Bundle Trust Board Public 1 August 2019

1 10:00 - Opening Business

Patient Story

1.1 10:20 - Welcome and Apologies

Apologies received from Rachel Credidio, Paul Hargreaves, Lisa Thomas

1.2 Declaration of Interests

Nick Marsden

1.3 Minutes of the previous meeting

Minutes attached from Public Trust Board meeting held on 4th July 2019
For approval
Nick Marsden

1.3 DRAFT Public Board mins 4 July 19.docx

1.4 Matters Arising and Action Log

Nick Marsden

1.4 Trust Board Part 1 (public meeting).xlsx

1.5 10:30 - Chairman's Business

Nick Marsden

1.6 10:35 - Chief Executive Report

Cara Charles-Barks
For information

1.6 CE Trust Board Report - August 2019.docx

1.6b CEO Briefing Appendix The future direction CCGs.docx

2 Assurance and Comittee Reports

2.1 10:45 - Clinical Governance Committee Report - 23rd July 2019

Paul Miller
Assurance

2.1 Clinical Governance Committee escalation paper 23rd July 2019.docx

2.2 10:50 - Finance and Performance Committee Report - 23rd July 2019

Paul Miller
Assurance

2.2 Finance and Performance Committee escalation paper 23rd July 2019.docx

2.3 10:55 - Audit Committee Report - 18th July 2019

Paul Kemp
Assurance

2.3 Audit Committee Escalation Report to Board - July 2019.pdf

2.4 11:00 - Workforce Committee Report - 25th July 2019

Michael von Bertele

2.4 Workforce escalation report - 25 July.pdf

2.5 11:05 - Integrated Performance Report

Lorna Wilkinson
Assurance

2.5 Integrated Performance Report 190801 IPR.docx

2.5 IPR August19 v2.pdf

3 Financial and Operational Performance

3.1 11:25 - Standing Financial Instructions

Mark Ellis
Approval

3.1 SFI review Jul19 cover sheet.docx

3.1 Appendix 1 - Standing Finacial Instructions Jul19.docx

3.1 Appendix 2 - Schemeofdelegation Jul19.docx

3.2 11:35 - Collaborative Procurement Approval

Mark Ellis
Approval

3.2 Cover sheet - FP Colloborative procurement.docx

3.2 Collaborative procurement.docx

4 Workforce

4.1 11:40 - Nursing Skill Mix Review

Lorna Wilkinson
Approval

4.1 Skill Mix Update cover sheet TRUST BOARD.docx

4.1 Skill mix paper August 2019 Final.docx

4.1 Appendix 1 - Policy Context.docx

4.1 Appendix 2 Calculating Care Hours per Patient Day.docx

4.1 Appendix 3 Ward Staffing Ratios.docx

4.1 Appendix 4 Midwives to Births Ratio.docx

4.2 11:50 - Guardian Safe Working Annual Report

Assurance
Presented by Paul Hargreaves

4.2 Guardian of Safe Working Annual Report 2019.docx

5 Governance

5.1 11:55 - Board Evaluation Process

Fiona McNeight
Approval

5.1 Board cover sheet Board Evaluation August 2019.docx

5.1 Appendix 1_Board Evaluation Tool - Template July 2019.docx

5.1 Appendix 2_ Good Governance Maturity-Matrix.pdf

5.2 12:05 - Register of Seals

Fiona McNeight
Approval

5.2 Register of Seals.docx

5.3 12:10 - Board Assurance Framework and Corporate Risk Register

Fiona McNeight
Approval

5.3 BAF cover sheet August 2019.docx

5.3 BAF v11.1 - for Board Committees.docx

5.3 Corporate Risk Register July 2019 v4.5.xlsx

5.3 CRR tracker v11.pdf

6 Approval

6.1 12:15 - Business Case for Insourced Weekend Endoscopy Lists

Andy Hyett
Approval

6.1 Endoscopy Board cover sheet Aug 19.docx

6.1 Business Case for insourced Weekend Endoscopy Lists v3.docx

7 Closing Business

7.1 Agreement of Principle Actions and Items for Escalation

Nick Marsden

7.2 Any Other Business

7.3 12:20 - Public Questions

7.4 12:25 - Date next meeting

Next public meeting - 5th September 2019

8 Resolution

Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted)

Salisbury NHS Foundation Trust

DRAFT

Minutes of the Public Trust Board meeting held at 09:30am on Thursday 4th July 2019 in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr Nick Marsden	Chairman
Ms Tania Baker	Non-Executive Director
Mr Paul Kemp	Non-Executive Director
Mr Paul Miller	Non-Executive Director
Mr M Von Bertele	Non-Executive Director
Mrs L Thomas	Director of Finance
Ms L Wilkinson	Director of Nursing
Dr Christine Blanshard	Medical Director and Deputy Chief Executive

In Attendance:

Fiona McNeight	Director of Corporate Governance
Kylie Nye	Corporate Governance Manager (minutes)
Esther Provins	Director of Transformation
Michelle Sadler	General Manager Facilities (item TB1 - 04/07/01)
Amanda Urch	Housekeeping and Portering Manager (item TB1 - 04/07/01)
John Mangan	Lead Governor
Dr Jennifer Lisle	Governor
Raymond Jack	Governor
Mark Wareham	UNISON Representative

ACTION

OPENING BUSINESS

TB1 - 04/07/01

Staff Story

J McGuiness introduced the Staff Story which focused on the Housekeeping team's efforts over the last year, with particular emphasis on how the team managed during the major incident in March 2018 onwards. A Urch, Housekeeping and Portering Manager and Michelle Sadler, General Manager Facilities attending the meeting to present.

Discussion:

- The Board noted that the department had recently won a Striving for Excellence Awards under the category 'Patient Centered and Safe' and thanked the team for going above and beyond during a challenging time.
- L Wilkinson explained that the team continue to face tough challenges, an example being the recent Norovirus outbreak, which meant enhanced cleaning regimes whilst also maintaining a business as usual service.
- C Blanshard noted that house-keeping staff regularly receive really positive feedback relating to their friendliness and willingness to help.
- N Marsden offered his thanks to the team and suggested that he and C Charles-Barks take some time to come and speak to the team to extend their thanks further.

TB1-04/07/02 **Apologies**

Apologies were received from:

- Cara Charles-Barks – Chief Executive
- Jane Reid – Non-Executive Director
- Rachel Credidio - Non-Executive Director
- Andy Hyett - Chief Operating Officer
- Paul Hargreaves – Director of People and OD (N Marsden noted that P Hargreaves was attending a meeting with the Health and Safety Executive team who were visiting the Trust as part of an inspection).

TB1-04/07/03 **Declarations of Interest**

Members of the Board were reminded that they have a duty to declare any impairment to being Fit and Proper and of good character as well as to avoid any conflict of interest and to declare any interests arising from the discussion.

No member present declared any such interest or impairment.

TB1 - 04/07/04 **Minutes of the Public Trust Board meeting held on 6th June 2019**

L Wilkinson noted that there were a few small amendments which she would pick up outside of the meeting.

Subject to the above amendments, the minutes were approved as a correct record of the meeting held on Thursday 6th June 2019.

TB1 - 04/07/05 **Matters Arising and Action Log**

N Marsden presented the action log and the following updates were discussed:

TB1 – 06/12/23 Clinical Strategy – C Blanshard noted that assistance was required from the communications team to develop a patient friendly Clinical Strategy document. J McGuinness to schedule time to review this with C Blanshard. **ACTION: CM/JMc**
P Miller suggested that our developing strategies should be communicated with the STP as they should complement each other. J McGuiness noted that she was attending a communication and engagement committee to ensure our message is aligned to the wider STP.

TB1 – 07/02/12 – Safer Staffing – A Board seminar is scheduled for 7 November. Item closed.

N Marsden noted that all other actions were included on the agenda or would come to a future meeting. There were no further matters arising**.**

TB1 - 04/07/06 **Chairman's Business**

N Marsden reported that the Long Term Plan (LTP) implementation framework had been released earlier in the week. N Marsden noted that the focus would be for Elizabeth O'Mahony, Regional Director, South West

NHS Improvement/NHS England, to drive and support organisations to work in parallel with each other. N Marsden noted that this work is ongoing but that SFT and other organisations will start to get direction from regional and national teams going forward.

TB1-04/07/07 **Chief Executive's Report**

C Blanshard presented her report and highlighted the following key points:

- The Trust continues to face challenges managing emergency pathways, achieving 88.1% for the 4 hour wait standard against a trajectory of 92.2%. The region and the Trust experienced a number of cases of Norovirus which impacted on patient flow which saw increased pressure on ED.

- The Trust reported two cases of C. Difficile cases during May. C Blanshard asked the Board to note that the way C. Difficile cases are reported is changing in line with new national guidance and will increase the number of Trust apportioned cases. Next month community onset healthcare associated cases will also be reported in the Trust's figures.

- The Armed Forces weekend held over 28-30 June was a real success. To mark the occasion there was a raising flag ceremony on the Green at the hospital, led by our armed forces champion. A 'real' field hospital was also located on the Green, which was a popular attraction at the weekend. C Blanshard noted that the hospital did not experience an increase in hospital attendances over the weekend, however, the Trust had experienced a very busy Monday after the weekend celebrations.

- The Trust's Striving for Excellence Awards ceremony took place on 13th June, providing the opportunity to recognise the contribution our staff make to the hospital. C Blanshard extended her congratulations to all the winners and to those nominated. C Blanshard explained that the staff awards for 2019/20 would be restructured, moving to a monthly award process which is more closely aligned with hospital values.

- The Trust is underway to ensure it is fully prepared for a potential flu season this winter. The staff vaccination campaign will officially begin on 30th September, with a launch event for all staff.

- The Health and Safety Executive are currently visiting the hospital to undertake an investigation focusing on manual handling, violence and aggression and management of asbestos. Feedback from this investigation will come in due course.

- The Trust has been honoured with two awards by CHKS. The Trust won most improved hospital and top hospitals award.

Discussion:

- P Miller asked if there was any update on the newly established Primary Care Networks (PCN) or if there had been any further

conversations with the Trust's STP partners. C Blanshard noted that the Primary Care Networks had formed and Clinical Directors had been appointed. The Trust is in the process of scheduling dates in the diary to link with these groups. C Blanshard further noted that a BaNES, Swindon, Wiltshire (BSW) Acute Alliance Review Workshop would be taking place with Nigel Edwards, CEO of Nuffield Trust on 17 July, to consider how the Trust's acute partners work collaboratively to ensure service provision. PM noted that as these partnerships evolve the Trust will need to enter these discussions with a strategic view.

ASSURANCE AND REPORTS OF COMMITTEES

TB1 - 04/07/08

Clinical Governance Committee Report – 14 May and 25 June

P Miller presented the report providing a summary of key aspects of the Clinical Governance Committee meeting on 14th May 2019:

- The provision of vascular services is still a concern and the Trust is currently seeking alternative arrangements to support new service models to ensure these services can continue to be provided at SFT. During this transition the current service provided is safe but could involve an unplanned patient transfer to another hospital in certain circumstances. In order to help resolve the issue the matter has been escalated to NHS England/ NHS Improvement.

- The committee received the Q4 Serious Incident report. The committee noted that progress on actions and inter-relationship with the risk register required further work.

- The committee received the Learning from Deaths Q4 report and noted that weekend HSMR is still statistically higher than expected. This relates to patients who are admitted over the weekend, not those who have passed away over the weekend. A full audit and investigation is underway and a report will be coming to September's meeting. Operational actions are being taken to address any potential patient safety risks.

- In relation to Non-Executive Director (NED) attendance at the Clinical Governance Committee it was explained that the Trust will be going out to advert for a new NED and in the interim M Von-Bertele will attend when available.

Discussion

- C Blanshard explained that the Interventional Radiology Vascular service provision continued to be a very important issue requiring fairly urgent resolution. The next step is for the NHS England Medical Director to meet with the Trust, University Hospital Southampton (UHS) and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) to work through the options and resolve the issue.
- P Miller queried if there were any other services in the Trust which could have similar risk in the near future. C Blanshard noted that there are a number of services whereby the Trust relies on

specialist staff from other hospitals to provide a full service, however most of these arrangements with partners work well. L Thomas suggested that governance processes required strengthening, particularly with commissioners and to ensure services are built for the population, not for the provider. T Baker noted that unless robust governance processes are adopted and reinforced by commissioners, this issue will continue to affect services that are provided across site.

TB1 – 04/07/09 **Finance & Performance Committee Report – 25 June 2019**

P Miller raised the key points discussed at the Finance and Performance Committee held on 25 June 2019:

- As a result of the increase in collaborative procurements with our Sustainability and Transformation Partners (STP) The Trust Board will be requested to consider delegating certain procurement decisions to the Finance and Performance Committee. A paper on this will be going to the Audit Committee. **ACTION: LT** **LT**

TB1 – 04/07/10 **Charitable Funds Committee – 20 June**

N Marsden raised the key points discussed at the Charitable Funds Committee held on 20 June 2019:

- The committee considered draft reports aimed at improving and supporting fund holders in ensuring appropriate governance and providing formal fundraising advice.

- Ongoing work will progress to look at the Charity's structures and processes, in particular how the Charity is governed and ensuring compliance with the Charity Commission.

- The committee approved three items, refurbishment of a DNA Laboratory, funding to introduce Endobronchial Ultrasound (EBUS) and Medical Thoracoscopy services to the Trust and a bid to refurbish a ward garden and day room to support improved patient experience and outcomes.

TB – 04/07/11 **Workforce Committee – 23 May 2019**

M Von-Bertele raised the key points discussed at the Workforce Committee held on 23 May 2019:

- The HSE inspection is currently underway (3/4 July) in relation to Manual Handling, Violence and Aggression and Management of Asbestos.

- Investment for an Employee Assistance Programme was not approved at TMC and some elements of the Health and Well-Being Strategy are currently at risk. The EAP will go back to TMC with further information of benefits to staff.

- The piece of work looking into concerns raised by the Hospital at

Night team regarding levels of junior doctor staff has been delayed due to long term sickness within the HR team. In the interim the concerns raised have been considered and any mitigating actions have been put in place.

Discussion:

- C Blanshard reported that a new toolkit had been released by the Royal College of Physicians looking at the number of practitioners across three levels, providing a useful way to calculate a safe level of staffing. Using this tool it is clear to see that SFT has a gap at tier 1 practitioner level (e.g. F1/F2 or Advanced Practitioner level). C Blanshard reported that work is ongoing and discussions have taken place with L Wilkinson to translate that gap. C Blanshard noted that additional junior doctor locum shifts had been added at weekends; however, explained that these were worked by the Trust's own staff and therefore this was not sustainable on a long term basis.
- P Miller queried if the reason for the delay in the in the report was due to lack of resources or due to staff. C Blanshard explained that the issue is trying to recruit an experienced interim replacement to cover long term sickness. L Wilkinson suggested that this issue be taken to the next Executive Director's meeting, looking at wider mitigation for this delay. **ACTION: PH**

PH

TB 1-04/07/12 **Integrated Performance Report**

C Blanshard presented the newly revised Integrated Performance Report (IPR) for May 2019 and highlighted the following keys points:

- K Humphrey, Associate Director of Strategy, had been working on the IPR over the last few months. The new layout has been introduced to clearly highlight themes of performance, quality, workforce and finance reports and seeks to set out interlinking issues and plans to move forward. The structure of the report is aligned with the Trust's strategic priorities and their related assessment frameworks. C Blanshard noted that a large amount of work had been done to improve the report and that feedback was welcome from the Board.

- ED 4 hour wait performance fell to 88.8% in May 2019. There were bed closures due to an increase in Norovirus cases, which affected patient flow. Workforce planning and a focus on the Patient Flow Programme remain key areas to drive improvement.

- Work is ongoing to increase the number of discharges earlier in the day using the SAFER (**S**enior review, **A**ll patients, **F**low, **E**arly discharge, **R**eview) care bundle.

- The Trust continues to meet the Referral to Treatment (RTT) 92% target. However, the Trust failed to deliver the diagnostic waiting time standard with the key driver of this being challenges in Endoscopy capacity. This has also had an impact on cancer wait times, although 6 of the 8 cancer standards were met during May.

- Agency spend has increased by £27k in month to £411k with the largest increase in Consultant Medical Staff. Sickness is over the 3% target in month with the rolling year at 3.45%. Short term sickness has decreased whilst long term has increased.

- All but 1 Stroke patient received a CT scan within 12 hours (96%). However, time to reach the Stroke unit within 4 hours decreased to 64% with delays largely due to first and specialty doctor assessment in ED. AH noted that patients that are not treated on Farley Ward are treated appropriately.

Discussion:

- P Kemp advised that the new SPC (Statistical Process Control) Charts were clear and effective. However, P Kemp noted that the graphics on the Summary Performance page were not very informative in relation to performance and suggested the page should have milestone measurements to provide context. L Wilkinson noted her support for the info-graphics as a front-facing information page for the public but agreed with P Kemp that it didn't provide any context in relation to benchmarking information. M Von-Bertele noted his support and advised that whilst there was further work to be done the report was a very good starting point.
- L Wilkinson reported that in May there were two cases of hospital onset healthcare associated C Difficile cases. From June onwards community onset associated cases will be reported in this Board report in line with the new national guidance and this will increase the number of Trust apportioned cases. L Wilkinson reminded the Board that the Trust's annual C Difficile target has been reduced from 18 in 2018/19 to 9 in 2019/20. Whilst definitions for reporting have broadened to patients who have community on-set C-Difficile this also includes all cases up to 4 weeks post discharge. This has been raised with NHSI due to the potential reputational and financial implications. A formal response is awaited. T Baker asked if there was any benchmarking data. L Wilkinson noted that once Q1 figures are released the Trust will be able to review where we sit in relation to other Trusts.
- P Miller queried the change in relation to reporting pressure ulcers. L Wilkinson confirmed that the number of category 2 pressure ulcers reported had also increased due to the change in national reporting. The new guidelines mean that pressure ulcers must be identified at the first skin inspection. The Trust's first nursing assessment documentation is recorded within 6 hours.
- T Baker noted her support for the newly revised IPR but noted that there needed to be a focus on outcome data. L Thomas agreed and suggested that there should be more of a focus on the actions and outcomes. It was agreed that any further comments on the IPR would be sent to K Humphrey.

GOVERNANCE

TB1 – 04/07/13 **Annual Review of Directors Interests**

F McNeight presented the Register of Members' Interests for the Board to note. F McNeight noted that as part of the annual governance cycle the

Register of Interests is received by the Trust Board.

Following a recent revision of the Conflicts of Interest Policy, going forward the Corporate Governance Department will collate and monitor a definitive list of those required to complete an annual Conflict of Interest Declaration. On an annual basis this will include all band 8d and above or equivalent staff. Those members of staff will be sent a Register of Interests Declaration form to complete. Following this annual review of Declarations of Interests, T Baker as the Senior Independent Director and F McNeight will review any positive declaration and document the agreed outcome.

QUALITY AND RISK

TB1 - 04/07/14 **Patient Experience Report Q4/Annual Report**

L Wilkinson presented the report providing the Board with a summary of activity for Q4, 2018/19. The following key points were highlighted:

- Compliance with agreed timescales continues to be challenging but has improved since the last quarter. A quarterly PALS/Clinical Risk meeting with all the directorates is being considered and will be a useful way to share learning.
- The complaint Handling Policy has been re-written and a new way of RAG rating complaints based on their complexity. This will mean complaints are fully investigated and responded to in a more appropriate timescale that is negotiated with the complainant.
- Complaints have shown a slight reduction over time and complaint response timescales for responses going beyond 25 working days has improved slightly in Q4. Further work is required in directorates to improve agreed response timescales.

Discussion:

- N Marsden noted that the report captured a large amount of work and suggested it would be useful to have more time to work through the report as a Board. N Marsden suggested K Glaister come to present the next report. **ACTION: LW/KG** **LW/KG**

FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 - 04/07/15 **Draft Operating Plan 2019/20**

L Thomas presented the report asking the Board to note the 2019/20 Operating Plan summary document which will be published on the Trust's website. L Thomas noted that the Operating Plan submission was approved at April's Trust Board meeting.

Discussion:

- P Kemp queried the tables highlighting the Trust's 5 key priorities as there were no titles to explain the context. J McGuinness noted that the titles would be added. It was further noted that the online document will be interactive.
- LW asked for the photo on p.4 to be replaced. J McGuinness advised this would be done and asked for all Board members to feedback on the document as soon as possible prior to publication

on the website.

STRATEGY AND DEVELOPMENT

TB1 - 04/07/16 **Interim NHS People Plan**

N Marsden noted that this item would be discussed in the private, part 2 Trust Board meeting.

TB1 - 04/07/17 **Estates Strategy**

N Marsden noted that the amendments to the Estates Strategy had been discussed in detail at June's F&P meeting.

Decision:
The Board approved the amendments that had been made to the Estates Strategy in line with Trust feedback.

CLOSING BUSINESS

TB1 - 04/07/18 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted that the key items discussed were:

- The risks relating to Hub and Spoke service models.
- The actions arising from the LTP implementation framework.
- The actions the Trust will need to take regarding the changes in the way we report certain aspects of quality, e.g. C Difficile and pressure ulcers.

TB1 - 04/07/19 **Any Other Business**

There was no other business.

TB1 - 04/07/20 **Public Questions**

R Jack noted that in relation to medical cover over the weekend, he had spoken to two people who had been inpatients over a Bank Holiday weekend. They had made him aware that the arrangements for medical staffing cover on the bank holiday Friday and Monday were not sufficient. C Blanshard explained that medical staff on Bank Holidays are rostered similarly to the weekend staffing plan. This does mean there is a lower level of staffing available than there would be on a normal week day. R Jack asked if this level of lower staffing across a four day Bank Holiday weekend is satisfactory. C Blanshard explained that Bank Holiday staffing cover has not been previously raised as a patient safety issue; However, it has been noted that from a patient experience perspective therapy input on these days is reduced.

R Jack queried if a patient is admitted on a Friday Bank Holiday will they be waiting to see a consultant until the following Monday or Tuesday, depending on the weekend. C Blanshard confirmed that there were consultant ward rounds at the weekend and on Bank Holidays. J McGuinness noted that there was an opportunity to better manage patient

expectations, particularly if they are going to be staying over the weekend. C Blanshard agreed and noted this is not solely a consultant's responsibility; all staff should be responsible to communicate to patients.

J Lisle raised a concern regarding an outpatient clinic which she had recently attended. It was noted that the allocated time for appointments was inaccurate as at one point there were 17 people in the waiting room. J Lisle asked if there was any way this could be rectified. C Blanshard explained that appointment slots are allocated internally by the booking team but would take this query and respond to J Lisle outside of the meeting.

TB1 - 04/07/21 **Date of Next Meeting**

Thursday 1st August 2019, 10:00 am, The Board Room, Salisbury District Hospital

TB1 - 04/07/22 **ITEMS FOR INFORMATION**

There were no further items for information.

TB1 - 04/07/23 **RESOLUTION**

Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Trust Board Part 1 (Public) Action log

Deadline passed. Completed Status = N	1
Deadline in future. Current progress made is updated. Completed status = 'N'	2
Completed status = 'Y'	3
Deadline in future. Current progress made is not updated	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
06 December 2018						
TB1-06/12/23 - Clinical Strategy **TB1 – 23/05/04**	Patient facing version of the document to be produced which also details the patient engagement and participation approach	CB	~~31/03/2019~~ ~~04/07/2019~~ 01/08/2019	Met with JM on 28/12/18 to discuss comms and engagement approach. No comments received. Comms team to undertake stakeholder mapping and developing an engagement strategy No update re patient engagement - meetings happening with GPs and CCGs CB noted that help from the comms team is required. CCB ill pick this up with JMc. 04/07 - J McGuinness to schedule time to review this with C Blanshard.	N	2
07 February 2019						
0702/12 - Doctor Safer Staffing Toolkit **TB1 - 06/06/06**	C Blanshard, the clinical director for medicine and head of medical workforce will consider the new doctor safe staffing toolkit and will look to bring a future report to Board via the Workforce Committee	CB	~~06/06/2019~~ 01/08/2019	Workforce agenda - 23rd May Trust Board - June Update: The action relates to doctor staffing and will come back to August's Board.	N	2
4-Apr-19						

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 - 04/04/04 - mortality rates	A paper will come to a future Board meeting following a detailed piece of work into weekend mortality rates.	CB	8/1/2019	C Blanshard noted that work is ongoing to look into the upward trend, however, clarified that the mortality rate isn't higher at the weekend; the indicator refers to the higher mortality rate of those admitted over the weekend. August's Board.	N	4
TB1 - 04/04/15 - Exit Interviews	PH to write to all staff who have left in a 6 month period to investigate reasons for leaving. This will feed back to Workforce Committee	PH	9/26/2019		N	4
6-Jun-19						
TB 1- 06/06/10 - LoS/ Model Hospital	AH to check with Model Hospital Team if clinicians can monitor their own individual performance in relation to LoS.	AH	7/4/2019		N	4
TB1 - 06/06/11 - Recruitment and retention of medical staff	Feedback required to F&P from the Workforce Committee to provide assurance that actions to recruit and retain medical staff are ongoing.	PH	9/3/2019	This will be pick up via the workforce committee	Y	3
4-Jul-19						
TB1 - 04/07/09 -Collaborative Procurement/ Delegated authority to F&P	As a result of the increase in collaborative procurements with our Sustainability and Transformation Partners (STP) The Trust Board will be requested to consider delegating certain procurement decisions to the Finance and Performance Committee. A paper on this will be going to the Audit Committee	LT	7/23/2019	Paper to Board on 1st August - on agenda	N	1
TB1 - 04/07/14 Patient Experience Report Q4/Annual Report	N Marsden noted that the report captured a large amount of work and suggested it would be useful to have more time to work through the report as a Board. N Marsden suggested K Glaister come to present the next report.	LW	9/3/2019		N	4

Report to:	Trust Board	**Agenda item:**	**1.6**
Date of Meeting:	1 August 2019		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	Yes			
Prepared by:	Cara Charles-Barks, Chief Executive			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	Appendix 1: Future direction of CCGs Consultation			

Recommendation:
That the Trust Board notes the content of this report

Executive Summary:

This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers:
 	
• **Performance –** update on current performance
• **Finance –** update on our financial recovery plan
• **Workforce –** update on workforce situation
• **Health and Safety Inspection**
• **Learning and sharing best practice**
  ○ Visit to West Suffolk Hospital and West Suffolk Alliance
• **Armed Forces weekend**
• **Simulation Suite**
• **Staff BBQ**
• **STP Update**
  ○ Future Direction of CCG's Consultation
  ○ Recruitment of STP Chair
  ○ Acute Alliance Workshop
  ○ BSW partnership workshop
  ○ Jerry Wickham

Performance

It has continued to be a busy period for the hospital and we continue to face challenges in managing our emergency pathways as a result. We achieved 91.82% for the 4 hour wait standard against a trajectory of 92.4%, an improvement on the previous month. Staff are working hard to improve patient flow across the hospital, and a new initiative focused on improving this, 'Ready, Steady, Go' was launched in July.

It is essential that we continue to provide good quality, safe care and we have had no cases of MRSA. We did have one case of C.difficile cases during June and changes in reporting of C difficile cases in line with national guidance has shown an increase in the number of Trust apportioned cases for Q1, due to the inclusion of community onset healthcare associated cases in our figures.

Finance

The Trust met its control total in June 2019, reporting a deficit of £0.6m. Although still in deficit, because the Trust's year to date performance is in line with that planned, we will receive a further £1m Provider in Sustainability Funding and Financial Recovery Funding for the first quarter of the year. Consistent levels of operational productivity has continued to be a challenge in the final month of the quarter, with increases in planned procedures offset by reductions in outpatient attendances.

As we move into the second quarter of the year planned savings delivery through our transformation programmes will remain an areas of focus, along with maximising our theatre capacity, and maintaining patient flow through the hospital. Another key work stream will be to reduce the dependence on additional ad hoc clinical sessions in order to increase our operational resilience.

Workforce

Recruitment remains an ongoing challenge and we continue to use overseas pipelines for qualified nurses, which has been very successful. Ten international nurses arrived in June and a further 17 are expected during July. The recruitment and retention strategy is going to Workforce Committee this month, and it is encouraging to see that we have slowed the numbers of nurses leaving the Trust, reducing the number of vacancies.

The Trust's overall sickness absence rate is 3.73%, which above the 3% target. This is a slight increase on last month's figure of 3.19%, with long and short term sickness both increasing during June. We continue to focus on specific "hot spot" areas to proactively manage sickness absence, with the aim of reducing it back below target to a sustainable level.

Health and safety inspection

Recently the Health and Safety Executive (HSE) conducted an inspection of our hospital. They looked at ED, AMU, Maternity, Orthopaedics, Spinal, Theatres and Elderly Care Departments and met with Directors, Senior Managers, Department Managers, Ward staff and employee representatives. I was delighted that the feedback from the HSE has been positive, with a couple of highlighted areas for improvement.

The assessment given by HSE is that the Trust is sufficiently controlling the risks arising from violence and aggression and musculoskeletal disorders. However, we need to do a bit more to manage asbestos, a legacy of our history and having WWII buildings. I should emphasise that the asbestos present in our building poses no risk to our patients, volunteers and staff: asbestos is harmless unless it is disturbed and the points that the HSE inspectors raised were regarding our

documentation.

I would like to thank all staff for their support during the inspection process. The HSE inspection team commented how welcoming staff were during the inspection. Being friendly is one of Trust's core values and it is terrific to hear visitors single it out as a point of praise.

Learning and sharing best practice

To help us to achieve our ambition of being 'outstanding everytime' it's important we take the time to learn from, and to share experience and best practice, with other organisations. Together with a small team from our hospital I recently visited West Sussex Hospitals, a CQC outstanding rated hospital with a similar rural geographical catchment to us. West Suffolk Hospitals generously shared their system quality journey experience and the digital lessons they have learnt in becoming a digital exemplar. Learning from each other is so important.

Armed Forces weekend

The recent Armed Forces weekend was an operational success. This was due to months of careful planning and thanks to the members of staff who worked during that weekend.

Just as successful was the 'real' field hospital that took place on the Trust Green on Sunday. Led by members of 243 (The Wessex) Field Hospital, the event allowed visitors to see how Armed Forces medics treat their patients under battlefield conditions. The military unit were particularly grateful to our catering and security teams for all their help and support.

Simulation Suite opening

I was delighted to officially re-open our newly refurbished Simulation Suite in July, funding for which was provided by Health Education England.

Using leading-edge audio and visual technology the suite provides an immersive training experience, so that hospital staff can train and practice different clinical scenarios under real-life conditions, in a completely safe environment. The Suite also contains a viewing gallery, so that staff not actively participating in the training can still learn from the demonstration, and a debriefing room with a video screen for staff to watch recordings of their training to discuss and learn from.

With these new and improved facilities, we are able to host regional training events for other hospitals and allied health providers within the local area.

Staff BBQ

On Monday 8 July we held our annual staff summer BBQ – our chance to say thank you to staff for all of their hard work throughout the year. The turnout from staff was great; large numbers of staff were able to take some time out of their busy day to enjoy a hotdog with colleagues in the lovely setting of Horatio's Garden. I would like to personally thank Horatio's Garden for supporting this. Thank you also to our catering team who made the event possible, serving almost 900 hotdogs to our staff. And lastly thank you to our Governors who staffed our cake stands, providing cakes to those staff who were unable to leave their wards or departments to attend the BBQ.

STP Update

Future Direction of CCG's Consultation

Bath and North East Somerset, Swindon and Wiltshire CCG's are currently working cooperatively as an 'alliance'. They have recently opened a consultation (Appendix 1) to progress to formal

merger. Formal merger is pending the approval of GP practices of which a majority above 50% of voting members is required. Following approval by GP members a formal application for merger will be made to NHSE in September 2019. If the merger is supported the new organisational format will commence from April 2020. The newly formed BSW CCG will serve a population of 900+k with a budget of £1.1 billion.

Recruitment of STP Chair
Recruitment is currently underway for a Chair for BSW STP following the resignation of Councillor Jerry Wickham 3 months ago for health reasons. It is expected that a new Chair will be in place by no later than Quarter 4 of this financial year.

Acute Alliance Workshop
A number of the board recently participated in a join workshop with counterparts from Great Western Hospital and Royal United Hospital Bath. The workshop was facilitated by Nigel Edwards from the Nuffield Trust to explore opportunities through which the three acute hospitals can work more closely together in order to support improving service provision across our communities. A formal report from Nigel Edwards will follow next month. Three key areas of work were agreed and these are now being developed into programs, these include

- Models of working together – specifically looking at virtual clinical teams
- Supporting sustainability – elective flow and capacity and demand modelling
- Enabling / building blocks – digital agenda

BSW Partnership Workshop
A number of the board members will be attending a workshop on the 8th and 9th August to support the development of the BSW operating plan. Further discussion regarding the contribution of Salisbury NHS Foundation Trust will be the focus in today's private session of the board.

Jerry Wickham
I wish to inform the board sadly that Councillor Jerry Wickham has recently passed away. Jerry has been a huge support for the trust in his role as lead for adult social services and more recently as STP chair. He always made a passionate contribution for improving services and will be sadly missed by many of those who worked with him.

Cara Charles-Barks
Chief Executive

The future direction

for Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Groups

Stakeholder briefing

July 2019

Working Together:
NHS Bath and North East Somerset Clinical Commissioning Group
NHS Swindon Clinical Commissioning Group
NHS Wiltshire Clinical Commissioning Group

Introduction

We are proposing to change the way NHS commissioning is arranged in Bath and North East Somerset, Swindon and Wiltshire.

Commissioning is about finding the most effective and efficient way of using all available resources to improve health outcomes for the local population. This involves planning, buying and monitoring local NHS services.

NHS Clinical Commissioning Groups (CCGs) are governed by members of local GP practices, and it is their clinical expertise and patient insight that helps CCGs to ensure health services are the best they can be. But GPs are not doing this alone. CCGs work with a team of healthcare professionals and patient representatives to plan and deliver services.

Bath and North East Somerset (BaNES), Swindon and Wiltshire CCGs are currently three separate statutory bodies, each with its own separate Governing Body (Board). This document sets out the rationale for moving from three organisations to one single CCG from 1 April 2020 and how you can share your views on our plans.

Background

BaNES, Swindon and Wiltshire CCGs serve a combined population of more than 934,000 people, and have a collective membership of 94 GP practices. They are responsible for a total combined annual budget of £1.1 billion. All three areas have areas of affluence and areas of significant deprivation.

The three CCGs have a history of working together effectively to deliver high quality care and to reduce inequalities for local people. In the past year, the organisations have increased partnership working by, for example, establishing a single Chief Executive and a single executive management structure to provide more consistent leadership and direction to staff. We have also begun to develop streamlined governance and decision-making processes and agreed shared system-wide priorities.

The NHS Long Term Plan

In January 2019, the NHS Long Term Plan was published and describes an ambitious programme of improvement for the next decade. It sets out the expectation that Integrated Care Systems will grow out of the existing Sustainability and Transformation Partnerships (STPs). Integrated Care Systems are when provider and commissioning organisations work together in a shared way; sharing budgets, staff and resources to best meet people's needs. Greater Manchester is an example of an Integrated Care System that is beginning to work in this way and has one health plan which is integrated into broader plans for economic development and growth.

For CCGs, there is an expectation that, by April 2021, every Integrated Care System will have more streamlined commissioning arrangements. For BaNES, Swindon and Wiltshire CCGs, this will involve moving from three separate CCGs to a leaner, more strategic single CCG for our combined system.

We need to maintain our focus on local needs within a neighbourhood or locality and Primary Care Networks (PCNs) have been set up to do this. From June 2019 there are 21 PCNs across Bath and North East Somerset, Swindon and Wiltshire consisting of groups of GP practices that will work together with a range of local providers, social care and the voluntary sector. They will focus on delivering more personalised, coordinated health and social care to meet the needs of their particular locality. All PCNs will belong to one of three Integrated Care Alliances or Providers. These will serve wider populations living within the geographical areas that reflect the local authority boundaries of Bath and North East Somerset, Swindon and Wiltshire.

Why do we want to make changes to our commissioning arrangements?

The NHS Long Term Plan makes it very clear that a single CCG should be created across Bath and North East Somerset, Swindon and Wiltshire and there are several advantages associated with merging:

Benefits for patients:

- A single, commissioning organisation would mean we can improve the quality and safety of services and treatments. Together we can reduce variation in care for people and standardise best practice approaches so everyone receives high quality treatment, regardless of where they live.

An example of where joint working is already benefitting patients is the integrated urgent care services contract that has been in place since May 2018. The provider, Medvivo, provides services across Bath and North East Somerset, Swindon and Wiltshire including GP out-of-hours, a single point of access, crisis response services and a wide range technology enabled care solutions. Separately the three CCGs would not have been able to fund these services and a clinical hub that means there are experienced health professionals available for anyone who calls NHS111 who can make clinical assessments, advise and arrange urgent care if required.

- This change would complement emerging developments within the NHS arrangements around us, in particular the Integrated Care System and Primary Care Networks. It would mean we have the right structure so health and care partners across the system can work more effectively and efficiently together to align our priorities around reducing health inequalities, supporting people to stay well and tackling the causes of illness.
- A merger also helps us to meet financial challenges. For example, there is the potential for cost savings through economies of scale and the streamlining of governance and administration processes, which mean we can invest more of our budget into frontline services or transformational projects.
- The proposal for a single B&NES, Swindon and Wiltshire CCG coincides with a drive to improve our engagement with local people, clinicians, partners and others across our three localities. We already have in place arrangements to engage everyone in the development of our commissioning plans and have begun to work together more closely on engagement activity such as our maternity transformation and Our Health and Future. Our proposed change is an opportunity to create a new communications and engagement strategy that builds on existing good practice and helps more people to get involved with our work at a local and system-wide level.

Benefits for partners:

- As one organisation, we can provide a single, coherent and consistent vision and voice to partners to focus ideas, energies and resources on achieving high quality outcomes across the system.
- Although commissioning would move towards a larger geographical footprint, there are well-developed local partnerships in place. For example, with our local authorities, primary care, mental health and community services and third sector, which we value greatly. Through our merger, we will continue to maintain these existing partnerships and also improve our integration with local councils. As one organisation, we can also build mutually-beneficial relationships across the wider health and care system.
- Operating at-scale, we can strategically commission services, and make it easier for our providers to deliver better value.

This would also mean designing more innovative contracts which will give providers more flexibility and scope while reducing the bureaucracy and inefficiency associated with multiple separate contracts.

Benefits for our staff:

- Working together as one CCG would generate economies of scale and reduce duplication, creating opportunities for staff to use their skills across a wider organisation, to work in new areas of work to support their own career development while also freeing up capacity. It presents us with a better opportunity to attract, afford and retain staff with the right talent and skills.
- The move to establish one organisation by April 2020, rather than waiting until the following year, reduces the uncertainty for staff, associated with potential incremental changes.
- A merged organisation would mean shared resources, expertise and learning, leading to a more effective and agile workforce.

Further financial benefits:

The NHS Long Term Plan asks us to make 20 per cent savings on our management costs. Coming together as a single CCG allows us to achieve that saving more easily than as three organisations.

What happens next?

The three CCG Governing Bodies recently approved the decision to pursue the creation of a single CCG with one Governing Body and one set of statutory duties for Bath and North East Somerset, Swindon and Wiltshire by 1 April 2020. Throughout July and August, we will be writing out to and/or meeting all our stakeholders and gathering their views on our plans.

All feedback will then be considered by the three Governing Bodies and our collective GP membership will be invited to vote on a final decision to apply for merger in mid-September. With their support, we will then formally apply to NHS England to make a final decision regarding the future of BaNES, Swindon and Wiltshire CCGs later this year.

How to respond

Please email bsw.mergerfeedback@nhs.net by 4 September 2019. Alternatively, you can write to BSW CCGs Merger, c/o Transition Programme Director, Kempthorne House, St Martin's Hospital, Clara Cross Lane, Bath BA2 5RP or call 03333 219464.

CLASSIFICATION:

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.1
Date of Meeting:	1st August 2019		

Committee Name:	Clinical Governance Committee		**Committee Meeting Date:**	23rd July 2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Clinical Governance Committee meeting of the 23rd July 2019.

Items for Escalation to Board
Maternity Services CNST sign off report – NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The scheme is based around demonstration of the achievement of ten safety actions. If this can be evidenced, and signed off by the relevant Trust Board, then that Trust is in line to recover some of their CNST payment. The Committee received this evidence and was content to recommend to the Trust Board that the Trust had effectively achieved all ten safety actions. **Weekend HMSR and wider "out of hours service" assurance** – The Committee noted that the requested case record audit of weekend admissions, to support better understanding of the increase in weekend HMSR, was on track to be received at the next meeting on the 24th September 2019. However given the number of other possibly related issues around the "out of hours services" i.e. weekend and evening working ,it was agreed that a separate more wide ranging report would also be brought to the September committee meeting. This separate report would aim to triangulate a number of issues arising from safer working, pharmacy cover, the HSMT audit outcome and any other relevant issues. **Board Assurance Framework (BAF) and Risk Register** – The Committee received these documents and following a detailed discussion, the Company Secretary was provided with a risk narrative that covered the key issues of concern to the Committee.

Gastroenterology Service Review and plan for Service sustainability – The Committee received this report and gained assurance that the recently outsourced gastroenterology additional capacity was being appropriately monitored and managed. However the Committee also noted that the Trust still did not have a long term solution to the sustainability of this key service and further work, both inside the Trust and with outside partners, was urgently required.

Trusts Clinical Strategy – Finally it was agreed that the Committee would take on the role of reviewing the Trusts Clinical Strategy and this would take place in the Autumn of 2019.

CLASSIFICATION:

Report to:	Trust Board	**Agenda item:**	2.2
Date of Meeting:	1st August 2019		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	23rd July 2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance Committee meeting of the 23rd July 2019.

Items for Escalation to Board
Operational Performance 2019/20 – The Committee discussed a range of operational performance issues, by in particular diagnostics i.e. radiology and pathology. The year to date performance is 97.9% against a target of 99%, but of more concern were the number of staffing and capacity issues that were still to be resolved. Therefore there is a possibility that the Trust Board may be required to discuss balancing the additional cost of further out-sourced capacity, against the possible non-achievement of the 99% diagnostic target. **Financial Performance 2019/20** – The Trust has undertaken its first quarter financial outturn forecast. The result being despite a wide range of financial risks totaling circa £4m, the Trust is still forecasting achievement of its control total deficit of £8.9m. However key to the achievement of this financial outturn would be (a) achieving the Trusts Cost Improvement Programme and (b) successfully managing Winter pressures. With regard to the latter the Trusts Winter Plan would come to the Committee at its meeting on the 21st October 2019. Fnally the Trust Board would discuss a range of supporting operational, contracting and financial issues on the 5th September 2019. **Transformation Programme update** – The Committee discussed this report and concluded that the short term in-year transformation programme, to support the achievement of the 2019/20 financial control total, was behind plan and there was an urgent need to catch up. Just as importantly the medium/long term transformation programme for 2020/21 and beyond was judged to be in need of additional support. To this end a

discussion will take place in September 2019 with the Trust Board to determine the best way of supporting this medium/long term change.

Business Case for insourced Weekend Endoscopy lists – The Committee received a business case to provide additional endoscopy activity on the weekend to reduce the current backlog of services to an acceptable level. The Cost of the business case was in excess of £600,000 but so was the income. Following a detailed discussion the Committee agreed to recommend this business case to the Trust Board at its meeting on the 1st August 2019 for approval.

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	
Date of Meeting:	1st August 2019		

Report Title:	Escalation Report from Audit Committee Held on 18th July			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		X		
Prepared by:	Paul Kemp			
Executive Sponsor (presenting):	Paul Kemp			
Appendices (list if applicable):				

Recommendation:
To note the report and consider any actions necessarily arising from it

Executive Summary:
A number of items were discussed, as detailed below. However, the most significant of these was an initial management response to the IT Penetration Test, carried out in February, delivered to the Trust IT team in March, but only visible to Executive management in the last week. Given the nature of the issues raised and the relatively short period for which the Executive have had sight of this matter, little tangible was available for discussion at Audit Committee and the committee felt that this was too urgent a matter to wait for next Audit Committee in September. This matter was already likely to have required discussion at the main Board at some point, but it is recommended that it is included on the agenda on the 1st August to allow the Executive an opportunity to provide the Board with details of their plans and timings for resolution of the various issues raised by this matter. The Committee also reviewed proposed changes in the Trust's Standing Financial Instructions. The majority of the changes related to the updating of delegated authority, including implemented the Board's wish that some Board authority for sign off of business cases and contracts should be delegated to the Finance and Performance Committee. The Committee were happy with the proposals made and recommend them to the Board for enactment

Meeting of the Audit Committee on 18th July 2019

1. IT Penetration Test

The Audit Committee had asked, as part of the actions from a previous internal audit, that the outcomes from the planned penetration test be brought to the committee, when available. When the report appeared in the papers for this meeting, immediate and significant concerns were raised by the Audit Committee Chair and discussed with the Executive Director responsible for IT, the Transformation Director. These concerns were quickly further escalated to the Chief Executive and picked up by the full Executive team.

The concerns were broadly in two areas;

a. The test identified 7 critical and 7 high risk areas, which indicates material issues with the security of the Trust's IT infrastructure.
b. The report had been received by IT management in March, but not escalated to the Executive team or the Board until appearing in these papers (mid July). Given the serious issues raised by the report, this appears to have been a potentially worrying breakdown in management control and escalation procedures.

The Transformation Director attended at the meeting and reported the following;

a. The Executive Team accept the findings of the external consultant, but do not accept the proposed action plan from the IT management team, citing concerns that the actions were neither comprehensive nor planned to be delivered at a required pace.
b. An executive led task and finish group had been established to ensure an appropriate set of management actions were identified and delivered in a timely manner. The action plan would be finalised by 26th July.
c. In response to the issues around lack of appropriate escalation of issues, the IT department has been placed in an 'intensive support process', whereby several executive team members will focus on providing appropriate governance and support to IT management. The criteria for the IT management team to successfully exit from these intensive support measures have not yet been established, but will be finalised by 26th July.
d. A challenge was made as to how the assurance given to the SFT Board in May regarding data protection could be valid, in light of these insights into multiple weaknesses in cyber security. The Transformation Director answered that the methodology used to report full compliance on data protection to the Trust Board in May only required, for example, that a penetration test had been conducted (not that penetration protection measures were adequate). The Committee expressed considerable concern at this approach to providing assurance to the Board.

The committee accepted that the Executive needed further time to complete their review and action planning for this matter, but felt that the concerns identified were sufficiently serious to ask that a further report should be made to the main Trust Board meeting on the 1st August, by which time plans for both security process fixes and the criteria for completion of the intensive management support exercise will have been completed.

2. Financial Accounts Deep Dive

   Partially as a response to the high risk rated internal audit report from March, the Financial Controller was invited to present to the Committee on controls and processes within the Financial Accounts department, with an emphasis as to how issues identified during the audit were being addressed.

   The presentation led to a useful discussion, with the Committee endorsing the direction adopted by management.

3. Procurement Fraud Review Submission

   As the first part of a national exercise initiated by the NHS Counter Fraud Authority, the Procurement team provided a response to a questionnaire on procurement processes.

   The responses to the questionnaire led to discussion on two topics;

   a. There were 8 contracts identified of value more than £100k each that were disaggregated in how they were processed. That is to say a number of smaller contracts were laid that avoided the established controls requiring tendering or higher level approval requirements. Whilst none of these instances engendered particular concern, the Head of Procurement committed to review the processes involved to see whether further improvements were needed.
   b. The degree of purchases made that were is scope to require a purchase order, but were completed outside of the purchase order system was unexpectedly high. In total during the period examined, £62m of qualifying expenditure was made, of which 34% was made without a purchase order being placed. It was agreed that, whilst some types of purchases were naturally of a type that did not lend themselves to purchase orders, 34% was far too high and further investigation into this would be carried out with processes adjusted if found necessary.

   The NHSCFA exercise continues through this financial year and a further update will come to Audit Committee in March 2020.

4. Other Matters

   Reports were also received from Internal Audit, External Audit and the Local Counter Fraud Officer.

   Of note in these reports was that a petty cash fraud and a cash theft have been reported. The fraud had been reported by management to the NHS Counter Fraud Authority early in the calendar year. However, the NHSCFA failed to notify this to the LCFO and so this was handled internally by management. An unconnected theft from a cash box by a member of staff has been reported to the LCFO and is under investigation. Local procedures to limit further exposures of this type have been put in place whilst more detailed reviews of processes are undertaken.

   We have been notified by NHSI that the audit of our 2018/19 Annual Report by Grant Thornton will be amongst the sample of Trust reports that will be reviewed by the Quality Assurance Directorate of the Institute of Chartered Accountants or England and Wales. This is a standard quality assurance process for which our selection is random and which is directed at the work of our external auditor, Grant Thornton, rather than the Trust.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	1st August 2019		

Report from: (Committee Name)	Workforce Committee Escalation Report		**Committee Meeting Date:**	25/07/2019
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele			
Board Sponsor (presenting):	Michael von Bertele			

Recommendation
The Trust Board are asked to note the items escalated from the Workforce Committee meeting held on 25 July 2019.

Key Items for Escalation

- The Committee discussed several risks relating to recruitment of staff and junior staffing in a number of areas. It was agreed that these should be combined into a broader risk relating to medical workforce.
- The Committee recommended approval of the Medical Revalidation and Appraisal Annual Report.
- The Committee received the Health and Safety Annual Report and the Health and Safety Executive inspection update - an action plan is due to come to the next meeting in September.
- The WDES (Workforce Disability Equality Standard) and WRES (Workforce Race Equality Service) reports were received. The reported data highlighted a diverse workforce but it was noted that the statistics are masking the complexity of work that is required to manage this workforce. Further work is required.
- The Committee discussed increasing the frequency of meetings. It is proposed that the Workforce Committee meet 9 times a year, similarly to the Clinical Governance Committee.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	01 August 2019		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Kieran Humphrey, Associate Director of Strategy Felicity Anscombe, Information Services Manager			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):				

Recommendation:
The Board is requested to note the report and highlight any areas of performance where further information or assurance is required.

Executive Summary:
The Integrated Performance Report consolidates the latest performance information and improvement actions across the Trust's strategic priorities. This report for August 2019 Board is a revised and agreed format using data and commentary available for performance in June 2019 across the Trust's services to produce a summary report. The structure of the report is aligned with the Trust's key strategic priorities and their related (CQC based) assessment frameworks. The progress made this month in the preparation of the report includes a greater feed in of analysis and action planning from across Trust directorates, based on a service level interpretation of data and agreement of mitigating actions. The next step is to progress the roll out of the Integrated Performance Report format to the reporting to Board sub-committees and other meetings of the Trust where performance is considered. The Trust is performing positively against a number of indicators, continuing to meet the Referral to Treatment standard and the majority of Cancer diagnosis and treatment standards (6/8). The Trust has delivered against its financial control total in the year to date. Positive progress is being made against the Trust's workforce key performance indicators.

Performance against the Emergency Access (4hr) and Diagnostic Standards and the Trust has mitigation actions in place to address this. Effective patient flow and discharge remains a challenge for the Trust and wider system to address.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

August 2019

(data for June 2019)

An outstanding experience for every patient

Executive Summary

Salisbury NHS Foundation Trust

The Integrated Performance Report highlights key themes and issues across the organisation, attempting to make links between the various aspects of the Trust's business. As such it brings together themes from the: performance, quality, workforce and finance reports and seeks to set out the interlinking issues and plans to move forward the challenges faced.

This report for August 2019 Board is now in an agreed format using data and commentary available for performance in June 2019 across the Trust's services to produce a summary report.

The Structure of the Report is being designed to align with the Trust's key strategic priorities and their related (CQC based) assessment frameworks.

Operational Performance – Constitutional Standards

ED performance was 91.8% in June, below trajectory for the month (92.4%). Workforce planning and focus on the Patient Flow Programme are key areas to drive improved performance. High attendance relative to previous years and periods is also a causal factor in performance (although attendances are running broadly to plan).

The Trust continues to meet the Referral to Treatment target of 92% for patients waiting less than 18 weeks for elective treatment. It is intended to show greater detail of progress in specialties not yet delivering the standard in future reports.

The Trust met 6 out of 8 cancer standards in June, and achievement of all standards for Q1 (19/20) except the 62 day standard; analysis of the causes and action against this is included in the report.

The Trust failed to deliver the diagnostic waiting time standard for a third consecutive month with primary challenges in Endoscopy capacity and Radiology.

Our Care and People

The rise in weekend HSMR previously reported will be reviewed through a case notes audit with findings reported to Clinical Governance Committee in September 2019. The change in C-diff target has affected the Trust's performance and discussions are ongoing with partners to address the impact of this.

Pay expenditure is broadly in line with plan, including agency costs. The Trust's vacancy and absence rates are broadly in line in June with the average for the last 6 months.

Use of Resources

The Trust met its control total in June 2019, reporting a control total deficit of £0.6m. Because the Trust's year to date performance is in line with plan, the £1m PSF and FRF for Q1 are now achieved and payment will be received during Q2.

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Structure of Report

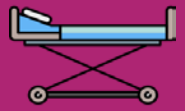
Performance against our Strategic and Enabling Objectives

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance – June 2019

NHS Salisbury NHS Foundation Trust

There were **2,618** Non-Elective Admissions to the Trust



We provided care for a population of approximately **270,000**

17% of discharges were completed before 12:00

We provided **18,772** outpatient attendances

RTT 18 Week Performance: **92.5%**
Total Waiting List: **17,808** ↑

Emergency (4hr) Performance **91.8%** ↑
(Target trajectory: 92.4%)

We met **6 out of 8** Cancer treatment standards

97.8% of patients received a diagnostic test within **6 weeks**

1,170 Patients arrived by Ambulance

We carried out **446** Elective Procedures & **2,006** Daycases

Our clinical income was **£16.2m**
(£889k under plan)

Our overall vacancy rate was 6.3% ↓

Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 24 months worth of data

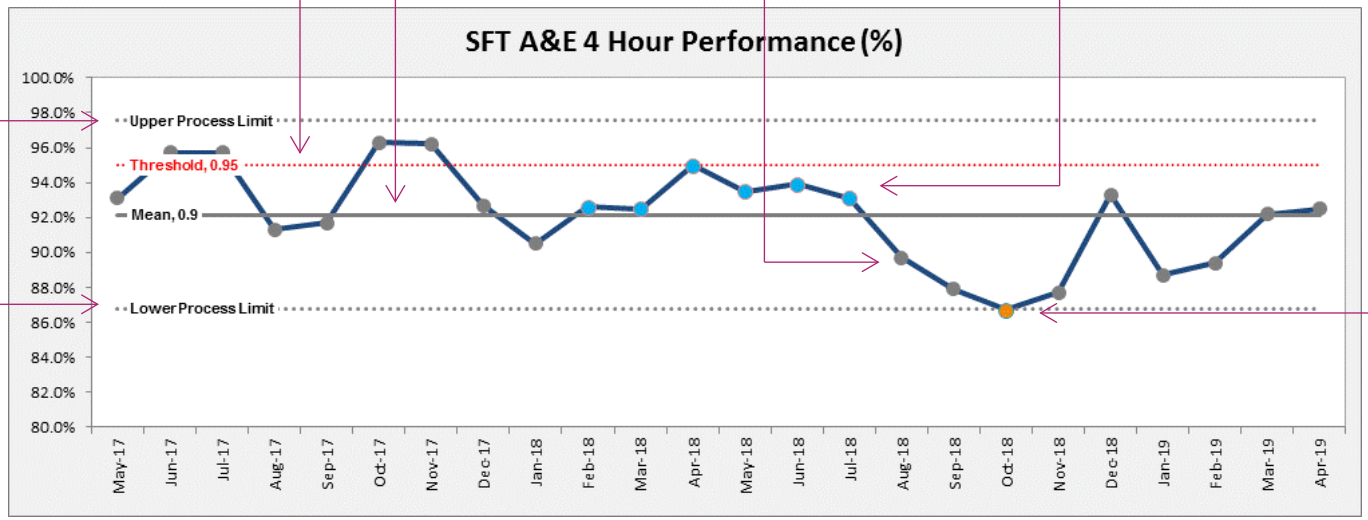
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 7 or more points above the Mean or one point greater than the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 7 or more points below the Mean or one point less that the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

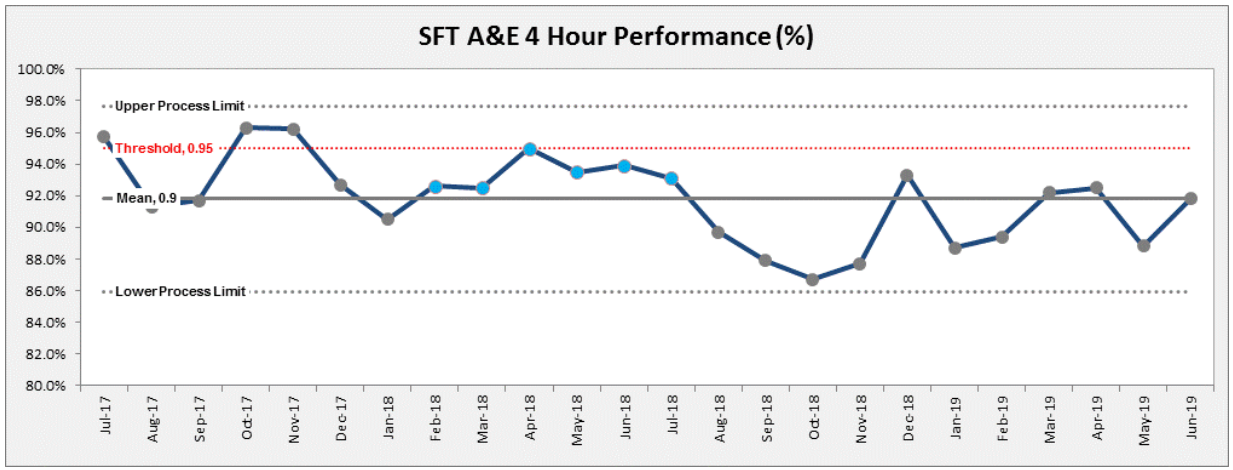
Salisbury NHS Foundation Trust

Part 1: Operational Performance

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Emergency Access (4hr) Standard Target 95% / Trajectory 92.4%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	91.8%
Attendances:	6074
12 Hour Breaches:	0
ED Conversion Rate:	27.0%

Background

Benchmarking of ED performance is more challenging with 14 Trusts nationally trialing new ED targets, including 3 of the Trust's 'peer' sites. These Trusts are no longer reporting against the 4 hour standard.

The Department continues to move along its improvement trajectory with specific work streams continuing from the Directorate and from the COO. An ED action plan was written in Q3 of 18/19, recognising the challenges being faced and now, six months on, this has been refreshed with particular focus on the new and current challenges being faced.

Improvement actions planned, timescales, and when improvements will be seen

There are ongoing staffing issues, vacancies exist at middle grade and Consultant levels which is making it challenging to completely fill the standard rota as well as bolster shifts to manage peaks. It can also be difficult to plan to bolster based on average trend as this can result in staffing not being necessary on all days as peaks in demand can change rapidly. The Department is also aware of the staffing establishment it is also budgeted to work within which can add challenge into what is achievable in terms of cost of additional staffing.

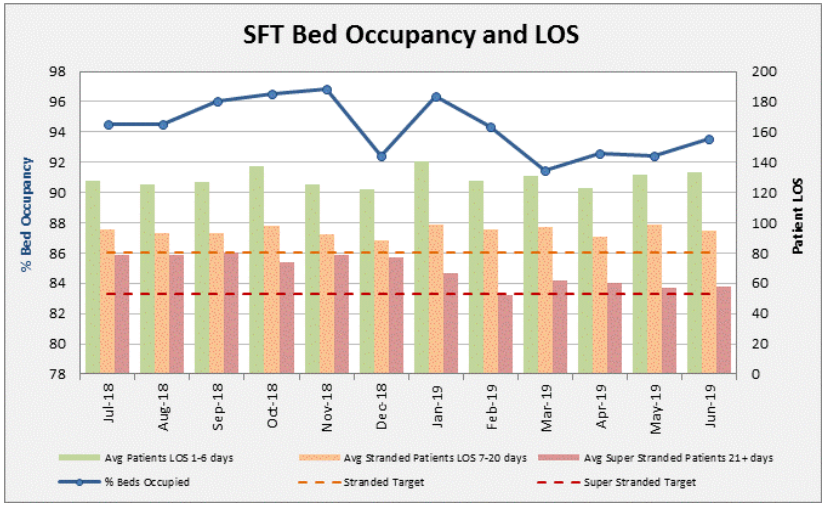
Risks to delivery and mitigations

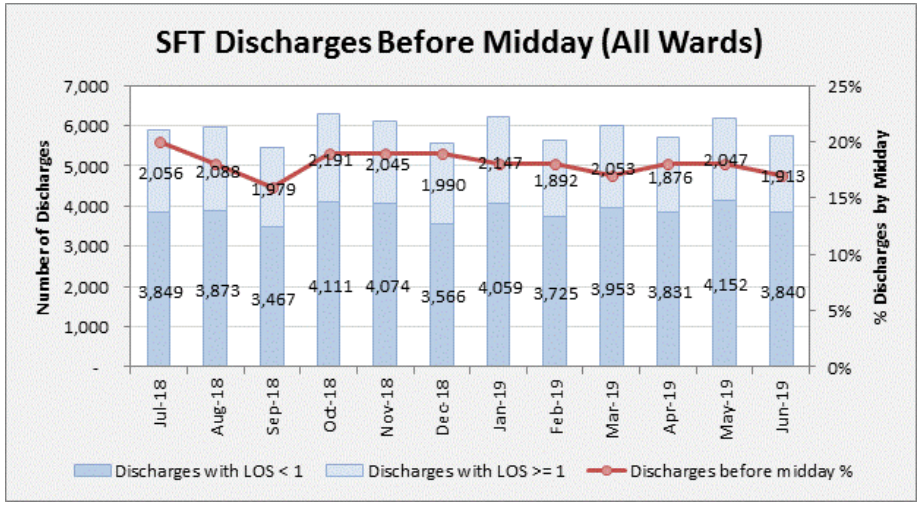
The continued increase in demand, in particular, the increases in peak hours of attendances (above 10 per hour) within a day is challenging the resilience of the Department and has potential to continue to put 4 hour performance at risk. The two key factors that support the Department in being able to manage new peaks in demand are staffing and patient flow. To mitigate the staffing issues, the Department responds as much as possible in a planned way to ensure staffing issues are resolved and that optimum cover is achieved to manage the demand.

Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Patient Flow and Discharge

Are We Effective?





Background, what the data is telling us, and underlying issues

There have been marginal improvements in stranded patient numbers moving toward the agreed thresholds, following the reduced flow during May's norovirus outbreak which affected bed availability across the Trust.

The Trust has reduced its proportion of discharges taking place before 1200 for the second consecutive month, a key indicator of improved patient flow. There has been little variation in pre-noon discharges in the last 12 months.

Improvement actions planned, timescales, and when improvements will be seen

The CD and DM for Medicine are working to improve clinical engagement in the Patient Flow Programme by resetting objectives and workstreams (whilst keeping the national work streams in mind, i.e. SAFER, ECIST etc.) The new programme, retitled, 'Ready, Steady, Go!' has now been formed. Three working groups now exist and have had an initial meeting with second meetings due to happen w/c 15/7/19. The DM for Medicine is leading the project support for each group and there are 41 initial workstreams/ideas identified by the groups as possible improvement ideas to take forward. Each working group is clinically led by either a Consultant, Nurse or Junior Doctor.

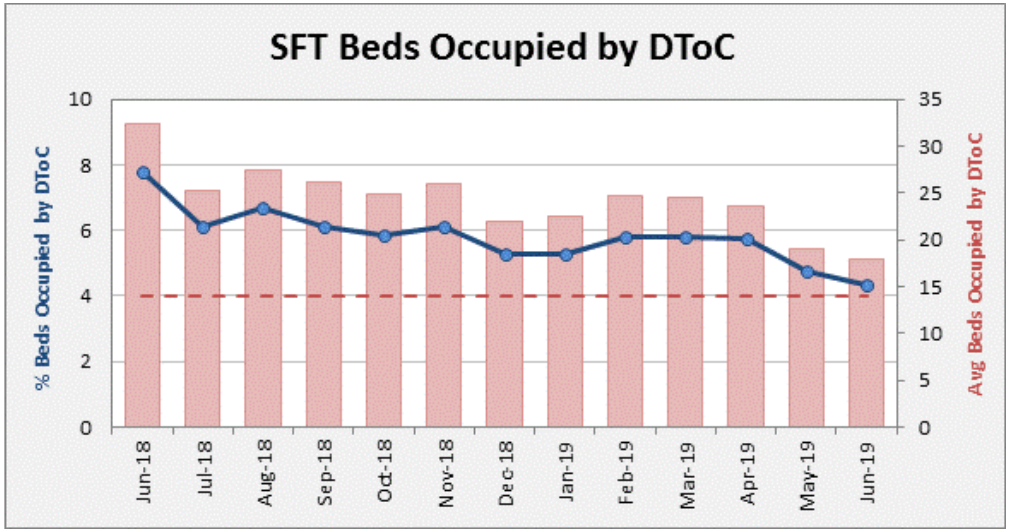
Risks to delivery and mitigations

The patient flow project plan continues to be updated, with key areas of focus in linked to:

- The intra hospital plan
- SAFER roll out and individual ward plans
- Ambulatory care pathways
- T&O Enhanced care pathway
- Action plan following ECIST workshops
- Breamore chair initiative (potential roll out in DSU)

Delayed Transfer of Care (DToC) Bed Days

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	
Days Lost to DToC (NHS):	185
Days Lost to DToC (SS):	133
DToC Patients (last Thursday of month snapshot):	9

Background, what the data is telling us, and underlying issues

Performance on reducing DTOCs has improved for the third consecutive month and is now nearing the targeted level of 14 cases on average through the Trust.

Improvement Action Planned

The weekly Expert Panel continues to meet, with the format of these meetings having been reviewed in the previous month. In addition to the patients who are medically fit for discharge, wards are now being asked to discuss their longest two waiting, not medically fit patients, so that discharge planning can commence earlier.

Following workshop sessions on the 2 and 3 May 2019 delivered by ECIST, the focus is on how the Trust can further support teams to continue to embed the principles of SAFER and good patient flow within their teams.

Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

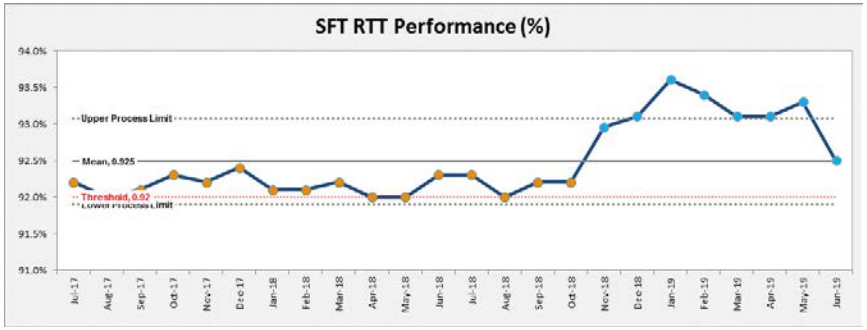
Total WL	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Dorset CCG (11J)	2,564	2,505	2,480	2,460	2,424	2,459	2,537	2,588	2,650	2,762	2,760	2,771	2,832	2,845
West Hampshire CCG (11A)	1,621	1,626	1,583	1,574	1,565	1,620	1,639	1,666	1,628	1,696	1,748	1,638	1,667	1,690
Wiltshire CCG (99N)	10,752	10,577	10,481	10,616	10,335	10,343	10,441	10,192	10,384	10,500	10,328	10,540	10,478	10,718
Other CCGs	3,024	3,138	3,135	3,016	2,989	2,834	2,526	2,411	2,180	2,105	2,113	2,083	2,323	2,498
Trust Total	**17,961**	**17,846**	**17,679**	**17,666**	**17,313**	**17,256**	**17,143**	**16,857**	**16,842**	**17,063**	**16,949**	**17,032**	**17,300**	**17,751**

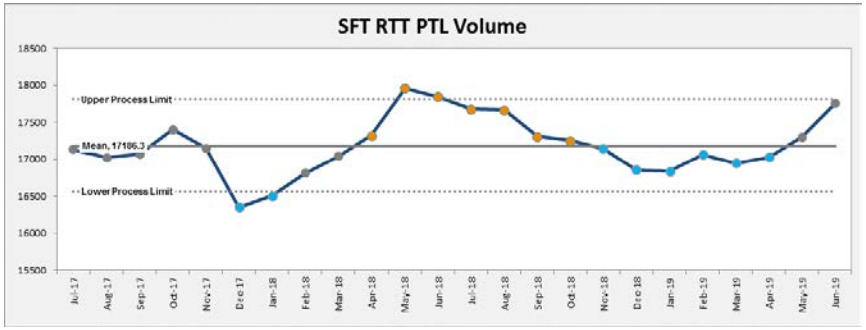
Data Quality Rating:

Performance Latest Month: 92.5%

PTL Volume: 17,751

52 Week Breaches: 0





Background, what the data is telling us, and underlying issues

The Trust continues to meet the RTT standard despite a dip in the most recent month's performance. The Trust's total waiting list has grown in each month since the beginning of the financial year, but the Trust benchmarks well (top quartile performance among NHS Providers) with the mean RTT performance among peer Trusts being 90.87%. Only 28 od 127 NHS Providers are currently meeting the RTT Incomplete Pathways standard.

Specialty Improvement actions

Those specialties not meeting the standard have individual improvement trajectories and actions. These include:

General Surgery: With a consultant returning from long term sickness, additional lists are being planned including one stop clinics where current waits for new appointments are lower. This will increase theatre capacity for those patients waiting longer than 18 weeks.

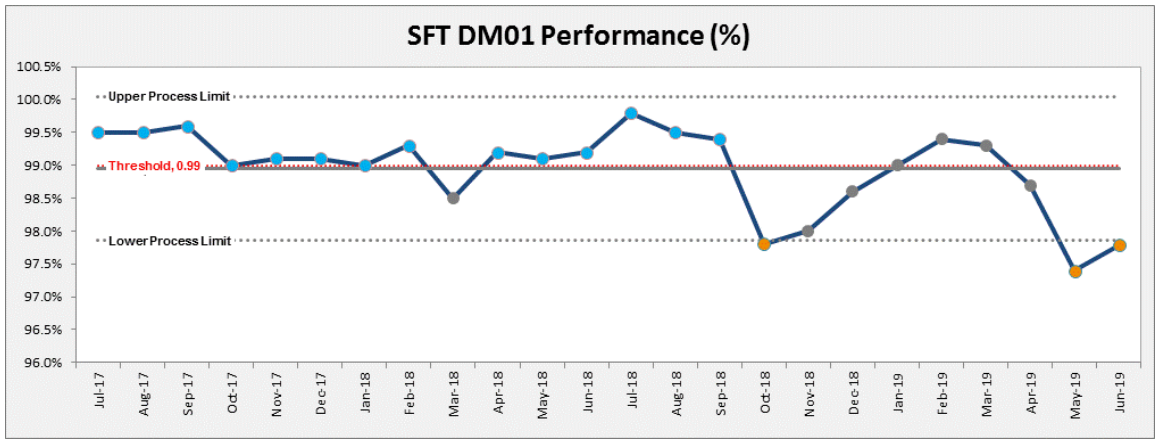
Urology: Plans for additional lists are being progressed with a 7PA consultant post commenced in June. A further consultant job plan has been agreed and patients have been triaged for virtual nurse led follow up to increase capacity.

Dermatology: Performance is challenged due to workforce shortages and an increase in rapid referrals – short and medium term plans are being progressed to address long waiting times for patients with inflammatory conditions.

ENT, T&O – a combination of additional lists, use of Registrars and new appointments to create additional capacity.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	97.8%
Waiting List Volume:	3,934
6 Week Breaches:	87
Diagnostics Performed:	6,882

Background, actions being taken and risks and mitigations

Endoscopy

Concerns raised in relation to capacity for June resulted in 63 in-month breaches. Executive approval was sought and obtained to enable outsourcing for 2 weekends, providing an additional 16 sessions of capacity and some mitigation against increased breaches over and above those identified in month.

Maximum capacity in hours continues to be secured by ensuring Monday to Friday lists are fully utilised, with a focus on DNA's and active prevention by phoning patients in advance of appointments. In hours capacity for July remains a concern, and there is an expectation that the DM01 target will not be met for the fourth consecutive month. Executive Intensive Support continues, resulting in the authorisation of two weekends in July, delivered by 18 weeks. Whilst this action will reduce the number of July in month breaches, and improve recent performance from Endoscopy against DM01, it is not expected to enable the Trust to meet the DM01 target.

As part of the JAG accreditation, an expectation was placed on the Trust to reduce waiting lists for all cohorts of Endoscopy patients during May, June and July 2019; this is being actively monitored by JAG. June's performance has contributed to an increase in waiting lists. This will be discussed with JAG, with an expectation that a recovery trajectory will be provided by the Trust in July 2019.

To address the above concerns, a recovery trajectory has been presented and discussed at Executive Intensive Support meetings in June. The resulting paper from the discussions will be submitted to July's Finance and Performance meeting, requesting funding to support Insourced weekend working, to address the backlogged waiting list and recover performance targets.

Radiology

There were 25 Radiology related breaches in June. 14 CT breaches were the result of a sustained period of down time for CT 1 (8.5 working days). Anticipated breaches relating to the downtime were anticipated to be in three figures, however, incredible levels of support were provided by the service with a combination of additional weekend lists and evening working to mitigate against the position.

11 Ultrasound breaches occurred as a result of staff sickness. Unfortunately this was over the last couple of working days in the month, so there was no opportunity to recover the position.

The MRI waiting list at the end of June was 457 with the majority of patients waiting less than 6 weeks. The demand remains constant so we continue with the use of the mobile scanner for 3/4 days per week on a regular basis, it is anticipated that this will continue for the remainder of the financial year. Whilst this is a significant cost, the demand and complexity of patient cohorts require additional capacity to the standard scanner which could not be met as efficiently with ad hoc arrangements.

Ultrasound staffing has become a concern owing to vacancies and staff sickness. A recruitment process is underway and the Department are reviewing temporary staffing options that will support the service during the summer months. Further work is ongoing to mitigate against high volumes of DNA's experienced by the service on behalf of the Admin Team.

Staffing in other modalities and at Consultant level continues to be challenging; there has been a significant reduction in clinicians willing to do additional sessions and measures continue to be investigated to improve recruitment and retention of staff.

Radiology Reporting is becoming a challenge to the service, as a result of the additional activity being undertaken to accommodate demand. This is being mitigated against by further additional sessions of Reporting being undertaken by Trust Consultants, and securing a second Radiology Reporting provider for the Trust which should be available for use at the beginning of Q3.

Cancer 2 Week Wait Performance Target 90%

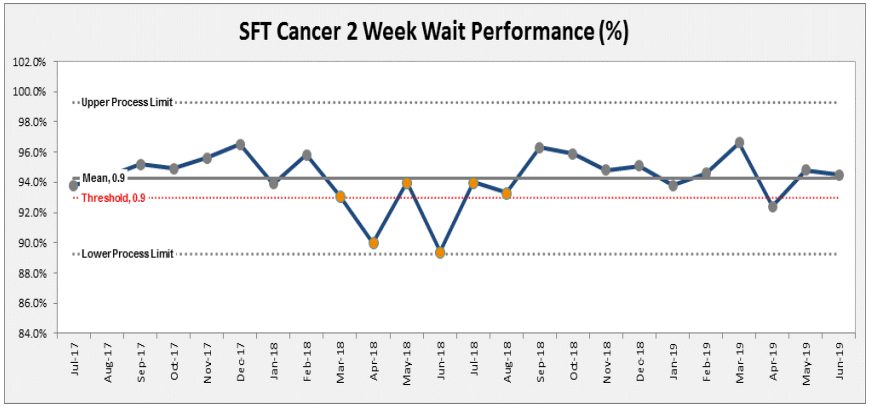
National Key Performance Indicators

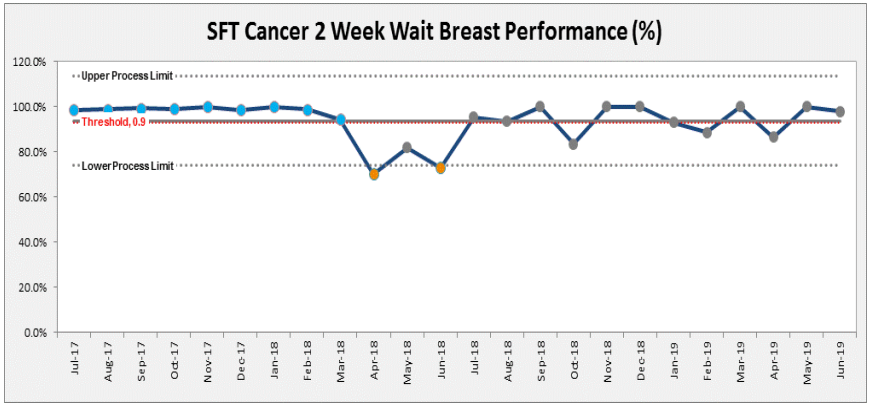
Performance Latest Month:

Data Quality Rating:

Two Week Wait Standard: 94.5%

Two Week Wait Breast Standard: 97.7%





Background, what the data is telling us, and underlying issues

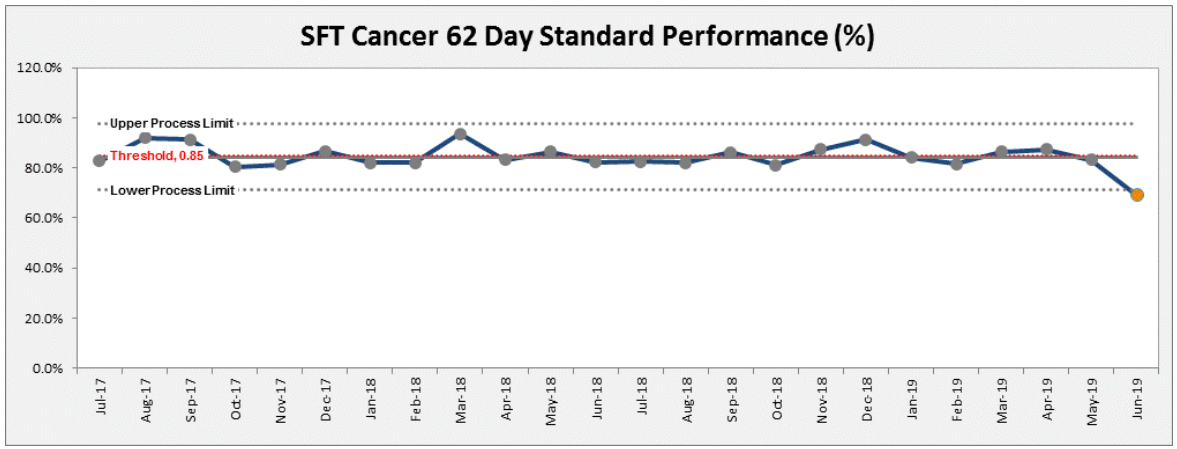
For both standards, there is no significant variation in performance since September 2018.

With Q1 data now available, the Trust achieved both the 2 week wait standards for the quarter (93.9% for all 2 weeks waits and 93.7% for Breast Symptoms). This is an improvement for breast symptoms where the standard wasn't met in Q4 (2018/19).

The Trust benchmarks in mid-quartile for both these standards among NHS providers.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard:	69.3%
62 Day Standard (without shared care):	68.6%
62 Day Screening:	97.5%

Risks to delivery and mitigations

The key areas where improvement action is being undertaken include:

Urology – breaches have been caused by delays at the tertiary centre and late referrals by us. Cancer clinical lead planning a meeting to discuss with call urology consultants to review the pathway. Cancer Services Manager (CSM) is reviewing the pathway with new Cancer Clinical lead to improve delays at the start of the process – we should see some benefits from this in Q2 and Q3.

Colorectal – breaches have been caused by delays with diagnostics (as requested by LGI team) which has resulted in urgent need for late capacity to be created causing unnecessary breaches. CSM met with Lead Surgeon – there is a colorectal meeting planned for Sept and there will be a change of cancer lead.

Endoscopy – breaches are being caused by ongoing capacity issues. A weekly escalation meeting is in place with the COO.

Skin - breaches have bee affected by capacity issues ongoing and these are being addressed through weekly meetings with COO.

The Trust performance is 57th of 155 NHS cancer service providers in most recent national data.

Statistical Process Control Chart Key:
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- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

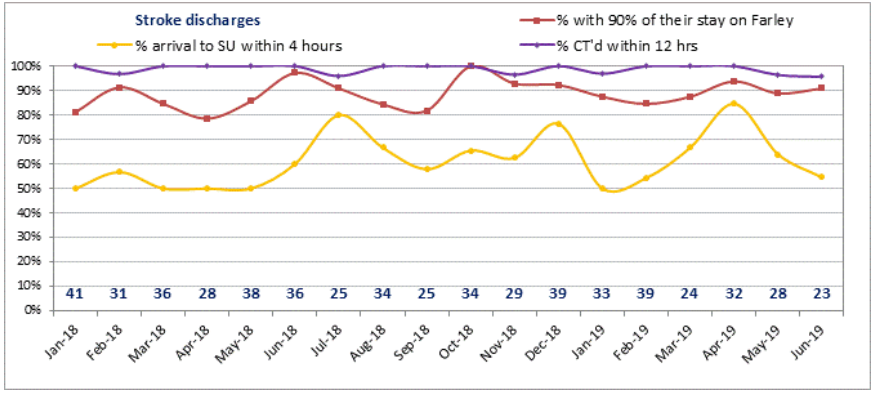
Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20				

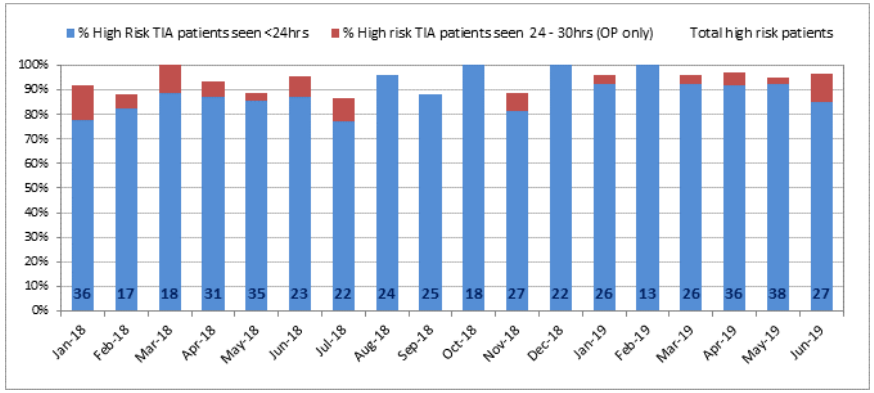
Data Quality Rating:

% Arrival on SU <4 hours: 54.5%

% CT'd < 12 hours: 95.7%

% High Risk TIA Seen < 24 hours: 85.2%





Background, what the data is telling us, and underlying issues

Time to CT scan within 12 hours achieved for all but 2 patients in Q1. New process for FAST positive patients straight from ambulance to CT embedded in practice.

Time to reach the stroke unit within 4 hours decreased with delays mainly due to first & speciality doctor assessment in ED. Performance however, is still relatively good compared to national figures.

Patients spending 90% of their stay in the stroke unit continued to exceed the national target (80%).

Improvement actions planned, timescales, and when improvements will be seen

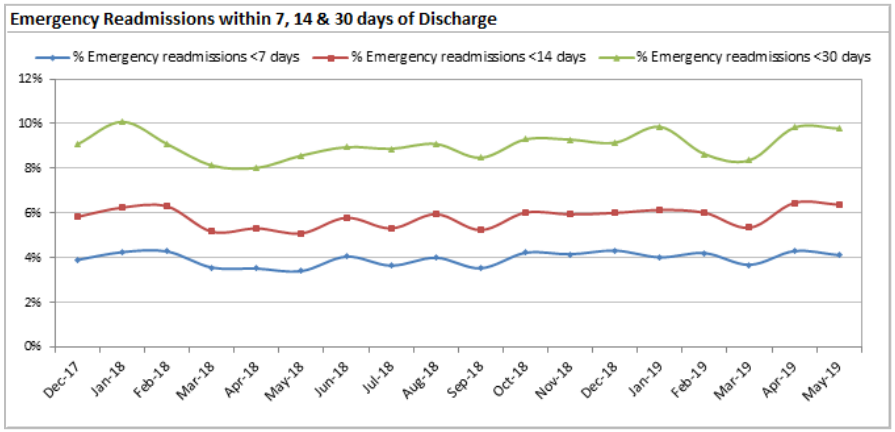
- SSNAP case ascertainment expected to improve and be sustained at A once 2.0 wte Speech and Language Therapists appointed. This will ensure patients receive the recommended input. Improvements should be seen from Q3 onwards.
- Medicine DMC part of a cross Directorate 'Ready Steady Go' project to improve down stream flow.
- Short term trial of a ANP role on stroke unit to assist with time to reach the stroke unit within 4 hours.

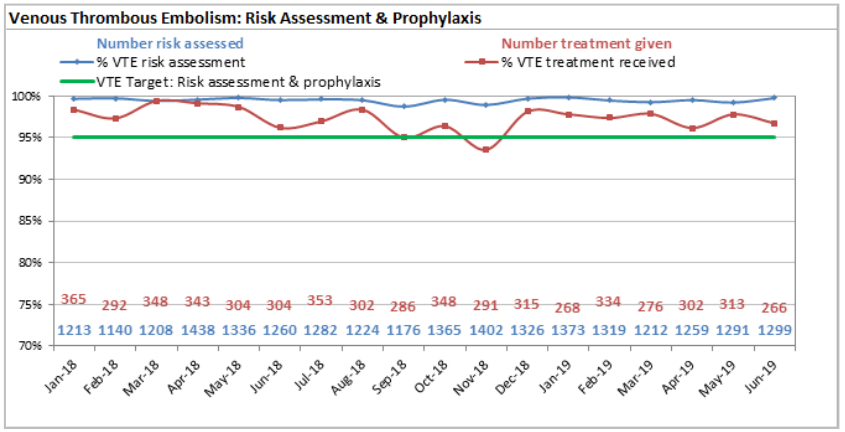
Risks to delivery and mitigations

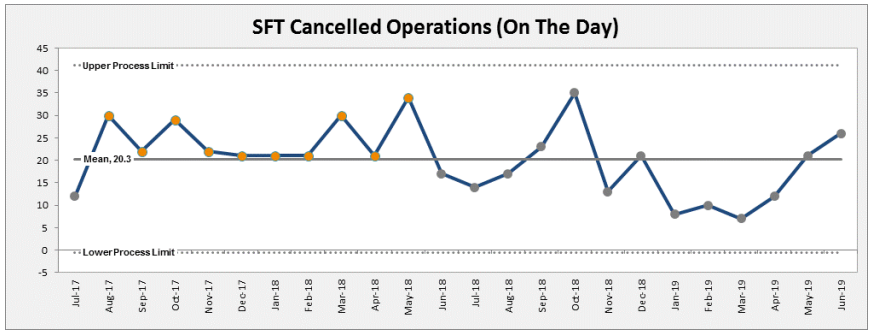
- Potential delay in recruitment of speech therapist and embedding new staff in practice. Mitigated by induction and ongoing support.
- Engagement with the 'Ready Steady Go' project group.

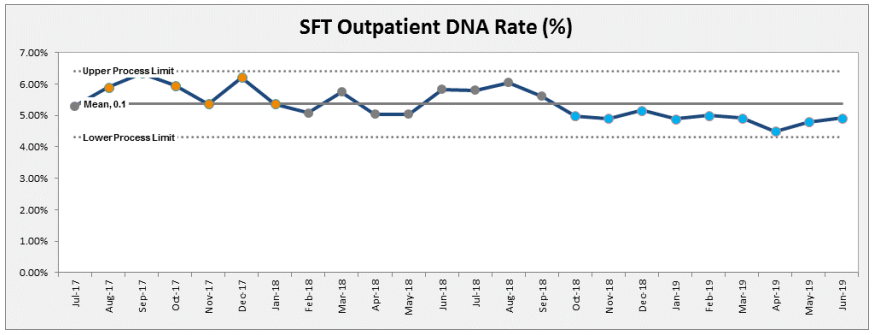
Other Measures

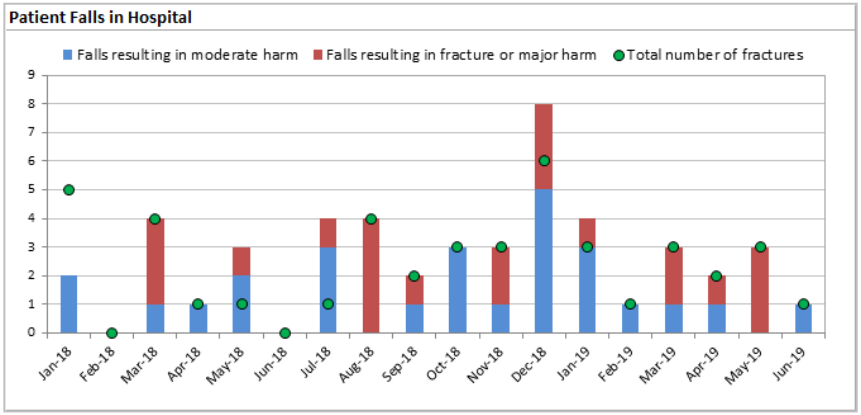
Are We Effective?









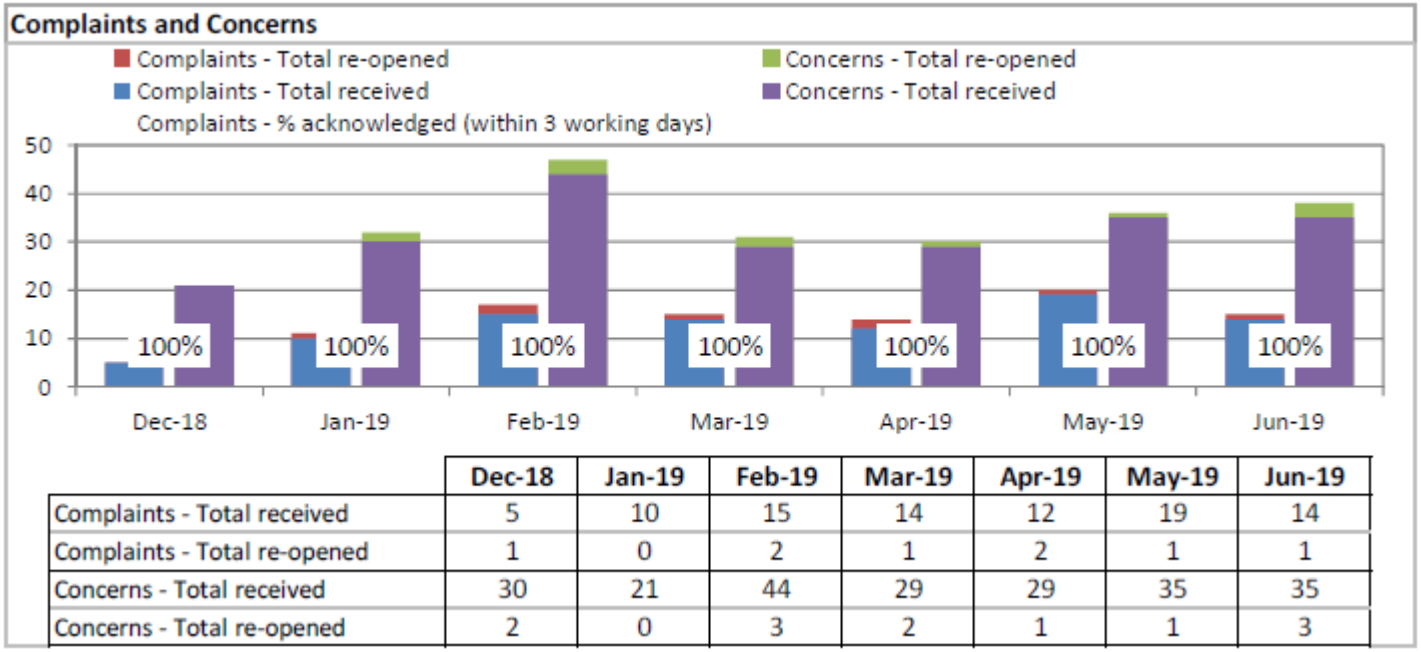


Year	2018-19	2019-20
Never Events	3	1

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

Data Quality Rating:



	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Complaints - Total received	5	10	15	14	12	19	14
Complaints - Total re-opened	1	0	2	1	2	1	1
Concerns - Total received	30	21	44	29	29	35	35
Concerns - Total re-opened	2	0	3	2	1	1	3

Four main themes are identified in feedback:

- Patient care (nutrition/hydration)
- Values and Behaviours
- Appointments
- Clinical treatment

Examples of actions:

- ED - robust senior cover overnight to improve the commitment and support offer to junior doctors. Communication skills (for all grades) have been discussed at team meetings
- Orthopaedics + Plastic's – increased capacity in specialties through additional sessions.
- Amesbury - ensured clear escalation pathway to the Heads of Nursing for staffing concerns. Continued monitoring of the delivery of patient care.
- Central booking - improvement requests have been submitted - to create automatic letters for ERS and to improve the automated call system.

Salisbury NHS Foundation Trust

Part 2: Our Care

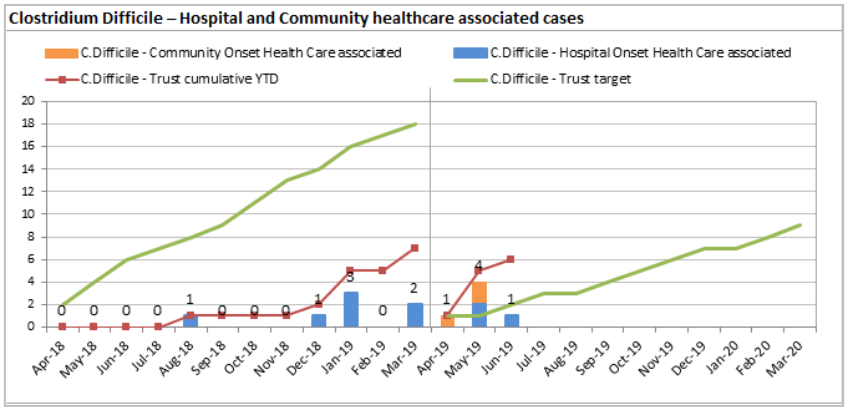
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

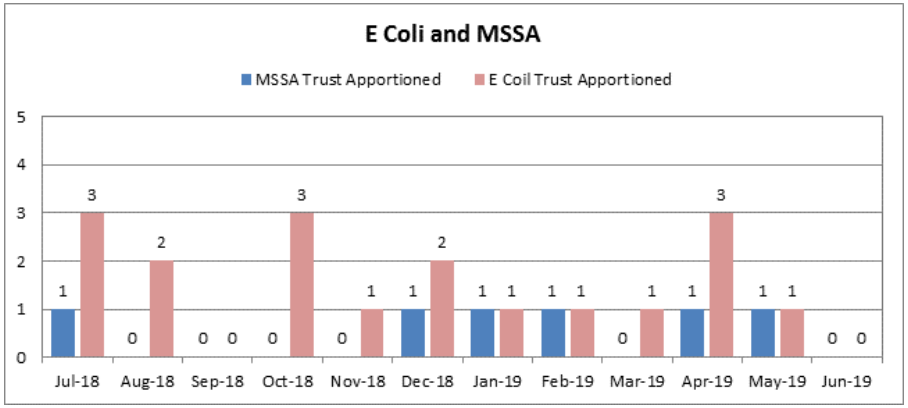
Infection Control

Are We Safe?

Year	2018-19	2019-20
MRSA (Trust Apportioned)	3	0

Data Quality Rating:





Summary and Action

A change in reporting of C difficile cases in line with national guidance has shown an increase in the number of Trust apportioned cases due to the inclusion of community onset healthcare associated cases in the Trust figures (this includes all cases up to 4 weeks post discharge).

Four cases are being considered for appeal for no lapses in care.

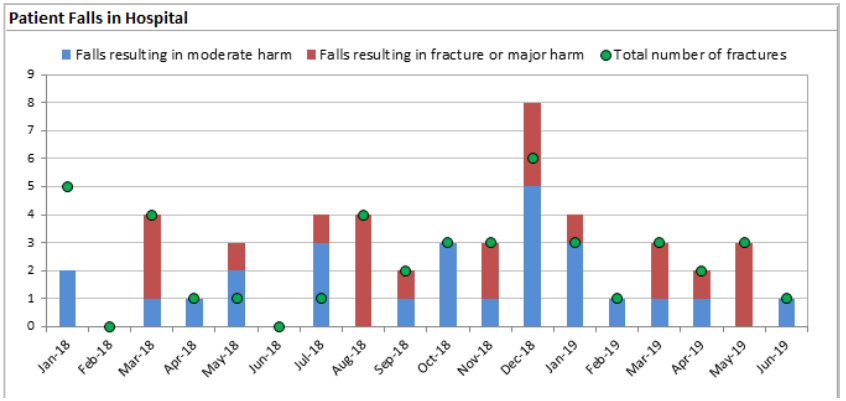
Concerns regarding the changes to the reporting definitions, coinciding with the 50% reduction of the upper limit, have been escalated to NHSI and Wiltshire CCG.

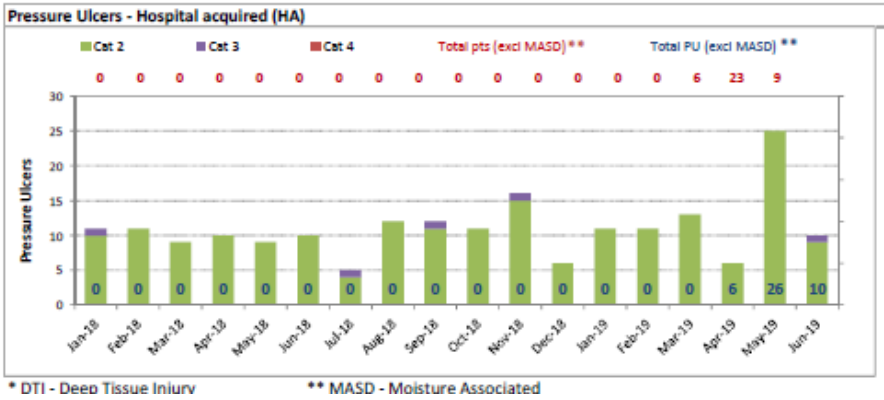
Pressure Ulcers / Falls

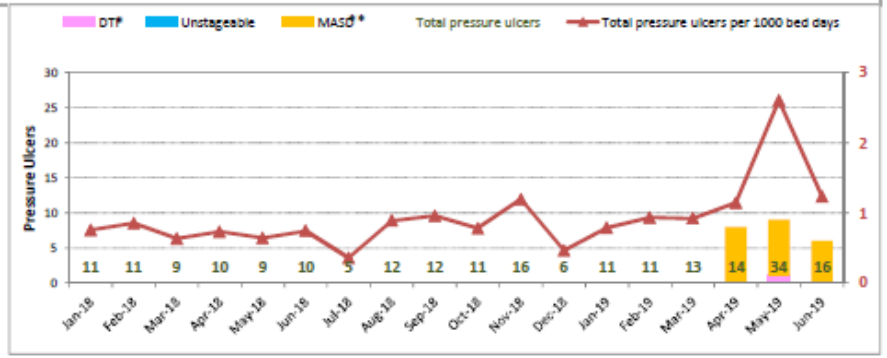
Data Quality Rating:

Are We Safe?

Per 1000 Bed Days	18-19 Q1	18-19 Q2	18-19 Q3	18-19 Q4	19-20 Q1
Pressure Ulcers	0.71	0.68	0.79	0.88	1.05
Patient Falls	0.10	0.25	0.34	0.20	0.16







Summary and Action

Pressure Ulcers

As predicted in Q1 the number of category 2 hospital acquired pressure ulcers increased and peaked in May. This was due to the change in national reporting whereby pressure ulcers must be identified at the first skin inspection but not all were identified within 6 hours of admission in May. One category 3 pressure ulcer was device related.

A 'swarm' meeting was held in June to ascertain the cause and actions needed to improve. Q1 work is being planned with AMU to improve capture of skin assessment with the first admission documentation. A peak of hospital acquired moisture associated skin damage (MASD) also occurred in May. Increased diarrhoea and norovirus activity likely to be a contributory factor.

Falls

In Q1, 4 falls resulting in major harm (all fractured hips requiring surgery) and 2 falls resulting in moderate harm (fractured clavicle and vertebral fracture). A CQUIN with 3 high impact interventions to prevent hospital falls is underway. Improvement work is led by the Falls Working Group and Patient Safety Steering Group.

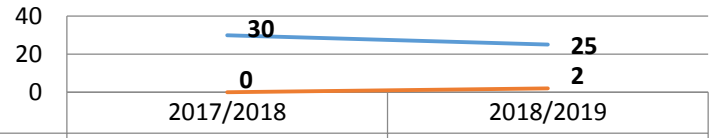
Incidents

Are We Safe?

Patient Safety Incidents per 1000 days (6 months)	38.55

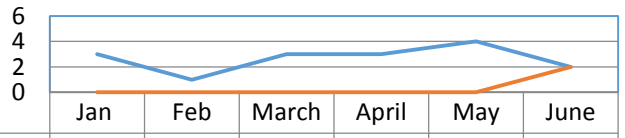
Year	2018-19	2019-20
Never Events	3	1

Clinical incidents Major and Catastrophic 24 month trend



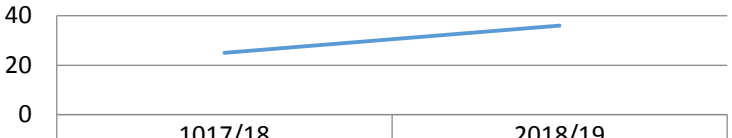
	2017/2018	2018/2019
Major	30	25
Catastrophic	0	2

Clinical incidents Major and Catastrophic Jan- June 2019



	Jan	Feb	March	April	May	June
Majors	3	1	3	3	4	2
catastrophic	0	0	0	0	0	2

Number of Serious Incidents 24 Month Trend



	1017/18	2018/19
No of SII's	25	36

No. of Serious Incidents Jan-June 2019

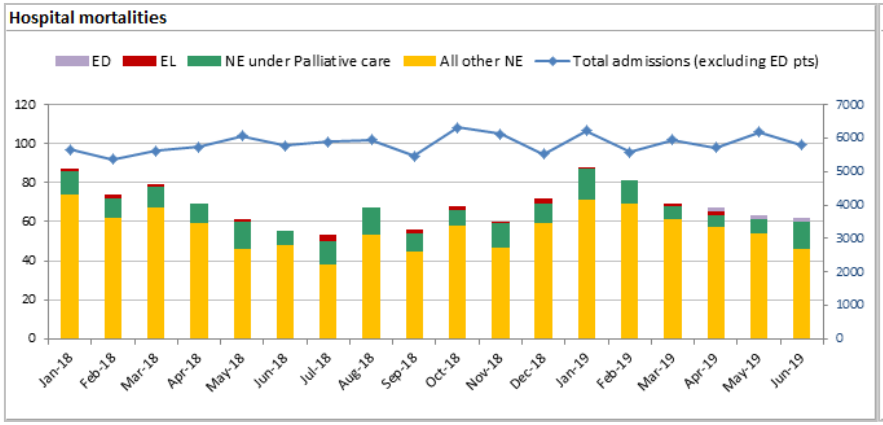
	Jan	Feb	March	April	May	June
No. of SII's	4	3	3	3	5	5

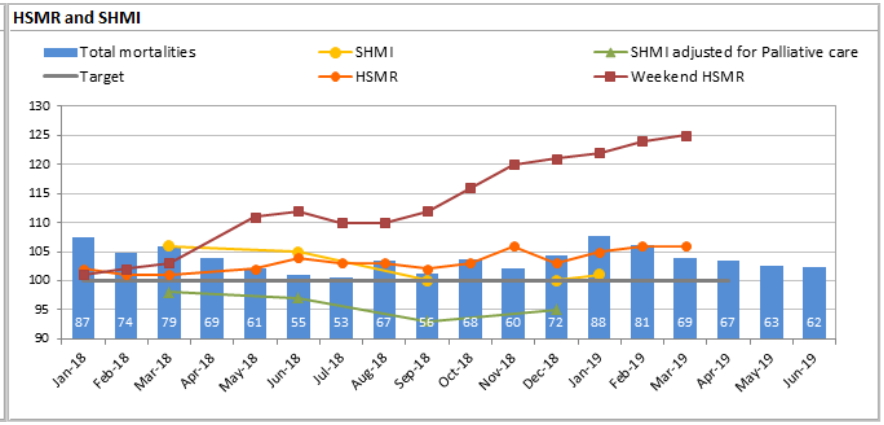
January-June 2019	No.
Patient Safety Alerts Outstanding	1

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

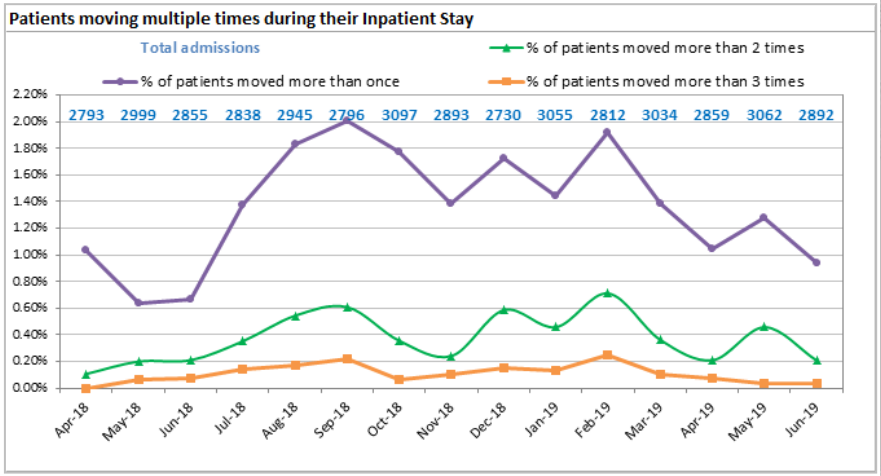
Overall, HSMR remains within the expected range. NHS Digital are now publishing SHMI data monthly which is within the expected range. Weekend HSMR increased for the 6th, 12 month rolling data period and is significantly higher than expected range. A case notes review based on a detailed analysis of the contributory factors has been undertaken and will be presented to the Clinical Governance Committee in September 2019.

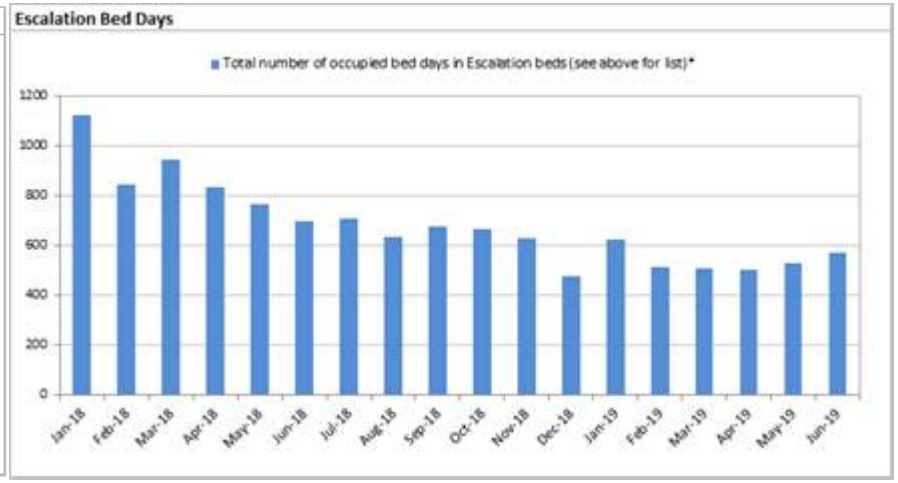
Are we caring?

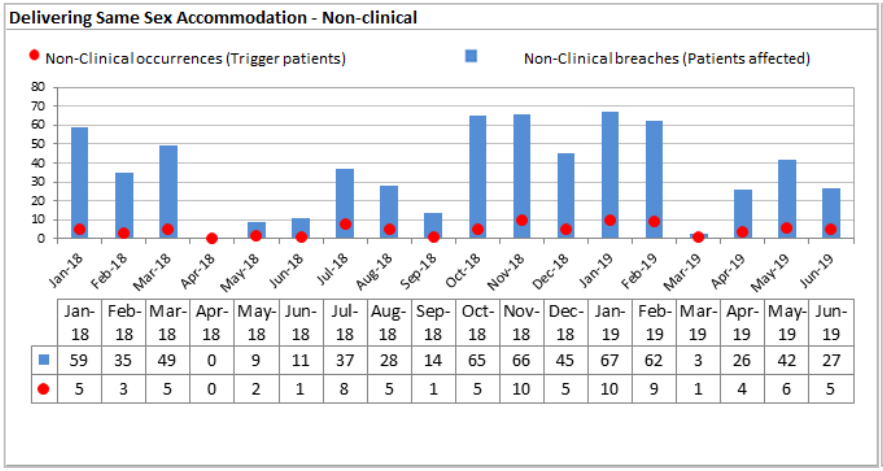
Are We Caring?

Last 12 months	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Bed Occupancy %	94.5	94.6	96.0	96.5	96.8	92.5	96.3	94.4	91.4	92.6	92.5	93.5

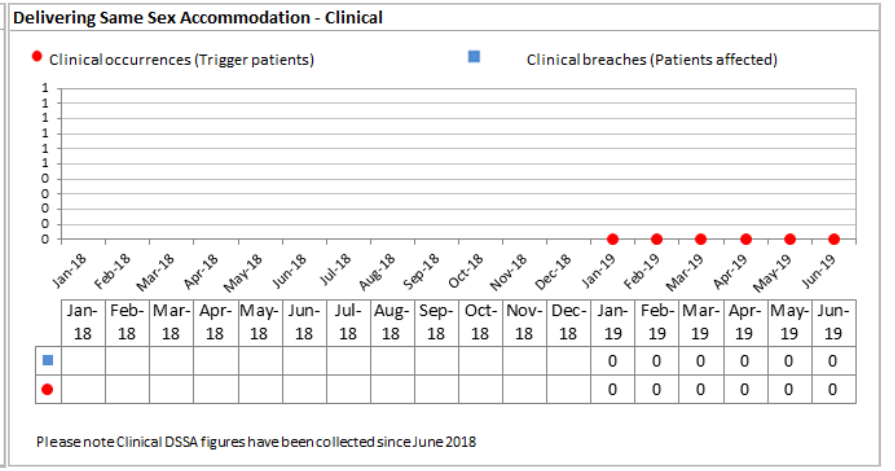
Data Quality Rating:







	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
■	59	35	49	0	9	11	37	28	14	65	66	45	67	62	3	26	42	27
●	5	3	5	0	2	1	8	5	1	5	10	5	10	9	1	4	6	5



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
■													0	0	0	0	0	0
●													0	0	0	0	0	0

Please note Clinical DSSA figures have been collected since June 2018

Part 3: Our People

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Jun '19		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	402.6	401.4	1.3
Nursing	939.7	897.3	42.4
HCAs	405.7	516.1	(110.5)
Other Clinical Staff	609.7	602.9	6.8
Infrastructure staff	1,193.0	1,213.5	(20.4)
TOTAL	3,550.8	3,631.2	(80.5)

		Turnover (FTE)			Sickness					
		Average Heads *(in year)*	Number of Leavers *(in year)*	Turnover *(rolling year)*	Long Term Sick WTE lost *(in month)*	%	Short Term Sick WTE lost *(in month)*	%	Total WTE lost to Sickness *(in month)*	Sickness Rate
YTD Trend										
Month Trend										
Target			260	10.00%					92.22	3.00%
Jan-19	3,053		282	9.24%	57.32	48%	62.79	52%	120.11	3.95%
Feb-19	3,064		282	9.20%	50.51	44%	63.49	56%	114.01	3.73%
Mar-19	3,077		278	9.04%	53.37	51%	50.60	49%	103.97	3.38%
Apr-19	3,078		283	9.20%	53.47	50%	52.75	50%	106.22	3.45%
May-19	3,076		277	9.01%	55.99	57%	42.76	43%	98.75	3.19%
Jun-19	3,079		277	9.00%	65.36	56%	50.44	44%	115.79	3.73%
totals			Average	9.11%					Rolling Year	3.52%

Summary and Action

Nursing (RN) vacancies will be significantly improved by the overseas pipeline of 35 due to arrive between now and October 2019, and a further 20 newly qualified expected in September. We continue the work on improving retention which will maintain control on the gap.

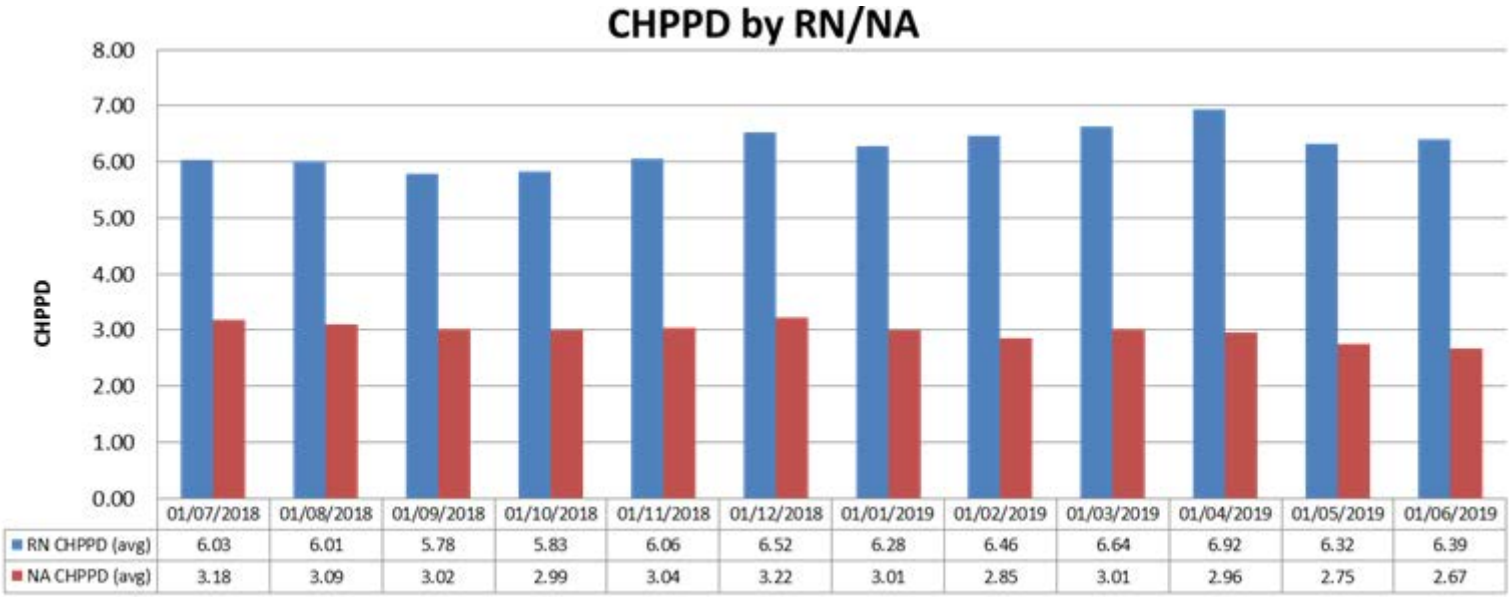
To demonstrate this, staff turnover is reasonably stable around the 9% mark and below the target of 10%. We are confident this can be maintained with the work continuing.

Sickness is being well controlled in the Directorates although Surgery have a number of challenging cases ongoing at present. There has been an increase in both long and short term sickness across the board and several cases are coming to the point of being able to return or leaving. There has been a concentration on the highest % reasons for sickness absence, namely stress and MSK, with appropriate involvement from Occupational Health. This involvement has been instrumental in reducing the sickness absence in Facilities.

Workforce – Nursing and Care

Use of Resources

Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend



	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019
RN CHPPD (avg)	6.03	6.01	5.78	5.83	6.06	6.52	6.28	6.46	6.64	6.92	6.32	6.39
NA CHPPD (avg)	3.18	3.09	3.02	2.99	3.04	3.22	3.01	2.85	3.01	2.96	2.75	2.67

Summary and Action

The total Care hours per patient day (CHPPD) can be used as a measure to compare available staffing with peers, however this needs to be done with caution as the specific configuration of services in any organisation will determine what level of CHPPD a Trust would require.

In Lord Carter's Review an approach of reporting Care Hours per Patient Day (CHPPD) was recommended in order to provide a single comparable metric for recording and reporting nursing and care staff deployment. Revised NHSI guidance mandates the use of planned versus actual CHPPD to measure deployment of the workforce and this pack reflects that requirement. The Trust is able to identify trends both Trust-wide and on individual wards, and key areas will be identified in the IPR.

In this month, Radnor was the only ward flagging red and this was for NA day shifts where the very small numbers involved exaggerate the overall % and shifts are managed by RN staff. The Nurse in Charge on each ward reviews a number metrics on a daily basis including staff skill set, SafeCare assessment, transfer of staff between wards, prioritisation of difficult to cover shits and balancing training and patient care.

Workforce – Staff Training and Appraisals

Use of Resources

Training	Appraisal	
Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
		
85.00%	90.00%	85.00%
91.32%	88.16%	86.30%
92.03%	91.46%	84.90%
92.09%	92.62%	86.00%
92.19%	90.65%	86.70%
91.99%	92.31%	85.05%
91.60%	92.42%	84.08%
Rolling 12 month total	Rolling 12 month total	Rolling 12 month total
91.87%	91.27%	85.51%

Summary and Action

Training

Compliance remains green at 91.6% this month.

Regular reports are provided from the education team to all Directorates, by individual, so that non-compliance can be followed up at the individual level.

Non Medical Appraisals

This month non-medical appraisal compliance has dipped below the 85% target to 84.08%.

CSFS and Corporate Directorates are both below compliance and managers are being reminded to complete and sign off appraisals for their individual reports.

As with training, the education team are able to produce reports by individual and BPs are following up within their Directorates.

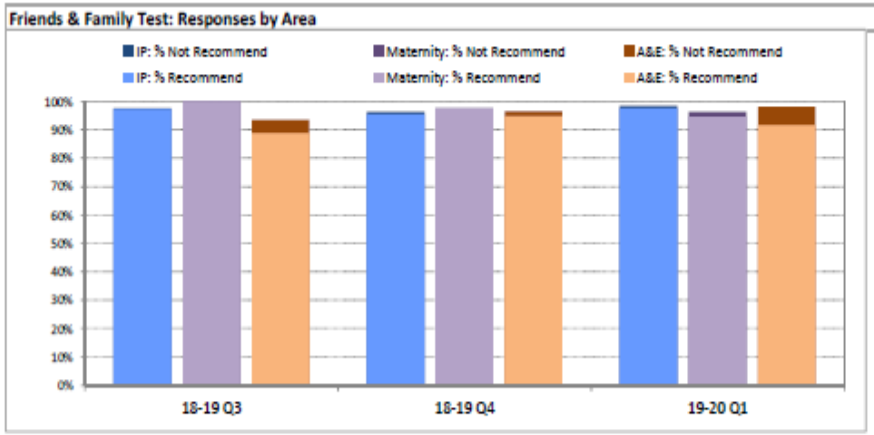
When following up we often find cases where the appraisal has been done but simply not signed off in the system, or an appraisal done on paper and not entered in the system.

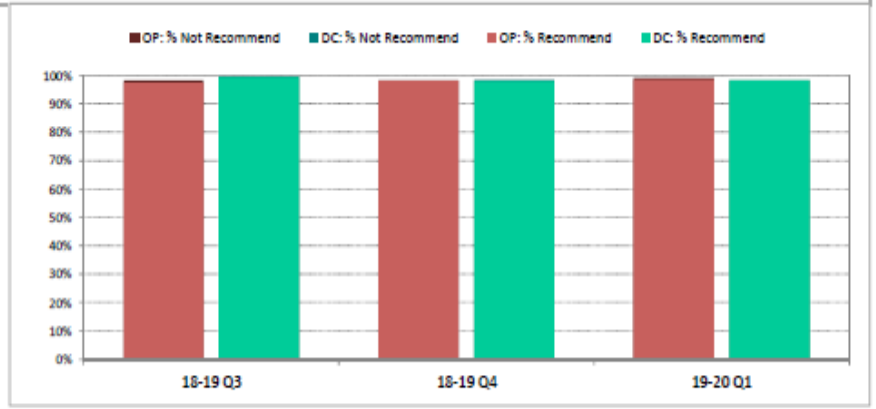
It is hoped that this situation can be improved through Phase 2 of our ESR Optimisation Project.

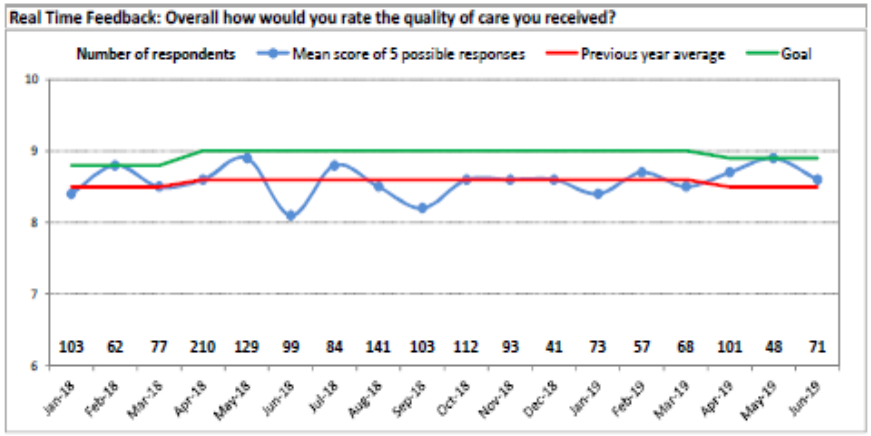
Friends and Family Test – Patients and Staff

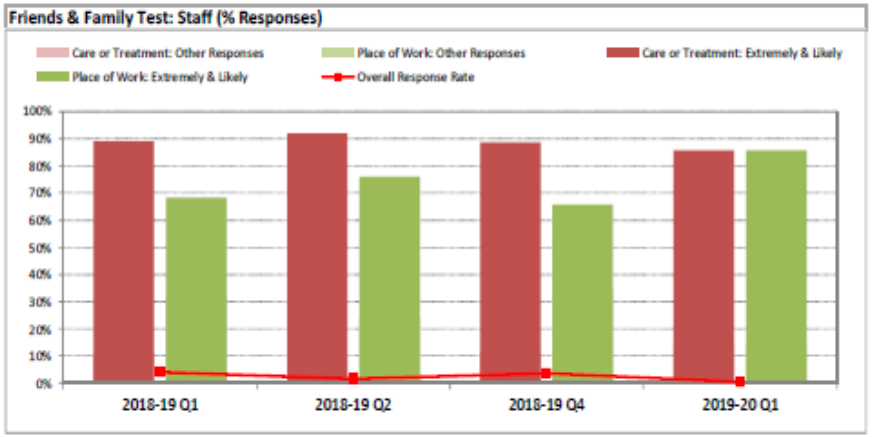
Use of Resources

SFT Friends & Family Test: Responses by Area









This score measures the % Recommended (Likely + Extremely Likely) and the % Not Recommended (Unlikely + Extremely Unlikely) to show the percentage of responses that would or wouldn't recommend the Trust.
Don't Know and Neither Likely or Unlikely responses are excluded from this measure.
This percentage is calculated by dividing the Extremely Likely + Likely responses by the Total Responses, and the same for Extremely Unlikely + Unlikely. These two measures will not always total 100%.

Part 4: Use of Resources

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

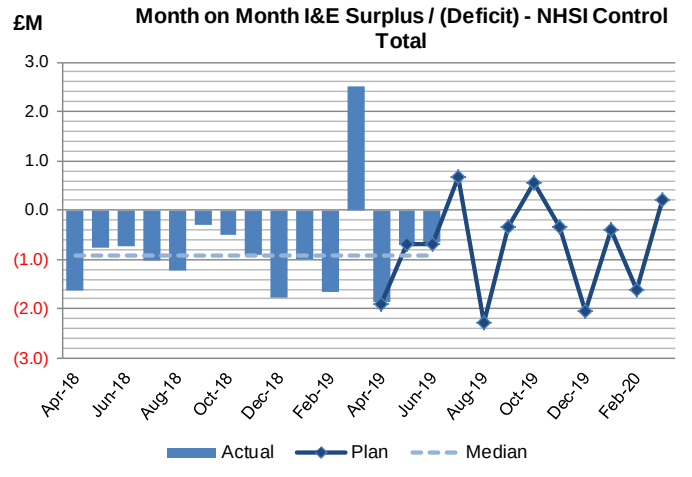
Use of Resources

Income & Expenditure

Status	Position

	Jun '19 In Mth			Jun '19 YTD			2019/20
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	17,135	16,246	(889)	50,934	49,542	(1,392)	196,036
Other Clinical Income	769	789	20	2,307	2,390	83	21,449
Other Income (excl Donations)	2,348	2,435	87	6,988	7,026	38	28,307
Total income	**20,252**	**19,470**	**(782)**	**60,229**	**58,958**	**(1,271)**	**245,792**
Operating Expenditure							
Pay	(13,069)	(13,020)	49	(39,609)	(39,357)	252	(157,326)
Non Pay	(6,452)	(5,744)	708	(19,613)	(18,615)	998	(80,163)
Total Expenditure	**(19,521)**	**(18,764)**	**757**	**(59,222)**	**(57,972)**	**1,250**	**(237,489)**
EBITDA	**731**	**706**	**(25)**	**1,007**	**986**	**(21)**	**8,303**
Financing Costs (incl Depreciation)	(1,429)	(1,345)	84	(4,289)	(4,206)	83	(17,157)
NHSI Control Total	**(698)**	**(639)**	**59**	**(3,282)**	**(3,219)**	**63**	**(8,854)**
Add: impact of donated assets	*105*	*(53)*	*(158)*	*315*	*(158)*	*(473)*	*1,260*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*173*	*174*	*1*	*521*	*521*	*0*	*2,082*
Add: PSF & FRF	*338*	*513*	*175*	*1,016*	*1,191*	*175*	*6,772*
Surplus/(Deficit)	***(82)***	***(5)***	***77***	***(1,430)***	***(1,665)***	***(235)***	***1,260***

Trend



Variation & Action

The Trust met its control total in June 2019, reporting a control total deficit of £0.6m. Because the Trust's year to date performance is inline with plan, the £1m PSF and FRF for Q1 is now achieved and payment will be received during Q2.

NHS clinical income of £16.2m was on 1% up on that achieved in June 2018, previously the year on year increase had been running at 7-8%. All points of delivery have seen activity shortfalls compared to those planned for, with planned pathway capacity being affected by a reduction in uptake on additional sessions and emergency pathways seeing 4% (c70 admissions) reduction when compared to May.

The Trust's Pay position continues to benefit from reductions in agency premium, following recruitment in the second half of 2018/19. Medical vacancies in hard to fill specialties, followed by escalation risk in the second half of the year are the key risks to delivery of the Workforce plan.

The Non Pay underspend has increased following the reduction in clinical activity, with clinical supplies spend were significantly lower than planned. Increased costs of outsourcing is driving a masked pressure against planned spend.

Income & Activity Delivered by Point of Delivery

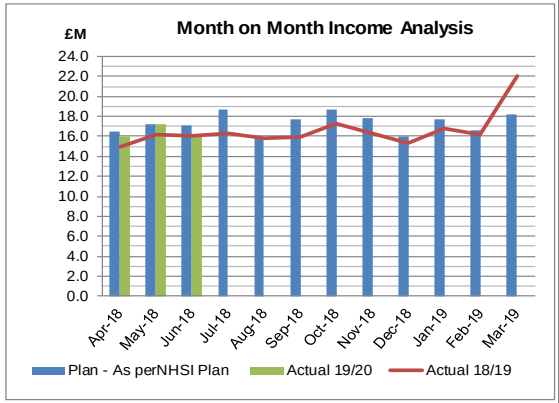
Use of Resources

Status	Position	Trend

NHS Clinical Income

Income by Point of Delivery (PoD) for all commissioners	Jun '19 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	2,236	2,165	(71)
Elective inpatients	4,653	4,498	(155)
Day Case	4,335	4,101	(234)
Non Elective inpatients	13,855	13,170	(685)
Obstetrics	2,689	2,674	(15)
Outpatients	8,175	8,097	(78)
Excluded Drugs & Devices (inc Lucentis)	4,328	4,344	16
Other	10,663	10,493	(170)
TOTAL	50,934	49,542	(1,392)

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	27,568	26,424	(1,144)
Dorset CCG	5,848	5,720	(128)
Hants CCG	4,215	4,150	(65)
Specialist Services	8,381	7,528	(853)
Other	4,922	5,720	798
TOTAL	50,934	49,542	(1,392)



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
Elective	1,310	1,228	(82)	1,260	(32)
Day case	5,499	5,361	(138)	5,391	(30)
Non Elective	6,871	6,633	(238)	6,434	199
Outpatients	64,977	62,534	(2,443)	61,992	542
A&E	17,613	17,373	(240)	17,139	234

Variation and Action

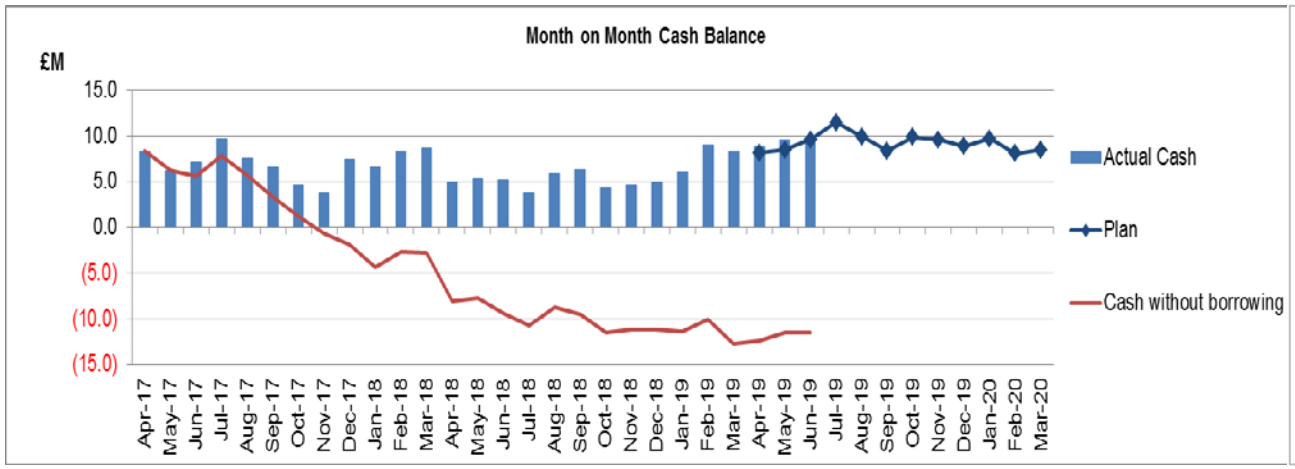
Income to date is £49,542k, £1,392k below plan and an under performance of £889k in June. Income has under performed on all points of delivery year to date with the exception of Excluded drugs and devices. Cardiology Day cases are 74 cases and £113k below plan year to date resulting from a reluctance to undertake additional lists due to the impact on Pensions with an improvement in month and Ophthalmology was lower in month but actions are being taken in July to resolve this. Elective Orthopaedics were 62 spells below the year to date plan of 313 in June which has improved from May. The Non Elective position is driven by a combination of under performance on spells and excess bed days activity mainly within Trauma and Orthopaedics, Cardiology and Gastroenterology.

An adjustment of +£181k is included to reflect the blended approach, +£141k for Wiltshire CCG and +£40k for West Hampshire CCG, due to under performance on the non elective element of the contract. An adjustment of £259k is included to increase income to reflect the under performance on the Dorset managed contract at Month 3.

NHS England and the Trust are working towards concluding remaining contract issues by 31st July 2019.

Cash Position & Capital Programme

Use of Resources

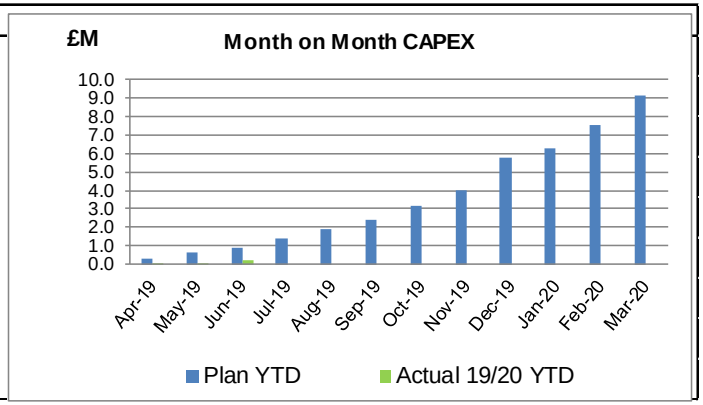


The Trust's working capital position is slightly ahead of plan. The majority of the extra non-recurrent income earned in the year to 31 March 2019 has been received. PSF funding of £4.5m will be received in full in July.

The cash flow will continue to be closely monitored during 2019-20 to ensure funds are available when required but the Trust is not planning for additional borrowing in 2019/20.

Capital Expenditure

Status	Position				
		Annual	Jun '19		
	Schemes	Plan £000s	Plan £000s	Actual £000s	Variance £000s
Capital Spend	Building schemes	700	0	10	(10)
	Building projects	1,814	195	71	124
	IM&T	3,540	450	21	429
	Medical Equipment	2,650	150	27	123
	Other	420	105	105	0
	TOTAL	9,124	900	234	666



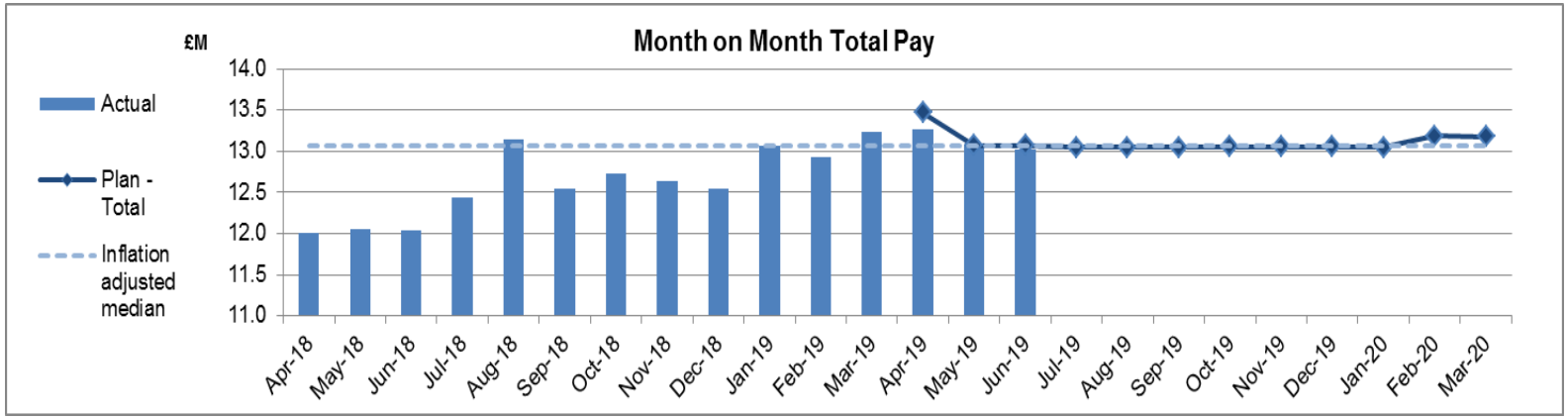
Variation & Action

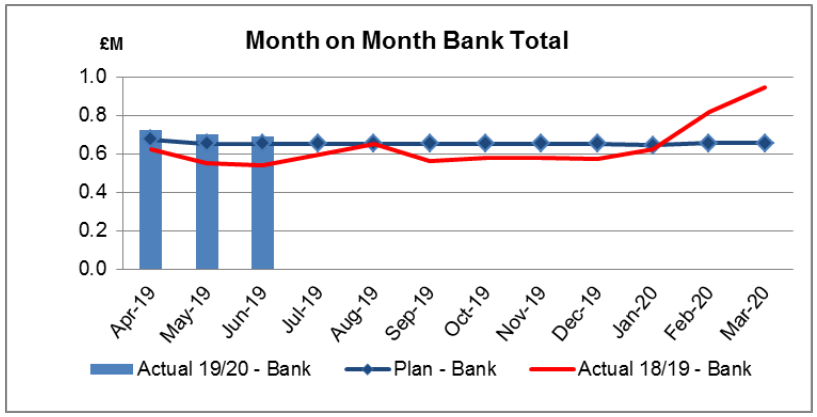
The Trust is financing its capital spend in 2019-20 through depreciation.

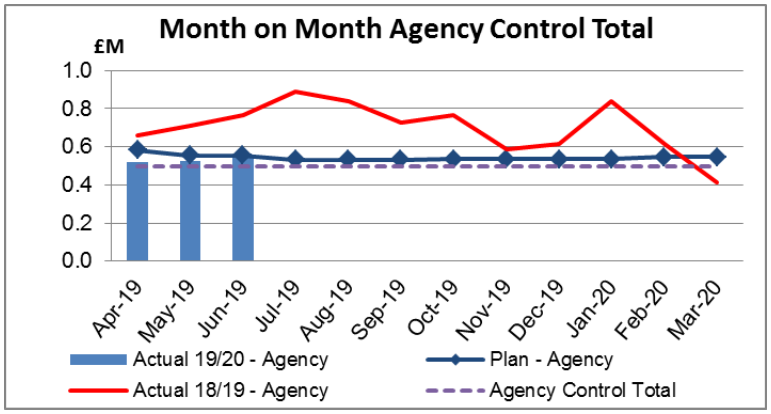
The Trust is anticipating to be behind plan for the first half of the year following a revision to the phasing of schemes within the capital programme. Expenditure is expected to come back in line with the plan later in the year with all funds fully spent by the year end. Plans are being monitored through the operational Capital Control Group which now reports into a Strategic projects group chaired by the Director of Finance.

Workforce and Agency Spend

Use of Resources







Pay expenditure of £13,020k in June is in line with planned expectation (Inclusive of a £689k CIP target). A £47k under delivery against the CIP plan is offset by an underlying vacancy factor, full delivery of the plan is therefore on a non-recurrent basis.

Agency costs were in line with plan at £560k, showing a modest increase on that reported in May due to the appointment of an agency consultant Histopathologist, a specialty with a known shortage at a national level. The other specialties being forced to cover consultant vacancies through agency are: General Medicine, Gastroenterology, Elderly Care, Emergency Medicine, and Dermatology. The Surgery and Medicine Directorates continue to mitigate nursing vacancies with the usage of Nursing Assistants, as demonstrated by the WTE and financial variance swings between the staff groups. Agency premium for the period is estimated at c£200k, spread evenly across the professional groups. The Trust has plans to increase its focus on hard to recruit areas in 2019/20 in order to continue the successful recruitment trend of the last 12 months.

Infrastructure staff WTEs reported for the laundry subsidiary have been corrected following the error flagged in May's report, leading to jump in the overall volumes reported of 72WTE.

Efficiency – Better Care at Lower Cost

Use of Resources

Status

Efficiency

Position							
Directorate	Annual Plan £000s	Jun '19			YTD		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	2,192	178	94	(84)	510	264	(246)
Musculo Skeletal	1,385	98	69	(29)	276	213	(63)
Surgery	1,728	135	103	(32)	397	220	(177)
Clinical Support & Family Services	1,965	143	97	(47)	418	285	(133)
Corporate Services	1,730	128	162	34	395	483	88
Strategic	1,000	40	24	(16)	(25)	69	94
TOTAL	**10,000**	**723**	**549**	**(174)**	**1,972**	**1,535**	**(437)**

Position							
Scheme	Annual Plan £000s	Jun '19			YTD		
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	1,068	123	0	(123)	267	0	(267)
Workforce	1,001	83	86	3	250	258	8
Diagnostics	600	42	42	0	125	125	0
Patient Flow	825	69	24	(45)	206	69	(137)
Outpatients	500	0	0	0	0	0	0
Non-Pay Procurement	1,494	112	111	(2)	281	275	(6)
Medicines Optimisation - Drugs	500	0	24	24	0	69	69
Clinical Directorate Plans	2,634	193	128	(65)	525	333	(193)
Corporate Directorate Plans	1,378	101	135	34	317	406	89
TOTAL	**10,000**	**723**	**549**	**(174)**	**1,972**	**1,535**	**(437)**

Variation & Action

The Trust has reported CIP delivery of £549k (76%) in June 2019, the shortfall YTD has been offset by non-CIP related budgetary underspends. Although the impact of non-delivery is mitigated in the short term, recurrent savings must be achieved to deliver the required improvement in the Trust's underlying financial performance.

Under performance is being driven by the theatres programme, where significant opportunities to improve list utilisation have been identified, but booking processes have yet to be adapted.

The patient flow programme has once again not met its financial target. The Trust once again managed without requiring it's escalation beds, delivering a saving of £24k but was unable to close down any of the 'core' bed base. The most notable operation KPI failure leading to this shortfall is the level of delayed transfers of care, currently running at over 20 higher than targeted.

CLASSIFICATION: please select

Report to:	Trust Board	**Agenda item:**	3.1
Date of Meeting:	01 August 2019		

Report Title:	Review of Standing Financial Instructions			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Mark Ellis, Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	Draft Standing Financial Instructions Draft Scheme of Delegation			

Recommendation:
To accept the proposed amendments to the Salisbury NHS Foundation Trust's Standing Financial Instructions, including changes to the delegated limits set out in the document and to update the text to accurately reflect the current decision structure of the organisation.

Executive Summary:
Following a review of the Trust's Standing Financial Instructions five key amendments are being proposed. The objective of these amendments are: to update the document in line with the current structure of the organisation, to improve responsiveness in decision making through targeted changes to delegated authorisation limits, and to improve the control environment and culture of the Trust by setting a clear standard in the signing of contracts.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐

CLASSIFICATION: please select

Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

1 Purpose

1.1 The purpose of this report is to brief the Board on the review of the Trust's Standing Financial Instructions, and to recommend amendments as appropriate.

2 Background

2.1 The Trust's Standing Financial Instructions (SFIs) have been in place since 1st December 2017. The SFIs are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs should be reviewed for effectiveness and appropriateness on a regular basis, the last such review of the Trust's SFIs was December 2017. Subsequent to this review opportunities to both streamline the decision making of the organisation, and improve controls around the signing of contracts have been identified.

2.3 Where the Board does elect to set delegated limits, the Chief Executive Officer remains ultimately accountable to the Board as Accountable Officer, retaining overall responsibility for the Trust's activities. All delegated powers can be re-assumed by the CEO should the need arise.

3 Changes to the decision management structure of the organisation

3.1 When the SFIs we last reviewed, the Joint Board of Directors (JBD) was the decision making body of the Trust management team, as set out in the SFIs. This forum has subsequently been replaced by the Trust Management committee (TMC).

3.2 It is recommended that all references to JBD in the SFIs are replaced by TMC, with all delegated limits remaining the same unless specifically recommended for amendment in section 4 of this review.

3.3 Where recommended changes relate to the delegated approval limits of Finance and Performance Committee, if approved a subsequent amendment to the delegated limits set by the Board will be required.

4 Delegated limits

4.1 <u>Revenue business cases</u>

At present the SFIs state in section 3.1.8:

Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to plans will be made in year for those that are subsequently approved. Business cases above £25k annual revenue implication are to be approved by the Joint Board of Directors (JBD) and subject to a business case recommended by the Trust Investment Group (TIG). Business cases less than £25k are subject to review and approval at the monthly Directorate performance review meetings.

The threshold up to which JBD (now TMC) may approve cases via the Chief Executive's delegated limit is set at £200, as set out in the Scheme of Delegation. In addition, at present Finance and Performance Committee has not delegated limit,

with all cases exceeding the £200k threshold required to go to Trust Board. As such, in order to improve responsiveness and autonomy around decision making it is recommended that section 3.1.8 is amended to the following:

Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to forecast will be made in year for those that are subsequently approved. Table # sets outs the delegated limits for the approval of business cases:

Table #

'In year' revenue value	***Authorisation to approve***
<£25k	*Division Management Team*
£20k to <£250k	*Trust Management Committee* *Chief Executive*
£250k to <£500k	*Finance and Performance Committee*
>£500k	*Trust Board*

4.2 Approval of Capital business cases

At present the SFIs state in section 12.2.2:

Approval of capital business cases will be as follows:

a) The Trust Board will approve any capital business case to be submitted to NHS Improvement.
b) The Cap CG may approve all in year schemes and virements up to £100,000. The JBD shall be informed via the minutes.
c) JBD may approve all in year schemes and virements from £100,001 to £200,000 and the Finance and Performance Committee and Trust Board notified.
d) All in year schemes over £200,000 (not included within the annual capital programme approved by the Trust Board prior to commencement of the year) will require approval by the Trust Board.

Two amendments to these limits are recommended: firstly an increase in TMC's delegated limit to £300k, and setting a delegated limit of up to £750k for Finance and Performance Committee. Both amendments are designed to improve the responsiveness of the organisation without diminishing the governance process of the organisation.

It is also recommended that the current programme allocation of 'Backlog Maintenance' is removed from the SFIs, to be replaced by 'Building and Works'. This reflects changes already made in the Capital Control Group (CapCG) reporting structure.

The amended section 12.2.2 should read:

Approval of Capital Business Cases will be as follows:

Table ##

Capital Plan	***Capital for new schemes (not in Capital Plan), or changes to the Capital Plan***	***Forum***
N/A	*<£200k*	*CapCG (TMC informed via minutes)* *Director of Finance*
N/A	*£200k to <£300k*	*TMC* *Chief Executive*
N/A	*£300k to <£750k*	*Finance and Performance Committee*
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	*£750k+* *Any proposed major scheme within FT compliance arrangements*	*Trust Board*
Any proposed major scheme within FT compliance arrangements	*Any proposed major scheme within FT compliance arrangements*	*NHS Improvement*

Where a capital scheme is approved within the annual capital plan, monitoring will take place through CapCG with only changes subjected to the delegated limits in table ##.

4.3 Placing Contracts

Section 7.3 'Placing Contracts' current states the following:

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 2 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 2.

Table 2

Contract Value	***Recommendation Report Requirement***	***Authorisation To Place or sign Contract***
<£10,000	*No*	*As per purchase order system approval hierarchy approval*
£10,000 – £24,999	*Recommendation report required only if contract has not be awarded to the most economically advantageous offer*	*As per purchase order system approval hierarchy approval*
£25,000 - £99,999	*Yes*	*Head of Procurement*
£100,000 – £249,999	*Yes*	*Director of Procurement*
£250,000 - £499,999	*Yes*	*Director of Finance*
£500,000 - £999,999	*Yes*	*Finance Committee*
>£1,000,000	*Yes*	*Trust Board/Chairman*

The Director of Finance, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

This section in the SFIs for placing contracts combines authorisation levels for the placing of requisitions and the signing of contracts. From a control environment and cultural perspective there is a clear benefit to being able to give a clear message that all contracts must be appropriately reviewed. As such it is recommended to remove the reference to the purchase order system, as it is already dealt with in section 7.2 of the SFIs, and to amend as follows:

Authorisation to sign a Contract and recommendation report requirements are detailed in Table ### below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table ###.

Table###

Contract Value (Excl VAT)	*Recommendation Report Requirement*	*Authorisation to place or sign Contract*
<£10,000 (inclusive of zero nominal value)	*No*	*Head of Procurement*
£10,000 to <£25,000	*Recommendation report required only if contract has not been awarded to the most economically advantages offer*	*Head of Procurement*
£25,000 to <£100,000	*Yes*	*Head of Procurement*
£100,000 to <£350,000	*Yes*	*Director of Procurement*
£350,000 to <£750,000	*Yes*	*Director of Finance*
£750,000 to <£1,500,000	*Yes*	*Finance and Performance Committee (minuted at trust Board)*
>£1,500,000	*Yes*	*Trust Board/Chairman*

The Director of Finance, Director of Procurement, and Head of Procurement may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

4.4 Contracting for Income

At present, Directorates have a delegated limit of up to £20,000 for the contracting of non-NHS income (annex 3), as stated in section 4.3 there is a clear control and

cultural benefit from removing an ambiguity around the authorisation for the signing of contracts. As such it is recommended that this limit is reallocated to the Director of Procurement, and the Deputy Director of Finance.

5 Recommendation

It is recommended that Audit Committee support the proposed changes for approval at Trust Board. Below is a summary of these changes:

1	Update JBD to TMC
2	Amendment to delegated limits for business cases: increase in TMC limit and creation of a limit for Finance and Performance Committee.
3	Amendment to delegated limits for capital expenditure: increase in TMC limit and creation of a limit for Finance and Performance Committee.
4	Removal of Directorate approval for signing of expenditure contracts
5	Removal of Directorate approval for signing of non-NHS income contracts

Mark Ellis
Deputy Director of Finance

Salisbury
NHS Foundation Trust

Standing Financial Instructions

Version:	**Audit Committee draft July 2019**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	
Signature of authorising Committee:	
Ratification Committee (Category 1 documents):	
Date of Ratification (Category 1 documents):	
Signature of ratifying Committee Group/Chair(Category 1 documents):	
Lead Job Title of originator/author:	**Director of Finance**
Name of responsible committee/individual:	**Lisa Thomas**
Date issued:	
Review date:	
Target audience:	**All Directorates**
Key words:	**Trust powers; Trust Board; Chairman; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Directorates**
Consultation:	**Audit Committee** **Executive Directors**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**55**
Type of document:	

Standing Financial Instructions

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Salisbury NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st June 2006, following authorisation by "NHS Improvement", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).

1.1.3 The *Single Oversight Framework* details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in *The Audit Code for NHS Foundation Trusts,* and the *Department of Health Group Accounting Manual (DH GAM)*, all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

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

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the 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 Standing Orders of the Board of Directors.

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

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the Director of Finance, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Trust Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

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

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

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

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Director of Finance (DOF)

1.2.4 The Chief Executive and DOF will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

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

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

The Director of Finance

1.2.7 The DOF is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

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

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

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

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the DOF include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

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

Board of Directors and Employees

1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

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

d) Conforming to the requirements of NHS Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

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

1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the DOF.

2. AUDIT

2.1 Director of Finance

2.1.1 The DOF is responsible for:

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

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

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

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Annual Governance Statement" and also provides assurances to the Audit Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

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

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

b) Access during normal working hours to any land, premises or members of the Board or employee of the Trust;

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

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

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

2.2.2 Internal Audit will review, appraise and report upon:

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

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

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

d) The efficient and effective use of resources;

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

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

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

g) Any investigations / project work agreed with and under terms of reference laid down by the DOF;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;

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

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

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

2.2.5 The reporting system for internal audit shall be agreed between the DOF, 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 "Audit Code," the "DH Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee.

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

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

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

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

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

2.3.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and DOF shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to NHS Protect's standards.

2.4.2 The DOF is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Protect anti-crime Standards.

2.4.4 The LCFS shall report to the DOF and shall work with staff in NHS Protect, in accordance with the NHS Protect anti-crime Standards, the anti-fraud manual and NHS Protect's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the DOF to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Protect.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the DOF and outcomes fed back to the Audit Committee.

2.4.8 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Protect.

2.4.9 The Trust will report annually on how it has met the standards set by NHS Protect in relation to anti-fraud, bribery and corruption work and the DOF shall sign-off the annual self-review and authorise its submission to NHS Protect. The DOF shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

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

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHS Protect anti-crime standards.

2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management

2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD). who is the Chief Operating Officer and also to the appointed LSMS.

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

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Trust Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in patient care activity, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS Improvement (NHSI).

3.1.2 The annual plan must be approved by the Trust Board and submitted to NHSI in accordance with their requirements.

3.1.3 All executive directors, directorate management teams and corporate service managers shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

3.1.4 The DOF will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Trust Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with patient care activity and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks and mitigating actions;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

3.1.5 The Trust Business Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.6 The DOF shall monitor financial performance against budget, and report to the Finance and Performance Committee and Trust Board of Directors.

3.1.7 All budget holders must provide information as required by the DOF to enable budgets to be compiled.

3.1.8 *Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to forecast will be made in year for those that are subsequently approved. Table 1 sets outs the delegated limits for the approval of business cases:*

'In year' revenue value	*Authorisation to approve*
<£25k	*Division Management Team*
£20k to <£250k	*Trust Management Committee* *Chief Executive*
£250k to <£750k	*Finance and Performance Committee*
>£750k	*Trust Board*

Table 1

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

3.2 Budgetary Delegation

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

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

e) Achievement of planned levels of service;

f) Authority to exercise virements.

g) The provision of regular reports.

3.2.2 Except where otherwise approved by the Chief Executive, taking account of advice from the DOF, budgets shall only be used for the purpose for which they were provided.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the DOF, subject to guidance on budgetary control in the Trust.

3.2.4 Non-recurring budgets shall be agreed by the Chief Executive or the DOF and should not be used to finance recurring expenditure without their authority in writing.

3.2.5 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.6 Clinical Directors or Service Leads, who are responsible for 'trading activities' must ensure the integrity and supply of information to other users. Price increases in such departments should be monitored by the DOF to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

3.3.1 The DOF will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Finance & Performance Committee and Trust Board of Directors in a form approved by the Trust Board of Directors containing sufficient information to allow the Finance & Performance and the Trust Board of Directors to ascertain the financial performance of the Trust. This may include the following:
   i) Income and expenditure to date, showing trends and the forecast year-end position;
   ii) Workforce spend and WTEs;
   iii) NHS commissioner's contractual performance to date;
   iv) Movements in working capital (including cash);
   v) Capital project spend and projected outturn against plan;
   vi) Explanations of any material variances from budget;
   vii) Details of any corrective action where necessary and the Chief Executive's and/or DOF'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 manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget-holder must account to their Directorate Management Team or line manager for the overspending and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

3.3.3 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Trust's Vacancy Control Panel, other than medical and nursing staff provided for within the budgeted workforce establishment.

3.3.4 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS Improvement's Single Oversight Framework, finance and use of resources metrics.

3.4 Capital Expenditure

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

3.5 Performance Monitoring Forms and Returns

3.5.1 The DOF on behalf of the Chief Executive, will ensure that the appropriate monitoring forms and returns are submitted to NHSI in accordance with the national annual timetable. The performance figures to the Trust Board of Directors should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The DOF, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS Improvement and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS Improvement as to their technical accounting content and information/data shown therein, before submission to NHS Improvement.

4.2 The Chief Executive will prepare the Annual Report in accordance with the guidance in the DH Group Accounting Manual.

4.3 The Director of Nursing will prepare the Annual Quality Report in the format prescribed by NHS Improvement/Care Quality Commission and in accordance with the DH Group Accounting Manual. The Quality Report presents a balanced picture of the Foundation Trust's performance over the financial year and up to the agreed submission date.

4.4 The Trust's Annual Report, Annual Accounts and financial returns to NHS Improvement and Annual Quality Report must be audited by the external auditor in accordance with appropriate international auditing standard, where relevant.

4.5 The Annual Report, Accounts and Quality Report (including the auditor's report), shall be approved by the Board of Directors after review by the Audit Committee. The Clinical Governance Committee will also review the Quality Report prior to its submission to the Audit Committee.

4.6 The Annual Report, Accounts and Quality Report (including the auditor's report) is submitted to NHS Improvement (in accordance with its timetable) by the DOF and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.7 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.8 The Chief Executive, Chairman and DOF, as appropriate, will sign the various documentation relating to the Annual Report, Annual Accounts and financial returns to NHS Improvements and Annual Quality Report on behalf of the Trust Board.

4.9 Where a subsidiary is owned or partially owned by the Trust in a manner to require consolidation under the requirements of IFRS then the annual accounts of the subsidiary will be completed as a part of undertaking the consolidated accounts for the Trust. Should the Trust be involved with an Associate Company the results will be reported in line with recognised accounting requirements.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The DOF is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The DOF will review the banking needs of the Trust at regular intervals to ensure they reflect current business patterns and represent value for money.

5.1.3 The Trust Board will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

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

5.2.2 The DOF is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made, or there is a right of set-off with another account held with that bank;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

f) Monitoring compliance with NHS Improvement or DH guidance on the level of cleared funds;

g) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The DOF will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit, if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

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

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

5.4.1 The DOF will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

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

6.1 Income Systems

6.1.1 The DOF is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

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

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

6.2.1 The Trust shall follow the "Payment by Results" ("PbR") financial regime determined by the DH where applicable.

6.2.2. The DOF is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Responsibility for arranging the level of property rentals, and for reviewing rental and other charges regularly shall rest upon the Director of Finance who shall take into account independent professional advice on matters of valuation. The Director of Finance shall be consulted about the pricing of goods and services offered for sale.

6.2.3 All Employees must inform the DOF promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The DOF is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Financial Controller
£10,001 to £100,000	DOF
£100,000 plus	Audit Committee

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

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The DOF is responsible for:

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

b) Ordering and securely controlling any such stationery;

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

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

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The Director of Finance shall be responsible for the arrangements for security and issue of bulk stocks of cheques.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the DOF.

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

6.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 14 Disposals and Condemnations, Losses and Special Payments).

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

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

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

Table 2

Contract Value (Excl VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 - Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage

of the procurement process.

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

The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

7.3 Placing Contracts

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 3 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 3.

Table 3

Contract Value	***Recommendation Report Requirement***	***Authorisation To Place or sign Contract***
<£10,000 (Inclusive of zero nominal value)	*No*	*As per purchase order system approval hierarchy approval*
£10,000 – £24,999	*Recommendation report required only if contract has not be awarded to the most economically advantageous offer*	*As per purchase order system approval hierarchy approval*
£25,000 - £99,999	*Yes*	*Head of Procurement*
£100,000 – £249,999	*Yes*	*Director of Procurement*
£250,000 - £499,999	*Yes*	*Director of Finance*
£500,000 - £999,999	*Yes*	*Finance Committee*
>£1,000,000	*Yes*	*Trust Board/Chairman*

The Director of Finance, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

7.4 Electronic Tendering

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

All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.12 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

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

7.5 Manual Tendering – General Exception Rules

No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.6 Receipt, Safe Custody and Record of Formal Tenders submitted manually

All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

The appropriate officer shall designate an officer or officers, not from the

originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.7.

7.7 Opening Formal Tenders

As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

Every tender received shall be stamped with the date of opening and if manually opened they shall be initialed by two of those present at the opening.

A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record, where a manual process has been conducted.

Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialed by two of those present at the opening.

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

7.8 Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Director of Finance, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

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

Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Director of Finance or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.8.

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

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

While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Director of Finance.

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

All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.10 below).

All tenders should be treated as confidential and should be retained for inspection.

7.9 Extensions to Contract

In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

7.10 Quotation & Tendering Procedures

Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2 and will involve procurement department in line with Table 2.

Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

No tender shall be considered which bears any mark or name indicating the sender.

Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

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

Tender lists for building and engineering works will be compiled in conjunction with the Director of Corporate Development from "Construction line" the Trust's approved list of Contractors.

Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Director of Finance for further instructions.

The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

Quotation/tenders will be completed accordance with these SFIs.

Adjudication must be made in accordance with SFI 7.8 recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

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

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

The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 2.

7.11 Quotation & Tendering Procedures Summary - Contracts

Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

No Pre Qualifications stages should be conducted in accordance with Public Contract Regulations
Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 2 in specified in SFI 7.2.

Quotations/ tenders will be issued in accordance with these SFI's and shall

incorporate standard NHS Terms and Conditions of Contract.

After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.8.

A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Table 2 in SFI 7.3 according to delegated limits.

All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee on a six monthly basis highlighting all waivers over £10,000 in line with STA's approved by the Director of Finance.

All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations.

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

7.12 Waiving or Variation of Competitive Tendering/Quotation Procedure

Signed Contracts will be required for all Single Tender Action waivers over £25,000.

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value out in in SFI 7.2 Table 2

b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with

c. The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (eg/ change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor

d. The expenditure relates to agency pay however internal governance and authorisation will apply

e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health

f. A direct award to a supplier on a national or regional framework is

permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with SFI 7.3 Table 2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. The requirement is to attend a seminar, conference or similar unique event

h. A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement but the nominated Officer must still ensure value for money

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Trust Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the NHS England (NHSE) or NHS Improvement are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

(a) Costing and pricing (in accordance with Payment by Results) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff. Any local price should be at least equal to the appropriate cost of the service being provided.

8.1.7 Any local changes in the counting and coding of patient activity will need to be notified to the DOF prior to implementation

8.1.8 The DOF shall produce regular reports detailing actual and forecast income.

8.1.9 The DOF shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

Annex

8.1.10 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs

and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where SFT is a competing body)

8.3.1 Where SFT participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Directorate Management Team	**Trust Management Committe**	**Finance & Performance Committee**	**Trust Board**
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£5m	<£15m	>£15m
Annual value	£20k pa	<£1m pa	>£1m<£5m pa	>£5m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to Executive Directors for noting.

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

9.1 Remuneration Committee

9.1.1 The Trust Board shall establish a Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and most Senior Manager Posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director Posts above the salary of the Prime Minister (currently circa £150k) must be referred to NHS Improvement and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Workforce Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees

after consultation with their Human Resources Manager and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off payroll engagements must be approved by the DOF prior to contract signature.

9.2.3 Each employee shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be submitted to the Director of Finance at the earliest opportunity.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the intranet.

9.2.6 A "Notification of Termination" form and such other documents as the Director of Finance may require, shall be completed and forwarded to the payroll department immediately upon the date of; an employee's resignation, retirement, or termination, being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Payroll Manager shall be informed immediately.

9.2.7 Changes forms covering an Employee's Personal Details i.e. Name, Address or Job Details shall be completed and forwarded to the payroll department immediately upon the Manager becoming aware of the change.

9.2.8 The Trust Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its Managing Implications of Organisational Change Policy.

9.2.11 The Trust must seek approval from NHS Improvement before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

9.3.1 The Director of Finance shall be responsible for the final determination of monetary pay, (including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts), the proper compilation of the payroll and for payments made. No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the Director of Finance.

9.3.2 All pay sheets, and other pay records including travel expense claim forms supported by vouchers/receipts where appropriate, shall be in a form approved by the Director of Finance (manual or electronic) and shall be certified and submitted in accordance with his/her instructions.

9.3.3 The Director of Finance shall determine the dates on which salaries and wages shall be paid.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed otherwise by the Director of Finance.

9.3.5 Payment shall not be made in advance of the pay dates determined as in 9.3.3 above except where prior approval has been obtained from the Chief Executive, Director of Finance (or duly appointed representative) or the Director of Organisational Development and People. In such cases the payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 Where the Trust HR Policies so allow, loans may be made to staff and recovered in accordance with arrangements that the Director of Finance and Director of Organisational Development and People shall determine jointly.

9.3.7 The Director of Finance shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours. Any claims over 3 months old will need to be approved by the DOF.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Director of Finance will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

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

10.3.1 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 Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the DOF shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition. Only for agreed goods and services (i.e. agency staff and utilities) should a good or service be obtained without a purchase order.

10.3.3 The DOF or if delegated, the Financial Controller, shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.4 The DOF will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

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

i) **Authorisation:**

- a list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are

evidenced;

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

iii) **Payments and Creditors:**

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

iv) **Financial Procedures:**

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.5 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

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

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The DOF must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.6 Managers must ensure that they comply fully with the guidance and limits specified by the DOF and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the DOF in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the DOF on behalf of the Chief Executive;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the DOF;

e) Petty cash records are maintained in a form as determined by the DOF;

f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and

g) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the DOF who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Where managers are unsure of the VAT status of any particular transaction advice will be provided from the Finance Department.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS Improvement's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Trust Board and will only be made by the DOF or a person with specific delegated powers from the DOF. Use of such loans or overdraft facilities must be approved by the DOF.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the DOF.

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

11.2 Public Dividend Capital ("PDC")

11.2.1 Any application for an increase in public dividend capital on behalf of the Trust shall only be made by the Director of Finance or their nominated representative and will be notified to the Trust Board or the Finance and Performance Committee on the Board's behalf.

11.2.2 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 Investment of cash on a short or long term basis shall be in accordance with the Trust's Treasury Management Policy as approved from time to time by the Finance and Performance Committee. The Director of Finance shall compile and regularly review the Trust's Treasury Management Policy and advise the Finance and Performance Committee of any necessary changes.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Trust Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

11.3.5 The DOF is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Finance and Performance Committee.

11.3.6 The DOF will prepare detailed procedural instructions on the operation of

investment accounts and on the records to be maintained.

11.3.7 The DOF (or a senior finance manager with specific delegated powers from the DOF) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Finance and Performance Committee.

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

12.1 Capital Investment

12.1.1 The Trust will establish a Capital Control Group (Cap CG) chaired by the Director of Finance to oversee its allocation of capital investment. The DOF will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The Cap CG will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The DOF shall establish systems to ensure that approved capital schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The financial performance of the Capital Programme shall be reported to the Trust Board on a monthly basis with fuller details of the larger schemes on a quarterly basis.

12.2 Approval of Capital Business Cases

12.2.1 *Approval of Capital Business Cases will be as follows:*

Table 4

Capital Plan	***Capital for new schemes (not in Capital Plan), or changes to the Capital Plan***	***Forum***
N/A	*<£200k*	*CapCG (TMC informed via minutes)* *Direcotr of Finance*
N/A	*£200k to <£300k*	*TMC* *Chief Executive*
N/A	*£300k to <£750k*	*Finance and Performance Committee*
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	*£750k+* *Any proposed major scheme within FT compliance arrangements*	*Trust Board*
Any proposed major scheme within FT compliance arrangements	*Any proposed major scheme within FT compliance arrangements*	*NHS Improvement*

Where a capital scheme is approved within the annual capital plan, monitoring will take

place through CapCG with only changes subjected to the delegated limits in table 4.

Programme allocations within Capital Plan	***Group/ individual responsible for approval***
Building and Works	The Building and Works Group
Medical Equipment	Medical Devices Committee
Information Systems	Information Systems Steering Group

12.3 Private Finance Initiative

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

12.4 Asset Registers

12.4.1 The DOF is responsible for the maintenance of registers to record capital fixed assets. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The DOF shall prepare procedural instructions on the disposal of assets.

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

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads.

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

12.4.5 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

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

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

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

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

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

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

12.5.3 The DOF shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the DOF who shall decide what further action shall be taken.

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

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for Equipment on loan.

12.6 Property (Land and Buildings)

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

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £200,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £200,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £200,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £100,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets requires the approval of NHS Improvement.

12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework requires the approval of NHS Improvement.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £200,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net reliable value. Inventory shall be controlled on a First in First out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the DOF for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the DOF. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; and the control of fuel oil the Head of Estates.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Logistics Manager wherever practicable; stocks should be marked as Health Service property.

13.1.4 The DOF, in conjunction with the Associate Director of Procurement, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the DOF and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the DOF.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the DOF.

13.1.7 The Director of Procurement shall be responsible for a system approved by the DOF for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the DOF (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net reliable value. The write down shall be approved by the DOF and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Director of Procurement shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The DOF shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice or the assistance of the Procurement department where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the DOF;

b) Recorded by the condemning officer in a form approved by the DOF 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 DOF.

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

14.1.5 Disposals of assets valued between £100,001 - £200,000k (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

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

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

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

14.2.4 The DOF is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHS Protect.

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

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

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

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

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

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Senior Information Risk Owner (SIRO), supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The DOF shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

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

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

15.1.5 Where computer systems have an impact on corporate financial systems the DOF shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Informatics Strategy;

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

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

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

It will be at the discretion of the Director of Corporate Development or the Director of Informatics whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

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

16.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the DOF.

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

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

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

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), and is responsible for the management of funds it holds on trust. For the purposes of these SFI's the Trust Board members shall be termed Trustees. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust with the exception that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and be made only with the approval of the Fund Manager appointed by the Trustees or the Trustees themselves. This section covers those instructions which are specific to the management and governance of funds held on trust.

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

17.1.4 The DOF has primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.2 Administration of Charitable Funds

17.2.1 The DOF shall:

a) Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust Board as Trustees of charitable funds. These shall be maintained in accordance with legislative requirements and any directions from the Charity Commission.

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within designated or restricted accounts in accordance with charity law;

e) Periodically review the funds, rationalise funds within statutory guidelines, and report changes to the Salisbury District Hospital Charitable Fund Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals to the Salisbury District Hospital Charitable Fund Committee at their quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Salisbury Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising and Incoming Funds

17.3.1 All gifts, donations and proceeds of fund raising activities are the responsibility of the Trustees and shall be handed immediately to the DOF to be banked in the Charitable Funds bank account.

17.3.2 All gifts accepted shall be receipted and held in the name of the Trustees and administered in accordance with the Trustees' policies, subject to the terms of specific trusts. As the Trustees can accept gifts only for all or any purposes relating to the Health Service, managers shall, in cases of doubt, or where there are material revenue expenditure implications, consult the DOF before accepting gifts.

17.3.3 The DOF shall advise the Trustees on the financial implications of any proposal for fund raising activities which may be initiated, sponsored or approved.

17.3.4 The DOF shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. All correspondence concerning legacies shall be dealt with on behalf of the Trustees by the DOF who alone shall be empowered to provide an executor a good discharge.

17.4 Investments and Investment Income

17.4.1 The Trustees shall be responsible for:

a) Appointing investments advisors to manage investments and provide relevant investment advice on these. Charitable funds shall be invested in a manner to maximize medium term value,

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

17.4.2 The DOF will allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Expenditure from any Charitable Fund shall be conditional upon the item being within the terms of the appropriate trust, the procedures approved by the Trustees and sufficient funds being available.

17.5.2 Day to day management of individual expenditure is delegated to Fund Managers who shall not enter into any transaction which will result in any fund under their control becoming overdrawn without first obtaining authorisation in writing from the DOF.

17.5.3 The DOF shall act on behalf of the Trustees in ensuring that all expenditure incurred is in accordance with the purposes identified by the donor.

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

17.5.5 A connected multiple orders could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.6 ***Levels of Authority***

No expenditure can take place without the approval of the following:

£	Orders can only be processed once the following people give their authority
Up to £10,000	The Fund Manager
Over £10,000	The Fund Manager + The Salisbury District Hospital Charitable Funds Committee (reported to the Trust Board)

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

17.6 Asset Management

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

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

17.6.3 The Charity shall not be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The DOF will be responsible for updating an annual risk register for

agreement by the Salisbury District Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. Public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. Breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

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

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Head of Corporate Governance for inclusion in the Register of Interests.

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

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

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

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

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Conflicts of Interest and Freedom to Speak Up: Raising Concerns policies, available via the intranet).

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

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

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS Improvement / DH guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	Director of Corporate Development
Building & Engineering Contracts	Director of Corporate Development & Director of Procurement
Estate Maintenance Contracts	Director of Corporate Development & Director of Procurement
Maintenance Contracts	Director of Procurement
Commissioner Contracts	Director of Finance
Contracts for goods and services other than the above	Director Procurement

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

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

19.3 Records and information held in accordance with latest NHS Improvement / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or DOF. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control

cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /NHS Improvement guidance.

20.2 Insurance

20.2.1 On an annual basis, the DOF shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Financial Controller shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.2.3 The Financial Controller shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Financial Controller shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3 Clinical Risk Management/CNST

20.3.1 The Director of Nursing shall:

a) Provide a central point of contact within the Trust for NHSLA/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

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

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

Up to £100k	NHSLA/Claims handler	Head of Litigation
£100k-£250k	NHSLA/Claims handler	Director of Nursing
£250k-£500k	NHSLA/Claims handler	Chief Executive
>£500k	NHSLA/Claims handler	Trust Board

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

21.2 Health and Social Care Act 2003 – NHS Charges

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

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

22. EMPLOYMENT TRIBUNALS

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

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

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

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

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

23. WHOLLY OWNED SUBSIDIARIES

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

24. RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, 'Attributing the costs of health and social care research and development' (AcoRD DH2012) using the national costing guidance/templates. Excess treatment costs should be submitted to CRN:Wessex for funding.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 The Standing Orders and other sections of the SFIs apply equally to the undertaking of research and this includes declaration of interests, security of assets, budgetary control, purchasing and contracting, charitable funds, and the section on casual gifts, hospitality and commercial sponsorship.

24.5 The submission of grant applications to support research shall be signed by the Director of Finance or designated representative.

24.6 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

24.7 The principles governing probity and public accountability shall apply equally to work undertaken through research.

Annex 1

Authorisation Levels For Electronic Requisitioning System

1.1 All staff authorised to approve the purchase of goods or services, and signing of invoices where appropriate, will be allocated an authorisation level. Each Directorate can set its own authorisation levels under Level 3 below (Levels 1 and 2 are shown as suggested levels only)

Level 1 - Up to and including £500 per total requisition (e.g. nurses, ward assistants, staff with requisitioning responsibility in smaller departments)

Level 2 - £501 - £5,000 per total requisition. The actual level of authority will depend on the work area and the following are examples**:**
- £1,000: requisitioning staff in larger departments
- £2,000: ward sisters
- £3,000: supervisory levels in departments, requisitioners in theatres, staff club manager
- £5,000: catering manager, medical physics manager, deputy head in genetics

Level 3 - £5001 - £10,000 per total requisition
- £10,000: DSNs, DMs, heads of larger departments
- £10,000: Head of Facilities

Level 4 - Up to £50,000 per total requisition: Deputy Director of Finance, Financial Controller

Level 5 - Up to £100,000 per total requisition: Chief Operating Officer, Director of HR, Director of Nursing, and Medical Director

Level 6 - Over £100,000 per total requisition (but subject to any other limits approved by the Trust Board): Chief Executive, Director of Finance

1.2 Each Directorate is responsible for compiling their own authorised signatories list, including determining which staff should be given authorisation below level 3.

Amendments to the above levels of authorisation may be approved in specific cases but will need to be approved by the Director of Finance.

1.3 The Finance Department will maintain a database of staff on each authorisation level per Directorate. Directorates will be responsible for notifying the Finance Department of any additions, deletions or other changes to their authorised signatories' lists. The Finance Department will ensure the database is amended to reflect the changes and ensure the computer security is amended accordingly**.**

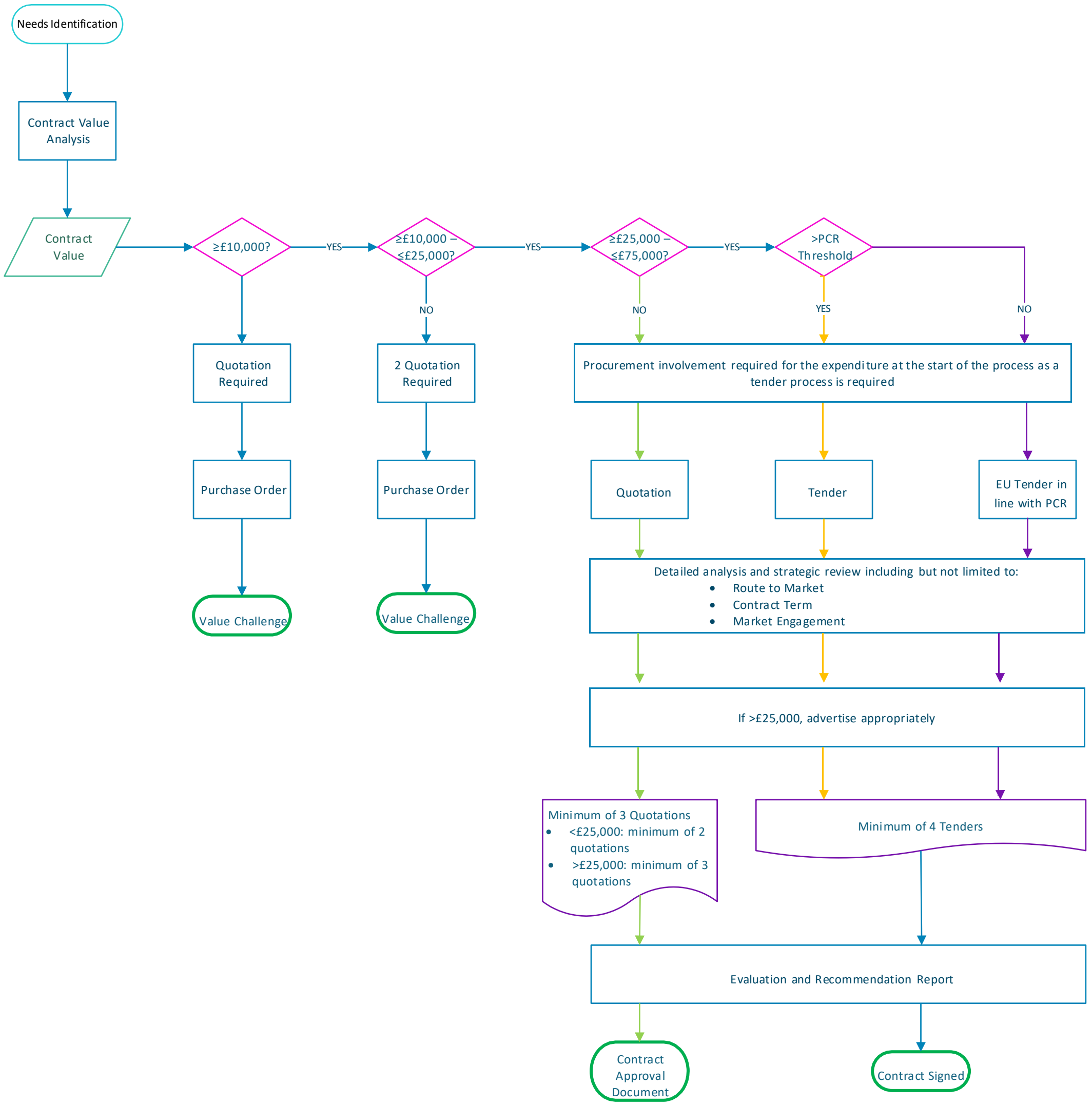
Authorisation Levels for Electronic Ordering System

2.1 All requisitions will be converted to Orders and processed within the Procurement Department where individual staff will have specific levels of authorisation below that of the Head of Procurement's £50,000 level. The electronic requisition will have already been authorised at the appropriate level within the organisation prior to receipt by Procurement.

2.2 The Director of Procurement will have authority to process orders up to - £350,000. Any orders beyond this amount will need to be authorised by the Chief Executive or Director of Finance.

Annex 2 Tendering & Contracting Procedures (where SFT is the procuring body)

Competitive Tendering Process Requirements



Annex 3

Contracting for Income - Financial Limits

NON NHS
All limits **exclude** Value Added Tax where applicable.

Lifetime Contract value	***Approval***
Up to £20,000 (Inclusive of zero nominal value)	***Deputy Director of Finance/Director of Procurement***
£20,000 to < £300,000	***DOF***
£300,000 to <£1.5million	***CEO***
£1.5m +	***Trust Board***

Lifetime Contract value (NHS)
Service Level Agreements
Up to £100,000,000 Director of Finance
Over £100,000,000 Chief Executive

Salisbury
NHS Foundation Trust

Schedule of Decisions Reserved to the Board and the Scheme of Delegation

December 2017

Introduction

1. The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. This document sets out the powers reserved to the Board and those that the Board has delegated.
2. The Board remains accountable for all of its functions; even those delegated to the Chair, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
3. All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee of the Board shall be exercised on behalf of the Board by the Chief Executive or another executive director.
4. The Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligations. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that targets are met.
5. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. Whilst the detailed responsibility can be further delegated the Chief Executive remains accountable for that responsibility to Board. All powers delegated can be re-assumed by him/her should the need arise.
6. The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.
7. In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Deputy Chief Executive Officer or in his/her absence by the Executive Director who is formally acting-up as Chief Executive. Formal acting-up status shall be confirmed in writing by either the Chief Executive or the Chair.
8. The Scheme of Delegation is reviewed annually.
9. As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

Schedule of Decisions Reserved to the Board

SFI Ref	Decision reserved to the Board
1.2.1	• Formulate the financial strategy • Approve budgets • Define and approve essential features of important procedures and financial systems • Define delegated responsibilities.
3.1.2	Approve the Annual Business Plan

4.5	Approve Annual Report and Accounts including the auditor's report.
5.1.3	Approve the opening of new bank accounts.
7.3	Authorise contracts with Suppliers which exceed £1.5m.
8.1.1	Regularly review and maintain capacity and capability to provide mandatory goods and services per the terms of the licence.
9.1.1	Establish a Remuneration Committee.
10.1.1	Approve the level of non-pay expenditure.
11.1.3	Approve application for a loan/overdraft.
11.1.5	Approve all long-term borrowing.
11.3.3	Approve investments made in forming/acquiring an interest in bodies corporate.
12.1.1	Establish a Capital Control Group.
12.1.3	Approve the Annual Capital Plan.
12.2.2	Approve all capital business cases above £750,000
12.6.2	Approve Estate Strategy and acquisition of property (freehold & lease) over £200,000.
12.6.8	Approve disposal of property over £100,000.
12.6.10 & 12.6.11	Seek approval from NHS Improvement for the disposal of protected assets and major disinvestments.
12.6.12	Approve the granting of property leases where the annual value is in excess of £200,000.
16.1	Provide safe custody for money and other personal property of patients.

Decisions/Duties delegated by the Board to Committees

Committee	Duties delegated by the Board
Audit Committee	See Terms of Reference (available from Head of Corporate Governance). In addition: SFI 11.3.2 Set investment policy. Oversee all investment transactions. Approve treasury policy. SFI 11.3.4 Approve short term investment vehicle.
Remuneration Committee	See Terms of Reference (available from Director of Corporate Governance)
Salisbury District Hospital Charitable Fund Committee	See Terms of Reference (available from Director of Corporate Governance)

Scheme of Delegation of Powers from the Standing Financial Instructions (SFIs)

SFI Ref	Delegated to	Authorities / Duties Delegated
1.1.8	Audit Committee	Referring action or ratification of any non-compliance with SFIs. Also need to be disclosed to the DOF.
1.2.6 & 1.2.9	Chief Executive	Ensuring that all members of the Board and employees of the Trust understand their responsibilities within SFIs.

1.2.7	DOF	• Ensuring that SFIs are appropriate and up to date • Implementing the Trust's financial policies • Maintaining an effective system of internal financial control • Maintaining records of financial transactions • Providing financial advice to Board and employees.
1.2.8 & 1.2.9	All directors, staff and contractors	Security of Trust property, avoiding loss, exercising economy and efficiency in the use of resources, and conforming to the Constitution, Standing Orders, SFIs and the Scheme of Delegation.
2.1.1	DOF	• 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. • Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards. • Ensuring that an annual internal audit report is prepared for the consideration of the Audit and Assurance Committee.
2.2.2	Head of Internal Audit	Reviewing, appraising and reporting upon compliance with established policies and procedures such as the Audit Code.
2.3	Chief Executive / Audit Committee	Ensure that an external auditor is appointed in compliance with the constitution and that they comply with the Audit Code. Ensure that the Council of Governors are aware as appropriate.
2.4	Chief Executive / DOF	Ensure compliance with the directions on NHS fraud and corruption. Appoint a Local Counter Fraud Specialist and consult with him/her as to the involvement of the police in cases of fraud and corruption.
2.5	Chief Executive	Control and coordinate security management. Appoint a Local Security Management Specialist.
3.1.1	Chief Executive	Submit to the Board the Annual Trust Business Plan which takes into account financial targets and forecast limits of available resources.
3.1.4	DOF	Prepare and submit an annual budget.
3.1.6	DOF	Monitor financial performance against budget and report to Board.
3.1.8	Chief Executive	Approve business cases up to £250,000.
3.1.8	Finance and Performance Committee	Approve business cases up to £500,000
3.1.9	DOF	Ensure that adequate training is delivered to budget holders to help them manage successfully.
3.2.1	Budget holders	The management of a budget to permit performance of a defined range of activities.

3.3	DOF	Devise and maintain systems of budgetary control including monthly reports to Board containing sufficient information to ascertain financial performance.
3.3.4	Chief Executive	Identify and implement cost improvement programmes.
3.5.1	Chief Executive/ DOF	Appropriate monitoring forms and returns are submitted to Monitor.
4.1	DOF	Prepare annual financial accounts and returns ensuring that they comply with current guidelines.
4.2	Chief Executive	Prepare an Annual Report.
4.3	Director of Nursing	Prepare the Annual Quality Account.
4.6	DOF	Submit the annual report and accounts to NHS Improvements.
4.8	Chief Executive & Chair	Sign the Statement of Directors' Responsibilities in Respect of the Quality Report.
5.1.1 & 5.4.1	DOF	Advise on and manage the Trust's banking arrangements ensuring that these are reviewed regularly.
5.1.2	DOF	Review banking arrangements.
5.2.2	DOF	Managing the Trust's Government Banking Service (GBS) bank account, establishing non-exchequer bank accounts, ensuring funds stay in credit unless arrangements have been made,
5.3	DOF	Prepare detailed instructions of the operation of GBS accounts and advise the Trust's bankers of the conditions under which accounts will be operated.
6.1	DOF	Design and maintain income systems.
6.2.2	DOF	Approve and review the level of all fees and charges.
6.2.3	All Staff	Inform the DOF of income arising from transactions which they have initiated.
6.3.1	DOF	Take appropriate recovery action on all debts.
6.4	DOF	Provide the required documents for recording cash, cheques and negotiable instruments, and ensure adequate system and procedures for handling cash etc.

7	Chief Executive	Arrangements for tenders where SFT is the procuring body.
7.8	Director of Finance	Report the acceptance of any late tenders to the Board.
7.11	DOF	Report all waiving of variation of competitive tendering/quotation procedures to Audit Committee.
8	Chief Executive	Arrangements for contracts re provision of services.
9.2.1	Budget holder	Recruit to vacancies provided that this is within the establishment.
9.4.1	DOF	Final determination of pay.
10.1.1	DOF	Determine level of delegation of non-pay expenditure to budget managers.
10.2	DOF	Set out the list of managers and their limits for requisitioning goods and services.
10.3.3	DOF	Prompt payment of accounts and claims.
10.3.4	DOF	Recommend the thresholds for quotations or tenders and prepare procedural instructions, ensure prompt payment and maintain a system for managing all amounts payable.
11.3.5 – 11.3.7	DOF	Determine the investments required and ensure that policies and procedures are drawn up for their operation and maintenance.
12.4.1	DOF	Maintain registers of assets.
12.4.2	DOF	Prepare procedural instructions in disposal of assets.
12.4.5	DOF	Approve procedures for reconciling fixed asset accounts to fixed asset register.
12.5.1	Chief Executive	Establish procedures for the control of fixed assets.
12.5.2 & 12.5.3	DOF	Approve asset control procedures and manage process.
12.6.2	Chief Executive	Approve acquisition of property up to £200,000.

13.1.2	DOF	Systems of control for stores and stocks.
13.1.4 - 13.1.5	DOF	Establish procedures for the management of stores and stocks.
14.1	DOF	Establish processes for disposals and condemnations.
14.2	DOF	Maintain a register of condemnations, losses and special payments, prepare a fraud response plan, and take appropriate actions for any losses, condemnations and special payments.
15.1.1	Senior Information Risk Owner	Devise and implement procedures to safeguard the Trust's data, programs and computer hardware, have regard to the Data Protection Act 1984, ensure adequate controls over data entry, processing, storage etc.
15.1.2 – 15.1.5	DOF	Ensure that financial systems are appropriately procured and tested; ensure that there are adequate controls in operation in place.
16.1.3	DOF	Arrangements for the administration of patient property.
17	DOF	Ensure that the charitable funds are appropriately administered and managed.
17.2.1	DOF	Prepare the Charity's annual accounts for audit and authorise transactions of funds between investment vehicles.
18.1	Chief Executive	Ensure all staff are aware of the behaviour expected of all staff as set out in the Conflict of Interests Policy.
19	Chief Executive	Maintain archives for all records, information and data.
20.1	Chief Executive	Ensure that the Trust has a risk management policy and procedures and that these are monitored.
20.2.1	DOF	Review membership of the Non-Clinical Risk Pooling Scheme and other insurance arrangements.
20.2.2 – 20.2.5	DOF	Liaise with insurance brokers; ensure timely reporting of incidents, losses and submission of claims against the third party liability scheme and insurance provision.
20.3	Director of Nursing	Manage claims on NHSLA and report activity to Board.
21	Chief Executive	Managing claims from staff, patients and the public.
22	Chief Executive	Managing Employment Tribunals.

23	Wholly owned subsidiary	Manage governance process.

Other issues to be delegated

10. Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Director of IM&T
Health and Safety Arrangements	Director of Organisational Development and People
Terms and conditions for non-AfC staff	Chief Executive provided this is in line with the AfC terms and conditions

11. This scheme of delegation covers only matters delegated by the 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 should produce a scheme of delegation for matters within his/her Directorate. In particular the scheme of delegation should include how the directorate budget and procedures for approval of expenditure are delegated.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	01 August 2019		

Report Title:	Collaborative procurement			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Mark Ellis, Deputy Director of Finance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

Recommendation:
The Committee is asked to approve the proposed changes, and for the recommendation to proceed to full board for approval.

Executive Summary:
Collaborative procurement allows us to share procurement resource, reduce duplication which can result in fewer tendering exercises, which leads to lower administrative costs. However the approval of the award has to navigate multiple organisations which in turn can lead to delays and in part reduce the benefits of such collaboration. This paper proposes a clear structure to how the SFT board may tackle approval of complex collaborative procurement contracts.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Introduction

Collaborative procurement is a means for SFT to deliver greater efficiencies through combined purchasing power, and with the trusts in the STP under pressure to deliver more for less; collaborative procurement has had to become embedded in the procurement process with the Banes Swindon and Wiltshire STP and with wider partners.

Collaboration provides an integrated approach to delivering procurement solutions, and helps the Trust to drive efficiencies, reduce risk and save money by buying together, through aggregating our volume and spend and committing to the market. In addition to the STP the Trust is part of wider collaborations such as the South six Pathology network, aligning to other trusts in Hampshire and Dorset.

Working with other procurement functions, collaborative procurement allows us to share procurement resource, reduce duplication which can result in fewer tendering exercises, which leads to lower administrative costs. However the approval of the award has to navigate multiple organisations which in turn can lead to delays and in part reduce the benefits of such collaboration. This paper proposes a clear structure to how the SFT board may tackle approval of complex collaborative procurement contracts.

Context

The benefits of collaborative working have been proven in the past 12 months within the STP in that:

- Helps STP trusts, leverage their combined purchasing power to deliver savings that would not be possible if we were purchasing alone.
- Collaborative procurement means that SFT can work with other organisations and expand their purchasing scale, which will bring down the average cost per unit.
- For example, the tender on managed print and cardiology, radiology and endoscopy together as an STP has seen the Trusts approach the market as one with their aggregated requirements, rather than have a separate deal for each organisation resulting in a higher cost per unit.
- It has also enabled the procurement functions at the 3 trusts to drive standardisation of best practices in procurement, which can help our organisation become more efficient, improve process management and save money in the long run by sharing procurement knowledge, expertise and experiences.
- Additionally, having a dialogue with other trusts interested in procuring the same solutions is a good way to benchmark our own performance and find out how you shape up against your peers.

Collaboration across the STP have been successful and the number of procurement exercises run as a collaborative with other trusts will continue to increase as the agenda for collaborative procurement grows and the need to share resource and aggregate spend to drive value and make best use of the resource we have grows. By its nature aggregation and collaboration centres around large value long term contracts that are often worth in excess of £1m spend which under SFT's Standing Financial Instructions needs to go to finance and Performance Committee and Trust board for approval.

Proposal

With the need to approve efficiently and at pace it is considered that a change to the SFI's is required to give the Finance and performance committee as a committee of the board full power in approving procurement contract awards above £500k rather than going to board as a secondary step and potentially holding up the procurement contract award process. This would enable more timely and efficient approval of collaborative contract awards without over burdening Trust board meetings with a duplicate review.

This would require a change to the terms of reference of the Finance and performance committee and the Trust standing financial instructions. It would support the recent discussion on streamlining the roles of the board committees. To ensure the wider board has full oversight, it would recommend that the approved contracts are included in the monthly escalation reports.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	1st August 2019		

Report Title:	Skill Mix Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		X	**X**	**X**
Prepared by:	Fiona Hyett, Deputy Director of Nursing Fiona Coker, Head of Maternity Services			
Executive Sponsor (presenting):	Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Appendix 1: Policy Context Appendix 2: Calculating Care Hours per Patient Day Appendix 3: Ward Staffing ratios Appendix 4: Birth – Midwife Ratios			

Recommendation:

This paper is presented to Trust Board:

- Discuss assurance on nursing and midwifery workforce risks and actions
- To provide an update on the impact of investment from the 2018 full skill mix review

Executive Summary:

Purpose:

- The report provides an update on the skill mix review which took place in 2018.
- The report is presented in full as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board of all aspects of the 6-monthly staffing reviews.

Background:

- A 6-monthly staffing review has been published to TMC (formally JBD) and Trust Board since it became a requirement in 2014. The review findings have been reviewed at the Nursing and Midwifery Forum.
- In November 2013 as part of the response to the Francis Enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This

guidance was refreshed and broadened and re-issued in July 2016 to cover all staff and to include the need to focus on safe, sustainable and productive staffing.

- SFT has developed a sustainable model for systematically reviewing staffing levels across all in-patient wards which has been strengthened year on year and that uses nationally recognized methodologies.

Key Findings

- Recruitment and retention remains the biggest risk to sustaining safe staffing levels, initiatives in this arena are starting to impact on vacancy levels and reduce the reliance on temporary staffing.
- Good performance across nurse sensitive quality indicators has been sustained

Recommendations:

The attached paper that will be presented to Board in August includes the following recommendations:

- To note the findings of the 6 monthly skill mix review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels
- To note the analysis completed which will be further updated in next full skill mix review
- To note the continued challenge that arises from nurse vacancies but note the impact in reducing vacancies from the continued focus on recruitment and retention initiatives
- To note the continued challenge that arises from nurse vacancies but note the impact in reducing vacancies from the continued focus on recruitment and retention initiatives
- To note the roll out of Safer Nursing Care tool across the Trust to ensure future skill mix reviews will have fully evidence-based staffing data as a triangulation point
- To note that nurse staffing is subject to change due to changes in acuity and dependency and patient volume and these will be reported on in the full skill mix review in December 2019. Particular focus is being given to the following areas who are experiencing change in model and/or demand (additional areas may arise through the full skill mix review):
    - Britford SAU
    - Farley and Pitton
    - Paediatric Outreach Service Team (POST) which was recruited to in 2017 – this service is currently subject to evaluation.

Trust Board August 2019

Title	Nursing Skill Mix Review Update
Meeting Date	August 2019
Sponsoring Executive	Lorna Wilkinson – Director of Nursing
Author	Fiona Hyett – Deputy Director of Nursing

1.0 Background

This report provides an update on the full skill mix review that took place in 2018 and forms part of the reporting requirements that every Trust is expected to have in place. The National Quality Board guidance on Safe Staffing (2016) sets out in expectation 1 that *' Boards should ensure there is an annual staffing review, with evidence that this is developed using a triangulated approach. …. This should be followed with a comprehensive staffing report to the Board after 6 months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.'*

The last full skill mix review was presented to Board in February 2019 and a full skill mix review will be reported to Board later this financial year. This paper is presented to provide an update/report on key areas and provide assurance of current staffing levels.
It is important to note that nursing requirements do change overtime due to the acuity/dependency and overall case mix changes which leads to the requirement to undertake an annual strategic staffing review/skill mix review. This report fulfils the need to consider whether current staffing plans are appropriate following implementation of the 2018 skill mix review recommendations.

This review is intended to provide an update and will focus on the following areas:

- Review of recommendations from 2018 skill mix review
- Overview of Insights Data to assure the workforce is deployed efficiently and effectively
- Care Hours Per Patient Day summary
- Recruitment and Retention update
- Key areas of challenge for nursing with updates from the directorates
- Maternity/Neonates

2.0 Policy Context

The full policy context has been provided in previous skill mix reviews, and can be found in appendix 1. Of note there additional requirements have been placed on Boards through Developing Workforce Safeguards which came into force in April 2019. The Carter review (2016) recommended the introduction of Care Hours per Patient Day (CHPPD) in order to provide a single comparable metric for recording and reporting nursing and care staff deployment NHS Choices now publishes data on CHPPD instead of the previous planned vs unplanned metric.

3.0 Review of Previous Recommendations

The Trust Board agreed £583k of investment into nursing following the 2018 skill mix review, £109k was additional funding.

The table below shows the investment agreed at Board in February 2019 which went into budgets from April 2019. The impact of this will be reviewed within the Directorate summaries.

Investment for 2019/20	**£ amount**	**Comments**
ED: Uplift of 3 x Band 6 to Band 7 0.5 B6 Clinical Educator 1 x B5 twilight shift (1.33wte)	 £2,319 £23,250 £60,268	Already included in run rate was approved in interim review
AMU: 1 x B2 Night Shift (2.55wte) 1 x B2 Day Shift (2.55wte) 1 x B5 Day shift (2.55wte)	 £67,111 £54,198 £95,351	Already included in run rate was approved in interim review
Pitton: Convert 1 x B5 to B6 1 x B5 night shift (2.55wte)	 £3,164 £109,974	Would be offset by reduction in cost on specials
Farley Cost of on-call rota (yet to be worked out) 1 x B2 twilight shift (1.33wte)	 N/K £35,003	Not approved - carry forward to next year skill mix review
Amesbury 1 x B2 night shift (2.55wte) 1 x B5 late shift (1.66wte)	 £67,111 £62,189	Already included in run rate was approved in interim review
Breamore Convert 1 x B5 to B6	 £3,164	Approved
Total	£583,102	£431,797 offset as within run rate £109,974 additional funding

4.0 Assessment/Findings

4.1 <u>Efficient and Effective Utilisation and Deployment of Staff through the use of INSIGHTS</u>

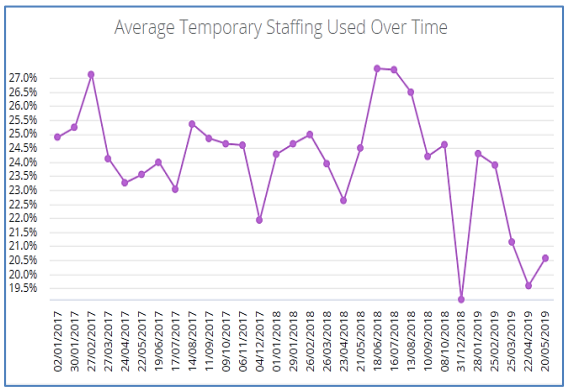
The Trust remains an Allocate Exemplar site and accesses Allocate-Insights – a managed service that combines monthly reporting, metrics and benchmarks designed to measure performance in rostering productivity and efficiency against 6 key metrics (Carter 2016). The Trust compares favourably when benchmarked providing assurance of effective deployment of substantive and temporary workforce efficiently.

The six key metrics are:

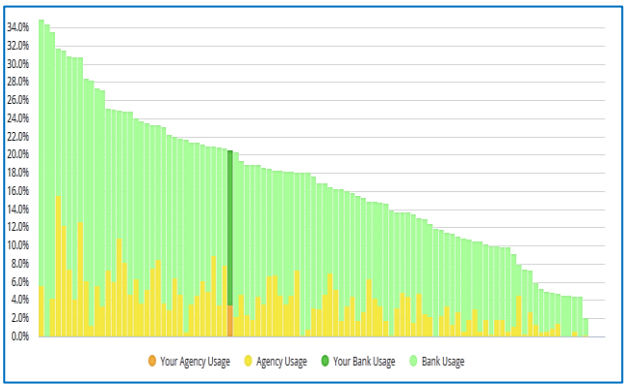
- Temporary staffing
- Roster approval lead time
- Unavailability (Headroom)
- Additional Duties
- Unfilled Duties
- Hours Balance

These metrics are viewable via a portal and enables a view of our performance both as a Trust with comparisons at ward level and also against all other Trusts using the portal, including those of similar size, Foundation Trusts and acute Trusts. A monthly call is held with the Insight team and progress against goals evaluated. Analysis below provides detail of each key metric and our current performance. An overview graph has been provided for each metric.

Temporary Staffing –percentage of the roster that is made up of temporary staff both bank and agency, and percentage of temporary staffing that is agency.



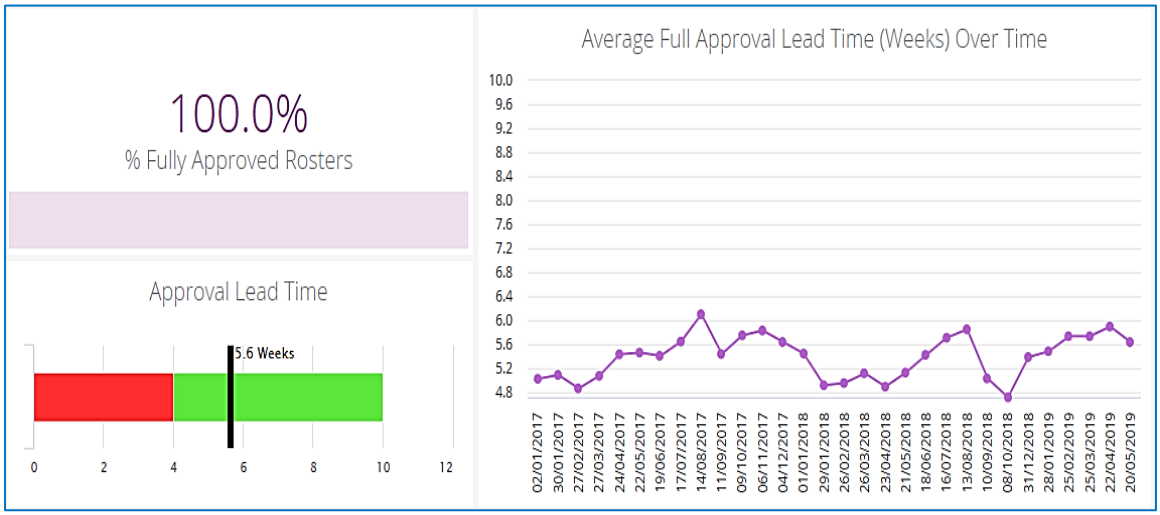
Trust View



Multi-Trust Comparator

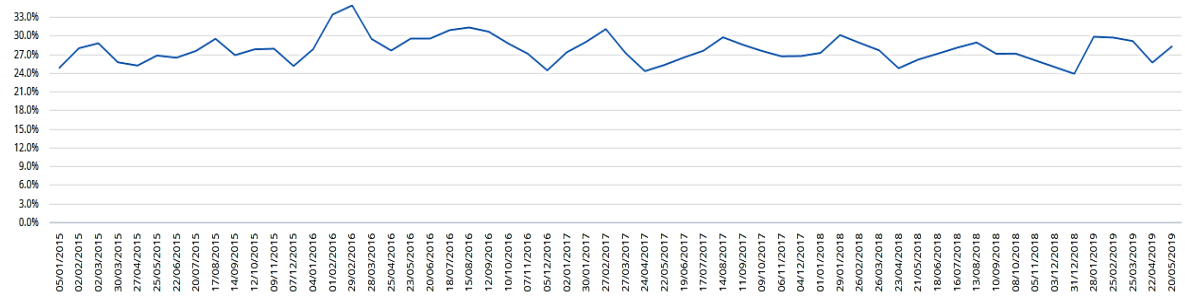
Analysis: Reduction in amount of temporary staffing being used in this year can be seen. This is as a result of improved vacancy position and less use of escalation capacity, and a significantly improving position. The 2nd graph shows split between agency and bank usage and how we compare to other organisations using the portal for the latest report.

Roster Approval Lead time – Effective Rostering Guide expectation rosters published minimum of 6 weeks in advance.



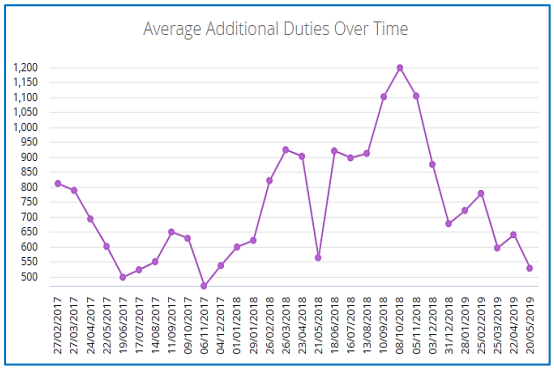
Analysis: Following a dip at the end of 2018, roster approval has improved and currently sitting at 5.6weeks, this has improved as result of E-roster team sending out reminders where rotas not approved.
All rosters are reviewed and have second sign off by the DSN and if they reject rosters this can impact on achieving 6 weeks. This KPI is subject to re-focus and close scrutiny through roster check and challenge meetings.

Unavailability (Headroom) –measures amount of staff rostered but who are not providing direct patient care; includes annual leave, study leave, parenting, sickness, working day and other.



Analysis:
The actual headroom has remained consistent, with same seasonal spikes. Actual headroom sits between 24-30%, compared to 19% headroom in budgets, with budget for maternity leave held at directorate level.

Additional Duties –number of additional shifts added to the roster template when extra staff are required and is broken down into legitimate reasons such as patients requiring enhanced care, high acuity, additional beds, induction/supervision and avoidable reasons such as using up staff hours or staff patterns where extra shifts are added to meet staff requests.



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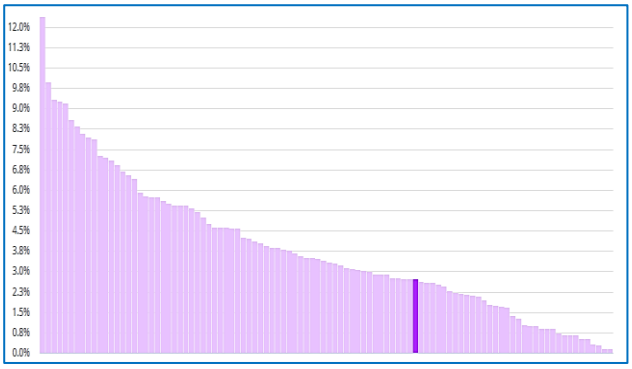
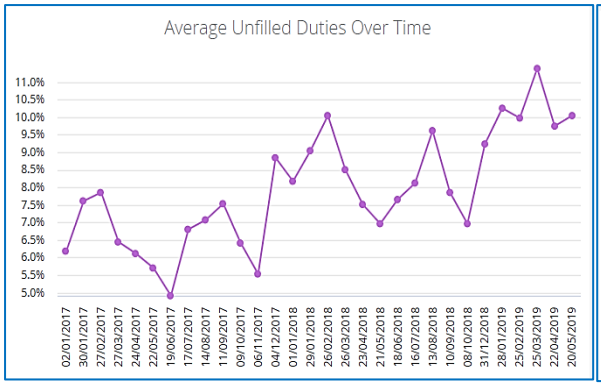


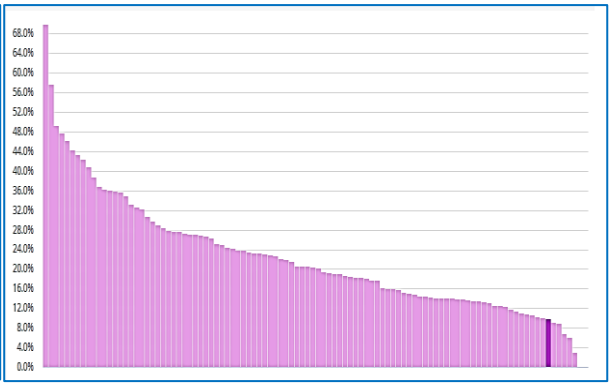
Multi-Trust Comparator

Analysis: Over the last year the number of additional duties has decreased. The main reason for use is for patients with enhanced care needs and induction/supervision of new staff (high due to overseas recruitment). Escalation capacity has been decreased this year compared to last. When benchmarking against others we are amongst the best performing - an improvement on last year.

Unfilled Duties –number of shifts that go unfilled on a roster measured in 2 ways – unfilled duty hours excluding additional shifts and unfilled roster which includes additional duties.

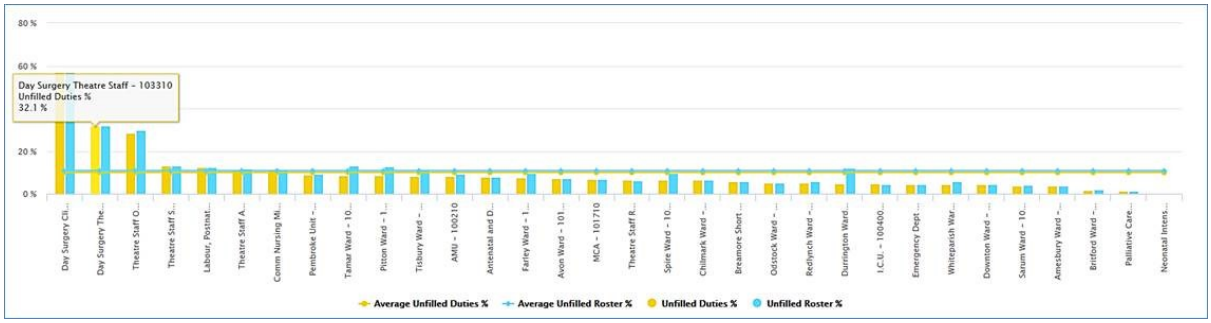


Trust View

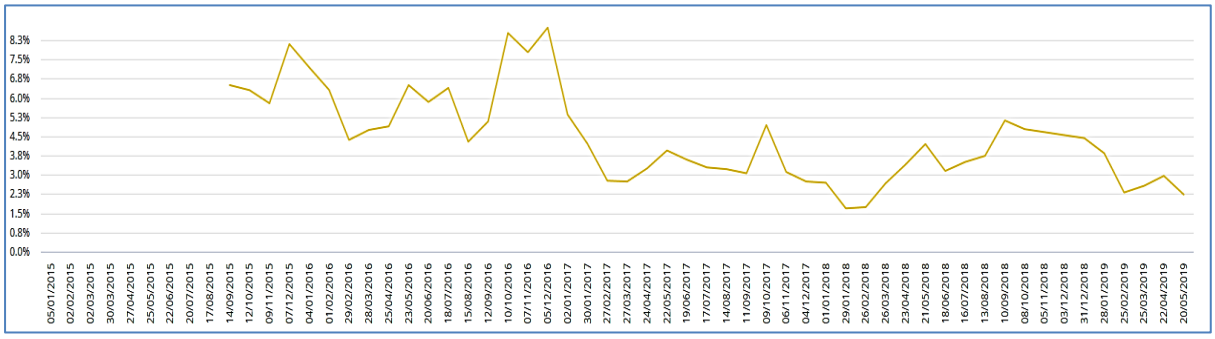


Multi-Trust comparator

Analysis: There has been an increase in this metric when a decrease would have been anticipated, however on further scrutiny it can be seen from the graph below that 3 areas within theatres skew the data for other areas (the unfilled in theatres is due to housekeeping of roster rather than actual unfilled duties). When benchmarking with other users of portal we remain one of the top performers for this metric – Trust current average of 11.4% compared to 26.7% for similar sized Trust.



Hours Balance –measures the hours balances on and between rosters i.e. ensuring staff hours are fully utilised.



Analysis: Again it can be seen over time that we have made a significant improvement since the introduction of Allocate, although there has been a slight increase over last couple of months which will be reviewed through Roster Check and Challenge meetings, and again is as result of theatres being rolled out this year. Nationally we remain one of the top performers with our average currently maintaining at 4.1% against benchmark of 16.1% for similar sized Trusts.

4.2 Care Hours per Patient Day

In Lord Carter's Review (2016) Operational productivity and performance in English NHS Acute Hospitals: Unwarranted variations.; an approach of reporting Care Hours per Patient Day (CHPPD) was recommended in order to provide a single comparable metric for recording and reporting nursing and care staff deployment. Revised guidance was produced by NHS Improvement (NHSI) in August 2018. The guidance mandates the use of planned versus actual CHPPD to measure deployment of the workforce and this report reflects this methodology, further information on how this is calculated is included in Appendix 2.

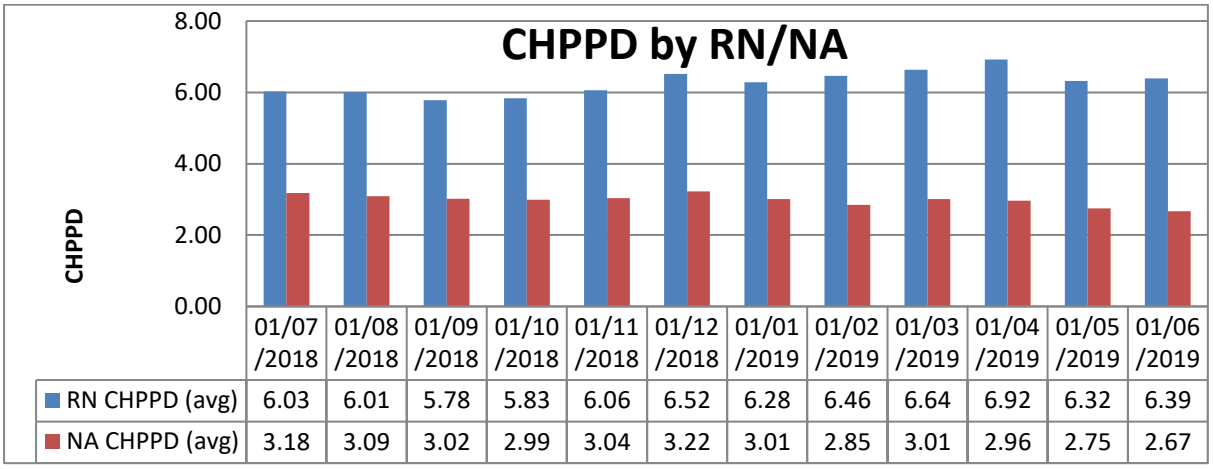
CHPPD data for June 2019

Table 1 shows the CHPPD data by ward and by RN/NA and combined for June 2019, and table 2 shows data by average per staff group for previous year. This shows an overall increase which is likely to be reflective of the reduction of vacancy rate.

Table 1

	RN	NA	Combined
Ward	**Jun-19**	**Jun-19**	**Jun-19**
Amesbury	3.06	2.77	5.83
AMU	6.25	3.51	9.76
Avon	4.06	4.15	8.20
Breamore Short Stay	3.33	2.53	5.86
Britford	5.74	3.53	9.27
Chilmark	3.44	2.60	6.04
Downton	3.15	2.48	5.63
Durrington	2.75	3.07	5.82
Farley	3.40	3.29	6.69
Hospice	5.84	4.95	10.79
Maternity	12.90	0.00	12.90
NICU	18.20	0.00	18.20
Odstock	4.97	2.82	7.79
Pembroke	5.25	2.31	7.56
Pitton	3.84	2.76	6.60
Radnor	28.25	2.84	31.08
Redlynch	3.16	2.71	5.87
Sarum	9.87	1.11	10.97
Spire	2.70	3.40	6.09
Tamar	2.95	3.57	6.52
Tisbury	4.84	1.49	6.32
Whiteparish	2.71	2.78	5.49

Table 2



	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019
RN CHPPD (avg)	6.03	6.01	5.78	5.83	6.06	6.52	6.28	6.46	6.64	6.92	6.32	6.39
NA CHPPD (avg)	3.18	3.09	3.02	2.99	3.04	3.22	3.01	2.85	3.01	2.96	2.75	2.67

The total Care hours per patient day (CHPPD) can be used as a measure to compare available staffing with peers, however this needs to be done with caution as the specific configuration of services in any organisation will determine what level of CHPPD a Trust would require. Of note below shows how SFT compares to both the national average, and to peer Trusts (through Model Hospital).

National Average	8.1 CHPPD
Peer median	7.9
Salisbury Trust Average	7.9

Model Hospital April 2019 (latest data)

From September the Integrated Performance report will no longer report planned vs actual hours but will instead reflect CHPPD and will include planned vs actual.

Appendix 3 gives the current nurse to patient ratios based on ward establishment; the challenge with the on-going vacancies is in ensuring these ratios are maintained balanced with avoiding the use of temporary staff.

4.3 Safer Nursing Care Tool

Developing Workforce Safeguards underpins the requirements for trusts to undertake a systematic annual staffing review in which evidence based staffing levels are triangulated with nurse sensitive indicator data and professional judgement. To date the trust has taken the evidence based staffing element of this from SafeCare, part of the electronic e-rostering system (Allocate). As the validity of this has not been tested, it is recommended that for future skill mix reviews we adopt an evidenced based tool such as Safer Nursing Care Tool (SNCT), which is currently the only tool to have been endorsed by NICE.

Using SafeCare within Allocate does allow assessment of the acuity and dependency levels of the patients in real-time i.e. on a shift, against both the budgeted roster template and the actual staff on duty and is fully embedded across the Trust.

The use of SafeCare has now been operationalised in the twice daily staffing meetings and is used to support decisions to review any gaps in shifts and review where staff can be moved or whether escalated to agency. This will continue with the introduction of SNCT.

The data from SafeCare will be used as a proxy for the Safer Nursing Care tool until the SNCT can be fully implemented and data collected which will take the minimum of 1year – as at least 2 data points are required across the year.

4.4 Recruitment and Retention

Nationally the number of RNs employed by the NHS in England grew by 0.5% between July 2017 and 2018 but vacancies were reported as 41,000, and significant increases in activity pressures have been experienced.

This picture has been mirrored at the local Trust level; however over the last year RN vacancies have reduced and are now at 13% compared to 24% in last years' report.

Nurse recruitment and retention has been identified for specific focus and attention in the NHSi/E Interim People Plan with opportunities for bringing new staff into the NHS identified. These include training more nurses, though 2018 saw the second year of a reduction in the number of applications for nurse degrees due to the removal of the bursary combined with dip in number of 18yr olds, international recruitment which whilst welcomed is constrained by broader migration policies and the uncertainties of Brexit, and improving staff retention, although there are some early indications of benefits from programmes this is not seen across all sectors.

The Trust has had a focused recruitment plan, with successful international programme taking over 60 nurses over the last year. The number of students the Trust can support has increased and we are diversifying educational providers. From September will also be taking an additional 20+ students from both the University of Winchester and the University of Southampton through a programme for international student nurses. The Trust also has a nurse retention plan in place in partnership with the NHSi Retention programme.

Work continues in growing our own registered workforce through career development opportunities, 7 Nursing Associates completed their training programme in March of this year and a further cohort of 14 has commenced training this year. Nurse degree apprenticeships are available nationally, however due to the backfill requirements significant investment is required and is therefore subject to a business case which is being developed.

4.5 Directorate Updates

Clinical Support and Family Services

Staffing on Sarum is mainly compliant with the RCN recommended nurse:patient ratio of 1:4, where not met this is due to patient acuity, staff sickness and maternity leave, and the outreach nurse is utilised to support ward staffing. The nursing leads on NICU and Sarum have worked well together to provide cross cover when there are appropriately trained staff available, this has resulted in a noticeable reduction in agency nurse use.

Sarum ward have also trialled a new location for the High Dependency Unit, locating it in a bay close to the nurses' station. This trial has further promoted safe staffing on Sarum as the layout and location mean that 1 nurse can safely care for 2 HDU patients (+/- a low acuity patient if ward at maximum capacity), whereas previously HDU patients would either be cared for in cubicles or in an area that was a distance from the nurses' station and made staff feel isolated.

Provision of paediatric outreach has been ad hoc due to the above. In the absence of a paediatric nurse on Day Surgery Unit (recruitment unsuccessful), regular bank shifts have been assigned to a paediatric nurse and DSU shifts are covered by Sarum whenever possible if outreach unavailable. Similarly, recruitment of a band 6 paediatric nurse in the Emergency Department (ED) has been challenging, so paediatric outreach support ED whenever possible but are not always able to physically assist, however telephone advice is often given.

There is currently 1 paediatric nurse vacancy outstanding within Sarum ward. A business case is being completed for an additional play therapist, who would support areas across the trust (theatres, DSU, ED, etc) as well as Sarum.

Musculo-Skeletal Directorate
The last skill mix review increased the RN establishment on Amesbury ward on the late and night shift which has greatly improved nursing care and patient experience, supporting the increased elective activity which sees post-operative patients return from recovery and help facilitate any remaining discharges, and the flow of patients between orthopaedic wards as a result of template to support GIRFT requirements.
Whilst the uplift in staffing was directly attributed to Amesbury ward, ongoing flexing and distribution of staff across both orthopaedic wards (Amesbury and Chilmark) ensures even coverage and ability to flex to match acuity and demand.
Odstock has seen a significant reduction in RN vacancies and anticipate to be fully staffed by September 2019. A plan to over-recruit is being investigated to enable constraints with burns/plastics capacity being managed by flexing into orthopaedic beds.
The spinal unit has 10 RN vacancies. The progression bed initiative is ongoing and awaiting NHSE approval. If approved it would allow for amalgamation of the wards and would reduce the current vacancies.

Surgical Directorate
Surgical Wards – maintain good levels of recruitment with minimal vacancies.
Surgical Assessment Unit (on Britford) has seen increase in number of patients attending – to an average of 15patients per day. The DMT have agreed a trial from July of an additional RN on a late shift from Monday – Friday. The previous skill mix review suggested an increase in administrative support which has been beneficial, freeing clinical staff from administrative duties.
ITU – have approximately 6wte vacancies, which are starting to reduce although the skill mix is junior, and the department have appointed international nurses for the first time. ITU are also looking at recruiting a newly qualified nurse for the first time and will support them in a rotation programme across medical and surgical wards before gaining competencies in ITU nursing.
Day Surgery Unit ward - there are vacancies in both the ward and theatres. Recruitment is ongoing and the main issue is to recruit a paediatric nurse who will support DSU ward nurses when children are having surgery in DSU. Currently the outreach team support when possible but if there are more than 4 children 2 paediatric nurses are required. DSU is working with Sarum ward to recruit a nurse who will send time in both DSU and Sarum.

Medical Directorate
The last skill mix review increased the RN establishment in the Emergency Department (ED), Acute Medical Unit (AMU) and Pitton ward, this has led to an improvement in both patient and staff experience but vacancies in all of these areas means that the full impact has not yet been realised. ED has benefited from the additional band 7 posts enabling more senior oversight, particularly on night shifts, and the clinical educator role has been well received and has supported skills training and development of junior workforce. The additional night shift on Pitton ward has been a resource shared across the directorate if the acuity on the ward is lower.
Medicine continues to be the most challenged with vacancies and there are approximately 35RN and 8NA vacancies although this is an improved position on last year, there has been a correlating decrease in temporary staff expenditure. The directorate remain engaged with all recruitment initiatives.
Known areas of challenge within the directorate which need to be explored in further detail at the full skill mix review include:

- Pitton ward report finding their reduction in in the numbers or RNs on a weekend to be challenging when the acuity on the ward is high and this will be explored further at the full skill mix review.
- Farley in relation to provision of thrombolysis nurse at nights which is reliant on backfilling with temporary staff
- Pembroke in relation to chemotherapy trained nurse provision and current absence of lead nurse.

In summary for the in-patient wards the planned establishments currently appear appropriate but with the main risk in sustaining this lying with recruitment and retention. There are a few key areas that will require further analysis due to new roles or increase in workload, and these will be presented in the full skill mix review:

- The trial within Britford Surgical Assessment Unit of an additional RN Monday-Friday to meet the increase in demand
- The Trust invested in the Paediatric Outreach Service Team (POST) which was recruited to in 2017 – this service is currently subject to evaluation.
- Acuity of patients on Farley and Pitton and required staffing resource

5.0 Maternity and Neonatal

5.1 Maternity

The Midwifery workforce is reviewed on a monthly basis alongside acuity and activity, using the evidence based tool Birthrate+©. Over the last year the midwife to birth ratio has decreased from 1:30 to 1:28,which is the nationally recommended level and also needs to be seen in the context of rising acuity levels amongst pregnant women. Detail can be found within Appendix 4.

5.2 Neonatal

The Neonatal Service remains a level 2 Local Neonatal unit with 10 cots and continues to comply with the standards set by the British Association of perinatal Medicine (BPAM); an expectation of the National Neonatal network. The acute unit has fluctuating activity as would be expected but has only escalated 8 times in the last 12 months, compared to 66 times the previous year. Escalation has been necessitated by absence and on occasion by acuity suggesting the skill mix is correct, which previous gap analysis and the peer review confirmed. This reduction in escalation has been due to new leadership in the team which has led to an improved moral and enhanced responsiveness and early evidence from the culture survey within the Maternity and Neonatal Safety collaborative supports this

Key challenge within the neonatal continues to be maintaining level 2 status within the network, where this is a drive to re-designate smaller units alongside a national drive to keep babies out of neo-natal unit.

6.0 Recommendations

The Board is asked to:

- To note the findings of the 6 monthly skill mix review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels
- To note the analysis completed which will be further updated in next full skill mix review
- To note the continued challenge that arises from nurse vacancies but note the impact in reducing vacancies from the continued focus on recruitment and retention initiatives
- To note the change from reporting planned vs actual nursing hours to planned vs actual CHPPD in line with national reporting requirements

- To note the roll out of Safer Nursing Care tool across the Trust to ensure future skill mix reviews will have fully evidence-based staffing data as a triangulation point
- To note that nurse staffing is subject to change due to changes in acuity and dependency and patient volume and these will be reported on in the full skill mix review in December 2019. Particular focus is being given to the following areas who are experiencing change in model and/or demand (additional areas may arise through the full skill mix review):
    - Britford SAU
    - Farley and Pitton
    - Paediatric Outreach Service Team (POST) which was recruited to in 2017 – this service is currently subject to evaluation.

Nurse Staffing Requirements – Policy Context

In February 2013, Sir Robert Francis QC published his final report of the inquiry into failings at Mid Staffordshire NHS Foundation Trust. Compassion in practice, the strategy for nurses, midwives and care staff (2012), the Francis report and the government response, Hard truths: the journey to putting patients first, led to fundamental changes in how NHS provider boards are expected to assure they are making safe staffing decisions. In November 2013 the National Quality Board set out these expectations in relation to getting nursing, midwifery and care staffing right. It provided a clear governance and oversight framework alongside recommended evidence-based tools, resources and examples of good practice, to support NHS providers in delivering safe patient care and the best possible outcomes for their patients. The National Institute for Health and Care Excellence (NICE) undertook work to produce guidelines on safe staffing for specific care settings, which led to the publication of Safe Staffing for Nursing in Adult In-patient Wards in Acute Hospitals and Safe Midwifery Staffing for Maternity Settings.

The Carter report and the NHS Five Year Forward View planning guidance make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and e-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

Nursing and midwifery leaders have built on Compassion in practice to create a national nursing, midwifery and care staff framework, Leading change, adding value. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the 'Triple Aim' measure of better health outcomes, better patient experience of care and better use of resources.

The 2015 Shape of Caring report recommended changes to education, training and career structures for registered nurses and care staff and is aimed at maximising the capabilities and contribution of healthcare assistants/ support workers/nursing associates to meet patient needs and provide fulfilling job roles and career pathways in nursing.

As an integral part of developing their Sustainability and Transformation Plans, local health and care systems need to develop local plans for how they will develop, support and retain a workforce with the rights skills, values and behaviours in sufficient numbers and in the right locations.

In July 2016 the NQB published an updated set of expectations for nursing and midwifery staffing which are aimed at helping NHS providers make local decisions that deliver high quality care for patients within their available staffing resource.
The first two sections of this guidance brings together the work of the Carter team and sets out key principles and tools which Boards can use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services.
The third section updates 3 of the expectations that form a triangulated approach (Right time, right staff, right place) to making staffing decisions. This triangulated approach moves from having judgements made based solely on numbers or ratios to one which decides staffing levels based on patients' needs, acuity and risk.

The box below show measures that can be used alongside CHPPD to demonstrate and understand the impact of staffing decisions on the quality of care that patients are receiving in acute inpatient wards.

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well-Led Care</th></tr>
<tr><td colspan="3">Measure and Improve
-patient outcomes, people productivity and financial sustainability -- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -</td></tr>
<tr><td colspan="3">- Implementation Care Hours per Patient Day (CHPPD) -
- develop local quality dashboard for safe sustainable staffing -</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff
1.1 evidence-based workforce planning
1.2 professional judgement
1.3 compare staffing with peers</td><td>Right Skills
2.1 mandatory training, development and education
2.2 working as a multi-professional team
2.3 recruitment and retention</td><td>Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency</td></tr>
</table>

NHS Improvement safe staffing improvement resources are now available for a range of care settings including: mental health, learning disability, acute adult inpatients, urgent and emergency care, neonatal and children and young people's services, maternity services, and community services.
In January 2019 Safe, sustainable and productive staffing improvement resource for the deployment of nursing associates in secondary care was issued.

In October 2018 NHSi issued Developing workforce safeguards which provide a comprehensive set of guidelines on workforce planning and new recommendations for the reporting and governance approaches to safe staffing. From April 2019 NHSi and CQC will be assessing all providers' compliance with the recommendations within the guidance to ensure a consistent approach to workforce decision-making. The 14 key recommendations are framed around:

- Effective workforce planning
- Deploying staff effectively
- New and developing roles
- Structured and systematic approach to workforce challenges
- Addressing risk and impact on quality
- Responding to unplanned workforce challenges
- NHSi approach to annual assessments and the integration of workforce into the standard operating framework

CALCULATING PLANNED AND ACTUAL CHPPD

CHPPD is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24 hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.

Twice a year each in-patient clinical area are required to assesses the care needs of patients in their ward/department, using an evidence based tool to help determine the Nurse/Midwifery staffing required to provide safe, compassionate and effective care to meet the needs of those patients, in Nursing the tool is the Safer Nursing Care Tool (SNCT) and in Midwifery it is Birthrate+©. Currently in nursing this is done via SafeCare as a proxy, but dull SNCT will be rolled out across the coming year. The result of this assessment, together with professional judgement is used to inform the number of Nursing and Care Staff needed on each shift. This forms the basis of the templates entered onto the e-Rostering system to calculate the planned staffing hours each calendar month.

The actual number of hours worked by permanent Nursing / Midwifery / Care Staff and those worked by temporary Nursing / Midwifery / Care Staff on a ward or department during that calendar month is extracted from the e-Rostering and bank systems. Both these systems should be up-to-date and accurate, however the logistics of extracting data from all clinical areas are complex and there is a degree of manual adjustment required in addition to the data extract. As a result the data will be accurate at a Trust and Hospital level but this is more difficult to achieve at a ward level.

Calculating CHPPD takes the actual hours from the safe staffing return and the daily patient count at midnight aggregated over the course of the month for each ward or department.
SFT's current reporting for CHPPD includes Registered Nurses/Registered Midwives (RNs/RMs) and Nursing Assistants (NAs). Guidance has now been issued to record Nursing Associates and Allied Health Professionals when they are included in a ward establishment (and e roster) to be included in the care hours per patient day reported. The upgrade of the e-rostering system in the summer of 2019 will enable this to happen.

CHPPD is different to the previously used planned hours versus actual hour's methodology in that it allows comparisons between staffing levels of different sized wards/departments; it is a single comparable figure using patient and staffing data, rather than considering each in isolation and it enables the differentiation between RN and NA skill mix for reporting purposes. It will be expected that the CHPPD will differ between wards and specialties to reflect the different needs of the patients being cared for; Critical Care areas for instance are likely to have much higher CHPPD than other areas because their patients will be receiving either 1:1 care (CHPPD would be a minimum of 24) or 1:2 care (CHPPD would be a minimum of 12).

Example:

RN hours worked (24 hour) + CSW hours worked (24 hour)

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Average daily count of patients in beds at 23.59 for the month

The limitations of using the 23.59 daily count for patients is acknowledged within the guidance as this single figure does not take into account hour by hour fluctuations in ward activity and is particularly limiting to those wards/departments that undertake large amounts of day case type activity, or have a high throughput such as assessment units, however, it offers a consistent point of time for benchmarking. CHPPD data will need to be used in triangulation with other methods for assessing staffing demand and patient acuity and dependency and should not be used in isolation.

Furthermore it does not take into consideration the competencies and level of experience required and other activities required on wards for example mentorship, preceptorship, training and appraisal completion.

Appendix 3 **Skill Mix Update Summer 2019**

Staffing Ratios by Ward

Ward	RN: Patient Ratio (Early)	RN: Patient Ratio (Late)	RN: Patient Ratio (Night)	Comments
Medicine				
AMU	1:4.8	1:4.8 (4.1from midday*)	1:4.75 (after midnight)**	19 beds and 10 ambulatory trolleys (area of high turnover) *Monday – Friday only **beds only not ambulatory
Durrington	1:7	1:7	1:10.5	
Farley	1:6	1:6	1:10	
Hospice	1:5	1:5	1:5	
Pembroke	1:5	1:5	1:5	
Pitton	1:5.4(6.75)	1:5.4 (6.75)	1:6.75	() is weekend ratios
Redlynch	1:6.75	1:6.75	1:9	
Tisbury	1:4.5(2.75)	1:4.5(2.75)	1:5.75	() is CCU ratios
Spire	1:7.5	1:7.5	1:10	
Whiteparish	1:7	1:7	1:11.5	With B4 then 1.5.75 on day shift.
MSK				
Amesbury	1:8	1:8	1:10.6	
Avon	1:5.25	1:7	1:7	
Chilmark	1:6	1:8	1:12	
Plastics & Burns	1:4.25	1:5.6	1:5.6	
Tamar	1:7	1:7	1:10.5	
Surgery				
Britford	1:5	1:5	1:7	SAU – 6 bay ambulatory area additional at 1:6 during day opening, 1:3 on late shift during trial
Downton	1:5.5	1:7.3	1:12	
Braemore	1:7	1:7	1:10	Based on the 20 beds
Radnor	ICS Levels of Care 1;1 or 1:2			10 beds commissioned from April 2016
CSFS				
Sarum	1:4	1:4	1:4	Based on 12 commissioned beds

Midwives to Births Ratio
(excluding HOM & non clinical time)

Aug-18	**76.21**	**198**	**0**	**198**	**1:31**	**31.18**	**30.3**
Sep-18	**76.21**	**180**	**2**	**182**	**1:29**	**28.66**	**29.9**
Oct-18	**76.56**	**194**	**2**	**196**	**1:31**	**30.72**	**30.1**
Nov-18	**76.56**	**166**	**3**	**169**	**1:26**	**26.49**	**29.5**
Dec-18	**78.56**	**160**	**2**	**162**	**1:25**	**24.75**	**29.2**
Jan-19	**79.56**	**184**	**3**	**187**	**1:28**	**28.21**	**29.0**
Feb-19	**79.56**	**164**	**1**	**165**	**1:25**	**24.89**	**28.7**
Mar-19	**79.56**	**185**	**2**	**187**	**1:28**	**28.21**	**28.7**
Apr-19	**79.56**	**162**	**4**	**166**	**1:25**	**25.04**	**28.4**
May-19	**79.96**	**204**	**1**	**205**	**1:31**	**30.77**	**28.1**

Since Jan 2017 ratio is based on midwife establishment minus non clinical percentage as recommended by Birthrate Plus©
From Oct 2018 actual establishment has exceeded budget to manage Maternity lead cover)
Total Births sourced from E3 reports
Ratios are rounded to nearest integer

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	01 August 2018		

Report Title:	**Guardian of Safe Working Annual Report on Rota Gaps and Vacancies: Doctors and Dentists in Training.**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Dr Juliet Barker, Guardian of Safe Working			
Executive Sponsor (presenting):	Paul Hargreaves			
Appendices (list if applicable):	Aug 18 new starters grid report			

Recommendation:
That the board be aware we are significantly understaffed (relative and absolute) at junior doctor level.

Executive Summary:
About 45% of our doctor shortfall is filled with trust grade doctors, but even with full rotas the workload is excessive and patient and doctor safety is potentially compromised.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Purpose

To delineate the extent of rota gaps within the junior doctor workforce and draw attention to the areas of concern generated by exception reports.

Background

There have been 253 exception reports detailing 283h overtime, almost exclusively from medical doctors – predominately F1s.
The vast majority are reporting weekday overtime hours.
The general theme is that there are not enough doctors to do all the work within hours.
There have been 7 immediate safety concern reports, pertaining to both weekend working and week day working.
7 reports have cited lack of support.
There are 3 reports citing missed educational opportunities.
Compensation payment has been agreed in 109 cases, 20 received time off in lieu and the remainder is still 'pending' or no further action.
There are significant rota gaps (see appendices) particularly at senior level in obs & gynae, plastics and general medicine.
Trust doctors are used to fill many of the gaps, however:
127 WTE months (10.6 WTE doctors) remain unfilled across the junior doctor spectrum, including less than full time gaps and deanery gaps.
Of note, the F1 cohort has been completely filled, however they are the main exception reporting group.

High level data

Number of doctors / dentists in training (total):	162
Number of doctors / dentists in training on 2016 TCS (total):	146

Annual Rota Gap Summary

Summary of the grade and specialty where the rota gap is *not* completely filled.

(Several rotas have gaps that *are* completely filled by trust grades).

Specialty	Grade	Deanery allocated posts (WTE)	Unfilled gap (WTE in months)	Number of months of gap filled.	Number of months unfilled
Anaesthetics	ST3+	5	2	0	2
Dental	DCT	4	2	0	2
General medicine	GPVTS	4	6.6	0	6.6
	F2	5	2.4	0	2.4
	CMT1/2	8	12	8	4
	ST3+	12	18.2	9	9.2
Obs and Gynae	ST3+	4	30.6	22?	8.6??
T&O	ST3+	6	4	0	4
Paediatrics	GPVTS	4	6	0	6
	ST3+	4	11	5	6
Plastics	F2	2	1.2	0	1.2
	ST3+	10	40.8	6	34.8
Primary Care	F2	3	8	0	8
Palliative	ST3+	1	1.6	0	1.6
General Surgery	ST3+	6	7.2	0	7.2
Histopathology	ST3+	1	9	0	9
Spinal/rehab	ST3+	1	7	0	7
Oral surgery	ST3+	1	7.4	0	7.4
Total					**127**

Issues arising

The rota gaps are due to a variety of issues including: less than full time workers in a full time slot, maternity leave and no doctor being allocated by the deanery. I estimate we have about a 10% shortfall – which is partially (just under 45%) filled with trust grades.

We are under-doctored as a hospital (i.e. other hospitals of a similar size have more doctors). This is historical – the conversion from Calman posts (house officer, senior house officer, registrar etc.) to MTAS posts c2007 was not direct and possibly the estimated new post number was too low.

In obstetrics and gynae, all 4 WTE deanery posts were filled by doctors either working part time and/or going on maternity leave. This caused a significant shortfall in numbers and was partially backfilled by trust grades.

Plastic surgery at ST3+ level also has very high vacancy numbers. The registrars submitted formal complaints about their rota last autumn, and a large number of 'protesting' exception reports (recorded as zero hours for these calculations). They have since started a new rota and received back pay for the time they were non-compliant.

There are difficulties in recruiting due to a lack in appropriately qualified doctors for the posts that remain unfilled.

Actions taken to resolve issues

Significant numbers of rota gaps have been filled with trust grade doctors, across all specialties and grades.

Requests for additional deanery posts have been made but have yet to have been allocated.

Internal locums have been provided to help during weekend medical takes and have had a notable effect on reducing the workload.

Summary

There are significant junior staffing issues in this trust. We are >10 whole time equivalent doctors short AFTER backfilling with trust grades. The actual shortfall is

much higher: about 18 whole time equivalents – 10% of posts. This is probably still not enough doctors to do the job, even if all deanery allocated posts are full.
At least 97 whole time equivalent months have been filled with trust grade doctors (8 WTE doctors)
Even in areas where all rota spaces are filled or covered, there are still reports of not enough doctors to do the job. Requests for more doctors from the deanery have not proved successful. Night working and senior decision makers at night have been noted to be particularly deficient (via the hospital at night committee). Out of hours medical work at weekends is especially onerous, although the extra locum shift has helped. Filling this internally though increases working hours and pushes struggling juniors closer to the brink of overwork. It is not a sustainable proposition.

I cannot currently assure the board that staffing in this trust is adequate. These issues have been raised at the workforce committee repeatedly. A shape of workforce report is being written to help define where the gaps in the workforce lie – it is not as simple as just looking at the rota gaps. Other options such as non-medical support (phlebotomy services, prescribing pharmacists etc) have been considered but do not solve the underlying problem of lack of seniority and pair of hands to do the job.

Recommendations

We define what our true staffing requirements are. The workforce report should answer this.
Once defined, how do we go about filling the gaps? Further deanery requests? Further reliance on trust grades? What can be done to make Salisbury an attractive place to work?
HEE has allocated SFT £60k to improve facilities for doctors working at night. Can this be utilised in part to make Salisbury more attractive?
Would restructuring the on call systems help? The hospital at night structure was designed for a very different situation (in terms of numbers and morbidities of patients) that the juniors now face. If so, a greater number of doctors to work a more padded rota would be needed. The same is true to increase the numbers of doctors at weekends.

Dr Juliet Barker

Consultant Anaesthetist, Guardian of Safe Working Hours, July 2019

Copy of Aug 18 New Starters Grid report.x

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	01 August 2019		

Report Title:	Board Evaluation Process			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	Appendix 1: Board Evaluation Tool Appendix 2: Good Governance Maturity Matrix			

Recommendation:
The Board to agree the process and content of the Board effectiveness evaluation

Executive Summary:
The NHS FT Code of Governance sets out the principles for evaluation and states "The board of directors should undertake a formal and rigorous annual evaluation of its own performance". The Code provisions include that the board of directors should state in the annual report how performance of the board has been conducted. The Chairman and Chief Executive have agreed to the following proposal being presented for approval by the Board. It is proposed that the following inform the board evaluation: • Facilitated 360 review • Board member questionnaire (Appendix 1) • Board member self-assessment against the Good Governance Maturity Matrix (Appendix 2) • Annual report 2018/19 overview of performance • Review of board papers – the purpose of papers to better understand the balance of items being considered If the above is approved, the review will take place throughout August/September 2019 and the outcome reported to the Board in October 2019.

Board Assurance Framework – Strategic Priorities	Select as applicable

Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

NHS
Salisbury
NHS Foundation Trust

Board Evaluation Questionnaire

Scoring criteria:

1 = Hardly ever/Poor/Strongly disagree
2 = Occasionally/Below average/Disagree
3 = Sometimes/Average/Neutral
4 = Most of the time/Above average/Agree
5 = All of the time/Fully satisfactory/Strongly agree

		N/A	*1*	*2*	*3*	*4*	*5*
A	**COMPOSITION AND PROCESSES**						
1.	**Size of Board**						
	The Board is of sufficient size that the requirements of the business can be met, without being so large as to be unwieldy						
2.	**Meetings**						
a)	The number of meetings of the Board is appropriate, including ad hoc meetings where necessary.						
b)	Board members attend and actively contribute at meetings						
3.	**Terms of reference**						
	The Board's role, responsibilities, and matters that it has reserved, are clearly defined						
4.	**Committees of the Board**						
a)	The Board's committees are properly constituted and perform their delegated roles under clear terms of reference;						
b)	Are subject to appropriate revision; and						
c)	Report back effectively and promptly to the Board, with sufficient time for the Board to consider matters arising.						
5.	**Mix of skills, experience and knowledge & diversity**						
a)	The Board has an appropriate mix of skills, experience, and knowledge;						
b)	Is made up of individuals from a diversity of gender, background and psychological type.						
6.	**Independence**						
	The Board has the right balance of independent Non-executive Directors and Executive Directors.						
7.	**Succession planning**						
	There is appropriate succession planning for key Board members and senior executives.						
8.	**Appointment process**						
	There is a formal, rigorous and transparent process for the appointment of new directors to the Board.						

9.	**Time commitment**						
	Non-executive Directors are able to commit sufficient time to the organisation to discharge their responsibilities effectively						
10.	**Induction and training**						
	Board members receive proper induction on appointment and ongoing training is available to meet development needs.						
11.	**Timeliness and quality of information**						
The information that is supplied to the Board is:							
a)	Provided on a timely basis; and						
b)	Of a quality that enables the Board to determine whether the organisation is on track to meet its strategic objectives and is acting within its risk appetite						
B	**BEHAVIOURS AND ACTIVITIES**						
12.							
a)	The Board operates in line with the values of the organisation; and						
b)	Sets an appropriate tone from the top that permeates through the organisation						
13.	**Board discussions**						
	Board meetings are characterised by a high quality of debate with robust and probing discussions and no 'no-go areas'						
14.	**Understanding of the business**						
	All Board members have a clear understanding of the organisation's core business and strategic direction.						
15.	**Setting strategy**						
a)	The Board sets the organisation's strategic aims robustly and effectively, with appropriate challenge from the Non-executive Directors; and						
b)	Ensures the necessary financial and human resources are in place to implement them.						
16.	**Risk appetite and risk management**						
a)	The Board is sufficiently involved in establishing the organisation's appetite for risk in respect of its strategic aims; and						
b)	Satisfies itself that the integrity of the financial controls and systems of risk management are robust and resilient.						
17.	**Monitoring performance**						
a)	The Board has appropriate data to monitor the organisation's performance, including around quality, operational, financial and workforce which includes appropriate benchmarking with peers; and						

b)	Uses the available data effectively.						
18.	**Crisis management**						
	The Board responds positively and constructively in the event of a crisis, and has well-established business continuity and disaster recovery plans						
19.	**Major developments and transactions**						
	The Board is involved in major developments in the business in the right level of detail and at the right time.						
20.	**Quality of decision-making**						
a)	The Board makes well-informed high quality decisions based on clear line of sight into the business; and						
b)	Appropriate processes are used to facilitate complex judgements – for example obtaining input from experts, establishing separate sub-committees or allowing additional time for debate and decision-making.						
21.	**Demonstrating the Board's stewardship**						
a)	The Board communicates effectively with all of the organisation's stakeholders and takes into account their interests;						
b)	Ensures that the standard of external reporting is high and that the annual report, taken as a whole, is fair, balanced and understandable; and						
c)	Reports on Board effectiveness including the role of the chairman, diversity, succession planning and Board evaluation.						
22.	**Role of the Chairman**						
a)	The Chairman has sufficient time to commit to the role;						
b)	Exhibits a leadership style and tone that promotes effective decision making, constructive debate and ensures that the Board works as a team; and						
c)	Sets an effective agenda for the Board and ensures it is debated fully.						
23.	**Chairman and CEO relationship**						
	The Chairman and the Chief Executive work well together and their different skills and experience complement each other.						
24.	**Role of the Senior Independent Director ('SID')**						
	The SID is effective and fulfils the role in a way commensurate with the circumstances of the Board.						
25.	**Executive directors**						
a)	The Executive Directors carry out their duties as directors as members of the Board rather than as						

	senior management; but also						
b)	Represent an effective link through to senior management.						
26.	**Trust Secretary**						
27.	The Trust Secretary is effective and works well with the Chairman, Non-Executive Directors and Executive Directors.						
28.	**Performance evaluation**						
a)	The Board sets itself objectives;						
b)	Carries out a rigorous annual evaluation of its own performance; and						
c)	There is effective external facilitation at least every third year						

Comments on particular questions can be entered here
It is recommended to add comments for any questions you have scored 1 or 2

Good Governance Institute

NHS TRUST BOARD
GOOD GOVERNANCE MATURITY MATRIX

AUGUST 2017

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
PURPOSE AND VISION	No	Purpose, values, and drivers are debated and priorities are being formulated. The board is involved in shaping these discussions demonstrating quality as a fundamental driver.	Our purpose and vision are agreed, and affirmed in public and internal / partnership documents. The board has an agreed set of values / principles.	National targets and local priorities agreed with stakeholders. Variance from HWB and commissioners plans / priorities recognised and explained.	The board has a robust and inclusive mechanism for adding and removing services and / or changing care settings that matches agreed purpose, values and priorities.	We can evidence that sustained progress towards the vision is being made. Our purpose and vision are systematically revisited as board membership changes or at least annually.	Partner organisations and internal stakeholders understand and support the purpose and vision of the organisation. Strategic decisions do not change our fundamentals.	Success has allowed trust / board to redefine / extend its role. We are able to consistently influence other organisations to meet our own and our wider stakeholders purpose.
STRATEGY AND BOARD ASSURANCE FRAMEWORK (BAF)	No	Our strategic objectives are agreed by the board and have been tested with our partners. Formal strategic planning is in place and is able to address HWB and CCG priorities.	The strategy is owned and agreed by the board, after canvassing views and input from commissioners, partners and other stakeholders.	The BAF is used as the key instrument to grasp strategic focus. Operational plans reflect trajectory milestones against agreed strategy.	Progress against our objectives is made during year. The board has protected long-term priorities from short-term pressures.	The board is continually testing how changing environment effects the delivery of its strategy. First goals being met.	We can evidence that strategic aims are being adhered to, meeting agreed milestones on trajectory.	The trust / board is able to demonstrate consistent achievement of strategic goals over the last 3 years.
LEADERSHIP AND CAPACITY	No	Role profiles for all board members agreed and understood, with specific job descriptions agreed.	We have undertaken a skills assessment of our board linked to the succession plan. A planned board development programme is in place.	Our board development programme is based on prior systematic review. Clinical leadership accepts accountability for delivery against strategic objectives. Assessment and PDPs are in place for board members.	Succession plan in place. Individual PDPs for directors being delivered.	The board is confident it is visible. The organisation is leading rather than following local development agenda.	The organisation is identified as well led throughout and as health and wellbeing system leader in local economy.	The board is considered a national leader, providing buddying support and examples to provider chains and other organisations.
MONEY/VFM	No	Budget, cost pressures and efficiency targets are clearly identified and understood by the board.	All in-year plans are costed and trajectory of spend / savings have been established to achieve breakeven / target. Quality implications are robustly tested.	The organisation has a record of meeting planned cost reductions / CIPs and agreed investments, whilst rejecting proposals with an unacceptable impact on quality.	The board is demonstrably reinvesting whole budget, rather than being limited by 'affordability' at margins.	Unexpected in year pressures are identified and the board show timely reprioritisation of deliverables.	Our services consistently run under benchmark cost. Headroom is created for developments / improvements.	We successfully leverage wider community resources to improve service delivery and outcomes.
QUALITY, RISK AND AGILITY	No	Known risks are identified and continuity plans in place. The board understands risk as a comprehensive strategic instrument.	A forward-looking risk system is in place for the board identifying both threats and opportunities. Quality impact is embedded in systems.	Risk appetite for key issues such as safe staffing levels is known and built into plans/BAF.	Continuity plans and 'what if?' scenarios are regularly tested to respond to material issues and opportunities.	The board is confident it can both anticipate and respond to a crisis/opportunity in timely fashion. The organisation can provide case studies of successful escalation and intervention.	The board is able to measure and demonstrate risk appreciation by avoiding or rapidly responding to predictable incidents.	The board has a successful and demonstrable risk mitigation track record. Organisational systems respond well to unknowns as they occur.

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PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL Principle accepted	2 BASIC LEVEL Agreement of commitment and direction	3 EARLY PROGRESS IN DEVELOPMENT	4 FIRM PROGRESS IN DEVELOPMENT	5 RESULTS BEING ACHIEVED	6 MATURITY Comprehensive assurance	7 EXEMPLAR
MEASUREMENT AND INTEGRATED REPORTING	No	The board understands and recognises the value of quality assured processed data. Board reports are accurate and timely.	Resources are aligned to sustainable targets, standards and local priorities. All board papers integrate activity, cost, quality and transformation agendas. the BAF and board reporting relate.	The board has agreed public reporting for social, economic and environmental impact / opportunities (integrated reporting).	Health improvement / harm reduction targets are agreed. Systematic outcome-related reporting to board and stakeholders is in place. The board is confident it understands how it deploys its capitals.	Annual review of the board demonstrates candid self awareness and progress against agreed action plans / deliverables.	The board systematically receives reports from stakeholders providing feedback of impact of plan implementation.	The organisation benchmarks as a national leader in terms of positive impact on local health economy.
ASSURANCE AND STEWARDSHIP	No	An integrated audit committee is in place, with an annual cycle of business agreed. The board assures itself that its Assurance Framework is balanced and can reflect changing priorities.	Control mechanisms are in place for the entire BAF. The board has identified, agreed and owns assurances. Annual review of the audit committee, and of committee cycles of business agreed by the board.	Independent assurance is systematically sought through internal and clinical audit. All regulatory compliances, tests and actions met or explained.	The board annually delegates / confirms tolerance levels for assurance to sub-committees. The board can demonstrate robust scrutiny.	The organisation is able to invest significant resources derived from its own savings / service change to community wellbeing, research, innovation and staff development.	The board is confident it has evidence based, intelligent analysis and assurance of all systems and drivers across the health economy.	The organisation benchmarks as a national leader in terms of sustainable outcomes and impact against resources.
PROBITY AND REPUTATION	No	Standards of Conduct for the board are explicit and accepted. Plans are in place to manage conflicts of interest.	Our conflicts of interest system includes board and senior staff, is up-to-date and records actions.	The board has third party evidence of its reputation and standing. Risk appetite thinking includes reputation.	Probity is expected of all partners, suppliers and providers and this is written into contracts.	Reputational risk is considered in scenario and 'what if?' exercises. Reputational risk appetite is agreed.	The organisation seeks and acquires good governance recognition by independent authority.	The organisation is able to demonstrate how its high-standing benefits achievement of the strategy including recruitment and partnership working.
DECISION-MAKING AND DECISION-TAKING	No	Decision-making includes appropriate consultation and option/impact appraisal.	Information processing and analysis is focussed on evidence. The board and committee agendas reflect materiality.	Integrated information, audit, assurance and risk-assessments are used by board.	The board consistently takes decisions based on materiality and evidence.	We can evidence that the board and staff are confident that decisions are taken in a robust, transparent manner. Assurances are made available to stakeholders.	The audit committee has reviewed the key decisions of the board and delegated committees for robustness and alignment.	The board is able to successfully to influence national decision taking on policy and priorities.
STAKEHOLDER ENGAGEMENT	No	An engagement policy and strategy is in place based on stakeholder mapping.	Service user, staff, public and partner engagement is recognised as a resource to focus, design and deliver service improvement.	Membership targets met and a board of governors / users panel in place with own development plans.	Stakeholders confirm the organisation effectively engages with them and this is reflected in strategies and plans. Governors' contribution is valued.	Governance between organisations issues regularly tested with partners.	Partners, service users and the local public trust organisation. The organisation is seen as employer of choice.	The organisation recognised as a national leader in effective engagement with stakeholders.
BOARD SUPPORTS AND COMMITTEE STRUCTURES	No	The audit committee's role is developed to take on the independent scrutiny function. Committee structure confirmed by last annual board review.	The board secretary or other holds compliance and tracking role for all assurance issues of the board. A SID has been appointed from the NEDs.	Workload and agendas for committees have been planned and task groups have time-limited existence.	The audit committee is meeting at least 'firm progress' against the audit committee matrix. Internal and external auditors and advisors aligned to agenda and role.	The annual cycle of board business is reviewed at year-end, planned activities are completed and developed roles are refreshed.	The overall time investment in board and committees is reduced through organisation effectiveness.	The board's systems adopted by others as examples of good governance practice.
APPRAISAL PROCESS OF DIRECTORS, AND OTHER FEEDBACK	No	Board member roles are understood and explicit.	A board induction and development process is in place and working. An annual board review has been conducted and actioned.	Third party views are included in the annual board review process. The chair reviews board contribution of all the executives.	Annual review and director appraisal has informed current board development programme which is clearly actioned.	Systematic feedback is sought on the added value of board. Exit interviews are always offered.	The board is recognised as adding value by CEO and stakeholders.	The board is recognised 'as public appointment of choice' nationally.

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Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	01 August 2019		

Report Title:	Register of Seals			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in April 2019. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
347	11/4/2019	Lease between SFT (landlord) and Salisbury trading Ltd (tenant) for Block 03A laundry store and extension for a term of 7 years	Laurence Arnold	Cara Charles-Barks	Nick Marsden
348	11/4/2019	Sublease between SFT (landlord) and Salisbury Trading Ltd (tenant) for Block 03 (PFI owned) laundry building for a term of 7 years	Laurence Arnold	Cara Charles-Barks	Nick Marsden

349	23/5/2019	Lease between SFT (landlord) and Odstock Medical Ltd (tenant) for parts of the Glanville Centre and the Laing Building for a term of 3 years	Laurence Arnold	Cara Charles-Barks	Nick Marsden
350	8/7/2019	Lease between SFT (landlord) and Oxford Health NHS FT (tenant) for part of Block 40 for a term of 3 years	Laurence Arnold	Cara Charles-Barks	Nick Marsden
351	12/7/2019	Deed of Surrender of lease for Douglas Arter Centre from SCOPE to SFT	Laurence Arnold	Cara Charles-Barks	Nick Marsden

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.3
Date of Meeting:	01 August 2019		

Report Title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):	Revised Board Assurance Framework (v11.1 2019) Corporate Risk Register (v4.5 July 2019) Corporate Risk Register Summary Tracker (v11 2019)			

Recommendation:
The Board to consider and approve the revised Board Assurance Framework

Executive Summary:
The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This informs the Annual Governance Statement and annual cycle of Business. The BAF has undergone a refresh following the setting of new corporate objectives for 2019/20. The BAF will continue to be reported to the relevant Board Committees bi-monthly to maintain appropriate scrutiny and updates. The Trust Board will receive a comprehensive update every 4 months. The revised BAF has been presented to Clinical Governance Committee, Finance and Performance Committee and Workforce Committee for scrutiny of the risk profiles relevant to each Board Committee. The discussion at these Committees has informed the summary narrative below. <u>Corporate risk profile summary</u> • There is emerging risks relating to diagnostics in respect of demand and capacity, workforce challenges and third party providers. Rising issues in pathology and radiology. Mitigation being worked through with key directorates.

- There are a number of risks, regarding weekend and out of hours with operational, quality and financial implications. A paper has been requested linking data and proposed mitigations across all these areas which will be presented to CGC in September.
- Key shortages in clinical staff in key areas with contractual, quality and financial consequence. Mitigation is being driven through the OD and People Strategy

Extreme Risks

There are 6 risks rated 15 or above.

- 4107 - Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes (Score 16)
- 5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Score 16)
- 5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients (Score 16)
- 5605 - Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment (Score 15)
- 5607 - Risk of error due to Hospital at Night Team capacity to address increasing workload (Score 16)

New risks added since last presented to the Board in June 2019

- 5808 - Lack of service provision for elective vascular angiography (Local): Score 10
- 5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients (Local): Score 16
- 5860 - Risk of failure to achieve financial plan and NHSI control total for 2019/20 (Resources): Score 12
- 5862 - Risk to buildings and equipment due to capital programme funding (Resources): Score 12
- 5850 – Potential non-delivery of CQUIN schemes resulting in a financial loss (Innovation): Score 12
- 5851 - Weekend HSMR significantly higher than expected (Care): Score 12
- 5870 - Failure to achieve quality projections set nationally due to changes in reporting definitions (CDiff, Pressure ulcers) (Care): Score 12
- 5605 - Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment (Care): Score 15
- 5863 – Risk of new HMRC rules for the NHS Pension Scheme impacting on consultant capacity across the Trust (Score 12)
- 5869 - Failure to achieve required ward nursing establishment impacting on quality and safety and patient experience. High agency expenditure (Score 12)

Risks removed since last presented to the Board in June 2019

- 5861 - Failure to deliver the financial plan (Resources) – duplicated 5860

Risks with an increased score

- Nil to note

Risks with a decreased score

- 5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients. From 20 to 16 (4x4) - local

services

Further potential risks

Horizon scanning for potential risks, both internal and external, formed part of the BAF revision and require further consideration for inclusion on the Corporate Risk Register.

These are listed below for each strategic priority.

Resources:

- The pace and capacity to build strong partnership relationships with newly formed organisations e.g. Primary Care Networks (PCN) who are still in their infancy of development.
- The reconfiguration of the three CCG's in the STP could mean a delay to the pace of change required in the South Wiltshire system.
- The ambiguity in the long term plan on hospital models for rural DGH's services could distract on the service and pathway changes required at SFT.

Local and Specialist:

- Linking capacity and demand planning within SFT to the wider planning in BSW

Innovation:

- Failure to deliver GIRFT action plans and monitor improvements
- Risk of inability to deliver the Digital Strategy
- Insufficient organization development resource to deliver the cultural change needed to drive continuous quality improvement
- Capacity and capability of the organization to deliver quality improvement training and support to staff
- Lack of horizon scanning and assessment of the external environment
- Limited streamlined and co-ordinated resources to support business change
- Outpatient and theatre transformation

Care:

- Services which are provided to the Trust by another provider on a networked or hub-and-spoke arrangement. If the provider runs into operational or workforce difficulties it is likely that services will be withdrawn from our site as they consolidate at the hub. Examples are vascular, interventional radiology, clinical oncology, medical oncology, renal medicine, neurology and various paediatric specialties.

People:

- Recruitment to hard to fill posts; mainly medical, AHP and other specialties with subsequent agency spend
- ESR optimization
- Cultural change and organizational development
- Medical Workforce gaps

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Salisbury
NHS Foundation Trust

Board Assurance Framework
2019/20

V11.1 For July Board Committees

Trust Vision: An Outstanding Experience for Every Patient

Delivery of our vision and the strategic objectives is underpinned by our Trust Values and Behaviours: Patient Centred and Safe, Professional, Responsive, and Friendly. A drive to be 'outstanding every time.' It is also recognised (as illustrated above) that woven throughout the delivery of the strategy is the need to successfully develop and work across partnerships and collaborations which is why the Corporate Risk Register highlights both internal and external risks to delivery of our objectives.

Strategic Priorities

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Board Assurance Framework – Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/ systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Internal Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2: semi-independent Assurance** For example – Non-Executive Director walk arounds, Internal Audits **Level 3 External Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

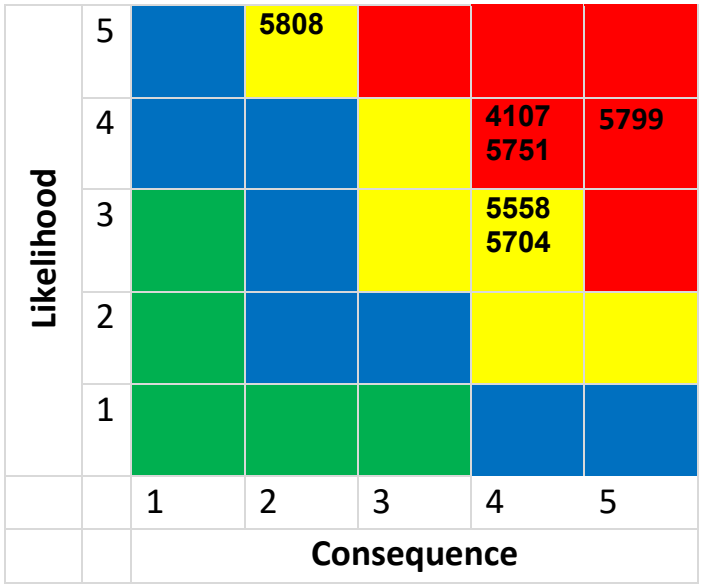
Strategic Priority:

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Executive Lead: Chief Operating Officer

Reporting Committee: Finance & Performance Committee

Distribution of Corporate Risks for Local Services



5808 – Lack of service provision for elective vascular angiography **(New risk)**
5558 – Medical workforce establishment within oncology
5704 – Inability to provide a full gastroenterology service due to a lack of medical staff capacity
4107 - Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes
5751 – Patient safety risk due to high numbers of delayed transfers of care due to lack of community capacity
5799 - Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impacting on 2WW and GP patients **(New risk)**

Principle Internal Risk: Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population					
Key Controls			**Assurance on Controls**		
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO)			• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group		
Gaps in Control			**Gaps in Assurance**		
• Variability in performance data to measure KPIs • Lack of a business intelligence tool • Informatics unable to access/link to all systems			• Use of multiple IT systems to manage performance • Data quality • Endoscopy data base does not record all activity		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Scoreboards and dashboards being developed	Director of Transformation	Programme commenced. High priority dashboards have been completed and are being used by Operational teams and transformation programmes	Procure and embed BI tool	Director of Transformation	2019/20 financial year
Develop and implementation of Integrated Performance Report for Board	Director of Finance	Implemented June 2019 and work on-going			

Principle External Risk: Managing the complexity of relationships with our partners to lead and share our joint strategy plans for a place based integrated care system	
Monitoring information	**Areas of influence**
• Integrated Performance Report – impact on metrics • Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard) • STP Operational Plan	• Requested improvement trajectories for decreased attendances and delayed transfers of care • STP Executive Board (CEO) • STP Sponsorship Board (CEO and Chair) • Wiltshire Integration Board (CEO) • Stakeholder meetings / engagement • Acute Hospital Alliance

2019/20 Corporate Objectives – Local Services

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Delivery of sustainable and improving local services through service and pathway review and develop new partnerships to deliver sustainable local services.	1. Patient Flow and Urgent Care Programme 2. Frailty Model Implementation 3. Gastroenterology Review 4. Implement Clinical Strategy	Lack of strategies to manage challenged services	Program for strategic review of services. Service reviews being linked to operational planning for 2020/21	31.12.2019 for high priority areas	A Hyett	5808 5558 5704 5799 5605 5751

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Work collaboratively with system partners to maximise patient and partnership benefits.	1. Delivery of Provider Alliance Programmes 2. Active role in BSW clinical and operational strategy 3. Leadership role in Wiltshire Health & Care 4. Work proactively with Primary Care Networks 5. Establish clinical leadership roles focussed on partnership and network development 6. Consider potential to return activity from the private sector to acute hospitals	Maturity and development of wider health and care system/partners to develop new models of care.	Work with new PCN's to develop relationships and new models of care.	31.03.2020	LT	
Improve access to services to support prompt responsive care.	1. Maintain waiting list size and delivery of RTT (incompletes) standard. 2. Reduce DNAs across service provision. 3. Benchmark First/Follow Up ratios as part of outpatients 4. transformation programme 5. Theatres capacity review and transformation programme 6. Delivery of new 28 day faster diagnosis cancer standard	Additional cases not scheduled on lists where gaps are evident (C) Lack of business intelligence tool	Outpatient and theatre project management Boards monitoring actions and improvement in utilisation Procure and embed tool	31.03.2020 31.03.2020	E Provins E Provins	4107

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Develop with partners a series of initiatives to ensure patients do not stay in hospital any longer than they need.	1. System wide MADE events 2. Roll out of increased ambulatory pathways 3. Consistent application and roll out of the SAFER care bundle and principles 4. Implementation of frailty new models of care 5. Increase the number of patients who are able to return to their preferred place of care at the end of their life 6. Plan to achieve/maintain top quartile performance in service delivery 7. Continue to increase the number of frail older people who are able to go home the same day or within 24 hours of admission	Lack of capacity / demand plan across Wiltshire	Urgent Care Delivery Group requiring capacity plan	31.08.2019	A Hyett	5751

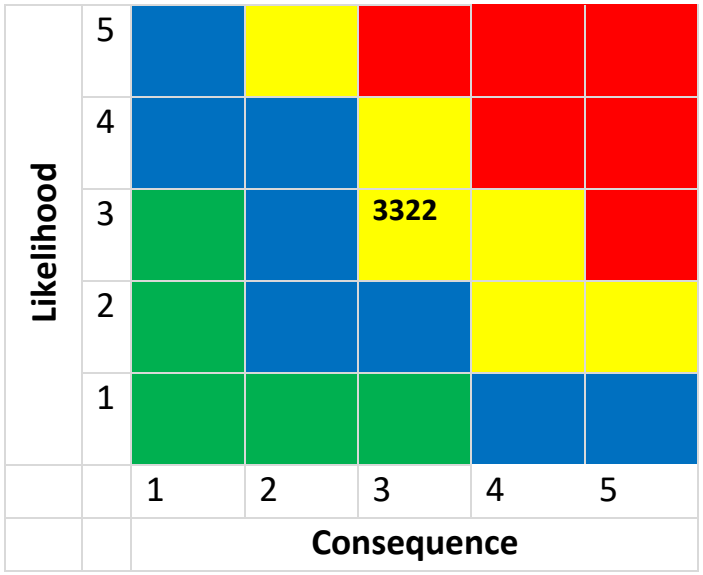
Strategic Priority:

Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Executive Lead: Chief Operating Officer

Reporting Committee: Finance & Performance Committee

Distribution of Corporate Risks for Local Services



3322 – National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services

Principle Internal Risk: Risk of balancing delivery of services that are 'outstanding' against the risk of economies of scale and cost effectiveness					
Key Controls			**Assurance on Controls**		
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board • COO Delivery Group • Genomics Consortium Board • Established performance monitoring and accountability framework • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO)			• Integrated Performance Report • Specialist Services dashboards • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group		
Gaps in Control			**Gaps in Assurance**		
• Clear SLAs for delivery of specialist services. Awaiting specialist Commissioners response to off-site spinal bed proposal.			CQC identified inadequate staffing in the spinal unit		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Development of Plastics SLA with Southampton	COO	~~30.04.2019~~ 30.09.2019	Liaising with UHS about future of service	Director of Finance	

Principle External Risk: National drive and policy regarding further centralisation	
Monitoring information	**Areas of influence**
• TARN data • Integrated Performance Report	• Plastics network

2019/20 Corporate Objectives – Specialist Services

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Work with partners in networks to develop care pathways for specialist services which improve effectiveness and patient experience.	1. Implementation of Clinical Strategy 2. Expanding and networking specialist services		Requires confirmation of roll-out plan		C Blanshard	
Develop our specialist services to be centres of excellence, delivering outstanding, innovative and responsive patient care.	1. Benchmark specialist services including spinal and plastics/burns against national comparators 2. Plan to achieve/maintain top quartile performance in service delivery 3. Establish future for genetics service within regional consortium 4. Secure future of spinal pathway pilot.	Lack of strategy for specialist services (C)	Clear program of work to complete a service review, comparison against benchmark and improvement plan	31.12.2019	A Hyett	3322

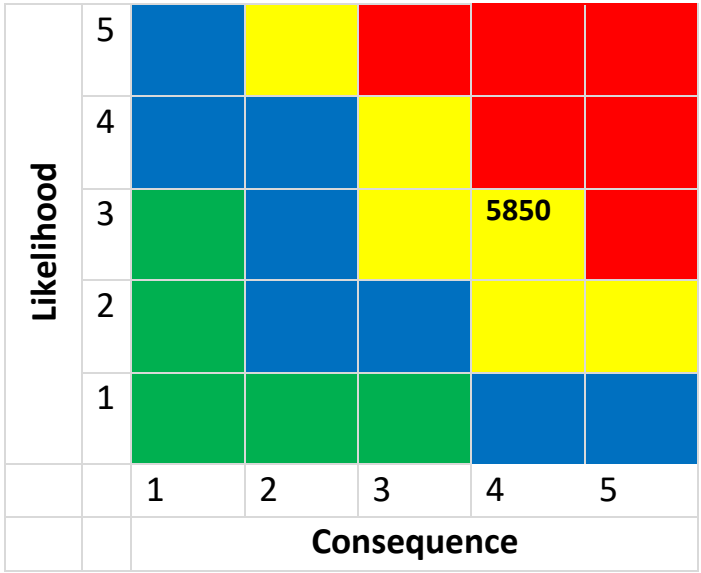
Strategic Priority:

Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: Medical Director

Reporting Committee: Clinical Governance Committee

Distribution of Corporate Risks for Innovation



5850 – Potential non-delivery of CQUIN schemes resulting in a financial loss **(New Risk)**

Principle Internal Risk: Risk of a lack of capability and capacity to deliver innovation					
Key Controls			**Assurance on Controls**		
• Transformation Board • QI Operational plan and improvement strategy • QI Steering Group • Workforce and Clinical Governance Committees • Research Governance Framework			• Model Hospital benchmarking • NIHR Wessex compliance reports • QI KPIs to evaluate success • Staff survey • Committee effectiveness review		
Gaps in Control			**Gaps in Assurance**		
• Quality Improvement Strategy and plan yet to be fully implemented					
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
QI Strategy and plan sign off	Director of Transformation	30.04.2019			
Implement QI plan	Director of Transformation	Commence April 2019			
Review effectiveness of plan	Director of Transformation	31.10.2019			

Principle External Risk: Risk of indecisiveness/fluidity in National policy and best practice	
Monitoring information	**Areas of influence**
• NHS Provider briefings • NHS Improvement briefings • NHS England briefings • Research networks	• Consultation on National policy • Representation on policy groups where appropriate • Contract negotiation

2019/20 Corporate Objectives – Innovation

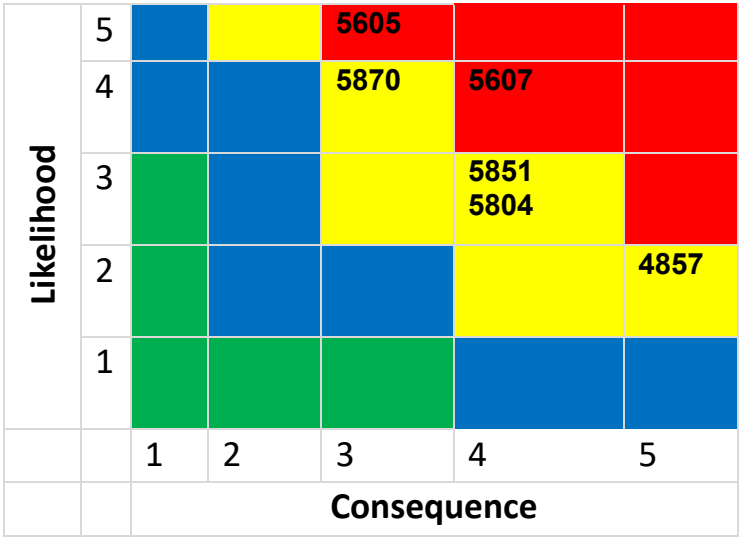
Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Develop the culture, capacity and capability to support innovation, improvement and research throughout the Trust.	1. Delivery of agreed programmes / deliverables in the transformation programme and service improvement programme for 19/20 2. Delivery of the QI operational plan for 19/20 3. Maximise participation and involvement in research within the Trust. 4. Hold a Dragon's Den forum to attract and support innovation 5. Strengthen links with AHSN	Lack of defined process to support innovation (C)	Develop and implement clear processes	31.12.2019	Esther Provins	
To maximise digital services to enable the provision of outstanding care.	1. Implement year one of the digital strategy 2. Deliver internal audit action plans 3. Team development 4. Strengthen opportunities for engagement 5. Engage with partners to ensure plans are aligned and opportunities exploited	Insufficient escalation reporting of deliverables (C)	Strengthen escalation reporting to the Digital Steering Group	30.09.2019	Esther Provins	5326

Strategic Priority:

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

Executive Lead: Medical Director and Director of Nursing **Reporting Committee:** Clinical Governance Committee

Distribution of Corporate Risks for Care



4857 – Risk of loss of all external communications to N3 due to current dual N3 connections (would affect clinical systems access)
5851 – Weekend HSMR significantly higher than expected **(New Risk)**
5804 – Risk of patients within hospital experiencing a fall
5870 – Failure to achieve quality projections set nationally due to changes in reporting definitions (CDiff, Pressure ulcers) **(New Risk)**
5605 – Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment **(New risk)**
5607 – Risk of error due to Hospital at Night Team capacity to address increasing workload

Principle Internal Risk: Insufficient resources (skilled staff and infrastructure) to deliver safe effective care					
Key Controls			**Assurance on Controls**		
• Quality Governance Framework • Integrated Governance Framework • Accountability Framework • Clinical and HR policies and procedures • Workforce plan • Workforce Committee • Directorate Performance Meetings • Contract Quality Review Meeting / contractual monitoring • Annual audit programme (national and local) • GIRFT Programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Learning from Deaths Policy • Appraisal and revalidation of doctors			• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime – last inspection report March 2018 • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review completed March 18 • Internal Audit report on morbidity and mortality meetings • CQC peer review process • GIRFT reports and action plans • Annual appraisal quality assurance review		
Gaps in Control			**Gaps in Assurance**		
•			Availability of data to give ward to Board assurance Safe medical staffing not yet defined		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
			Ward Accreditation Programme	Director of Nursing	31.03.2020

Principle External Risk: National initiatives may be unsuitable to deliver high quality care to the population of a small rural DGH	
Monitoring information	**Areas of influence**
• Integrated performance report – impact on metrics • National Policy – horizon scanning • Commissioning/decommissioning of services	• STP Boards and sub-groups • NHS Rural Hospitals Alliance • Clinical senates and networks • NHSE Specialist Commissioning • Local MPs

2019/20 Corporate Objectives – Care

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead	Linked corporate risks
Continue to reduce avoidable harm through agreed safety priorities and annual infection targets.	1. Demonstrate a responsive safety culture by training our staff in human factors, learning and sharing lessons when things go wrong and from when things go right					5851 5804 5870 4107 5799
	2. Achieve HCAI rates below trajectory	Redefinition of HCAI trajectories and what falls within 'hospital' apportioned at a national level (C)	Monthly reporting of hospital and community cases. Board transparency on any change being definition or internal issue	31.07.2019	C Gorzanski	
	3. Improve the recognition of deteriorating patients through the embedding of NEWS2.					
	4. Reduce harm from sepsis by improving the number of inpatients screened for sepsis and treated with intravenous antibiotics within an hour of diagnosis of sepsis.	Development time available to POET (C)	POET Board working through development time requirements and associated case for prioritisation	31.08.2019	JBurwell /L Wilkinson	
	5. Introduce Saving Babies Lives care bundle v2, and participate in wave 3 of the national maternity/neonatal safety collaborative					
	6. Demonstrate the implementation of high impact actions in the work to reduce falls	Development time available to POET to make necessary upgrades to capture all information (C)	POET Board working through development time requirements and associated case for prioritisation	31.08.2019	JBurwell /L Wilkinson	

Objective	Actions to be delivered in 2019/20	Gaps in Control (C) /Assurance (A)	Action	Deadline	Lead	Linked corporate risks
		Number of falls resulting in injury not decreasing (A)	Commence an SII of serious falls and embedding learning	31.03.2019		
Build our assurance on standards of ward-based care and compassion through development of ward accreditation process.	1. Design and develop ward accreditation programme 2. Develop range of metrics to support accreditation 3. Identify pilot areas to test and refine.	Availability of data to support the programme (C)	Deputy Director of Nursing working with subject matter experts	31.08.2019	D Major	
Work with our patients and partners to plan and develop services which meet the needs of our community.	1. Launch and implement the Treat Me Well campaign in April 2019. 2. Ensure that Patient voice is included in the planning and development of major Trust schemes.					
Work towards a CQC rating of Outstanding	1. Delivery of improvement plan arising from 2018 CQC inspection 2. Improve consistency of governance arrangements across Directorates and Clinical Units 3. Alignment of risks to corporate objectives through strengthening the Board Assurance Framework 4. Continued Board development programme to facilitate the Board developing into a high performing, unitary Board					

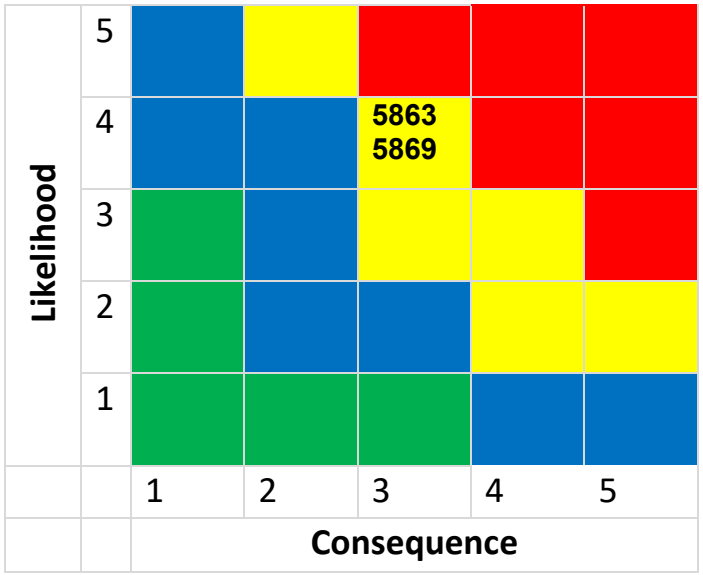
Strategic Priority:

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: Director of Organisational Development and People

Reporting Committee: Workforce Committee

Distribution of Corporate Risks for People



5863 – Risk of new HMRC rules for the NHS Pension Scheme impacting on consultant capacity across the Trust **(New Risk)**
5869 – Failure to achieve required ward nursing establishment impacting on quality and safety and patient experience. High agency expenditure **(New Risk)**

Principle Internal Risk: Risk that the Trust will be unable to recruit and sustain an engaged and effective workforce	
Key Controls	**Assurance on Controls**
• Workforce Committee (EWC) • Health and Wellbeing strategy Board (from 19/7) • HR Policies • Directorate Performance meetings • People strategy Delivery Board • Safer Staffing Group • Equality, Diversity and Inclusion Committee (launch 29 July) • Health and Safety Committee • Freedom to Speak Up Guardians • JCC Staff Side Meeting • JLNC Committee (medical staff) • Vacancy control group	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • Integrated Performance Report at Board • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report • Health and safety annual report • Guardian of safe working report • Volunteers annual report • Monthly Workforce Dashboard at EWC • Executive Safety Walks

Gaps in Control			**Gaps in Assurance**		
• Ineffective data capture and reporting			• Lack of real time staff feedback		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Develop phase 2 and 3 business case and investment for ESR optimisation	Director of OD&People	21.08.2019	Develop Health& Wellbeing Strategy business case to purchase real time feedback solution	Director of OD&People	21.08.2019

Principle External Risk: Risk that the local authority priorities for housing, retail and leisure results in Salisbury not being a place to work for your people	
Monitoring information	**Areas of influence**
• Integrated performance report – impact on workforce KPIs	Member of Wiltshire workforce group (local place based care, part of ICS)

2019/20 Corporate Objectives – People

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
To build, value and develop a skilled and motivated workforce.	1. Lead STP plans on workforce transformation. 2. Undertake Therapies/AHP workforce review to better align with operational functions 3. Build on leadership development of ward leaders through a formal leadership programme (with Director of Nursing and Quality) 4. Roll out e-rostering system across professional groups	Skills and capacity of Business Partners (C) Lack of roll-out plan (C)	Continuing to embed BP model in directorates Under discussion with Quality directorate	31.12.2019 31.03.2020	S Crane G Toms	5869 5863
Develop a diverse and inclusive culture where staff feel engaged.	1. Support to Speak Up Programme 2. Roll out Phase 2 and 3 of ESR. 3. QI strategy 4. OD Programme	Lack of consistency of champions within defined networks	Meet with current dignity at work ambassadors – design and recruit to new role Diagnostic model to be finalised	30.09.2019	R Webb	
Improve the health and well-being of staff.	1. Improved on site staff facilities 2. Targeted health/well-being campaigns and programmes 3. Consistent application of a flexible working policy	No investment for the proposed programme Policy requires significant update	Business case to TMC Paper to execs 5 August to propose what is included in the policy	21.08.19 05.08.2019	A Evans G Dawson	

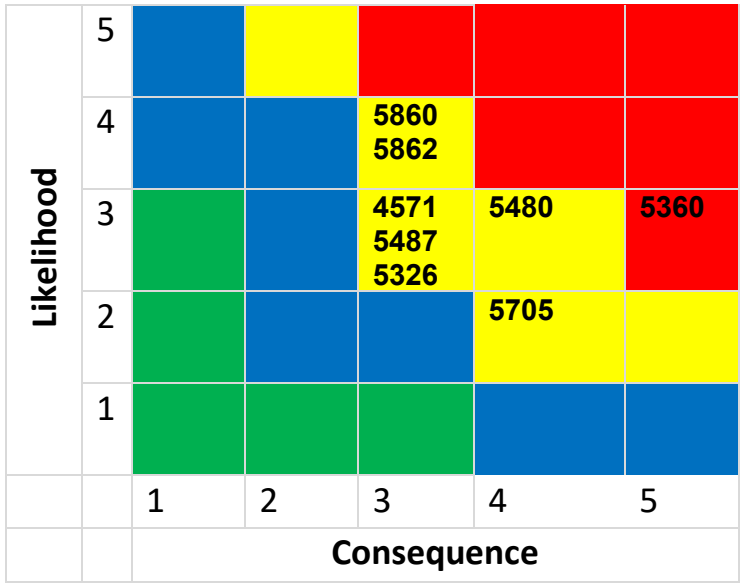
Strategic Priority:

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Executive Lead: Director of Finance

Reporting Committee: Finance & Performance Committee

Distribution of Risks for Resources



5705 – Unknown impact on the running of the hospital as a result of the EU Exit
4571 - Potential risk of failure of sterilisers, washers and associated plant to sterilise equipment
5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
5326 – Risk of access to patient information through variety of clinical information systems and overhead of access
5860 – Risk of failure to achieve financial plan and NHSI control total for 2019/20 **(New Risk)**
5480 – Risk of poor controls to ensure the consistency and accuracy of information reporting
5862 – Risk to buildings and equipment due to capital programme funding **(New Risk)**
5360 - Risk of cyber attack or ransomeware attack

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities					
Key Controls			**Assurance on Controls**		
• Finance and Performance Committee • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • OETB • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • Strategy Committee			• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement		
Gaps in Control			**Gaps in Assurance**		
• Oversight of corporate processes and policies			•		
Actions	**Owner**	**Deadline**	**Actions**	**Owner**	**Deadline**
Set up task and finish group to develop a framework	Director of Finance	30.06.2019			

Principle External Risk: Risk of a lack of available and qualified clinical resource	
Monitoring information	**Areas of influence**
• Workforce Committee • HEE Board reporting • NHSI Board reporting	

2019/20 Corporate Objectives – Resources

Objective	Actions to be delivered in 2019/20	Gaps in Control/Assurance	Action	Deadline	Lead	Linked corporate risks
Rationalise and re-profile the Trust estate in line with the Trust clinical and estates strategy, working in partnership to support sustainable delivery of patient services.	1. Complete SOC for estates redevelopment programme.	Lack of capital funding and STP process to progress case due to pressure on NHS funding.	Ensure SFT SOC completed and complies with STP deadlines.	31.03.2020	LT	5862
Improve financial sustainability of SFT and the wider health economy.	1. Development and implementation of Transformation programme 2. Further develop our role within BSW to deliver financial sustainability. 3. Progression of outpatients transformation programmes in partnership 4. Implementation of Model Hospital based schemes where benchmarking shows opportunities for efficiency – for example pharmacy and medicines optimisation. 5. PMO maturity assessment of productivity 6. Clinical service reviews 7. Delivery of services in partnership with external organisations.	Maturity and development of wider health and care system/partners to develop new models of care.	Work with new PCN's to develop relationships and new models of care.	31.03.2020	LT/CCB	5861 5487 4857 5850 5860

Corporate Risk Register
July 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5705		Trustwide	1/31/2019	National guidance	12	Unknown impact on the daily running of the hospital as a result of Great Britain's exit from the European Union. The consequence is that the resources (stocks and staff) could be depleted affecting service provision.	Do not expect it to happen again but it is possible	Major	8	Completion of risks assessments.	3/31/2019	4/25/2019	Hyett, Andy	EU Exit Planning Group	8/1/2019	8		Resources Trust Board (Corporate Risk Register)	Chief Operating Officer
										Delivery of any new national actions.	3/31/2019	4/25/2019	Hyett, Andy						
										Task and finish group to continue to meet on a monthly basis.	11/1/2019		Hyett, Andy						
5326	Informatics	Trustwide	12/20/2017	Electronic Patient Record	6	Review, PACS, POET, Lorenzo, WinDip & Paper Records - information in these systems are required to fully assess patients - access is required to all the above systems and there is a risk that information may be missed due to overhead of access and or clarity on what information is where - leading to inefficiency delays and potential patient harm	May recur occasionally	Moderate	9	Training review being commissioned to provide holistic training for clinical staff	1/31/2019	2/8/2019	Lees, Susan	Directorate Management Team Meeting	9/30/2019	4		Resources	Director of Transformation
										Describe within digital strategy how information from a range of sources will be used	3/7/2019	4/15/2019	Burwell, Jonathan						
										Set up governance structure for development of digital strategy	9/28/2018	10/24/2018	Arnold, Laurence						
										Secure support from clinicians to be CCIO and Clinical safety officer	10/30/2018	10/24/2018	Blanshard, Dr Christine					Trust Board (Corporate Risk Register)	
										Upgrade to WinDip	8/30/2019		Ford, Nicola						
										STP EPR Model options appraisal to be undertaken by July 2019. Post this future consideration of Lorenzo modules will be undertaken.	7/31/2019		Burwell, Jonathan						
3322	Clinical Support and Family Services	Genetics	8/29/2013	Organisational risk assessment	12	National reconfiguration of genetic services planned. Potentially a major threat to the future of genetic lab services in Salisbury. 05/07/2018 CAW: Funding flows for Genetic testing will change following re-procurement. NHSE planned start date is 1st Oct 2018. SNHSFT will no longer be commissioned for Genetic tests via the SW specialist services commissioning group so the Block contract will end. Instead funding for rare and inherited genetic tests will be received via the Genomics Hub (Birmingham). All acquired cancer genetic tests will be moved to provider to provider funding. This includes many haemato-oncology tests currently funded by the Block contract (estimated £900k p.a.)Referring departments will be expected to fund genetic tests from within tariff. There is therefore a risk that income will be reduced if Clinicians/Trusts have to mitigate against the increased costs by applying greater clinical thresholds to testing. 20-12-18: Funding arrangement for 2019/20 likely to be rolled over by NHSE.	May recur occasionally	Moderate	9	A genomics strategy group, co-chaired by Christine Blanshard (MD), has been established that involves University Hospitals Southampton and the University of Southampton. A pilot project is planned for 2015 and will formulate a regional strategy once details of the proposed reorganisation are known. This was not released until Nov 2016 These meetings have restarted with additional parties due to the updated project named "re-procurement" Genomic tender meetings occurring regularly between UHS and SFT including Trust representative. Partnership negotiations begun for a wider partnership bid. Update Oct 18: Wessex Oxford and West Midland Genomics Consortium (WOWMC)has been established and chosen as the preferred provider of genetic/genomic diagnostic testing for Wessex, The West Midlands, Oxfordshire and Thames Valley. The Central Laboratory Hub will be in Birmingham.	4/1/2018	1/25/2018	Blanshard, Dr Christine	Trust Board	8/30/2019	6		Specialist Services	Medical Director
										Tender document issued. Alliance formed with UHB, BWCH, OUH and UHS to respond to the tender. BWCH proposed to become the central laboratory hub and WRGL will become a local genomics laboratory.	10/31/2018	11/30/2018	Blanshard, Dr Christine					Clinical Governance Committee, Finance Committee, Trust Board (Corporate Risk Register)	
										Need to consolidate DNA extraction into a single lab in Wessex. Will require negotiations with UHS.	8/30/2019		Cross, Prof. Nick						
										Communication plan with referring hospitals to inform they will be required to fund cancer testing from tariff.	4/1/2019		Thomas, Lisa						
										Options approval strategy to be prepared by the Associate Director of Strategy (initial strategy not approved in March 2019).	8/30/2019		Blanshard, Dr Christine						
4571	Facilities	Estates	6/17/2016	Other assurance not listed	12	Potential risk of failure of sterlisers, washers and associated plant and equipment used to sterlise equipment for the Trust and external customers.	May recur occasionally	Moderate	9	Refurbishment of 3 x Autoclaves	5/13/2019	5/13/2019	Cropp, Terry	Not known	9/2/2019	6		Resources (Care)	Chief Operating Officer
										SSL looking at options for the replacement of the AER's as instructed by the SSL Board, a report with the options and costs will be presented at the October 18 SSL board meeting.	7/26/2019		Cropp, Terry					Trust Board (Corporate Risk Register)	
										Replacement of 1 x Autoclave, as an interim measure prior to the refurbishement of the new facility.	2/28/2019	2/28/2019	Cropp, Terry						
5487	Finance and Procurement	Finance Department	7/26/2018	Other assurance not listed	12	Subsidiary Governance. Where SFT is the major shareholder, and the financial position is included in the SFT financial position, if a significantly deteriorating financial position occurs it places SFT at risk both in terms of cash flow and reputation.	May recur occasionally	Moderate	9	- Subsidiary have slight improvement in financial forecast, cash flow to be updated to reflect changes and actions. - Subsidiary asked for detailed action plan of short term mitigations and longer term alternative care models	12/21/2018	12/19/2018	Thomas, Lisa	Finance and Performance Committee	7/31/2019	9		Resources	Director of Finance
										Subsidiary to produced revised strategic plan for future operating model to ensure a sustainable business plan for 2019/20 and beyond.	7/31/2019		Thomas, Lisa					Trust Board (Corporate Risk Register)	

Corporate Risk Register
July 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
4857	Informatics	Information Technology	10/14/2016	Trustwide risk assessment	10	The current dual N3 connections both arrive in the Trust in the same location and travel through the Trust to the Main Computer room in the same fibre and on to the same panel. If a major incident should effect any of these elements the Trust would loose all external communication to N3, taking down Lorenzo, RIS, PACS archiving, PACS cross platform, email and internet access.	Do not expect it to happen again but it is possible	Catastrophic	10	14/09/18 A/w pricing and plans from MLL (HSCN supplier)	11/30/2018	4/8/2019	Noble, Bob	Departmental Team meeting	9/27/2019	5		Care	Director of Transformation
										Business case to be written for phase 2 of N3 to HSCN migration which will include creating a diverse entry into the Trust and mitigate this risk.	6/14/2019	5/31/2019	Cowling, Andrew					Trust Board (Corporate Risk Register)	
										Order second HSCN line and implementation	3/27/2020		Arnold, Jon						
5808	Surgery	Surgical Directorate Management offices	5/1/2019	Other assurance not listed	10	Lack of service provision for elective vascular angiography as a result of the attendance of vascular surgeons and attendance of IR consultants not being aligned. This results in a risk of a backlog of patients awaiting elective treatment until a pathway is agreed.	Will undoubtedly recur, possibly frequently	Minor	10	Medical Director has escalated to Regional Medical Director and awaiting a meeting.	7/1/2019		Blanshard, Dr Christine	Finance and Performance Committee	7/1/2019	6		Local Services Trust Board	Chief Operating Officer
										Approach UHS to ask if they can take the referrals and agree a pathway.	5/31/2019	6/12/2019	Hyett, Andy					(Corporate Risk Register)	
5850	Quality Directorate	Trustwide	6/13/2019	Commissioning for Quality & Innovation (CQUIN)	12	Potential non delivery of CQUIN schemes that are high risk which would result in a financial loss for the Trust. CCG 1a) Antimicrobial resistance/lower urinary tract infections in older people. £170K at risk. CCG1b) Antimicrobial resistance/antibiotic prophylaxis in colorectal surgery. £170K at risk. CCG2) Staff flu vaccinations. Improve the uptake of flu vaccine for frontline staff to 80% (no opt-out for West Hampshire. £353K at risk. CCG7) 3 high impact actions to prevent hospital falls to achieve 80% of older inpatients receiving 3 key falls prevention actions. £353K at risk. CCG11c) Same day emergency care/community acquired pneumonia. £126K at risk. NHSE Specialised commissioning - Medicines Optimisation 4 workstreams (risk to be assessed). Please note the payment calculation has changed in 19/20 and in essence the better the performance between the minimum and maximum payment levels, the greater the income. The calculation of the loss is based on achievement below the minimum level and at this stage is hard to predict before quarter 1 data is known. Total potential loss £1.1 million.	May recur occasionally	Major	12	CCG1a)Antimicrobial resistance/lower UTI in older people. Band 6 full time pharmacy technician is being appointed to lead on this work.	7/31/2019		Williams, Lou	Finance and Performance Committee	7/31/2019	6		Innovation (Resources)	Director of Finance
										CCG1a). Trustwide education programme to change practice and ongoing data collection and regular feedback to ED and the wards and the Junior medical staff.	7/31/2019		Williams, Lou					Trust Board (Corporate Risk Register)	
										CCG1b) Antimicrobial resistance/antibiotic prophylaxis in colorectal surgery. Clinical Lead for colorectal service to engage with Surgeons and Anaesthetists with the results of the April and May 19 audit and implement improvement actions.	7/31/2019		Branagan, Mr Graham						
										CCG2) Staff flu vaccinations. Improve the uptake of flu vaccine for frontline staff to 80%. A flu working group to plan the annual flu campaign and vaccination approach.	9/30/2019	6/13/2019	Evans, Alison						
										CCG7) 3 high impact actions to prevent hospital falls to achieve 80% of older inpatients receiving 3 key falls prevention actions. Patient Safety Facilitator supporting improvements via the Falls Working Group. Key improvement required is the recording of lying and standing blood pressures.	7/31/2019		Lowe, Tarah						
										CCG7) 3 high impact actions to prevent hospital falls to achieve 80% of older inpatients receiving 3 key falls prevention actions. POET is to have mandatory fields added to ensure the recording of lying and standing blood pressures as routine for patients over 65.	7/31/2019		Ford, Maria						
										CCG11c) Same day emergency care/community acquired pneumonia. Collect quarter 1 data to determine baseline performance and report to the SDEC working group.	7/31/2019		Finneran, Dr Nicola						
5851	Quality Directorate	Trustwide	6/13/2019	Clinical audit	12	Weekend HSMR Significantly Higher than Expected (at 123.5 for the last 5 12 month rolling data periods to February 2019)- A potential risk to patient safety in the diagnosis groups of pneumonia and sepsis, and patients with a length of stay of 7-13 days with no co-morbidities aged 65 to 74. A risk of reputational damage to the Trust.	May recur occasionally	Major	12	Undertake a case notes review of all the patients in the categories defined in the above section to determine the cause and any improvement actions required. To be reported to the mortality surveillance group and Clinical Governance Committee in September 2019.	9/30/2019		Cornforth, Dr Belinda	Clinical Governance Committee	9/30/2019	6		Care	Medical Director
5860	Finance and Procurement	Trust Offices	6/17/2019	Financial management, Trusts Objectives, Trustwide risk assessment	12	Trust fails to achieve the financial plan and NHSI Financial Control total for 2019/20. This impacts on the ability to achieve national funding including PSF and FRF, which in turn could lead to unplanned cash borrowing.	Will probably recur, but is not a persistent issue	Moderate	12	Identify savings programme for residual £2m gap for 2019/20	7/23/2019		Thomas, Lisa	Finance and Performance Committee	7/29/2019	9		Resources Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Identify cost effective solution to increased costs associated with Gastro and endoscopy services.	7/31/2019		Thomas, Lisa						
										Ensure contract with commissioners reflects appropriate risk for blended tariff in 2019/20 and is consummate with the ICS partners.	7/12/2019		Thomas, Lisa						
5862	Finance and Procurement	Trust Offices	6/17/2019	Financial management	12	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will probably recur, but is not a persistent issue	Moderate	12	Programme prioritised for national requirement for 20%	7/15/2019		Thomas, Lisa	Finance and Performance Committee	7/29/2019	9		Resources Committee, Trust Board (Corporate Risk Register)	Director of Finance
										QIA assessment to be completed for all delayed schemes.	7/15/2019		Thomas, Lisa						
										Process agreed with the STP providers on managing in year slippages	7/15/2019		Thomas, Lisa						

Corporate Risk Register
July 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5863	Finance and Procurement	Trust Offices	6/17/2019	Specialty Risk assessment	12	The risk that the HMRC rules on higher earners who in the NHS pension scheme are increasing the number of consultants who are reducing their job plan PA's and retiring earlier than planned. Leading to a loss of capacity across the Trust.	Will probably recur, but is not a persistent issue	Moderate	12	Collecting the data to confirm lost capacity identified to date.	7/12/2019		Thomas, Lisa	Finance and Performance Committee	7/29/2019	6		People Committee, Trust Board (Corporate Risk Register)	Director of Finance
										Identify strategic partners to offer staff financial advice.	8/30/2019		Thomas, Lisa						
5869	Quality Directorate	Trustwide	6/20/2019	Trustwide risk assessment	12	Failure to achieve required ward nursing establishment with the following implications: Quality and safety concerns at ward level Poor patient experience High agency expenditure (financial risk to the Trust)	Will probably recur, but is not a persistent issue	Moderate	12	Contribute to Trust work on developing workforce safeguards.	10/1/2019		Hyett, Fiona	Trust Board	9/2/2019	9		People (Care)	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Contribute to levels of attainment work on e-rostering /e-job planning.	4/1/2020		Hyett, Fiona						
										Overseas recruitment campaigns 19/20.	4/30/2020		Hyett, Fiona						
										Skill mix review x2 per year - 2019/2020	4/30/2020		Wilkinson, Lorna						
										Retention workstream to plan, including exit meetings, STAY conversations and career pathways, to be embedded.	9/30/2019		Hyett, Fiona						
										Develop apprenticeships and nursing associate opportunities to broaden access into nursing.	4/30/2020		Wilkinson, Lorna						
										Maintain full recruitment of Nursing Assistant Staff.	4/30/2020		Hyett, Fiona						
										Twice daily staffing review using safe care and roster data.	4/30/2020		Hyett, Fiona						
										Domestic recruitment campaign 2019/2020	10/30/2019		Holt, Sharon						
										Implementation of safer nursing care tool to evidence staffing levels.	4/1/2020		Hyett, Fiona						
5870	Quality Directorate	Trustwide	6/20/2019	National guidance	12	Failure to achieve quality projections set nationally or to appear as though quality declining due to changes in reporting definitions from April 2019. **Clostridium difficile reporting requirements changed so that patients who develop C. difficile in the community but who have had a hospital admission in previous 4 weeks will count in Trust figures and be deemed as 'Community onset, healthcare associated'. This will increase the numbers attributable to the Trust at a time when the ceiling was reduced by 50% (18 to 09). Potential risk to attract fines, contract notices and reputational damage. **Pressure Ulcers- definition of hospital acquired changed from developed post 48 hours of admission to anything not identified within 6 hours of admission.	Will probably recur, but is not a persistent issue	Moderate	12	Transparent discussions with commissioners and NHSI re: the implications of the changes in reporting definitions.	6/20/2019	6/20/2019	Wilkinson, Lorna	Trust Board	9/1/2019	8		Care	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing
										Board and public awareness.	8/1/2019		Wilkinson, Lorna						
										Continued improvement work on these safety work streams.	4/1/2020		Wilkinson, Lorna						
										Transparent and clear reporting to Board.	8/1/2019		Wilkinson, Lorna						
										Use of appeals process.	4/1/2020		Wilkinson, Lorna						
										Update Datix NRLS coding in order to become compliant with the new NHS Improvement Pressure Ulcer Framework, to ensure submission of accurate pressure ulcer data to NRLS.	7/31/2019		Densham, Annie						
5558	Medicine	Oncology Outpatients	9/21/2018	Specialty Risk assessment	15	The medical workforce establishment in oncology comprises 3 medical and 2 clinical oncology consultants (all employed by UHS but working at SFT 2-3 days per week), a specialty doctor working 2 days a week, plus 1.0wte middle grade doctor employed by SFT to provide medical support to the Acute Oncology team (AOT). Each consultant works only within a specific tumour type, so there is no cross cover for scheduled or unscheduled leave, with reliance on locum support for prolonged periods of leave such as vacancies or maternity/sickness leave. NHS locum support has been extremely hard to obtain, and agency locum cover is expensive, and can be unreliable or of substandard quality. This has potential to result in inability to provide tumour site specific services to patients if posts are unfilled either substantively or by locums. The middle grade AOT post has historically been hard to recruit to, with long gaps between appointments, or expensive agency locums. This means that there may be no medical input to the AOT which may result in inadequate medical assessment of patients or unnecessarily prolonged inpatient stays.	Will probably recur, but is not a persistent issue	Moderate	12	Discuss with UHS re plan for cover - ? locum to be put in place whilst substantive appointment is made Deputy DM for Medicine to meet with team at UHS to discuss plan and obtain weekly updates.	8/1/2019		Barrett, Mrs Jessica	Directorate Management Team Meeting	7/31/2019	8		Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Telephone call with UHS planned between DDM, Clinical Lead and DM at UHS re future provision	3/6/2019	4/17/2019	Barrett, Mrs Jessica						

Corporate Risk Register
July 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5480	Informatics	Trustwide	7/23/2018	Incident reports	16	Risk of poor controls to ensure the consistency and accuracy of information reporting including validation practices leading to inaccurate information being used either within the organisation or leaving the organisation which could lead to reputational harm or misinform for internal/external stakeholders.	May recur occasionally	Major	12	Agree content and approach to undertaking analysis work and reporting approach to IGSG	8/31/2018	11/1/2018	Doubtfire-Lynn, Heidi	Audit Committee	8/30/2019	6		Resources	Director of Transformation
										Complete Serious Incident Inquiry in order to review what additional controls require adding.	11/30/2018	11/2/2018	Arnold, Laurence					Finance Committee, Trust Board (Corporate Risk Register)	
										Creation of Information Standards Committee to oversee external information accuracy and timeliness	1/31/2019	2/18/2019	Burwell, Jonathan						
										Review of progress to improve medium and high risks for external information reports	4/23/2019	6/11/2019	Burwell, Jonathan						
										IS undertaking review of DQ against core DQ standards for key metrics as part of development of new Integrated Performance Report.	6/28/2019		Anscombe, Felicity						
										Extend review of metrics against data quality standards across all information services reports and metrics	11/29/2019		Anscombe, Felicity						
5704	Medicine	Trustwide	1/31/2019	Directorate risk assessment	16	The inability to provide a full gastroenterology service due to a lack of medical staffing capacity. This could result in inability to deliver contractual obligation, failure to meet diagnostic standards and failure to deliver cancer standards which may result in patient care, treatment and diagnosis being delayed. See also linked Risk 5644 (CSFS Gastroenterology Risk).	Will probably recur, but is not a persistent issue	Moderate	12	Ongoing recruitment drive.	9/30/2019	4/25/2019	Clarke, Lisa	Intensive Support Meeting	9/30/2019	8		Local Services (Care, People)	Chief Operating Officer
										Continual clinical prioritisation to ensure that high risk areas are covered.	4/1/2019	4/17/2019	Clarke, Lisa					Trust Board (Corporate Risk Register)	
										Continuing insourcing of private provider to endoscopy.	6/30/2019	4/25/2019	Vandyken, Ali						
										Quantification and mitigation of the risk to bowel scope.	4/1/2019	4/17/2019	Vandyken, Ali						
										Tender for elements of the Gastroenterology service.	4/1/2019	4/17/2019	Stagg, Andrew						
										Monthly update to F&P Committee and CGC.	5/10/2019	4/25/2019	Hyett, Andy						
										Presentation of gastro strategy to Finance and Performance Committee.	5/31/2019	6/12/2019	Hyett, Andy						
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision prior to discussion with external parties.	7/31/2019		Hyett, Andy						
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	8/1/2019		Henderson, Dr Stuart						
5804	Trustwide	Trustwide	4/26/2019	Incident reports	12	Risk of patients within hospital experiencing a fall, with the potential to result in significant harm. This is an issue recognised nationally due to the increasing frail population.	May recur occasionally	Major	12	Create version 2 of nursing post falls assessment sticker for cascade out across the Trust	8/1/2019		Lowe, Tarah	Falls Group	8/31/2019	8		Care Trust Board (Corporate Risk Register)	Director of Nursing
										Falls improvement plan to be written for 2019/20. The actions from the strategy will then be added to this risk.	7/31/2019		Lowe, Tarah						
5360	Informatics	Information Technology	2/28/2018	Data Protection	15	There is a significant risk that Salisbury NHS Foundation Trust could potentially be hit by a rogue cyber attack or ransomeware attack in the not too distant future. This could result in IT systems being shut down, compromising patient care which will result in lost revenue. Even the most robust information security and disaster recovery plan is never failsafe. At this present moment in time SFT will be unable to obtain cyber security and ransomeware insurance as it is unable to demonstrate that all appropriate organisational and technical measures are in place to prevent the Trust IT infrastructure being breached.	May recur occasionally	Catastrophic	15	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	12/14/2018	Noble, Bob	Information Governance Steering Group	7/26/2019	9		Resources	Director of Transformation
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	2/28/2019	2/20/2019	Noble, Bob					Trust Board (Corporate Risk Register)	
										Review of practicalities of getting ransomware with financial controller.	7/24/2019		Burwell, Jonathan						

Corporate Risk Register
July 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5605	Clinical Support and Family Services	Histopathology	10/18/2018	Departmental risk assessment	15	Problem: insufficient staff in cellular pathology laboratory Risk: - slow report turnaround time - leading to failing UKAS accreditation - delaying patient treatment - delaying cancer treatment - increasing costs if work is outsourced to address the risks above - losing staff	Will undoubtedly recur, possibly frequently	Moderate	15	Locum Biomedical Scientist in laboratory for 3 months to cut backlog of tissue blocks awaiting microscopy.	1/11/2019	3/13/2019	WHIC	Departmental Team meeting	7/31/2019	6		Care, Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Cancer Lead - Dr J Cullis, to attend and watch MDT process to see if any recommendations can be made.	1/11/2019	3/13/2019	Cullis, Dr Jonathan						
										Dr M Flynn has discussed this with Cancer Lead and Nichola House, Deputy Directorate Manager. Ideally Histology would be notified at the time of biopsy/surgery, that a case is of a higher priority. If this notification took place, these cases would be prioritised and would very nearly remove the likelihood of delays in meeting Trust treatment time targets.	1/11/2019	3/13/2019	HOUS						
										New Locum Consultant arrived in department on 12th June. Review affect this has on risk score in 6 weeks.	7/31/2019		Baden-Fuller, Dr Joanna						
5607	Surgery	All clinical areas	10/19/2018	Data quality, Incident reports	12	Hospital at night (H@N) data has shown a year on year increase in workload, but no increase in night team staffing. The workforce (originally set up in 2010) is regularly under pressure to manage the volume of new admissions and respond to unwell inpatients. The H@N management board feel there is a high risk of minor errors regularly occurring (i.e. delayed patient review & medicine prescriptions) and a risk of an occasional serious event, as a result of delayed review and intervention, particularly during busy periods, when the Trust is in escalation.	Will probably recur, but is not a persistent issue	Major	16	Throughout the month of December the H@N board will monitor workload to examine the impact of extra workload due to winter pressures. The Clinical Lead for H@N will then escalate to DMT if appropriate.	6/7/2019	5/7/2019	Payne, Gill	H@NT Management Board	7/31/2019	6		Care	Trust Board (Corporate Risk Register)	Medical Director
										Workforce review of H@NT team	7/31/2019		Henderson, Dr Stuart						
										Review of weekend mortality rates.	7/31/2019		Blanshard, Dr Christine						
										Nursing lead for H@N to attend April DMT to formally present H@N activity report.	5/31/2019	6/19/2019	Payne, Gill						
4107	Musculo-Skeletal	Musculo-Skeletal Directorate Management Offices	9/17/2015	Service Delivery Plan, Specialty Risk assessment	12	Patients are not being followed up in the time that has been stipulated by Consultants due to lack of clinic capacity, clinicians not recording correctly or failures in administrative processes. Which could result in patient harm. clinical deterioration in between follow-ups which could lead to untreatable disease progression. This risk relates to outpatients and to patients needing local anaesthetics (the risk to patients needing local anaesthetics was previously on risk 5421 which was merged with this risk on 07/01/19). Appointments requested for patients are not always being given in a timely manner, particularly a risk for oncology patients (follow up clinic) Failure to follow national guidelines for the management of patients with skin cancer - particularly melanoma patients not being seen at regular 3 month intervals. Significant risk of patient mis-management with long term effects - disease progression making treatment options limited. Risk of duty of candour. SEE ALSO CLOSED RISK ID 5421	Will probably recur, but is not a persistent issue	Major	16	Further recruitment of 2 plastics consultants	12/18/2015	10/11/2016	Wright, Jonathan	Directorate Management Team Meeting	7/31/2019	6		Local Services (Care)	Clinical Governance Committee, Joint Board of Directors, Trust Board (Corporate Risk Register)	Medical Director
										Prospective reporting of booked activity to facilitate communication and ultimately improvements in the booking of clinics.	1/17/2017	1/25/2018	Insull, Victoria						
										review Lorenzo and Somerset data and create PTL and book all patients into an appointment by end of March 2018	1/17/2018	1/17/2018	Insull, Victoria						
										monitor and review capacity and time to follow up	12/31/2018	12/21/2018	Vandyken, Ali						
										Reviewing the cause of all patients lost to follow up. Cross refereeing Lorenzo, with Somerset Cancer registry. And reviewing admin process for follow-ups.	4/30/2018	5/8/2018	Hyett, Andy						
										Reviewing the cause of all patients who have been lost to follow up and reviewing admin processes.	8/31/2018	8/16/2018	Hyett, Andy						
										Full follow up PTL being validated at patient level for 2017 and 2018.	3/29/2019	4/25/2019	Hyett, Andy						
										Trajectory for clearing skin backlog to be agreed with COO by 31/04/2019.	4/30/2019	6/12/2019	Wright, Jonathan						
										Executives to review approach to patient pathway redesign.	3/31/2019	4/26/2019	Blanshard, Dr Christine						
										Trajectory for urology backlog clearance to be agreed by 31/05/19 by COO.	5/31/2019	6/12/2019	stephens, Mrs Davina						
										Internal auditors (pwc) to review process for booking new patient and follow up outpatient appointments including cancer.	7/31/2019		Blanshard, Dr Christine						
										Organise a Risk Summit to address Human Factors causing patients to be lost to follow-up.	9/30/2019		Blanshard, Dr Christine						

Corporate Risk Register
July 2019

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead
5751	Trustwide	Trustwide	3/11/2019	Directorate risk assessment	16	Risk of impact on patients from high numbers with a delayed transfer of care. This risk is caused by lack of capacity within the community.	Will probably recur, but is not a persistent issue	Major	16	Winter director managing Trustwide ECIST actions.	5/1/2019	6/12/2019	Hyett, Andy	Trust Board	8/1/2019	4		Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Winter Director coordinating trajectory for delivery of DTOC target.	5/1/2019	6/12/2019	Hyett, Andy						
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	5/1/2019	6/12/2019	Hyett, Andy						
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	5/1/2019	6/12/2019	Hyett, Andy						
										Trust implementing discharge PTL	7/1/2019		Hyett, Andy						
										Escalation to EDLDB non delivery of trajectory	7/1/2019		Hyett, Andy						
										Mitigation actions being prepared to mitigate lack of capacity in the community.	8/1/2019		Hyett, Andy						
5799	Clinical Support and Family Services	Radiology	4/18/2019	Access targets, Cancer Plan, Directorate risk assessment	15	Due to increased activity there is a significant backlog of reporting. There is a high risk of reports being delayed. This is particularly significant to 2WW and GP patients.	Will probably recur, but is not a persistent issue	Major	16	Action plan for mitigation of this risk is development.	7/31/2019	7/8/2019	Lloyd-Jones, Graham	Departmental Team meeting	7/31/2019	6		Care, Local Services	Trust Board (Corporate Risk Register)	Chief Operating Officer
										Local tender undertaken, evaluated and awarded.	7/31/2019		Vandyken, Ali						
										Implementation meeting with new supplier.	7/3/2019	7/3/2019	Clarke, Simon						
										Go live second 3rd party reporting provider	8/31/2019		Clarke, Simon						
										Continuation of additional sessions provided by Radiologists. Ongoing for at 3 month intervals.	12/31/2019		Lloyd-Jones, Graham						
										Active monitoring/management of outsourced backlog by Radiology Service Manager – ongoing for review monthly.	12/31/2019		Clarke, Simon						
										Explore opportunity for Radiographers and Radiologists to have reporting station at home, as a method of increasing reporting capacity	7/31/2019		Clarke, Simon						
										Appointment of substantive Radiologist.	9/3/2019		Lloyd-Jones, Graham						

Corporate Risk Register Summary - July 2019

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Jul-18	Sep-18	Nov-18	Jan-19	Mar-19	Jun-19	Jul-19	Target
Risk Detail				Score Trend								
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do												
5808	Lack of service provision for elective vascular angiography	Chief Operating Officer	01-May-19	10						10	10	6
5558	Medical workforce establishment within oncology	Chief Operating Officer	01-Mar-19	15					12	12	12	8
5704	Inability to provide a full gastroenterology service due to a lack of medical staff capacity	Chief Operating Officer	31-Jan-19	16				16	16	12	12	8
4107	Risk of clinical deterioration of patients between follow up (outpatients) due to non-adherence to requested timeframes	Medical Director	17-Sep-15	12	9	9	9	9	12	16	16	6
5751	Risk of impact on patients from high numbers with a delayed transfer of care	Chief Operating Officer	11-Mar-19	16					16	16	16	4
5799	Significant backlog in reporting due to increased activity with a risk of delayed reports particularly impoacting on 2WW and GP patients	Chief Operating Officer	18-Apr-19	15						20	16	6
Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population												
3322	National reconfiguration of genetic services planned which potential major threat to the future of the SFT genetic lab services	Medical Director	29-Aug-13	12	12	12	12	9	9	9	9	6
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered												
5850	Potential non-delivery of CQUIN schemes resulting in a financial loss	#REF!	13-Jun-19	12						12	12	6
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm												
4857	Risk of loss of all external communications to N3 due to current dual N3 connections (would affect clinical systems access)	Director of Transformation	01-Jan-19	10				10	10	10	10	5
5851	Weekend HSMR significantly higher than expected	Medical Director	13-Jun-19	12						12	12	6
5804	Risk of patients within hospital experiencing a fall	Director of Nursing	26-Apr-19	12						12	12	8
5870	Failure to achieve quality projections set nationally due to changes in reporting definitions (CDiff, Pressure ulcers)	Director of Nursing	20-Jun-19	12						12	12	8
5605	Insufficient staff in cellular pathology laboratory resulting in risk to turnaround times, UKAS accreditation, delayed treatment	Chief Operating Officer	18-Oct-18	15						15	15	6
5607	Risk of error due to Hospital at Night Team capacity to address increasing workload	Medical Director	19-Oct-18	12				12	16	16	16	6
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams												
5863	Risk of new HMRC rules for the NHS Pension Scheme impacting on consultant capacity across the Trust	Director of Finance	17-Jun-19	12						12	12	6
5869	Failure to achieve required ward nursing establishment impacting on quality and safety and patient experience. High agency expenditure	Director of Nursing	20-Jun-19	12						12	12	9
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources												
5705	Unknown impact on the running of the hospital as a result of the EU Exit	Chief Operating Officer	31-Jan-19	12				12	8	8	8	8
4571	Potential risk of failure of sterilisers, washers and associated plant to sterilise equipment	Chief Operating Officer	17-Sep-18	12		15	20	20	20	9	9	6
5487	The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation	Director of Finance	26-Nov-18	12			12	12	12	9	9	9
5326	Risk of access to patient information through variety of clinical information systems and overhead of access	Director of Transformation	20-Dec-17	6	9	9	9	9	9	9	9	4
5860	Risk of failure to achieve financial plan and NHSI control total for 2019/20	Director of Finance	17-Jun-19	12						12	12	9
5480	Risk of poor controls to ensure the consistency and accuracy of information reporting	Director of Transformation	23-Jun-18	16	12	12	12	12	12	12	12	6
5862	Risk to buildings and equipmwnt due to capital programme funding	Director of Finance	17-Jun-19	12						12	12	8
5360	Risk of cyber attack or ransomeware attack	Director of Transformation	28-Feb-18	15			15	15	15	15	15	9

b

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.1
Date of Meeting:	01 August 2018		

Report Title:	Business Case for Insourced Weekend Endoscopy Lists			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Ali Vandyken			
Executive Sponsor (presenting):	Andy Hyett			
Appendices (list if applicable):	N/A			

Recommendation:
To approve the business case to secure weekend insourced Endoscopy capacity from a third party provider.

Executive Summary:
This business case seeks to request approval to secure Weekend Insourced Endoscopy capacity, from a third party provider, for a specified time period to enable the Endoscopy Department to address a backlogged waiting list of Surveillance patients and re-establish a 6 week waiting list for routine patients. Approval of this business case will support recovery of the Trust's DM01 Diagnostic Access performance target, and underpin the requirements of JAG in accordance with the Trust's accreditation renewal. It is acknowledged that a further business case will be required to identify the management of Endoscopy capacity and its enablement to accommodate demand on a long term basis; this will be submitted in during the early part of Q3.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒

Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Salisbury NHS
NHS Foundation Trust

Business Case for Insourced Weekend Endoscopy Lists

1. Executive Summary

This business case seeks to request approval to secure Weekend Insourced Endoscopy capacity, from a 3rd party provider, for a specified time period to enable the Endoscopy Department to address a backlogged waiting list of Surveillance patients and re-establish a 6 week waiting list for routine patients.

Approval of this business case will support recovery of the Trust's DM01 Diagnostic Access performance target, and underpin the requirements of JAG in accordance with the Trust's accreditation renewal.

2. Brief Background

Endoscopy capacity during the Monday to Friday working week has reached saturation point. The Endoscopy Suite comprises of 3 rooms, each of which is timetabled Monday to Friday to guarantee maximised utilisation.

It is not possible to undertake Endoscopy procedures outside of the Endoscopy Suite, therefore any additional capacity required to meet the demands on the service must be undertaken out of hours.

Endoscopic work is currently undertaken by the Colorectal or Gastroenterology teams from the Surgical and Medical Directorates at SFT, the income stream follows the work. To date, additional weekend capacity from Clinicians has not been possible to secure due to limited interest in weekend working, ad hoc arrangements for weekend insourced working have historically provided a solution.

This proposal requests funding to enable a recovery plan against the current waiting list; clearing a backlog of patients associated with the Surveillance pathway, re-establishing a 6 week wait for routine procedures, and sustaining capacity within the service for a period to meet demand.

3. Strategic Context

Colorectal and Gastroenterology services are core at SDH. Elements of delivery associated with these services, plus the Bowel Cancer Screening Program, and Bronchoscopy procedures are undertaken in the Endoscopy Suite.

These services are all subject to National access standards in some capacity, those particularly relevant being Cancer Standards, DM01 and RTT/18 weeks.

Endoscopy patients follow 3 pathways within the Trust; 2 week waits, 6week routines and Surveillance Procedures within an identified period based on clinical priority.

Endoscopy capacity during the Monday to Friday working week has reached saturation point and as a result it has not been possible to schedule ANY Surveillance patients since JUNE 2018 for procedures, owing to the demands on the service from the 2ww and routine pathway.

There is now a backlog of 404 patients (808 points), 300 (600 points) of which have breached the JAG tolerances for the Surveillance pathway (see appendix 1).

Increased demand on the 6week routine pathway has been compounded by increased 2ww referrals, resulting in an inability to book patients in line with the DM01 target. This is evidenced in a deteriorating DM01 performance position. This position will continue to decline exponentially if no action is taken.

To re-establish the 6 week wait for routine procedures it is necessary to clear a backlog of 217 patients (345.5 points) and undertake an additional 1.5 sessions (x3 12 point lists) each week.

4. Case for Change

Following the JAG assessment in 2018 the Trusts accreditation was placed in 6-month deferral period. During this time the Trust maintained robust action plans and communication with JAG in advance of a reassessment in March 2019, following which JAG acknowledged there are still challenges around the bookings system that are making reliable data collection difficult and therefore impacting on the Trust's ability to manage capacity and demand. The accreditation was awarded for one year, subject to the service providing further waiting list data every month for three months to demonstrate ongoing reliability and stability in the booking system.

JAG have advised that accreditation will be with WITHDRAWN (see appendix 2) if this cannot be demonstrated. The monthly returns submitted to date demonstrate an INCREASE in our waiting list month on month and therefore suggest the Trust are not managing their capacity and demand, and therefore booking system effectively.

As previously identified in this case, Endoscopy procedures can only be undertaken in the Endoscopy Suite, and as capacity within the service is saturated on a Monday to Friday basis, the only option is to secure additional capacity at the weekend. It is not possible to staff weekend working from within the current SFT staffing establishment, as such insourcing is the only viable option.

5. Options

1. <u>Do nothing</u>

This is not a viable option owing to the negative impact on the waiting lists for all patient pathways. DM01 performance would continue to decline month on month, the

Trust will likely lose their JAG accreditation and there is more scope for harm being caused to our patients by not being seen in a timely manner.

This is not an option.

2. Address Surveillance backlog in line with JAG Tolerances, re-establish 6 week wait time for routine patients, and provide 1.5 additional sessions (3 lists) to maintain 6 week wait time.

This course of action will have a positive impact on the waiting lists for the majority of patient pathways, and satisfy JAG's expectation around waiting times within the Trust. The Trust's DM01 position will improve, enabling Endoscopy to meet and sustain the target.

This is the preferred option

3. Address Surveillance backlog in its entirety, re-establish 6 week wait time for routine patients, and provide 1.5 additional sessions (3 lists) to maintain 6 week wait time.

This course of action will have a positive impact on the waiting lists for all patient pathways, and satisfy JAG's expectation around waiting times within the Trust. The Trust's DM01 position will improve, enabling Endoscopy to meet and sustain the target.

This option is an option, but would be over and above the expectation of JAG.

6. What is Cost of the New Proposal

Please see appendix 3 for costing model. Please be advised all figures below reflect the current costs associated with 18 Weeks providing a weekend insourced service. It is acknowledged and understood by the Directorate that should this case be approved, a competitive tender exercise will need to be undertaken to satisfy Trust SFI's. These costs are therefore subject to change.

Option 2

Option 2 requires additional capacity at weekends comprising of 12 sessions (3 rooms, 2 sessions per day) over a period of 15 weeks;

Cost per weekend inclusive of scope cleaning and other consumable costs	£40,939.20 inc VAT
Cost per weekend of additional SFT staffing	£3,230
Cost for 15 weekends	£662,538 inc VAT

Option 3

Option 3 requires additional capacity at weekends comprising of 12 sessions (3 rooms, 2 sessions per day) over a period of 20 weeks;

Cost per weekend inclusive of scope cleaning and other consumable costs	£40,939.20 inc VAT
Cost per weekend of additional SFT staffing	£3,230
Cost for 20 weekends	£883,384 inc VAT

Clinical Income

Current Activity available within 5-day Endoscopy Service	10,200 points
Activity associated with Lead Clinician Role	720 points
Total	10,920 points
Activity associated with 19/20 Directorate Plans	10,810 points
Capacity over and above Activity Baseline	+ 110 points
Points included in Option 2	2,160 points
Points attributable to additional income	2,160 points
2 points per Colon patient	680 patients
FE32Z tariff plus MFF £480 per case	£326,400
1 point per OGD patient	800 patients
FE21Z tariff plus MFF £423 per case	£338,400
Total clinical income	£664,800

Clinical income minus cost of Option 2 results additional income of £2,262

NB all clinical income is reportable in the Surgery and Medical Directorates.

7. Workforce Planning

To deliver this business case there may be an element of SFT staffing required as followed per weekend;

B5 Endoscopy Governance Nurse
Additional Reporting SDH Consultant
Additional Reporting SDH Histopathology Consultant

It is understood the provision of this staffing is possible within all identified areas and the costs for these members of staff have been factored into the cost of the proposal identified in section 6.

8. What are the Benefits of the Proposal

- Improved Endoscopy service delivery
- Supports recovery of DM01 target
- Supports improvement of 2ww performance
- Enables JAG re-accreditation
- Reduces risk associated with Surveillance patients being seen outside of the JAG tolerances.
- Improves quality of the service delivered, therefore enhancing patient experience.

9. How will the Outcomes of the Proposal be Monitored?

- Reduction in the waiting list for patients on the Surveillance waiting list, and compliance with JAG tolerances.
- DM01 position recovered for Endoscopy
- KPI's to include utilization, number of points undertaken per list, patient outcomes, cancellations
- A monthly report will be included in the CSFS Executive Performance pack; tracking performance of the recovery trajectory to ensure this remains on track. This report will also be shared monthly with JAG to provide assurance that the recovery plan requested as part of the revalidation process, is delivery against plan, and that mitigations are in place for any identified deviation.

10. Risks

- Costs associated with this Business Case are over and above any costs associated with the provision of Endoscopy Services in the CSFS 19/20 Budget, resulting in a financial burden.
- Possible loss of JAG Accreditation. Negative impact on Trust's reputation, reduced income associated with Endoscopy procedures.

- Income associated with this Business Case is not recoverable for CSFS as activity sits with the Surgical and Medical Directorates.
- This business case reflects a short term solution to address the current challenges within the service only. To meet the current demand on the service a minimum of 3 additional sessions per week is required, to prevent a reoccurrence of the current position.
- The number of Surveillance patients being added to the waiting list increases on a weekly basis; the number of additional sessions required to address the patient backlog will therefore do the same.
- Owing to the value of this proposal, if approved, a Tender exercise will need to be undertaken to satisfy Trust SFI requirements. There will be a need for further ad hoc weekend sessions in the interim, to mitigate against the risk cited above.
- Long term solution to address capacity gap in service must be worked up. This heavily relies on the availability of Clinicians in the Surgical and Medical Directorates. It is not possible for CSFS to run this service in isolation.

11. Summary

This business case seeks to request approval to secure Weekend Insourced Endoscopy capacity from a 3rd party provider, for a specified time period, to enable the Endoscopy Department to address a backlogged waiting list of Surveillance patients in line with JAG tolerances and re-establish a 6 week waiting list for routine patients.

It is acknowledged that a further business case will be required to identify the management of Endoscopy capacity and its enablement to accommodate demand on a long term basis; this will be submitted in during the early part of Q3.

12. Business Case Sign Off

Confirmation of DMT approval of this proposal – Clinical Director	
Confirmation of date of DMT meeting where proposal signed off	
Directorate Manager support confirmation	
Directorate Senior Nurse support confirmation	
Directorate Finance Manager support confirmation	
Directorate HR Manager support	
Other DMT member – specify (eg Head of Midwifery, Head of Therapy, etc)	

Date of Exec's meeting at which this proposal has been approved	
Executive Director Sponsor	

Salisbury NHS
NHS Foundation Trust