance												
Integrated Business Plan	Director of Strategy												
Well-Led Review	Chief Executive												