Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Chief Finance Officer
DATE:	2 July 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☒ For Information

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Areas in which performance has been sustained or has notably improved include: • 28 Day Faster Diagnosis – All Cancers – significantly higher than the national reporting standard. • CAMHS Eating Disorders - Routine referrals seen within four weeks remains above the national standard and the national average. • access to our perinatal service was significantly above the 10% mandated standard. • the number of patients waiting 52 weeks or more from referral to acute treatment reduced. • patients followed up within 72 hours of discharge from an adult mental ward remained above 90%. Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include:

	• No Criteria to Reside within our acute beds continues to impact on patient flow. • the percentage of people waiting under six weeks for a diagnostic test. • the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Departments. • the number of patients waiting 18 weeks or more for a community service. • the number of patients waiting 18 weeks or more to be seen by our community dental service In Appendix 3, data relating to a range of patient safety / incident measures, including falls, ligatures, restraint, and medication incidents is currently unavailable whilst we implement updates to the datasets, due to the move to the new national Learn from Patient Safety Events (LFPSE), which requires changes to definitions and categorisations of incident data.
Recommendation	The Board is asked to discuss and note the report.

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

☒ Obj 1 Improve health and wellbeing of population
☒ Obj 2 Provide the best care and support to children and adults
☒ Obj 3 Strengthen care and support in local communities
☒ Obj 4 Reduce inequalities
☒ Obj 5 Respond well to complex needs
☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7 Live within our means and use our resources wisely
☒ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☒ Legislation	☒ Workforce	☐ Estates	☐ ICT	☒ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
A range of key indicators, relating to waiting times for treatment including acute hospital services, cancer services, and mental health services, are routinely monitored to provide assurance that there is equity of provision and access in relation to people with protected characteristics. This includes standards delivered according to recorded ethnicity and learning disability. Our workforce measures also include indicators relating to ethnicity, gender and disability.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Not considered for this report but considered at service group level.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is considered at every meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: MAY 2024

1. BACKGROUND AND PURPOSE

1.1 Our Quality and Performance exception report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends.

1.2 The report presents information relating to the five key questions which the Care Quality Commission considers when reviewing and inspecting services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well-led?
- Are they responsive to people's needs?

1.3 Underpinning each of these key questions are Quality Statements, which outline the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', these show what is needed to deliver high-quality, person-centred care. As a provider, we aim to ensure that we meet the requirements of these 'we statements', as well as the accompanying 'I statements', which reflect what people have said matters to them.

1.4 The exception reports include run charts, produced using Institute for Healthcare Improvement (IHI) methodology, and in consultation with the Academic Health Sciences Network. An explanation of how to interpret these charts is attached as Appendix 1.

1.5 A summary of our current Care Quality Commission ratings is included as Appendix 2.

1.6 A summary of the monthly data and run charts for our key quality measures is attached as Appendix 3.

1.7 Our Corporate Balanced Scorecard is attached as Appendix 4. The measures included in the Corporate Balanced Scorecard may change during the year as new priority areas are identified.

1.8 Supporting information relating to referral levels, activity levels, lengths of stay, tumour-site-specific activity and performance, and other key measures for our community and mental health services is included in Appendix 5. The activity information in Appendix 5 shows the levels and trends for the current year and previous two years.

1.9 Appendix 6 provides additional details and commentary in relation to Infection Control and Prevention.

CHIEF FINANCE OFFICER

Overview

The table below provides a summary of key successes, priorities, opportunities, risks and threats in relation to our current levels of performance.

Successes	**Priorities**
• our eating disorders service for children and young people continued to exceed the national waiting times standard for routine appointments. • Talking Therapies achieved all nationally mandated standards. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • there was a reduction in the number of patients waiting over 52 weeks from referral to treatment. • the national 75% 28-day Faster Diagnosis standard was achieved again. • the compliance level in respect of mandatory training remains high despite the operational challenges faced by services. • our mental health perinatal service continues to exceed the 10% national reporting standard.	• continue to maintain a safe service and making sure urgent patients are treated as quickly as possible within the context of the challenges the current coronavirus outbreak brings. • continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated backlogs arising from the time of the COVID-19 pandemic, and rising levels of demand. • continuing to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built-up. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• the growth in the size of waiting lists caused by the reduction in capacity during the COVID-19 pandemic continues to present a significant challenge to the restoration of waiting times. • delays in discharge of inpatients not meeting the criteria to reside and needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • sickness / absence presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

Infection Prevention and Control (IPC) performance is assessed by means of the numbers of key healthcare associated infections (HCAI) (Trust apportioned) against agreed thresholds. These are: MRSA bloodstream infections (BSI): zero tolerance, Clostridioides difficile (C. diff) infection (CDI): 54 cases, MSSA BSIs: 64, E. coli BSIs: 105 cases, Klebsiella BSIs: 31 Pseudomonas aeruginosa BSIs: 15.

Current performance (including factors affecting this)

- Trajectories for 2024/25 have yet to be published nationally, thus we are using 2023/24 trajectories until the 2024/25 trajectories are agreed.
- **MRSA:** One Trust-attributed MRSA bloodstream infection (BSI) was reported in May 2024.
- **MSSA:** There were eight Trust-attributed MSSA BSIs reported in May 2024, bringing the total to 13.
- **E. coli**: There were 16 Trust-attributed E. coli BSIs reported in May 2024, bringing the total to 24.
- **Klebsiella:** There was one Trust-attributed Klebsiella BSI reported in May 2024, bringing the total to four.
- **Pseudomonas:** There were two Trust-attributed Pseudomonas aeruginosa BSI reported in May 2024, bringing the total to two.
- **C. diff**: There were 11 Trust-attributed cases reported in May 2024, bringing the total to 19.

Respiratory Viral Infections

- **COVID-19:** 200 inpatient cases of COVID-19 were identified during May 2024, of which 87 were healthcare-attributed.
- **Influenza:** 11 inpatient cases were identified during May 2024, almost all of which were Flu A.

Outbreaks

- During May 2024 a total of 17 outbreaks affected inpatient wards, 16 due to COVID-19, and one due to norovirus.
- Carbapenemase Producing Organism, the outbreak on the YDH site, remains ongoing with a total of 44 cases between January and May 2024.

Surgical Site Infections – Data as of April 2024

Total Hip Replacement

- MPH rate of infection = 0%
- YDH rate of infection = 1.46%

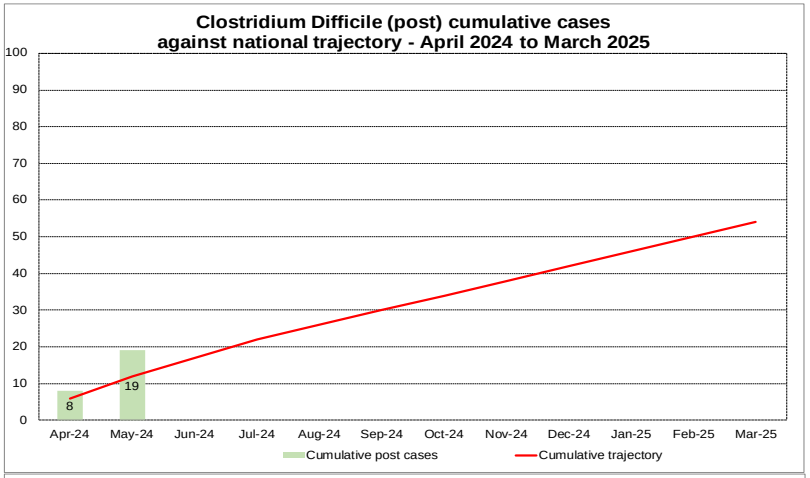
Total Knee Replacement

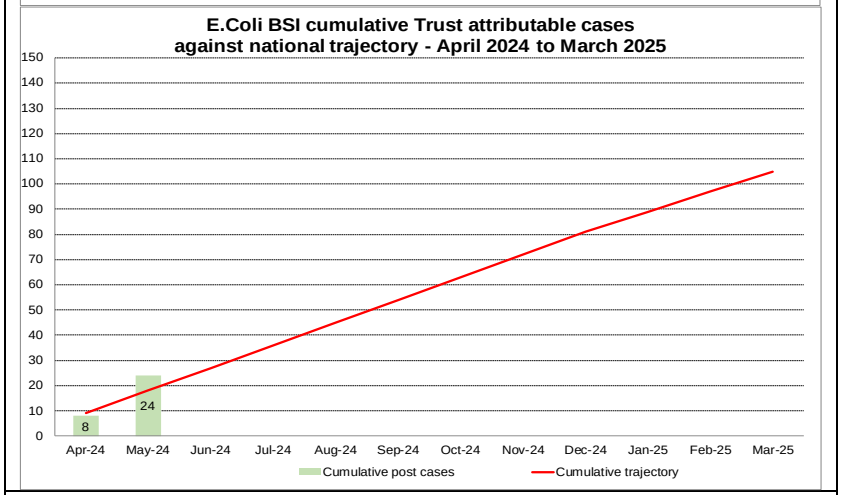
- MPH rate of infection = 0.53%
- YDH rate of infection = 0%

Spinal Surgery

- MPH rate of infection = 0.5%

Line/Bar Charts





Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
MRSA	0	1	0	0	0	1
C.Diff	7	13	9	11	8	11
MSSA	5	10	6	2	5	8
E.coli	9	7	7	8	8	16

Responsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 78% of patients will wait less than four hours in the Emergency Department by March 2025.

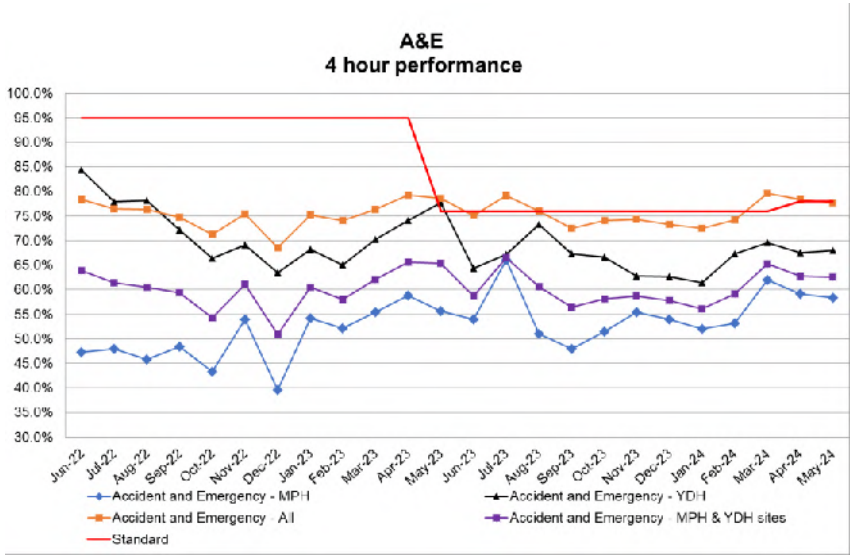
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 62.5% during May 2024, almost unchanged from 62.7% in April 2024. With Urgent Treatment Centres (UTCs) compliance included at 97.3%, overall compliance was 77.7%, down from 78.3% in April 2024, and below the revised 78% national standard that took effect from 1 April 2024.
- Compliance in respect of our two A&E departments was:
  - Musgrove Park Hospital (MPH): 58.4%.
  - Yeovil District Hospital (YDH): 68.0%.
- Combined rolling 12 months A&E attendances at MPH and YDH (for the period from 1 June 2023 to 31 May 2024) were 3.5% higher than the same months of 2022/23. Since 1 January 2024, the average number of attendances has increased to 425 patients per day compared to 408 per day between 1 April and 31 December 2023, which has affected performance against the four-hour standard.
- The number of patients spending more than 12 hours in the departments in April 2024 was 1.4% at MPH and 2.3% at YDH.

Focus of improvement work

- Three new Trust fellows have been appointed at YDH. Specialist, associate specialist and specialty doctor interviews for six posts are scheduled for late June 2024.
- Request for extra doctor staffing has gone out to support the Glastonbury festival. Planning is under way for the forthcoming industrial action, with additional shifts requested to provide support during this period.
- Bi-monthly meetings are under way with the surgical directorate to improve referral pathways.
- New ED screens are in place to show live demand and performance within the department for staff.
- A Quality Improvement (QI) project has commenced around transfers from ED to wards. Data analysis is now complete, and root cause analysis is progressing.
- Rotational Clinical Fellow posts are commencing in August 2024 at MPH.

Line Chart



How do we compare

In May 2024, the national average performance for Trusts with a major Emergency Department was 59.7%. Our performance was 62.5%. We were ranked 46 out of 122 trusts. With Minor Injury Unit attendances included, we were ranked 23, with performance of 77.7%. National average performance was 71.5%.

Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
A&E only	57.8%	56.1%	59.2%	65.2%	62.7%	62.5%
Including MIU	73.3%	72.5%	74.2%	79.6%	78.3%	77.7%

Responsive

Ambulance handovers are to be completed within 30 minutes of arrival at hospital. The target is that at least 95% of patient handovers are within the 30 minute standard.

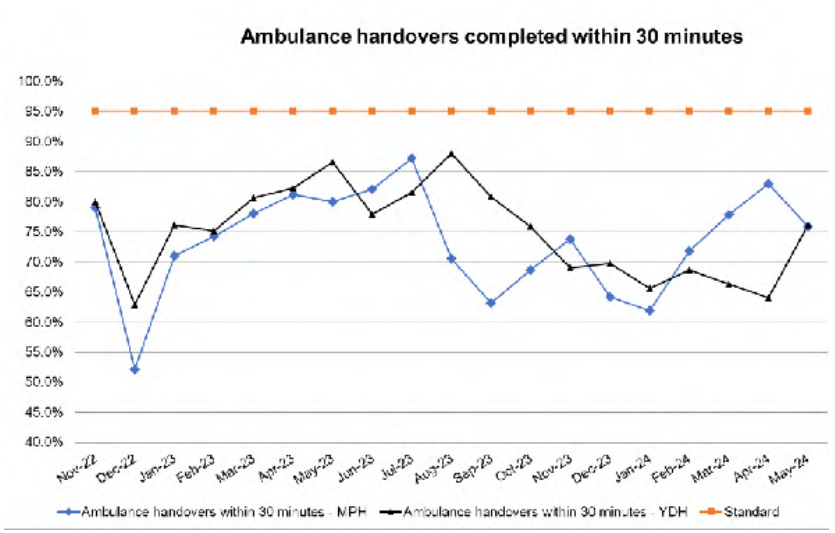
Current performance (including factors affecting this)

- During May 2024, performance for the handover within 30 minutes of patient arrivals by ambulance decreased at Musgrove Park Hospital (MPH) but increased at Yeovil District Hospital (YDH) when compared to April 2024. Compliance in May 2024 was as follows:
  - MPH: 75.8% (1,904 out of 2,513 handovers were within 30 minutes).
  - YDH: 76.1% (975 out of 1,281 handovers were within 30 minutes).
- The average performance across all hospitals served by SWAST in May 2024 was 58.4%. YDH was ranked sixth out of 19 sites served by South Western Ambulance Service NHS Foundation Trust (SWAST) across the Region and MPH was ranked seventh.

Focus of improvement work

- Both departments are planning to undertake an in-depth front door audit over a seven-day period, with the support of the system co-ordination centre to review appropriate conveyance and reasons for delays in handover.
- Sporadic problems with XCAD (the SWAST hospital ambulance arrivals system) has caused apparent ambulance handover delays. This has now been resolved and is being monitored.
- A new process of live validation for ambulance handovers of two hours or more has been agreed.
- A new ambulance handover and four-hour breach working group will launch in July 2024 to formalise an ambulance handover action plan to support improvement trajectories. A review of delay reasons is being completed jointly with SWAST, to provide more accurate data regarding the reasons for delays.
- A proposal has been developed to amend the handover process at YDH ED to support ambulance handover times through the nurse in charge determining 'notify' time.

Line Chart



How do we compare

In May 2024, 75.8% of all ambulance handovers at Musgrove Park Hospital and 76.1% of all ambulance handovers at Yeovil District Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 58.4%.

Recent performance

Performance in recent months against the 30-minute standard was as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
MPH	64.1%	61.9%	71.8%	77.8%	83.0%	75.8%
YDH	69.7%	65.6%	68.6%	66.3%	64.0%	76.1%

Responsive

Referral to Treatment Time (RTT) is a measure of the length of time a patient waits from the point of referral through to receiving treatment. The target is for at least 92% of patients, who have not yet received treatment, to have been waiting less than 18 weeks at the month-end. Trusts should have no patients waiting over 65 weeks for treatment by 31 March 2024.

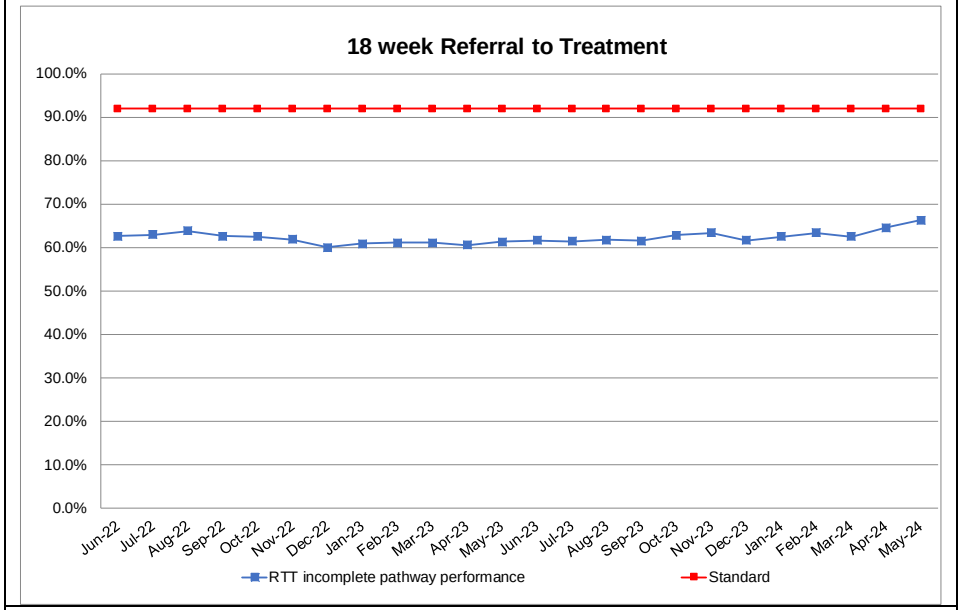
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 66.3% (combined acutes + community) in May 2024, an increase of 1.8% on the April 2024 position.
- The total waiting list size increased by 387 pathways, and was 1,383 higher (i.e. worse) than the planning trajectory (55,014 actual vs. 53,631). The rise in the size of the waiting list partly contributed to the improved percentage performance against the 18-week standard.
- The number of patients waiting over 52 weeks decreased by 98 pathways in May 2024 to 1,871 pathways, against a trajectory of 2,392 or fewer.
- The number of patients waiting over 65 weeks was 484 at month-end, which was 111 higher (i.e. worse) than the planning trajectory of 373.
- The number of patients waiting 78+ weeks decreased by two to 35, 13 over the trajectory of 22.

Focus of improvement work

- The number of patients needing a first outpatient appointment or surgery, to avoid becoming a 65-week RTT waiter by the end of September 2024, has been quantified for each specialty to support the development of capacity plans.
- Cohort-clearance monitoring reports have been established for all high-volume specialties, split by hospital site and pathway type.
- Detailed plans continue to be progressed to manage the capacity gaps identified, through improved productivity, increased capacity (including use of the Independent Sector insourcing and outsourcing) and reprioritisation of available theatre capacity across the System.
- A significant programme of improvement work to support elective care recovery in the medium and long-term remains in place.
- A programme of waiting list validation continues, which includes contacting patients to check they still need to be seen.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 58.3% in April 2024, the latest data available; our performance was 64.6%. National performance improved by 1.1% between March and April 2024; our performance improved by 2.1%. The number of patients waiting over 52 weeks across the country decreased by 6,711 to 302,589 (4.0% of the national waiting list compared with 3.4% for the Trust). The number of patients waiting over 78 weeks nationally increased by 243 to 5,013.

Performance trajectory: 78 week and 65 week wait performance

Area	Dec	Jan	Feb	Mar	Apr	May
78-week trajectory	55	50	40	35	34	22
78-week actual	61	50	48	40	37	35
65-week trajectory	734	710	698	673	483	373
65-week actual	725	605	538	434	463	484

Appendix 5a shows a breakdown of performance at specialty level.

Responsive

Acute bed days lost due to patients not meeting the criteria to reside: Working with strategic partners to facilitate the timely and appropriate discharge of patients from our hospitals, and reduce the number of patients occupying a bed who no longer require treatment or therapy.

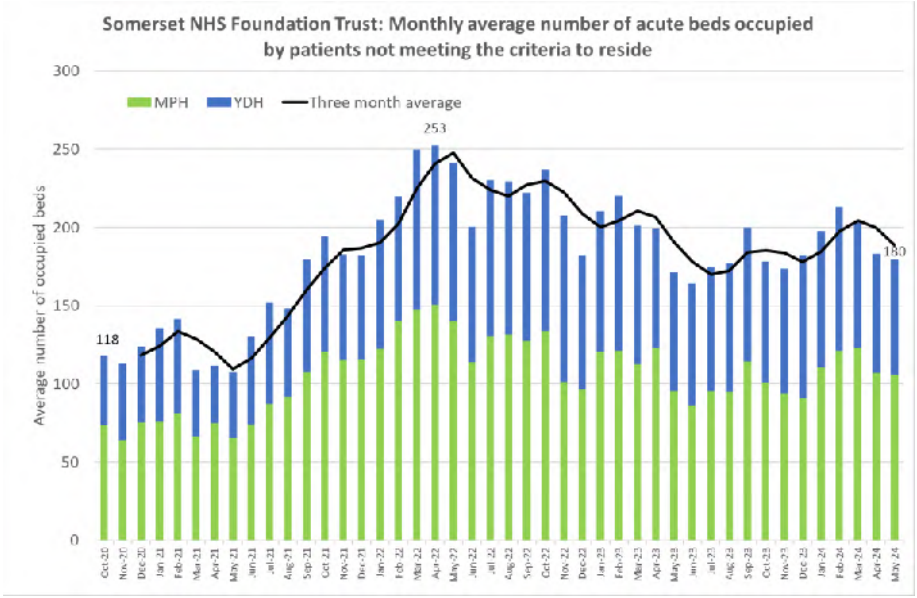
Current performance (including factors affecting this)

- During May 2024, the Trust-wide number of acute bed days occupied by patients not meeting the criteria to reside was 5,574 (3,267 at MPH and 2,307 at YDH), down up from 5,498 in April 2024. This equates to 180 fully occupied beds for the month of May 2024, down from 183 in April 2024, and the third month in a row that the numbers have reduced.
- In our community hospitals, the number of patients not meeting the criteria to reside decreased significantly, from 69 as at 30 April 2024 to 46 as at 31 May 2024.
- Of the 1,700 acute inpatients discharged during May 2024 who had a Discharge Ready Date recorded, the average duration between the Discharge Ready Date and the actual date of discharge was 2.6 days, up from 2.5 days during April 2024. 64.6% of patients discharged in May 2024 were discharged within seven days of their Discharge Ready Date, and 81.3% were discharged within 14 days.
- Recording of Ready to Discharge Dates in respect of all discharges was 48.5%, the same as the rate achieved during April 2024. A performance improvement trajectory has been set to increase recording compliance.

Focus of improvement work

- A range of actions are being taken to improve patient flow, care for people at home where appropriate, facilitate timely and appropriate discharge and address the difficulties in the domiciliary care market.
- These actions include the expansion of Criteria-Led Discharge, to discharge a patient when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in the discharge process and ensures discharges are in an appropriate and timely way.
- A review is being undertaken of the YDH system, as it not currently possible to record, on all patient records, the Ready to Discharge dates.

Trend Chart



How do we compare

As at 31 May 2024, national best-quartile performance was that 6.9% of Adult General & Acute and critical care beds were occupied by patients who did not meet the criteria to reside. Our performance as at that date was 22.8% of beds. We were ranked 105 of 119 Trusts nationally.

Recent performance

Bed days lost where patients did not meet criteria to reside over recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
MPH	2,807	3,435	3,516	3,805	3,215	3,267
YDH	2,844	2,691	2,660	2,487	2,283	2,307
Total	5,651	6,126	6,176	6,292	5,498	5,574

Responsive

Patients spending >90% of time in stroke unit – Stroke units are able to offer the best quality of stroke care both acutely and in the long-term. Management of eligible patients in a stroke unit will result in long-term reductions in death, dependency and the need for institutional care. Our aim at least 80% of patients spend more than 90% of their pathway in designated stroke wards.

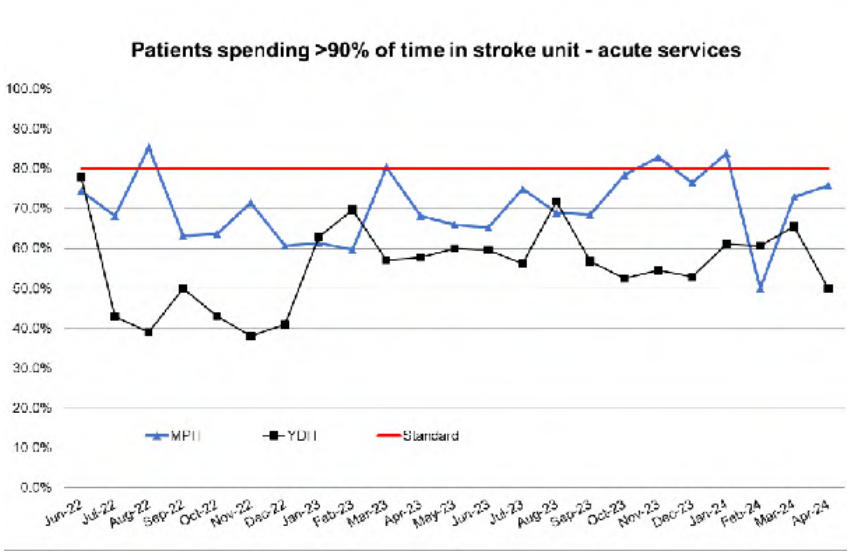
Current performance (including factors affecting this)

- During April 2024, compliance increased at Musgrove Park Hospital but decreased at Yeovil District Hospital. Performance at the two sites was as follows:
  - Musgrove Park Hospital (MPH): 75.8%
  - Yeovil District Hospital (YDH): 50.0%
- As is the case with the four-hour standard, performance in respect of this reporting standard is heavily influenced by patient flow and the availability of stroke beds.
- Compliance at YDH fell in April 2024, mainly because of levels of demand and available bed capacity.

Focus of improvement work

- It should be noted that, regardless of whether or not they are on a Stroke ward, all patients remain on a stroke pathway throughout the whole time of their care and are seen by specialist stroke practitioners on non-Stroke wards and also throughout their time with our community Stroke rehabilitation services.
- The number of hyper acute stroke beds available at MPH increased from four to eight in January 2024 ,which has helped improve patient flow, although the position remains challenging.

Line Chart



How do we compare

During April 2024, compliance increased at Musgrove Park Hospital but decreased at Yeovil District Hospital when compared to March 2024.

Performance over the last six months

Area	Nov	Dec	Jan	Feb	Mar	Apr
% compliance MPH	82.9%	76.5%	83.3%	50.0%	72.9%	75.8%
% compliance YDH	54.5%	52.9%	61.0%	60.6%	65.5%	50.0%

Responsive

Intermediate Care – Our aim is to ensure that at least 95% of patients aged 65 years or over discharged from acute hospital beds are discharged home on pathway 0 or 1.

Current performance (including factors affecting this)

During May 2024, 93.5% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

These are discharges to patients' homes that are arranged at ward level and do not require core intermediate care support on discharge. These discharges are often supported by the voluntary sector and/or other community health services such as district nursing and the community rehabilitation service (CRS).

Pathway 1

These discharges are supported by the Intermediate Care Discharge to Assess Service (D2A). These people require reablement and ongoing assessment within their own home.

Focus of improvement work

The percentage of pathway 0 patients for the over 65 years group fell from 85% in April 2024 to 84% during May 2024.

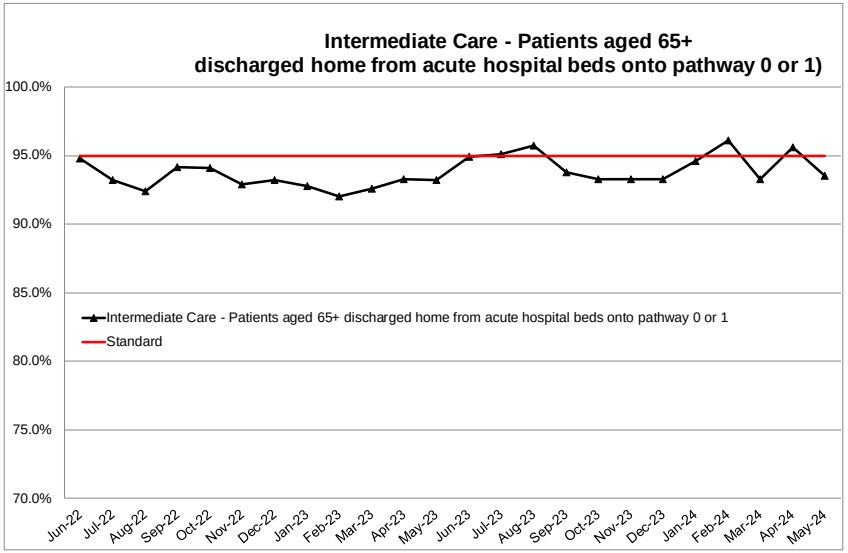
The percentage of people accessing P1 also fell, from 11% in April 2024 to 9% during May 2024.

The above has led to a reduced percentage of people going directly home from hospital in Somerset.

Actions being taken include:

1. **Continuing to strengthen the decision-making within the Transfer of Care (TOC) Hubs** – positive risk taking, personalised care approach.
2. **Out of Hospital Care models –** promoting alternatives to hospital-based acute care early in a person's hospital stay, to prevent deterioration.
3. **Increase P1 capacity –** making this an easily accessible, timely way of supporting people to return directly home.

Trend Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during May 2024 decreased compared to April 2024.

Performance over the last six months

Area	Dec	Jan	Feb	Mar	Apr	May
Total Discharges	2,132	2,139	2,148	2,126	2,230	2.021
Pathway 0	1,745	1,733	1,794	1,743	1,888	1,703
Pathway 1	244	290	271	240	244	187
% onto P0 or P1	93.3%	94.6%	96.1%	93.3%	95.6%	93.5%

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having their first appointment. The data shown relates to our community physical health services, including dentistry.

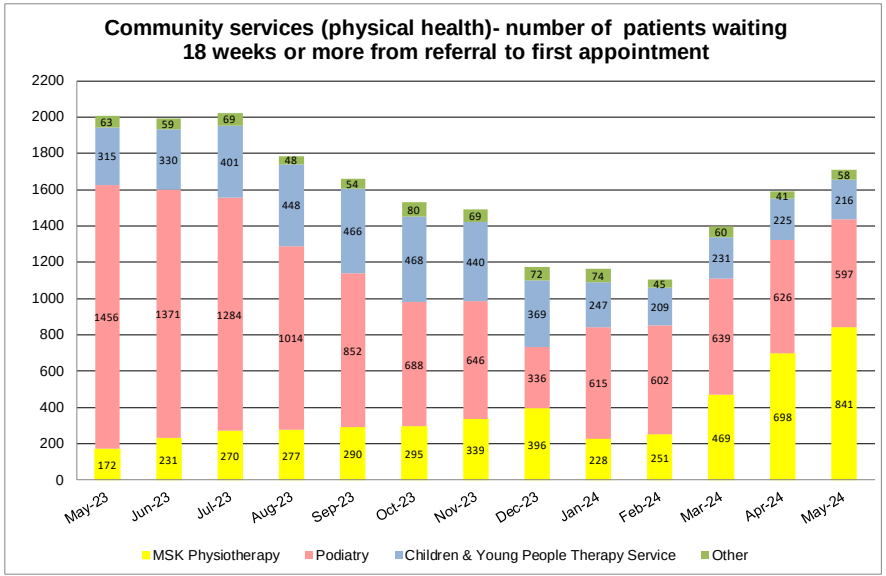
Current performance (including factors affecting this)

- As at 31 May 2024, the number of patients waiting 18 weeks or more totalled 1,712 an increase of 122 compared to 30 April 2024.
- Our Musculoskeletal Physiotherapy Service had the highest number of patients waiting 18 weeks or more with 841, up from 698 as at 30 April 2024. The recent increase in the numbers waiting has primarily been due to vacancies within the service.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service decreased to 597 patients, from 626 as at 30 April 2024. The service continues to have significant levels of vacancies, which is a national issue.
- Numbers with our Children and Young People Therapy Service totalled 216, a slight decrease from 225 as at 30 April 2024.
- Of 259 patients waiting 52 weeks or more as at 31 May 2024, a total of 257 related to Podiatry, with the other two patients being within the Children and Young People's Therapy Service.

Focus of improvement work

- The Musculoskeletal Physiotherapy Service is developing actions to reduce numbers waiting that includes a review of the patient pathways.
- For Podiatry, priority continues to be given to high risk vascular / diabetic foot care and acute nail surgery cases. All routine patients are contacted by letter and telephone to provide advice and guidance. A review of current and previous actions is being undertaken.
- The Children and Young People Therapy Service is undertaking a waiting list initiative to reduce waiting times and the numbers waiting.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 May 2024 increased by 122 when compared to 30 April 2024.

Recent performance

The numbers of people waiting 18 weeks or more at the month end, in recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Number waiting	1,173	1,164	1,107	1,399	1,590	1,712

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having their first appointment. The data shown relates to our community dentistry service.

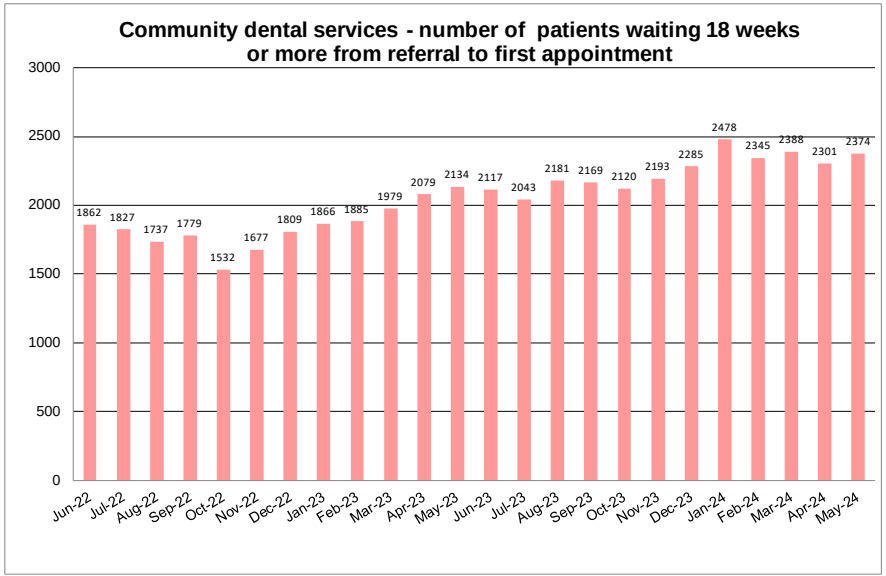
Current performance (including factors affecting this)

- As at 31 May 2024, the number of patients waiting 18 weeks or more totalled 2,374, an increase of 73 compared to 30 April 2024.
- Of the patients waiting 18 weeks or more to be seen, there were 1,695 waiting within Somerset (up from 1,625 as at 30 April 2024), and 679 within Dorset (up from 676 as at 30 April 2024).
- The number of people waiting 52 weeks or more increased from 531 as at 30 April 2024 to 584 as at 31 May 2024.

Focus of improvement work

- The Dental service continues to face considerable challenges due to vacancies, sickness absence and insufficient cover for colleagues on maternity leave. Recruitment campaigns now include a testimonial service video, glossy brochures, social media material and open drop in events for all posts including senior specialists.
- With demand currently exceeding capacity, the service has been reviewing pathways and is also reviewing trajectories and actions to reduce numbers waiting.
- The service is balancing seeing core primary care patients and completing their courses of treatment, with those who have been referred into the service. Unfortunately, the with the volume of referrals it is proving very challenging, and the service has been asking for a catch-up meeting with the Integrated Care Board, to try to work with them to review how this can be approached.
- The service works regionally, through the Managed Clinical Network structure, the Local Dental Committee, and work with NHS England network managers, to ensure we are able to align with the latest thinking, and to share challenges and initiatives with all other similar services in the South West.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 May 2024 increased by 73 when compared to 30 April 2024.

Recent performance

The numbers of people waiting 18 weeks or more at the month end, in recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Number waiting	2,285	2,478	2,345	2,388	2,301	2,374

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to reduce the number of people waiting over 18 weeks from being referred to having treatment. The data shown relates to our Somerset and Dorset Dental services, specifically children and young people waiting 18 weeks or more from assessment for an appointment to have a procedure requiring a general anaesthetic (GA).

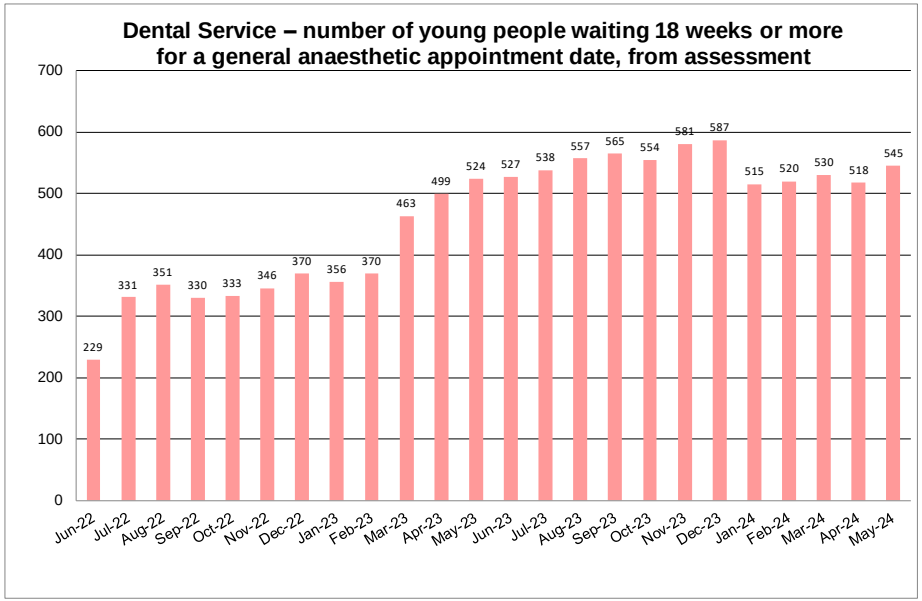
Current performance (including factors affecting this)

- As at 31 May 2024 a total of 545 young people had waited 18 weeks or more, up from 518 as at 30 April 2024.
- Of the 545 patients waiting, 451 related to our Dorset service (up from 435 as at 30 April 2024), and 94 related to our Somerset service (up from 83 as at 30 April).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by four GA dentists now on maternity leave for whom there is insufficient cover.
- Demand for these services across the counties remains high.

Focus of improvement work

- Recruitment campaigns now include a testimonial service video, brochures, social media material and open drop-in events for senior specialist posts.
- A business case has been completed and submitted by the service to Dorset Integrated Care Board (ICB) to have more theatre sessions from September 2024. If approved, this will increase the theatre sessions from two to four adult sessions per rolling four-week period and from nine to 15 children's sessions per rolling four-week period.
- At YDH there has been an increase in the number of children being seen, moving from an average of four per session before improvement initiatives, to an average of six per session. However, the environmental factors of the ward, recovery capacity and anaesthetics remain a challenge to seeing more dental patients in the current theatre set-up.
- The Get It Right First Time (GIRFT) report is imminent, to support community services across the South West to access to theatre space for dental paediatric patients, and for accountability of waiting lists.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 May 2024 increased compared to 30 April 2024.

Recent Performance

The numbers of young people waiting 18 weeks or more at the month end in recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
Number waiting	587	515	520	530	518	545
% > 18 weeks	68.3%	66.7%	70.2%	67.7%	66.4%	66.1%

Responsive

31-day decision to treat to cancer treatment is a measure of the length of wait from the patient agreed decision to treat, through to treatment. The standard is for at least 96% of patients to be treated within 31 days of a decision to treat. This target includes first and subsequent treatments for cancer.

Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 91.2% in April 2024, below the 96% national standard but above the national average performance.
- There were 58 breaches of the combined treatment standard, of which 20 (34% of breaches) were for skin, 12 were for urology (21%), 10 were for colorectal (17%), and nine were for breast (16%). There were smaller volumes of breaches across a range of tumour sites.
- 50% of the breaches were for radiotherapy treatments and 48% were for surgical treatments. The ability to start treatment within 31 days of the decision to treat is affected by bulges in demand, which we have been seen, in particular, in colorectal and breast.
- There has been an increase in breaches of the 31-day standard for skin patients which has followed the full repatriation of the skin cancer service for the west of the county from University Hospital Bristol Weston NHS Foundation Trust (UHBW) from the start of November 2023.

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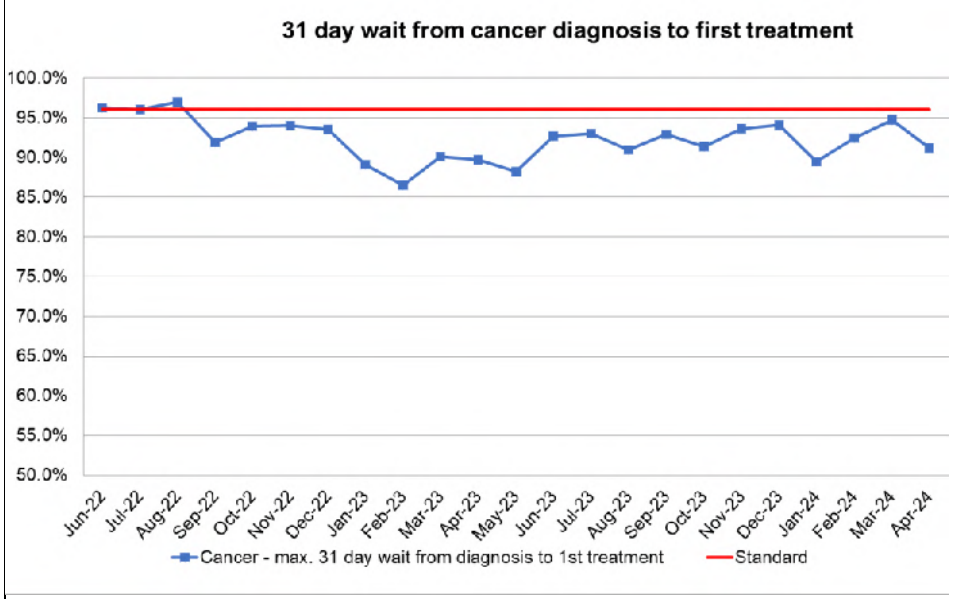
Focus of improvement work

- The work outlined in the combined 62-day cancer standard will help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer surgery.
- Capacity and demand modelling has been undertaken for the repatriated dermatology two-week wait service. Additional capacity continues to be established, including further consultant appointments, GPs with Extended Roles being trained, and insourcing. Allied service capacity is also being planned for, including pathology, plastics and melanoma oncology. A new Artificial Intelligence (AI) system will be piloted, which will help with the triage and management of suspected cancer referrals. The new teledermatology system (Cinapsis) is live across both sides of the county, helping to manage routine demand and free-up capacity for suspected cancer and other specialist referrals.

Line Chart



How do we compare

National average performance for providers was 89.2% in April 2024, the latest data available. Our performance was 91.2%. We ranked 93 out of 140 providers.

Recent performance

31-day diagnosis to first treatment performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	93.7%	94.0%	89.5%	92.4%	94.7%	91.2%

Responsive

62-day Cancer is a measure of the length of wait from referral from a GP, screening programme or consultant, through to the start of first definitive treatment. The target is for at least 85% of patients to be treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

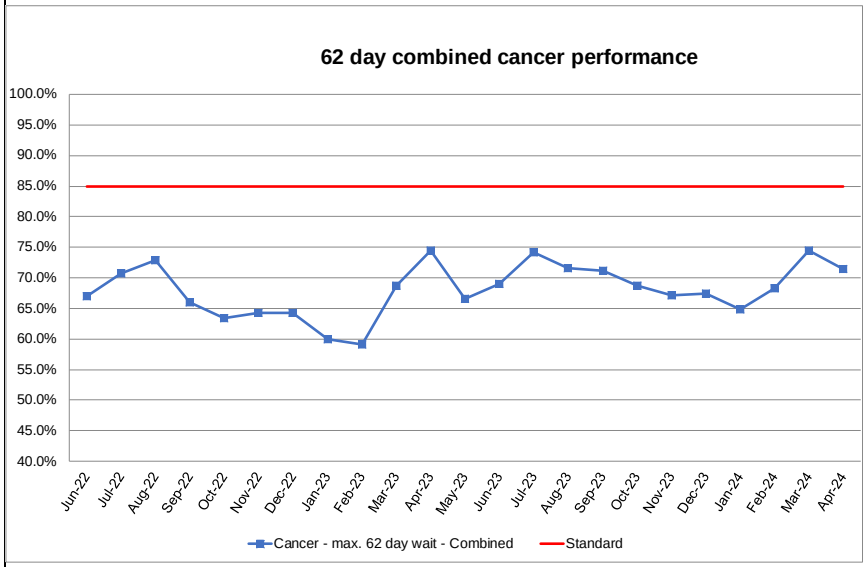
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 71.5% in April 2024, and above the national average.
- The main breaches of the 62-day GP cancer standard were in urology (34% of breaches), colorectal (19%) and skin (10%).
- The main cause of the breaches continues to be high demand (urology 19% growth, colorectal 12% growth, relative to the same three-month period last year). This has resulted in an increase in diagnostic and treatment waiting times, both at the Trust and other treating providers.
- The increase in skin breaches relates to the sooner than planned repatriation of the service from University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).
- Twenty-one GP-referred patients were treated in April 2024, on or after day 104 (the national 'backstop') – please also see Appendix 5a.
- 28-day Faster Diagnosis Standard performance was 78.6% in April 2024, above the current national target of 75%, which rises to 77% to be achieved by March 2025.

Focus of improvement work

- A new cancer 'front door' is under development, for implementation in the summer; this will create a single-entry point for cancer referrals across Somerset, helping to smooth demand across the two hospital sites; it will include nurse-led triage and management of the initial diagnostic phase of cancer pathways.
- Prostate pathway redesign work continues on the diagnostic phase, focusing on nurse-led management and steps being condensed or removed to achieve a diagnosis sooner.
- Additional colorectal diagnostic capacity continues to be established, to try to meet increasing demand. This includes additional CT colon scans being undertaken at Musgrove for Yeovil patients, as well as additional CT colon lists at Yeovil.
- Please also see the 31-day exception report for actions relating to skin.

Line Chart



How do we compare

National average performance for providers was 66.6% in April 2024, the latest data available. Our performance was 71.5%. We were ranked 68 out of 144 trusts.

Although the national standard remains 85%, the operating plan guidance for 2024/25 sets the improvement target as 70% for March 2025.

Recent performance

62-day GP cancer performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	67.1%	67.4%	64.9%	68.3%	74.5%	71.5%

Appendix 5a provides a detailed breakdown of tumour-site level performance.

Responsive

The Diagnostic six-week wait is a measure of the length of wait from referral through to diagnostic testing being carried out. This standard is applied to the top 15 national high-volume tests. The target is for at least 95% of patients to have been waiting less than six weeks for a test at the month-end, by March 2025.

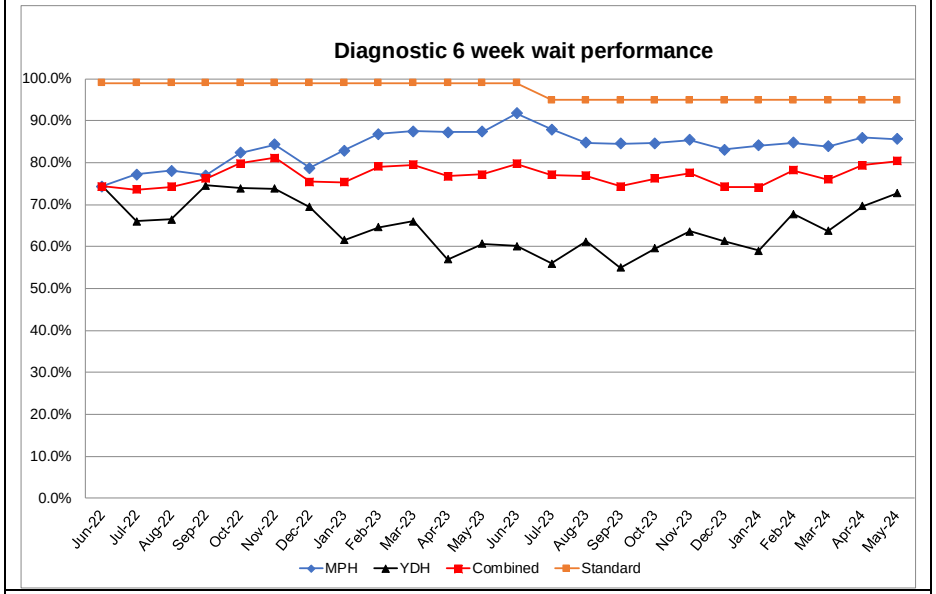
Current performance (including factors affecting this)

- The combined percentage of patients waiting under six weeks for their diagnostic test increased to 80.4% in May 2024, which is below the regional March 2024 ambition of greater than 85%, but above the planning trajectory, and the highest level of compliance since November 2022.
- The number of patients waiting over six weeks in May 2024 decreased by 83 patients in the month; the highest numbers of patients waiting over six weeks were waiting for the following diagnostic tests:
  - MRI (down from 485 to 432, 18% of over six-week waiters),
  - echo (up from 271 to 405; 17%),
  - gastroscopy (down from 284 to 255; 11%),
  - colonoscopy down from (252 to 217; 9%),
  - ultrasound (down from 440 to 211; 9%),
  - CT (up from 160 to 211; 9%).
- Together these six diagnostic modalities made up 71% of the over six-week diagnostic waiters.
- The total waiting list size increased by just over 1% (164 patients).

Focus of improvement work

- Additional endoscopy sessions continue to be run at the weekend in Yeovil and Musgrove; appropriate patients on the Yeovil waiting list are also being offered Musgrove Park and Bridgwater Community Hospitals as an alternative site for their surveillance procedure.
- Endoscopy capacity and demand modelling for the Yeovil site has been refreshed, to look at the proportion of capacity that needs to be dedicated to each procedure type.
- Additional MRI capacity has been established, through the rental of a modular scanning unit, which is now being rented until March 2025 using Community Diagnostic Centre funds.
- A locum echo physiologist has been appointed, vacancies are being recruited to and insourcing is being secured for the remainder of the year.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 76.1% in April 2024, the latest data available. Our performance was 79.4%. We were ranked 83 out of 157 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
Musgrove Park Hospital (MPH)	83.1%	84.1%	84.8%	83.9%	86.0%	85.7%
Yeovil District Hospital (YDH)	61.3%	59.0%	67.8%	63.8%	59.4%	72.7%
Combined	74.3%	74.1%	78.2%	76.0%	79.4%	80.4%
Trajectory					75.2%	77.2%

Well Led

Mandatory training – Our aim is to maintain a compliance rate of 90% or more for all mandatory and statutory training courses.

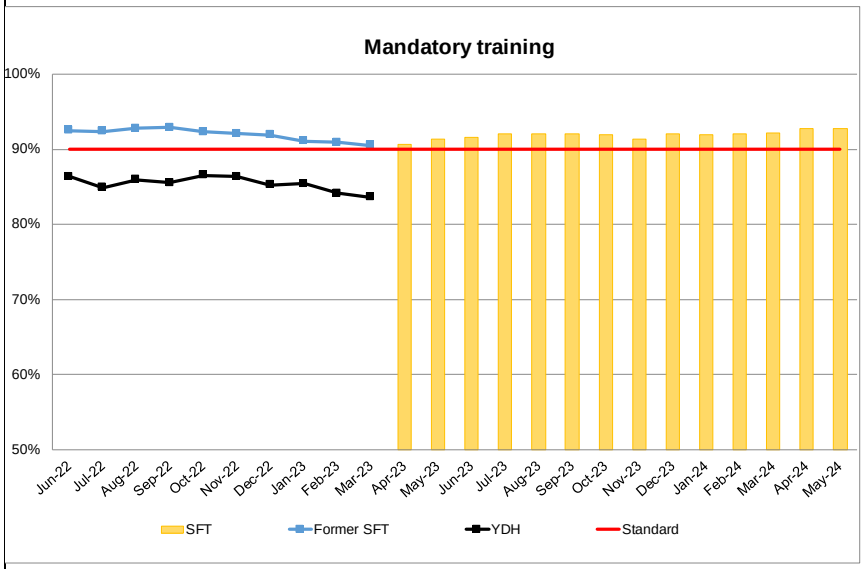
Current performance (including factors affecting this)

- As at 31 May 2024, our overall mandatory training rate was 92.8%, the same rate as at 30 April 2024.
- Apart from Symphony Health Service (SHS), all colleagues moved to the new Trust training system, LEAP, on 1 April 2023. As at 31 May 2024, compliance reported from the two separate systems was as follows:
  - LEAP: 92.9% (92.9% as at 30 April 2024)
  - SHS: 75.7% (64.9% as at 30 April 2024)
- Operational pressures, and limited capacity in areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.

Focus of improvement work

- Resuscitation weekend courses are being trialled in both Musgrove and Yeovil sites to make use of empty rooms in the two Academies. Early morning / late night Basic Life Support (BLS) sessions are being held in community hospitals to enable night workers to attend either before or after a shift. BLS ended the e-learning element from 1 April 2024 and became a one-session course in order to be more streamlined.
- Service Groups and Corporate Directorates continue to receive tailored reports via their People Business Partners and have real-time access via the learning management system to data on their teams, and access to Sharepoint reports to help identify areas which require action.
- The Safeguarding Team continue to undertake a review to consider moving a risk-based solution to cover periods when operational pressures occur.
- The Trust's Performance Team are following up on reported compliance of SHS to confirm actions being undertaken to improve performance.

Run Chart



How do we compare

Compliance as at 31 May 2024 remained unchanged when compared to 30 April 2024.

Recent Performance

The overall month-end compliance rates for mandatory training in recent months are set out below:

Area	Dec	Jan	Feb	Mar	Apr	May
% Compliance	92.1%	91.9%	92.1%	92.2%	92.8%	92.8%

Well Led

Career Conversations: We are committed ensuring that colleagues have timely and appropriate career reviews, at least annually, to outline all aspects of their role, to highlight and promote excellence and identify core or developmental training needs to enable colleagues to progress in their chosen careers.

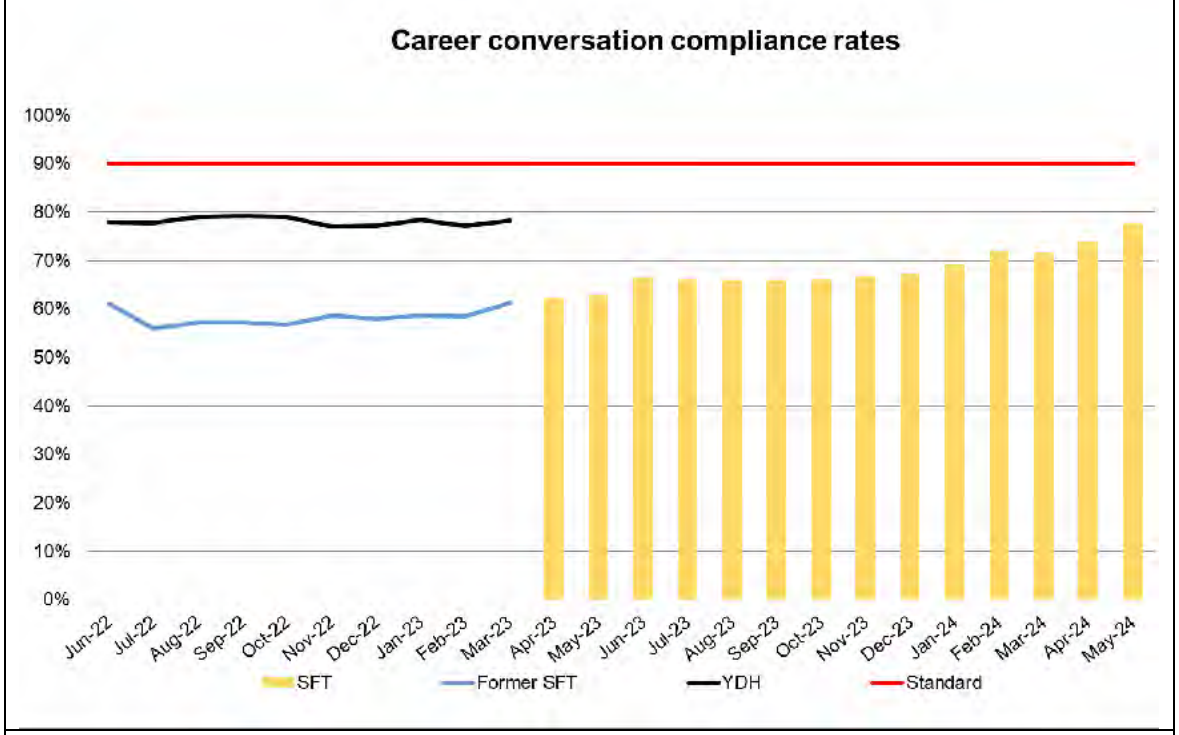
Current performance (including factors affecting this)

- Compliance as at 31 May 2024, in respect of career conversation reviews being undertaken at least annually was 77.4%, the highest rate reported since the new Trust was established in April 2023, but still significantly below the standard of 90%.
- Neighbourhoods is the best performing service group, with compliance of 82.5%.

Focus of improvement work

- Improvements to the reporting system for Agenda for Change colleagues has removed the concerns raised around reporting. The process is now automated and has reduced administration time by 30 minutes per day and removed human error.
- All service groups and corporate areas have been asked to review their performance and to report progress in the Quality, Outcomes, Finance and Performance meetings.
- A review of medical appraisal processes is under way, although excluding medical colleagues there is a minimal improvement in performance as this is a relatively small proportion of colleagues.

Run Chart



How do we compare

Compliance as at 31 May 2024 increased by 3.6% compared to the position as at 30 April 2024.

Recent performance

The compliance rates in recent months were as follows:

Area	Dec	Jan	Feb	Mar	Apr	May
% compliance	67.3%	69.1%	71.9%	71.5%	73.8%	77.4%

Well Led

Vacancy: We are committed to recruiting and maintaining a strong workforce. Our aim is to reduce and maintain vacancy levels to 5% or less. The data outlined shows the difference between contracted full time equivalent (FTE) number of colleagues in post and our budgeted establishment.

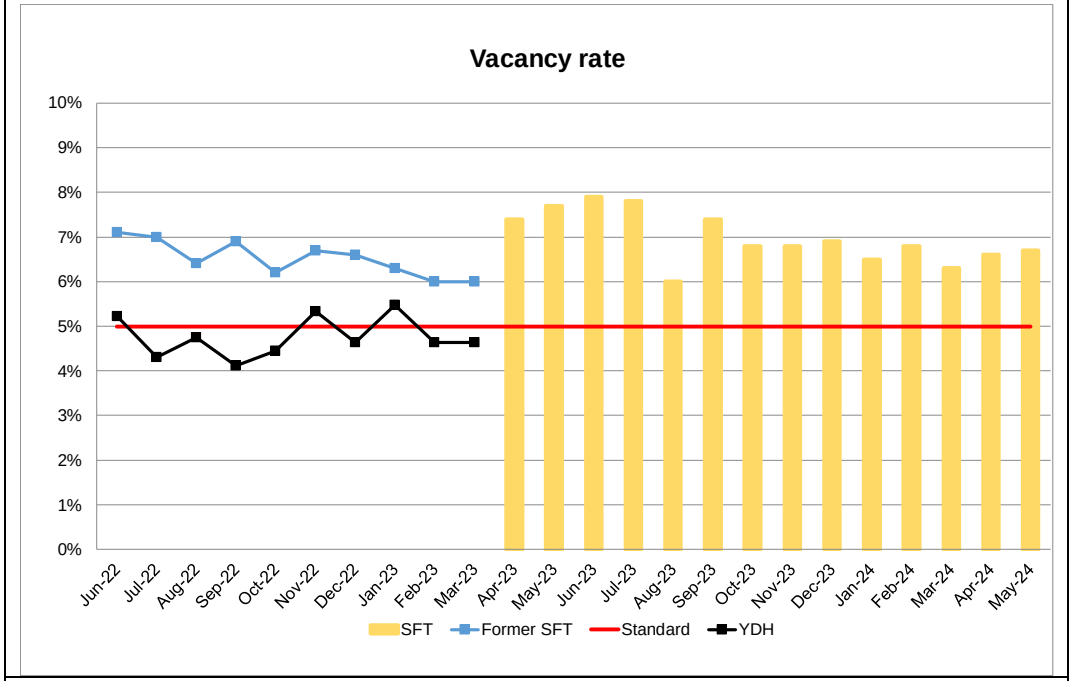
Current performance (including factors affecting this)

- Our vacancy rate as at 31 May 2024 was 6.7%, up from 6.6% reported as at 30 April 2024.
- The areas with the highest vacancy rates are:
  - Neighbourhood Services: 12.3%
  - Estates and Facilities: 11.0%
  - Medical Services: 8.2%
  - Mental Health and Learning Disabilities: 7.8%
- Across the Trust, medical and dental, Allied health professionals (AHPs), maintenance and a few specialist roles across Digital and People Services are particularly hard to recruit roles, affected by either national or local shortages.

Focus of improvement work

- An output of the Productive Care programme will be improved workforce planning processes and a greater understanding of the true vacancies to be filled.
- As a result of the Operational Plan workforce cap, a new vacancy approval approach has been implemented, which will create flexibility to allow the outputs from Productive Care to deliver and maintain Whole Time Equivalent levels.
- Known hard-to-fill roles are being reviewed and additional processes put in place to assess if the vacancy can be filled with different staffing models.

Run Chart



How do we compare

The vacancy rate within the Trust for May 2024 increased slightly when compared to April 2024.

Recent performance

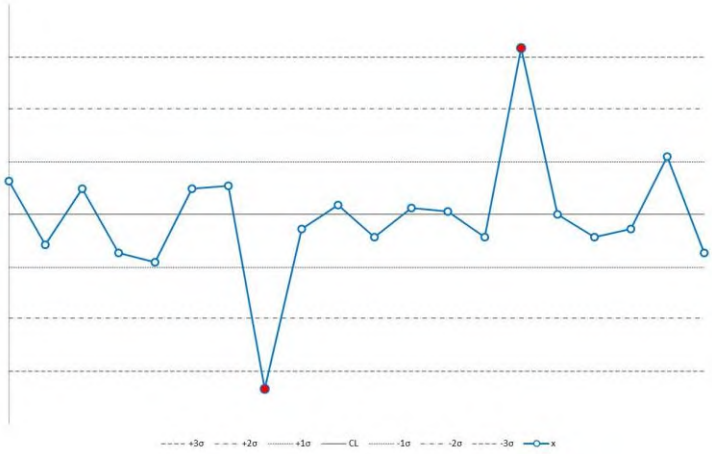
The performance against the vacancy rate standard in recent months was as follows:

Dec	Dec	Jan	Feb	Mar	Apr	May
Vacancy rate	6.9%	6.5%	6.8%	6.3%	6.6%	6.7%

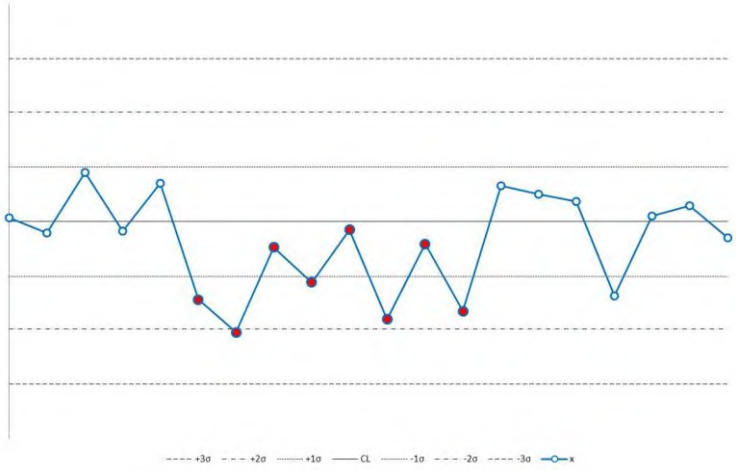
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

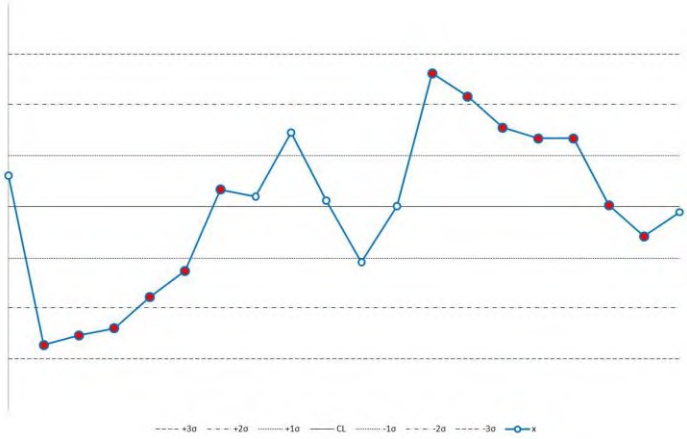
1. A single point outside the control limits



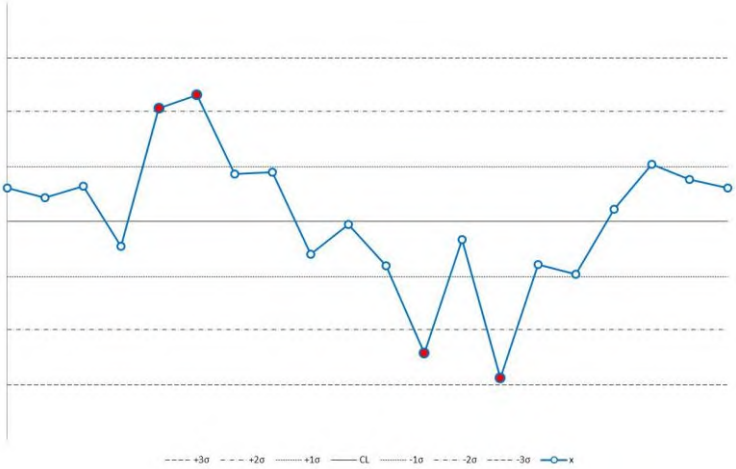
2. A run of eight or more points in a row above (or below) the centreline



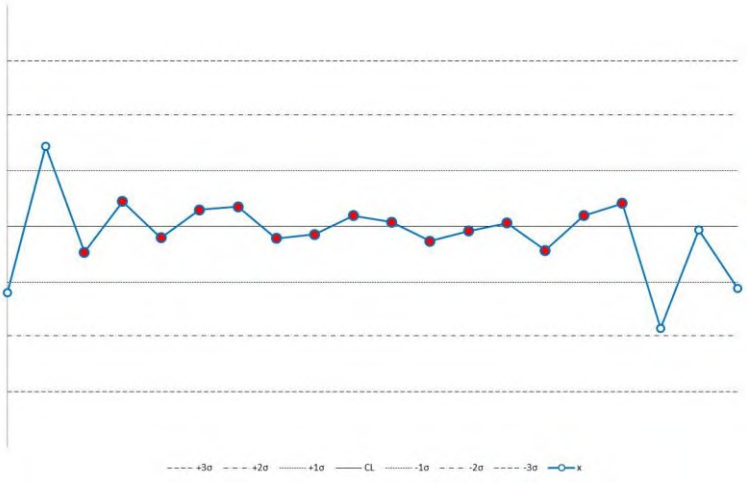
3. Six consecutive points increasing (trend up) or decreasing (trend down)



4. Two out of three consecutive points near (outer one-third) a control limit



5. Fifteen consecutive points close (inner one-third of the chart) to the centreline



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

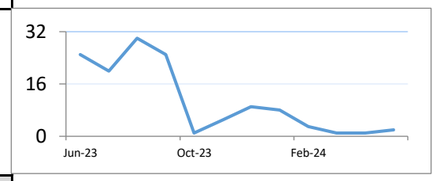
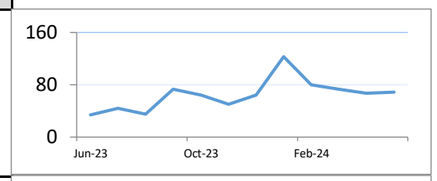
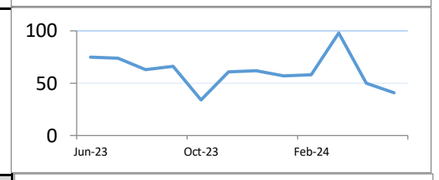
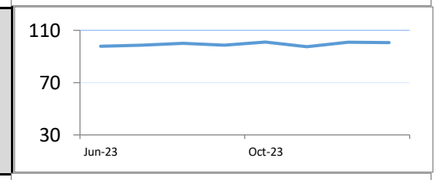
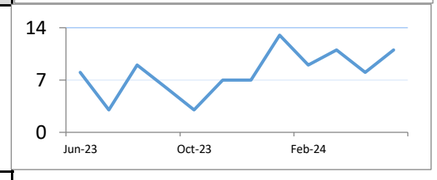
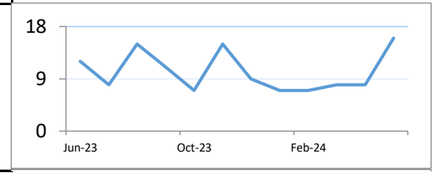
Our current Care Quality Commission ratings are as follows:

	Former Somerset NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust
Overall rating for the Trust	**Good**	**Good**

Are services safe?	**Requires improvement**	**Requires improvement**
Are services effective?	**Good**	**Good**
Are services caring?	**Outstanding**	**Good**
Are services responsive?	**Good**	**Good**
Are services well led?	**Good**	**Good**

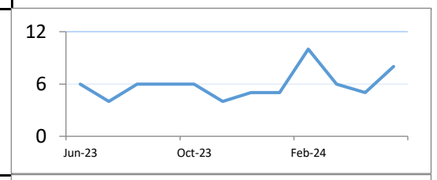
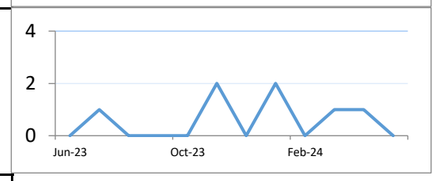
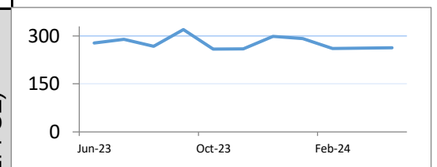
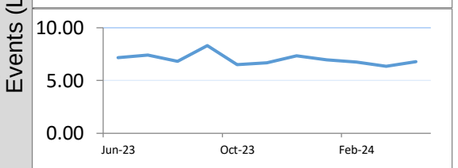
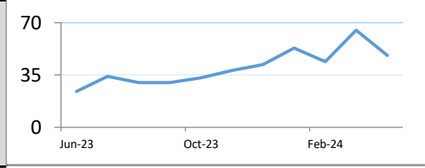
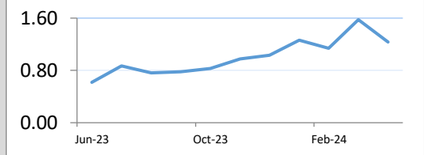
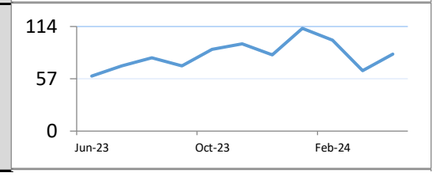
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	
Admissions	1	Average daily number of medical and surgical outliers in acute wards during the month	MPH	25	20	30	25	1	5	9	8	3	1	1	2	
	2		YDH	Reporting criteria to be changed to be same as MPH reported numbers												
	3	Number of patients transferred between acute wards after 10pm	MPH	34	44	35	73	64	50	64	123	80	73	67	69	
	4		YDH	75	74	63	66	34	61	62	57	58	98	50	41	
Mortality (acute services)	5	Summary Hospital-level Mortality Indicator (SHMI)		97.68	98.52	100.04	98.57	101.00	97.45	100.98	100.67	Data not yet due - February 2024 to be reported after May 2024				
Infection Control	6	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)		8	3	9	6	3	7	7	13	9	11	8	11	
	7	MRSA bacteraemias (post)		0	0	1	0	0	0	0	1	0	0	0	1	
	8	E. coli bacteraemia		12	8	15	11	7	15	9	7	7	8	8	16	

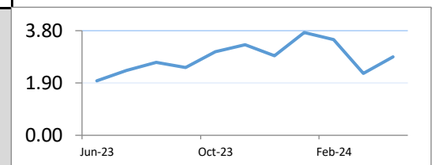
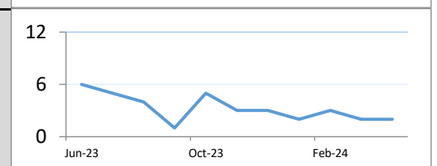
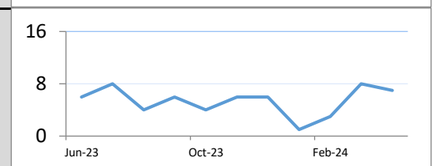
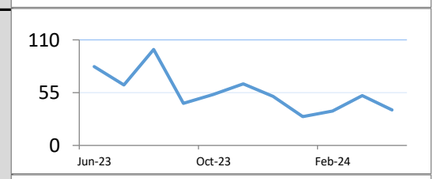
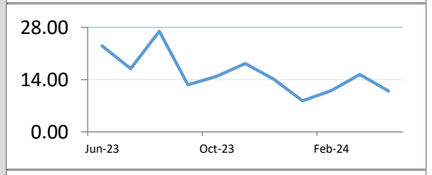
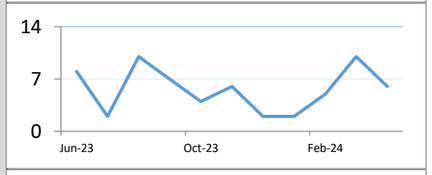
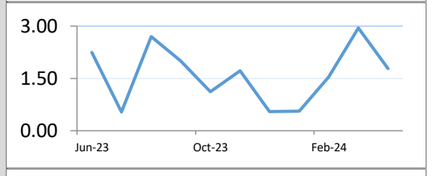
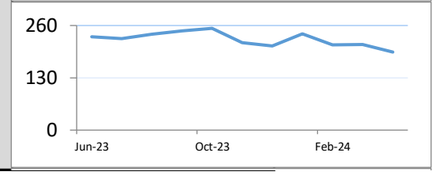
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	
Infection Control	9	Methicillin-sensitive staphylococcus aureus	6	4	6	6	6	4	5	5	10	6	5	8	
Maternity	10	No. of still births	0	1	0	0	0	2	0	2	0	1	1	0	
	11	No. of babies born in unexpectedly poor condition	0	0	0	0	0	0	0	0	0	0	0	0	
Falls	12	Total number of patient falls	278	290	268	320	259	260	299	292	261	262	263	Changes being implemented due to the introduction of Learning From Patient Safety Events (LFPSE)	
	13	Rate of falls per 1,000 occupied bed days - all services	7.15	7.43	6.83	8.31	6.51	6.69	7.34	6.97	6.76	6.35	6.78		
Pressure ulcer damage	14	Inpatient wards - number of incidents	24	34	30	30	33	38	42	53	44	65	48	Data not yet due	
	15	Rate of pressure ulcer damage per 1,000 inpatient ward occupied bed days	0.62	0.87	0.76	0.78	0.83	0.98	1.03	1.26	1.14	1.58	1.24	Data not yet due	
	16	District nursing - number of incidents	60	71	80	71	89	95	83	112	99	66	84	Data not yet due	

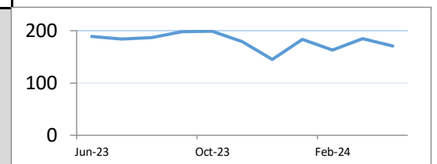
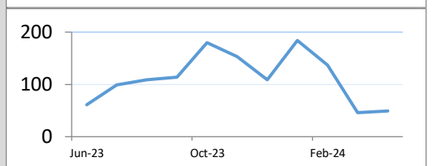
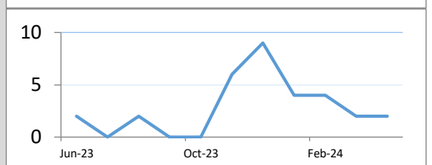
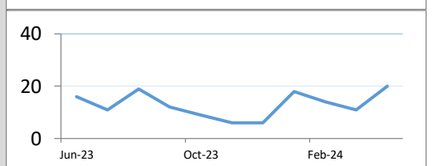
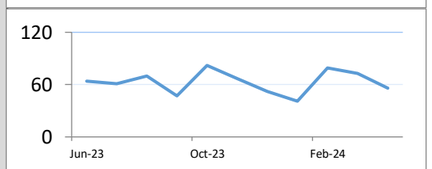
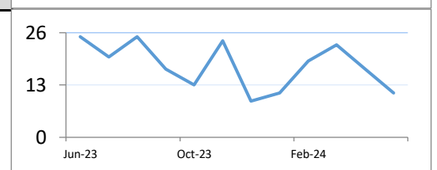
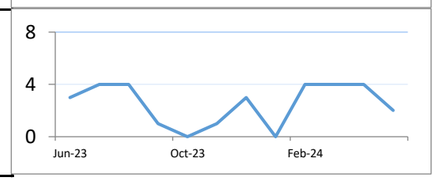
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	
Pressure ulcer damage	17	Rate of pressure ulcer damage per 1,000 district nursing contacts		1.98	2.35	2.65	2.46	3.03	3.29	2.89	3.73	3.48	2.24	2.85	Data not yet due	
Cardiac Arrests	18	No. ward-based cardiac arrests - acute wards	MPH	6	5	4	1	5	3	3	2	3	2	2	Data awaited	
	19	No. ward-based cardiac arrests - acute wards	YDH	6	8	4	6	4	6	6	1	3	8	7	Data awaited	
Restraints (mental health wards)	20	Total number of incidents	Mental Health Wards	82	63	100	44	53	64	51	30	36	52	37	Chnages to be implemented due to introduction of Learning From Patient Safety Events (LFPSE)	
	21	Restraints per 1,000 occupied bed days	Mental Health Wards	23.05	16.94	26.94	12.57	14.84	18.31	14.11	8.32	11.08	15.32	10.97		
	22	Number of prone restraints	Mental Health Wards	8	2	10	7	4	6	2	2	5	10	6		
	23	Prone restraints per 1,000 occupied bed days	Mental Health Wards	2.25	0.54	2.69	2.00	1.12	1.72	0.55	0.55	1.54	2.95	1.78		
Medication incidents	24	Total number of medication incidents		232	227	238	247	253	217	209	239	212	213	194		

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2024/25

Area	Ref	Measure		Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	
Medication incidents	25	Medication incidents - drug errors		189	184	187	198	199	179	145	183	163	185	171	Changes being implemented due to the introduction of Learning From Patient Safety Events (LFPSE)	
Ligatures and ligature points	26	Ligatures: Total number of incidents	Mental Health Wards	61	99	109	114	180	153	109	184	137	46	49		
	27	Number of ligature point incidents	Mental Health Wards	2	0	2	0	0	6	9	4	4	2	2		
Violence and Aggression	28	Violence and Aggression: Number of incidents patient on patient (inpatients only)	MPH, Community Hospitals and Mental Health wards	16	11	19	12	9	6	6	18	14	11	20		
	29	Violence and Aggression: Number of incidents patient on staff	MPH, Community Hospitals and Mental Health wards	64	61	70	47	82	67	52	41	79	73	56		
Seclusion	30	Number of Type 1 -Traditional Seclusion	Mental Health Wards	25	20	25	17	13	24	9	11	19	23	17	11	
	31	Number of Type 2 -Short term Segregation	Mental Health Wards	3	4	4	1	0	1	3	0	4	4	4	2	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Thresholds
1	Accident and Emergency / Urgent Treatment Centre 4-hour performance	Accident & Emergency department (ED) - MPH	4, 6, 9	54.0%	66.0%	51.0%	48.0%	51.4%	55.5%	54.0%	52.0%	53.1%	61.9%	59.2%	58.4%	From April 2024 >=78%= Green >=68% - <78% =Amber <68% =Red
2		Accident & Emergency department (ED) - YDH		64.3%	67.2%	73.3%	67.3%	66.6%	62.8%	62.6%	61.4%	67.3%	69.5%	67.5%	68.0%	
3		Accident & Emergency department (ED) - Combined		58.7%	66.5%	60.6%	56.4%	58.1%	58.7%	57.8%	56.1%	59.2%	65.2%	62.7%	62.5%	
4		Urgent Treatment Centres (formerly Minor Injury Units)		96.9%	96.9%	97.5%	95.1%	96.9%	97.4%	96.3%	96.0%	95.1%	97.9%	98.9%	97.3%	
5		Trust-wide		75.1%	79.2%	76.0%	72.5%	74.1%	74.3%	73.3%	72.5%	74.2%	79.6%	78.3%	77.7%	
6	Accident and Emergency / Urgent Treatment Centres: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED) - MPH	4, 6, 9	1.8%	0.7%	2.9%	4.7%	2.4%	1.7%	4.8%	6.2%	3.3%	2.4%	1.1%	1.4%	<=2%= Green >2% - <=5% =Amber >5% =Red
7		Accident and Emergency department (ED) - YDH		3.4%	3.6%	1.6%	3.2%	3.3%	4.1%	5.9%	7.6%	3.6%	5.1%	4.7%	2.3%	
8		Urgent Treatment Centres (formerly Minor Injury Units)		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
9	Ambulance handovers waiting less than 30 minutes: MPH		4, 6, 9	81.8%	86.2%	70.5%	63.1%	68.6%	73.8%	64.1%	61.9%	71.8%	77.8%	83.0%	75.8%	>=95%= Green >=85% - <95% =Amber <85% =Red
10	Ambulance handovers waiting less than 30 minutes: YDH			77.9%	80.8%	88.0%	80.8%	75.8%	69.0%	69.7%	65.6%	68.6%	66.3%	64.0%	76.1%	
11	Cancer - 28 days Faster Diagnosis All Cancers		4, 6, 9	72.0%	79.4%	78.8%	76.0%	77.0%	76.9%	76.6%	70.8%	84.7%	84.1%	78.6%	Data not yet due	From April 2024 >=77%= Green <77% =Red
12	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment			92.7%	93.0%	90.9%	92.9%	91.3%	93.7%	94.0%	89.5%	92.4%	94.7%	91.2%	Data not yet due	>=96%= Green <96% =Red
13	Cancer - 62 day wait - from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment			68.8%	74.2%	71.7%	71.3%	68.8%	67.1%	67.4%	64.9%	68.3%	74.5%	71.5%	Data not yet due	>=85%= Green <85% =Red
14	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104			22	26	22	28	22.5	23	23	19	22	29	21	Data not yet due	0= Green >0 = Red
15	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		3, 4, 9	Change to a rolling 3 month period	100.0%	100.0%	-	-	-	-	-	-	-	100.0%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
16	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		3, 4, 9		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.9%	96.9%	97.1%	97.2%	>=95%= Green >=85% - <95% =Amber <85% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	93.6%	93.2%	92.8%	92.5%	90.0%	93.9%	93.6%	94.2%	96.8%	92.8%	93.0%	95.7%	>=90%= Green >=80% - <90% =Amber <80% =Red
18	Mental health referrals offered first appointments within 6 weeks	Adult mental health services		94.5%	95.2%	90.4%	93.7%	91.6%	92.2%	93.9%	93.5%	96.1%	92.2%	92.1%	94.7%	>=90%= Green >=80% - <90% =Amber <80% =Red
19		Older Persons mental health services		92.0%	91.2%	94.0%	89.0%	87.5%	95.3%	93.0%	93.7%	96.0%	90.3%	93.8%	97.0%	
20		Learning disabilities service		100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	87.5%	100.0%	100.0%	100.0%	83.3%	100.0%	
21		Children and young people's mental health services		95.4%	93.2%	96.9%	100.0%	92.0%	96.6%	94.7%	96.1%	100.0%	100.0%	95.0%	95.4%	
22	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		4, 6, 9	9.5%	9.9%	10.5%	11.0%	11.1%	11.7%	11.6%	12.2%	12.4%	12.6%	12.9%	13.0%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red
23	Diagnostic 6-week wait - acute services	MPH	4, 9	91.8%	87.9%	84.8%	84.6%	84.7%	85.4%	83.1%	84.1%	84.8%	83.9%	86.0%	85.7%	From April 2024 At or above trajectory = Green Below trajectory = Red
24		YDH		60.1%	56.0%	61.2%	55.0%	59.6%	63.6%	61.3%	59.0%	67.8%	63.8%	59.4%	72.7%	
25		Combined		79.7%	77.1%	76.9%	74.4%	76.2%	77.6%	74.3%	74.1%	78.2%	76.0%	79.4%	80.4%	
26	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	61.7%	61.5%	61.8%	61.6%	62.9%	63.4%	61.7%	62.6%	63.4%	62.5%	64.6%	66.3%	>=92%= Green <92% =Red
27	52 week RTT breaches - Patients of all ages			2,396	2,375	2,419	2,504	2,547	2,577	2,519	2,252	2,158	2,270	1,969	1,871	From April 2023 At or below trajectory = Green Above trajectory = Red
28	52 week RTT breaches - Patients aged 18 or under			New reporting - to commence from May 2024											185	
29	65 week RTT breaches - Patients of all ages			712	659	724	741	687	661	725	605	538	434	463	484	
30	Referral to Treatment (RTT) incomplete pathway waiting list size			54,319	55,037	54,986	55,532	54,777	53,406	53,667	53,787	53,800	53,524	54,625	55,014	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Thresholds
31	Average length of stay of patients on wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	4, 9	6.1	5.9	6.0	6.4	6.5	6.1	6.1	6.4	6.5	6.1	5.9	6.0	Monitored using Special Cause Variation Rules. Report by exception.
32		YDH		7.3	7.0	6.8	7.0	6.8	6.9	7.5	7.7	6.9	7.1	7.0	Data awaited	
33	Patients not meeting the criteria to reside: % of occupied bed days lost	MPH	4, 9	15.1%	17.2%	16.5%	20.3%	18.1%	17.1%	15.9%	18.4%	20.5%	21.0%	18.9%	19.2%	<=9.8%= Green >15% =Red
34		YDH		21.1%	22.1%	23.7%	23.4%	22.1%	21.0%	24.6%	22.8%	24.7%	21.4%	20.8%	21.4%	
35	Acute bed days lost due to patients not meeting the criteria to reside	MPH	4, 6, 9	2,588	2,947	2,942	3,432	3,134	2,819	2,807	3,435	3,516	3,805	3,215	3,267	TBC
36		YDH		2,333	2,476	2,565	2,569	2,519	2,394	2,844	2,691	2,660	2,487	2,283	2,307	
37	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)		4, 6, 9	1,991	2,024	1,787	1,662	1,531	1,494	1,173	1,164	1,107	1,399	1,590	1,712	From April 2024 <1,399 = Green >=1,399 = Red
38	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)			705	570	311	249	237	245	223	232	229	264	257	259	From April 2024 <264 = Green >=264 = Red
39	Community dental services - General, Dominciliary or Minor Oral surgery waiting 18 weeks or more		4, 6, 9	2,117	2,043	2,181	2,169	2,120	2,193	2,285	2,478	2,345	2,388	2,301	2,374	From April 2024 <1,979 = Green >=1,979 = Red
40	Community dental services - General, Dominciliary or Minor Oral surgery waiting 52 weeks or more			620	573	551	539	476	491	541	584	575	574	531	584	From April 2024 <574 = Green >=574 = Red
41	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	527	538	557	565	554	581	587	515	520	530	518	545	From April 2023 <463 = Green >=463 = Red
42	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	83.3%	81.3%	83.3%	82.4%	84.6%	85.7%	82.4%	89.5%	93.3%	87.5%	86.7%	75.0%	>=60%= Green <60% =Red
43	Talking Therapies RTT : percentage of people waiting under 6 weeks		4, 6, 9	70.3%	73.7%	74.6%	72.5%	77.7%	77.8%	82.9%	81.1%	78.4%	83.0%	84.3%	83.8%	>=75%= Green <75% =Red
44	Talking Therapies RTT: percentage of people waiting under 18 weeks		4, 6, 9	99.1%	99.0%	99.0%	99.5%	98.9%	99.6%	98.5%	99.4%	99.2%	98.9%	99.0%	98.9%	>=95%= Green <95% =Red
45	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		4, 7, 9	57.9%	59.8%	60.3%	55.6%	58.1%	59.2%	59.8%	57.5%	60.7%	56.5%	58.3%	60.0%	>=50%= Green <50% =Red
46	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		4, 7, 9	77.7%	78.6%	79.6%	76.2%	76.7%	80.6%	74.0%	74.7%	74.1%	75.9%	69.0%	78.6%	>=67%= Green <67% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Thresholds
47	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		4, 7, 9	54.6%	56.9%	57.0%	53.6%	55.8%	57.2%	54.7%	55.5%	57.0%	54.6%	54.3%	57.6%	>=48%= Green <48% =Red
48	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	97.3%	100.0%	96.2%	96.9%	100.0%	97.0%	100.0%	100.0%	100.0%	92.9%	97.6%	90.9%	>=80%= Green <80% =Red
49	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		4, 5, 9	1	0	0	0	0	1	1	2	1	1	2	1	1= Green >1 = Red
50	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		4, 5, 9	94.9%	95.1%	95.7%	93.8%	93.3%	93.3%	93.3%	94.6%	96.1%	93.3%	95.6%	93.5%	>=95%= Green >=85% - <95% =Amber <85% =Red
51	Urgent Community Response: percentage of patients seen within two hours		4, 5, 9	90.9%	94.6%	92.3%	94.4%	93.8%	95.9%	90.9%	91.1%	91.6%	95.9%	90.5%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red
52	% Stroke Patients direct admission to stroke ward in 4 hours	MPH	4, 6, 9	48.9%	57.1%	54.6%	55.9%	51.4%	64.7%	58.1%	52.8%	47.5%	56.4%	Reporting being reviewed		>=90%= Green >=75% - <90% =Amber <75% =Red
53		YDH		32.4%	25.0%	33.3%	23.3%	42.5%	24.2%	29.4%	35.9%	48.5%	37.9%			
54	Patients spending >90% of time in stroke unit - acute services	MPH	4, 6, 9	65.2%	75.0%	68.9%	68.4%	78.4%	82.9%	76.5%	83.8%	50.0%	72.9%	75.8%	Data not yet due	>=80%= Green >=70% - <80% =Amber <70% =Red
55		YDH		59.5%	56.2%	71.7%	56.7%	52.5%	54.5%	52.9%	61.0%	60.6%	65.5%	50.0%	Data not yet due	
56	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, community hospitals and mental health wards	4, 9	75.8%		79.7%		88.4%		80.4%		Review of reporting being undertaken and should be resolved before June 2024 reporting				>=90%= Green >=80% - <90% =Amber <80% =Red
57	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	4, 9	Testing of a reporting solution using electronic forms has been completed by the Trust's Digital Team. Identified users of systems started to received training in the second week of September 2023 and reporting via this system is to commence by June 2024.												>=90%= Green >=49% - <90% =Amber <49% =Red
58	Percentage of emergency patients screened for sepsis - acute services	MPH		98.0%	93.0%			89.5%			Review of reporting being undertaken and should be resolved before June 2024 reporting					
59	Mandatory training: percentage completed	Combined	1,8,9	91.6%	92.0%	92.1%	92.1%	91.9%	91.4%	92.1%	91.9%	92.1%	92.2%	92.8%	92.8%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
60	Proportion of days lost due to sickness		1,8,9	4.2%	4.8%	4.8%	5.0%	5.3%	5.1%	5.2%	5.5%	5.5%	5.1%	5.0%	4.8%	SPC
61	Sickness absence levels - rolling 12 month average (Trust-wide)		8, 9	5.1%	4.9%	4.9%	5.0%	5.0%	5.0%	4.9%	4.9%	5.3%	5.3%	5.2%	5.2%	SPC

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2024/25

No.	Description		Links to corporate objectives	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Thresholds
62	Career conversations (12 months) - formerly 'Performance review (12-month)'		1,8,9	66.4%	66.1%	65.9%	65.9%	66.0%	66.6%	67.3%	69.1%	71.9%	71.5%	73.8%	77.4%	>=90%= Green >=80% - <90% =Amber <80% =Red
63	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		8, 9	7.9%	7.8%	6.0%	7.4%	6.8%	6.8%	6.9%	6.5%	6.8%	6.3%	6.6%	6.7%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
64	Retention rate – rolling 12 months percentage of colleagues in post		8, 9	88.1%	88.2%	88.5%	88.7%	89.0%	89.0%	89.2%	88.9%	89.0%	89.2%	89.1%	89.0%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red
65	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	1,8,9	19.8%	20.3%			20.9%			21.6%			Quarterly reporting		>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red
66		Who are female	1,8,9	58.8%	58.4%			58.7%			58.1%			Quarterly reporting		
67		With a recorded disability	1,8,9	3.0%	2.8%			3.1%			3.0%			Quarterly reporting		
68	Number of formal HR case works (disciplinary, grievance and capability).		1,8,9	Reporting in respect of this new indicator was being developed				31	23	23	38	38	38	33	Data awaited	TBC

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in May 2024, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
Cardiology	584	7	3,160	81.5%
Cardiothoracic Surgery	13		43	69.8%
Dermatology	354	9	2,669	86.7%
Ear, Nose & Throat (ENT)	2,214	275	5,121	56.8%
Gastroenterology	794	66	2,331	65.9%
General Medicine	10		22	54.5%
General Surgery	571	47	2,312	75.3%
Geriatric Medicine	149		612	75.7%
Gynaecology	1,175	105	3,742	68.6%
Neurology	761	35	1,956	61.1%
Ophthalmology	1,919	96	5,274	63.6%
Oral Surgery	806	46	2,182	63.1%
Other – Medical Services	799	65	2,678	70.2%
Other – Other Services	267	7	1,087	75.4%
Other - Paediatric Services	359	12	1,421	74.7%
Other - Surgical Services	2,192	381	5,799	62.2%
Plastic Surgery	50	1	184	72.8%
Rheumatology	303	6	922	67.1%
Thoracic Medicine	713	6	2,273	68.6%
Trauma & Orthopaedics	3,206	529	8,091	60.4%
Urology	1,280	178	3,135	59.2%
Total	**18,519**	**1,871**	**55,014**	**66.3%**

Table 2 – Performance against the 62-day GP cancer standard in April 2024.

Tumour site	No of breaches	Trust performance
Brain	0.0	100.0%
Breast	8.0	81.4%
Colorectal	18.0	44.6%
Gynaecology	3.0	81.3%
Haematology	3.0	80.0%
Head & Neck	5.0	66.7%
Lung	9.0	64.0%
Other	1.0	0.0%
Skin	10.0	87.2%
Upper GI	7.0	60.0%
Urology	33.0	63.5%
Total	**97.0**	**71.5%**

Twenty-one patients were treated in April on or after day 104 (the national 'backstop' for GP pathways). Eighteen were deemed as having unavoidable delays. A breakdown of the breaches is as follows:

- Six patients had a complex pathway, including patients requiring additional or repeat diagnostics, transferring from a different cancer pathway and being treated at the same time for another cancer.
- Ten patient pathways had internal delays, which in some cases resulted in a late transfer to the treating provider. But these pathways also had unavoidable delays, due to additional investigations, medical complexity, waiting times at other organisations and periods of patient choice.
- Two patients chose to delay their investigations or treatment planning for a significant period of time.
- Three pathways were impacted by capacity issues only.

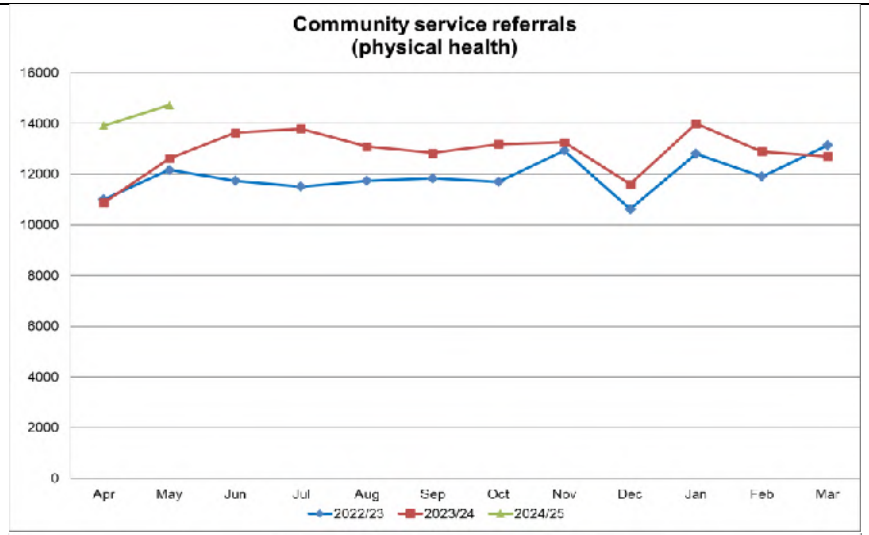
Appendix 2 – RTT validation progress

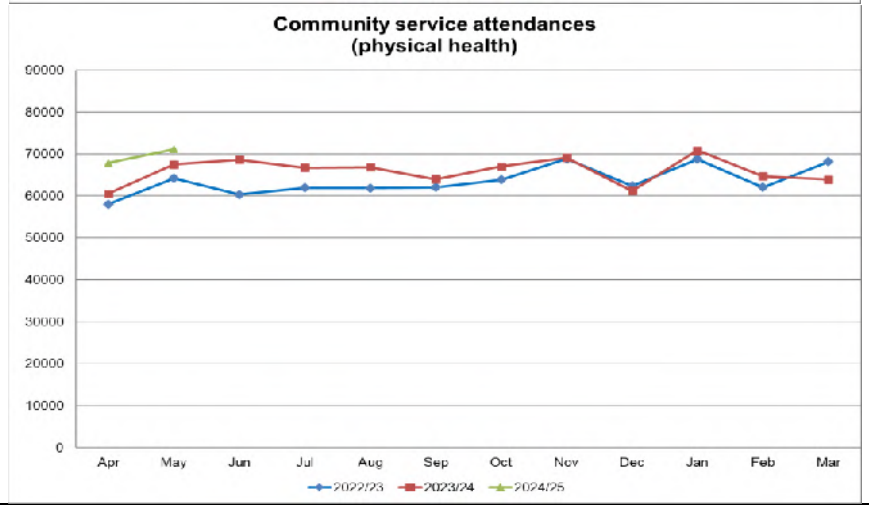
The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by the 31 of October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

RTT waiting times bands	**Week ending 8th Oct**	**Week ending 12th Nov**	**Week ending 17th Dec**	**Week ending 14th Jan**	**Week ending 4th Feb**	**Week ending 10th Mar**	**Week ending 14th Apr**	**Week ending 12th May**	**Week ending 9th June**
12 weeks and over	44%	63%	69%	70%	69%	74%	77%	75%	765
26 weeks and over	57%	72%	76%	73%	72%	77%	77%	77%	76%
52 weeks and over	90%	92%	89%	89%	87%	93%	93%	97%	99%

Operational context

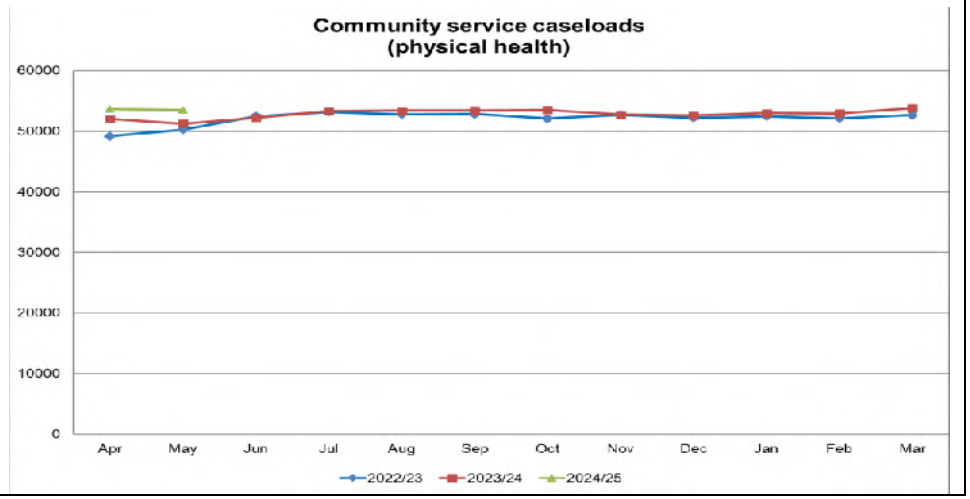
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





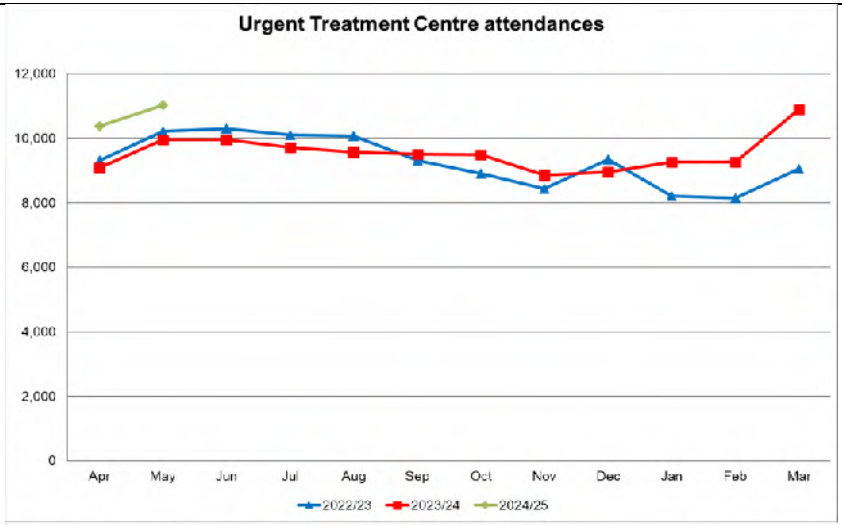
Summary:

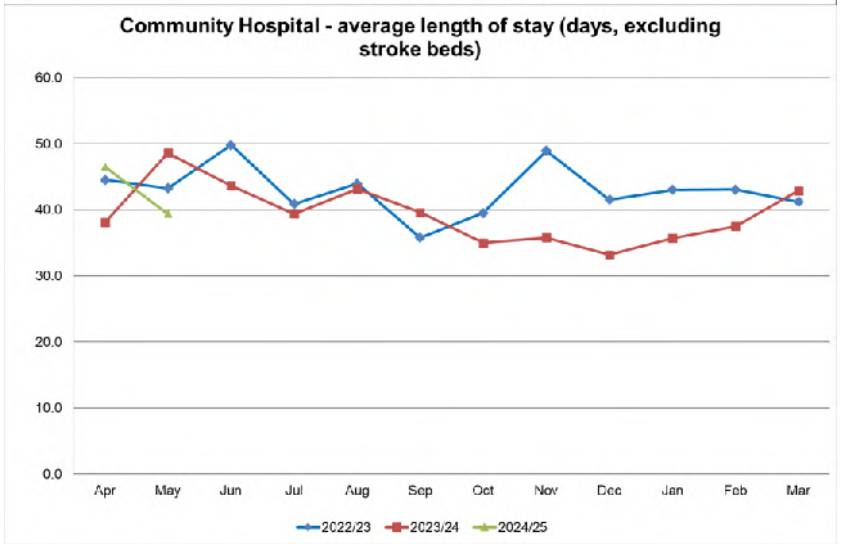
- Direct referrals to our community physical health services between 1 April and 31 May 2024 were 21.9% higher than months of 2023/24 and 23.6% higher than the same months of 2022/23. Services with the highest increases include Rapid Response, Musculoskeletal Interface and District Nursing.
- Attendances for the same reporting period were 8.5% higher than the same months of 2023/24 and 13.7% higher than the months of 2022/23.
- Community service caseload levels as at 31 May 2024 were 4.4% higher than as at 31 May 2023, and 6.4% above 31 May 2022 levels.



Operational context

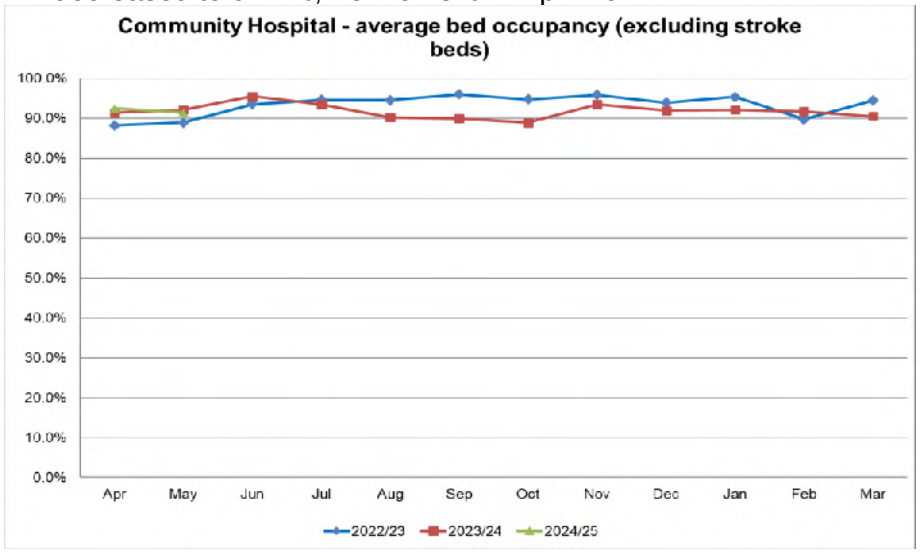
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





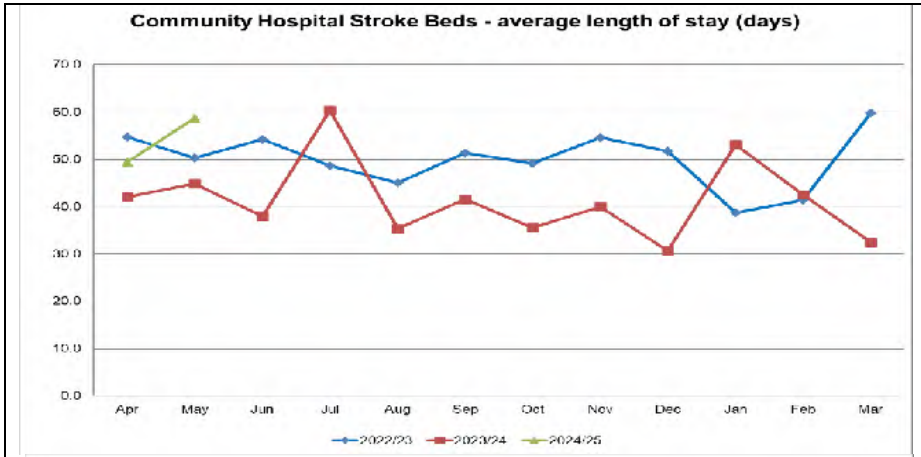
Summary:

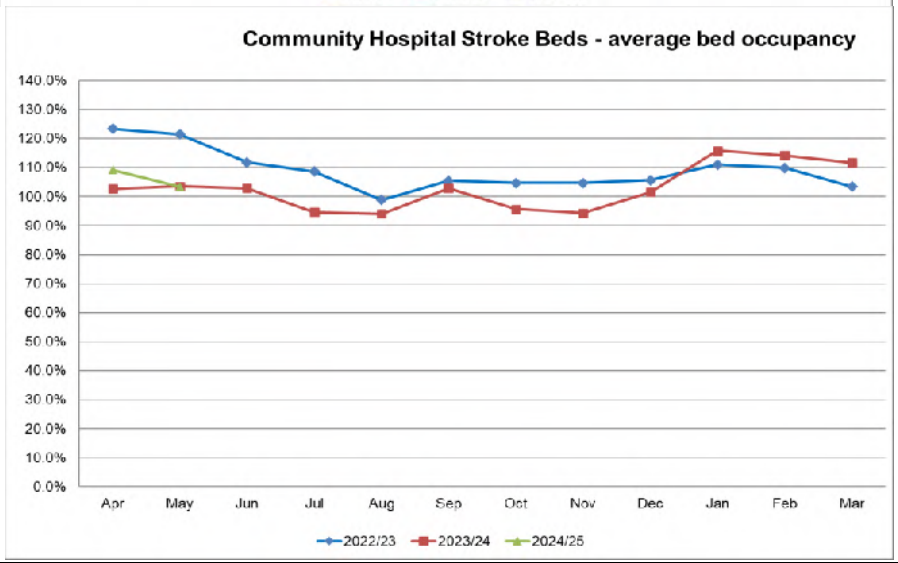
- Between 1 April and 31 May 2024, the number of Urgent Treatment Centre (formerly Minor Injury Unit) attendances was 14.2% higher than the same months of 2023/24, and 9.6% higher than the same months of 2022/23. During May 2024, 97.3% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%, to be achieved by March 2025.
- The average length of stay for non-stroke patients in our community hospitals in May 2024 was 39.4 days, a decrease compared to April 2024. Seven patients were discharged with lengths of stay longer than 100 days; the longest was 222 days for a patient at Wincanton community hospital. The community hospital bed occupancy rate for non-stroke patients in May 2024 decreased to 91.4%, from 92.5% in April 2024.



Operational context

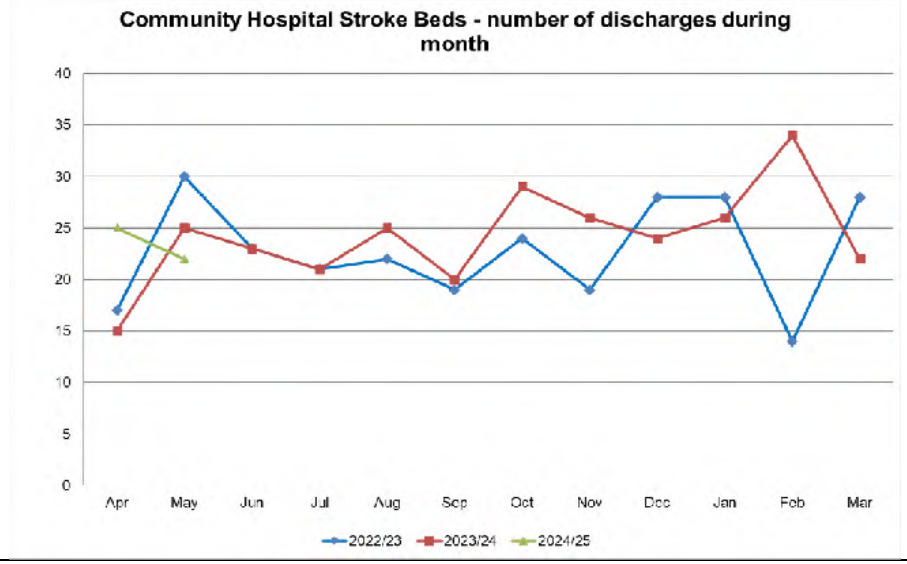
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





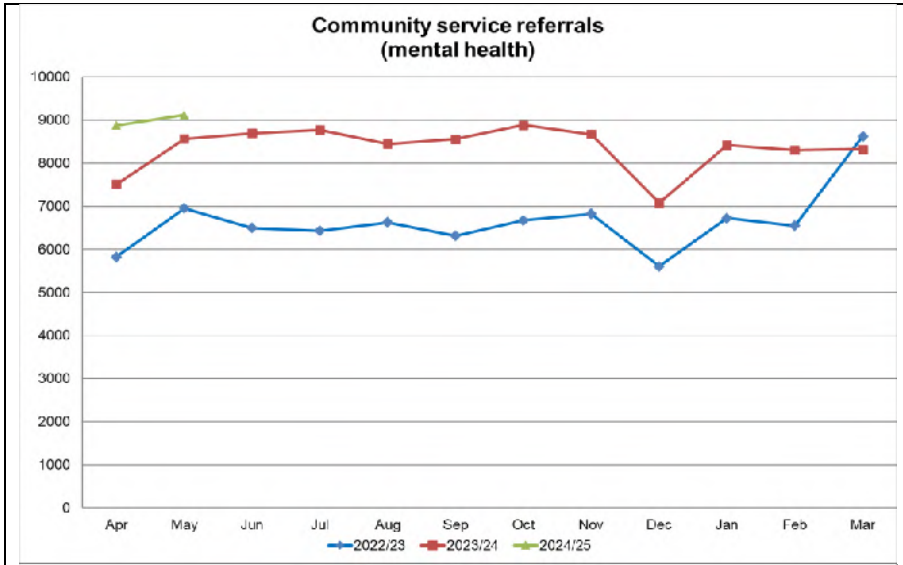
Summary:

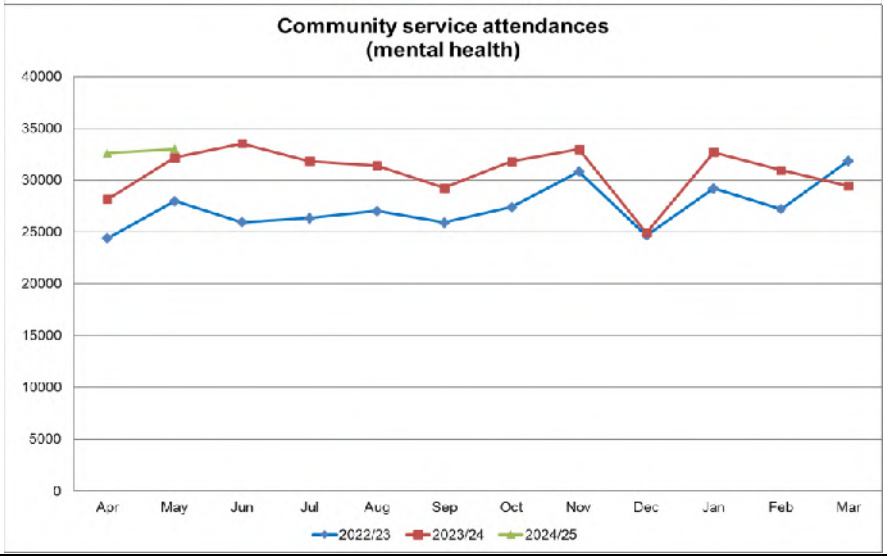
- The average length of stay for stroke patients in our community hospitals in May 2024 increased to 58.7 days, from 49.4 days in April 2024. One South Petherton community hospital patient was discharged with a length of stay of 277 days.
- Stroke bed occupancy in May 2024 decreased compared to April 2024.
- During May 2024 there were 22 discharges of stroke patients, down from 25 discharged during April 2024.



Operational context

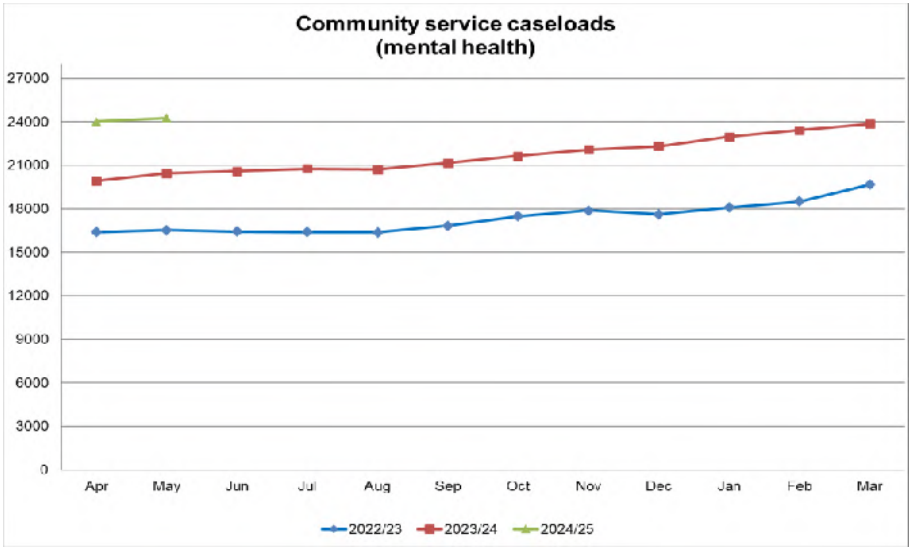
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





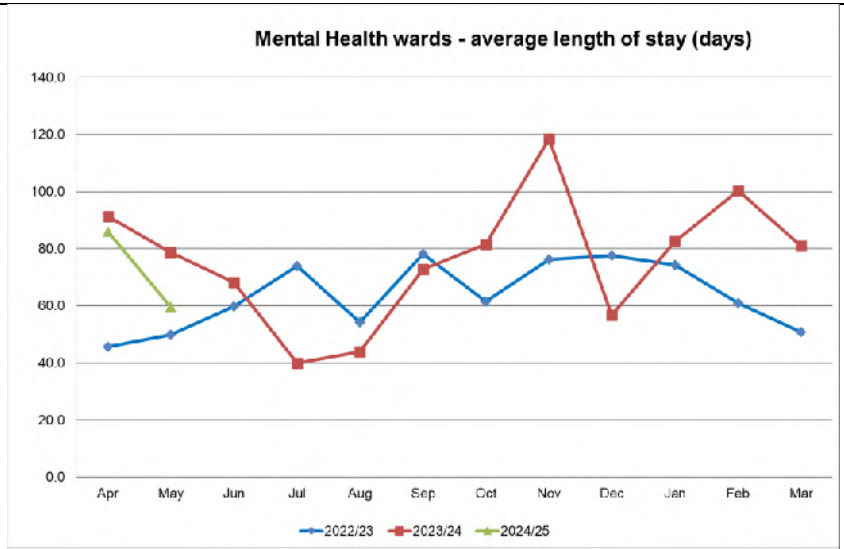
Summary:

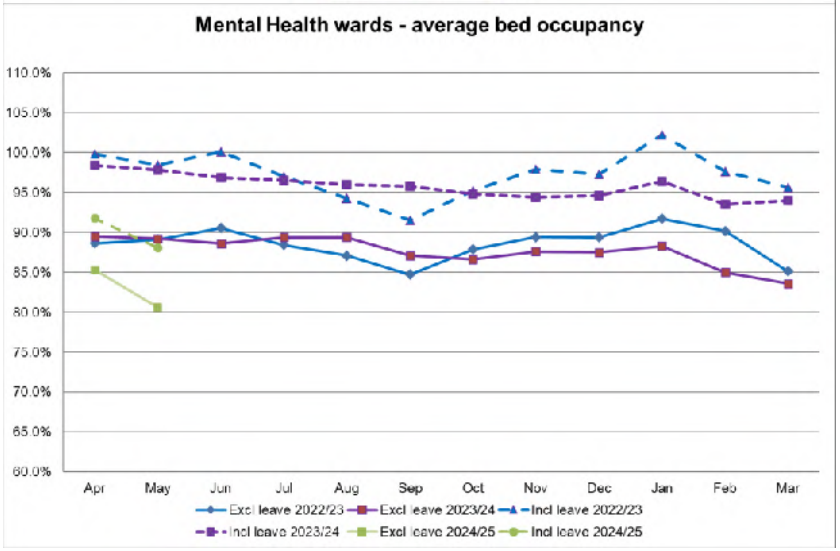
- Direct referrals to our community mental health services between 1 April and 31 May 2024 were 11.9% higher than the same months of 2023/24 and 40.8% higher than the same months of 2022/23.
- Attendances for the same reporting period were 8.7% higher than the same months of 2023/24 and 25.3% higher than the months of 2022/23. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 May 2024 increased by 18.7% when compared to 31 May 2023 and were 46.8% higher than as at 31 May 2022. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

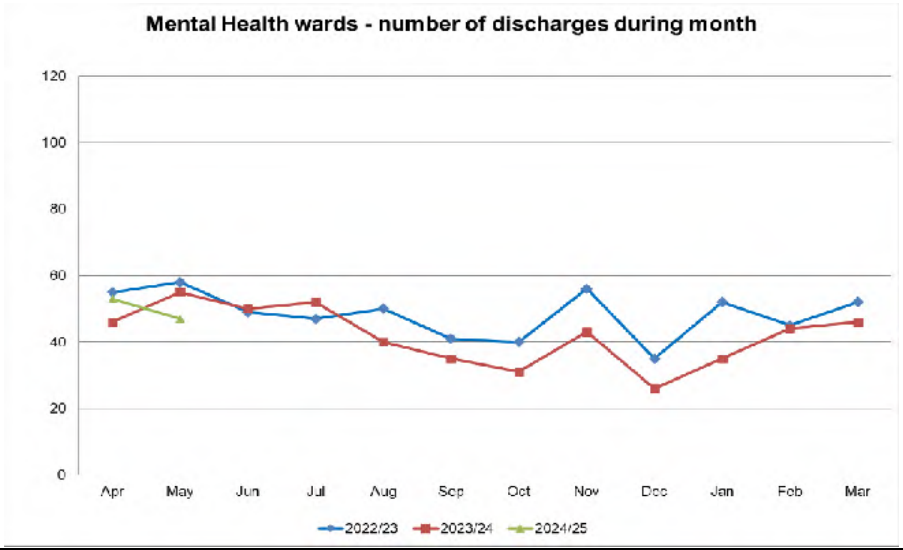
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





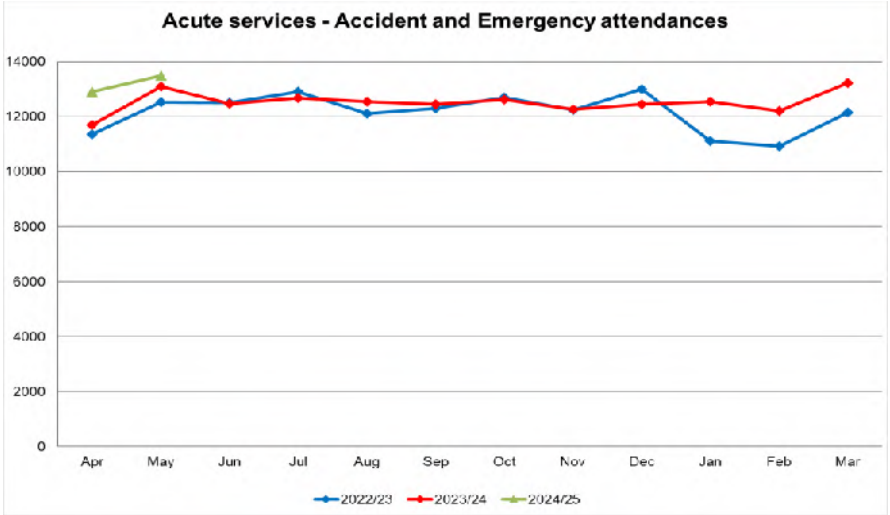
Summary:

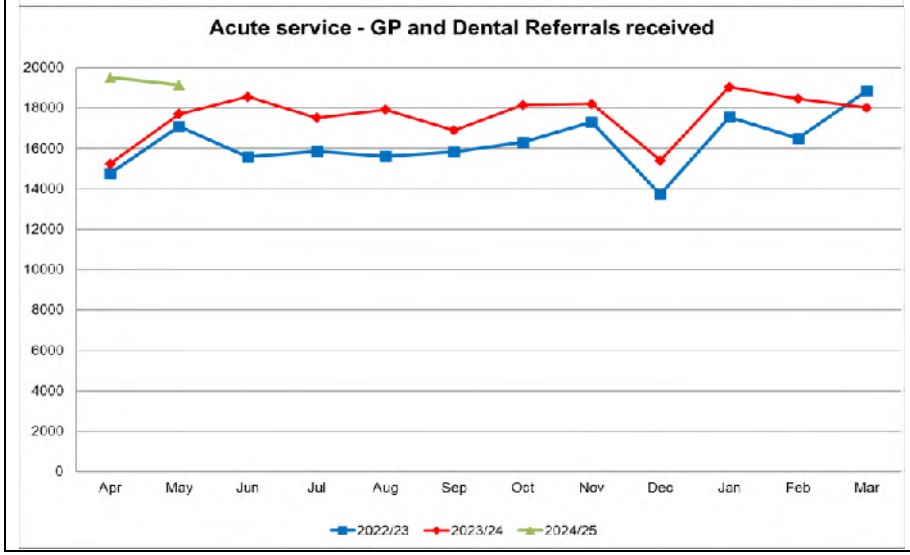
- The average length of stay in our mental health wards in May 2024 decreased compared to April 2024. During April 2024, eight patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Ash ward, our low secure unit, who had a length of stay of 575 days.
- The mental health bed occupancy rates, on the basis of including and excluding leave, decreased in May 2024 compared to April 2024.
- A total of 47 patients were discharged in May 2024, down from 53 in April 2024.



Operational context

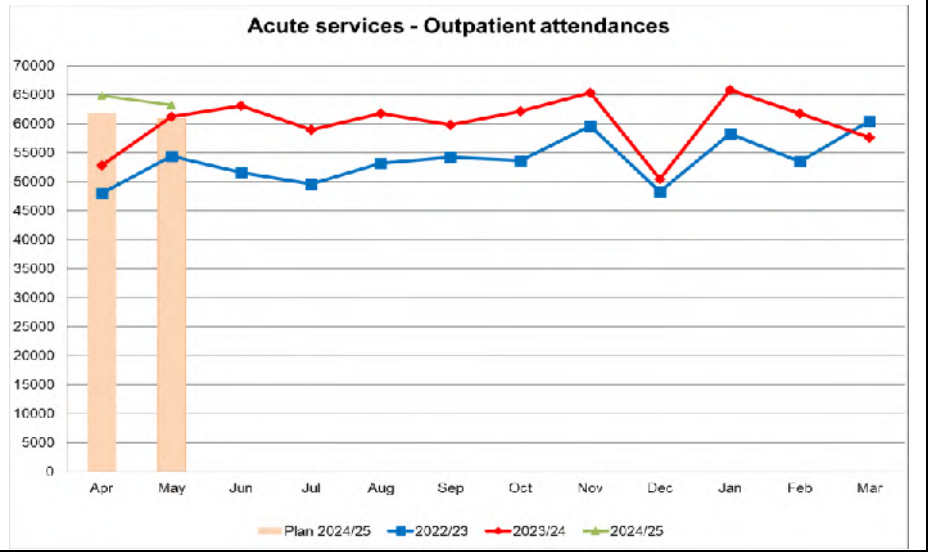
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior years.





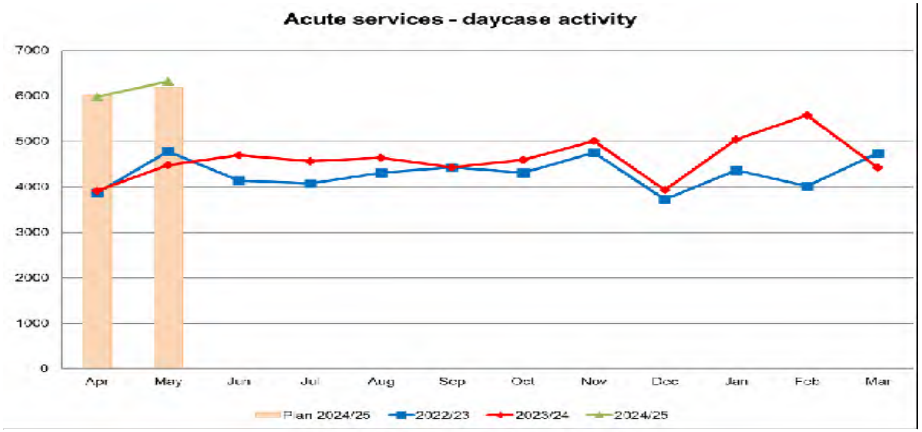
Summary:

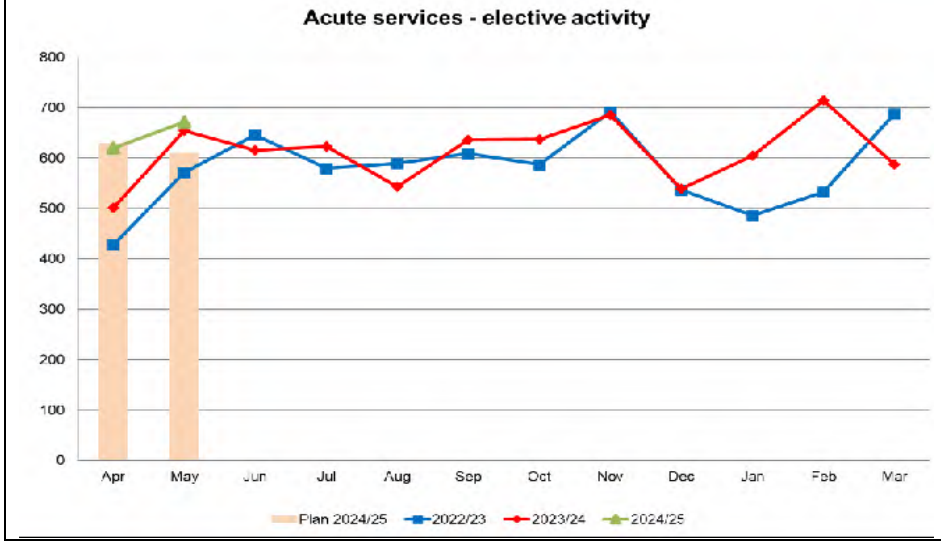
- Between 1 April and 31 May 2024 attendances to Accident and Emergency were 6.4% higher than the same months of 2023/24 and 10.4% higher than the same months of 2022/23. In April 2024, 62.5% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- GP and Dental referrals between 1 April and 31 May 2024 were 17.4% higher than months of 2023/24 and 21.4% higher than the same months of 2022/23.
- Outpatient attendances for the same period were 12.4% higher than the same months of 2023/22 and 25.0% higher than the same months of 2022/23. Currently attendances are 4.5% above the interim plan for 2024/25.



Operational context

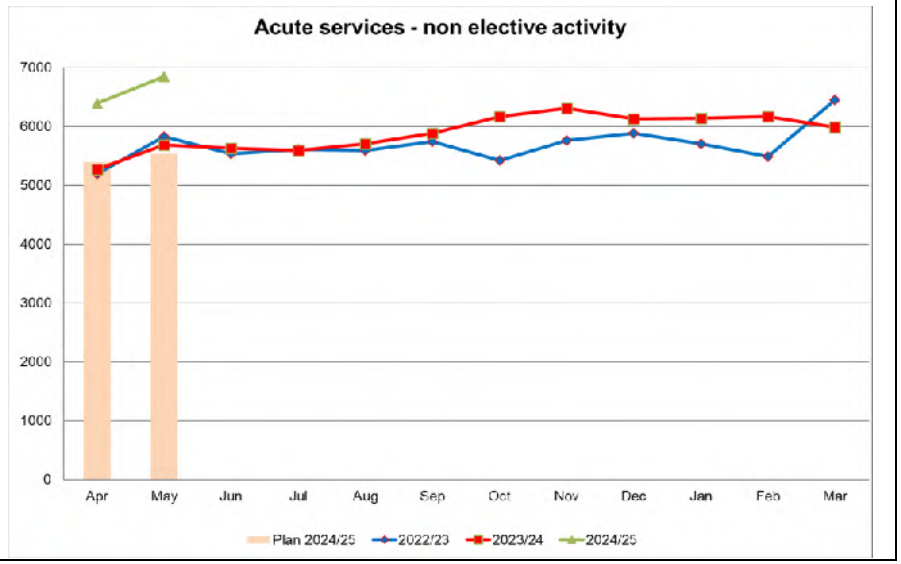
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior years.





Summary:

- The number of day cases undertaken by our acute services between 1 April and 31 May 2024 increased by 46.4% compared to the same months of 2023/24 and 42.2% compared to the same months of 2022/23.
- Over the same period, elective admissions were 11.9% higher than the corresponding months of 2023/24 and 29.3% higher compared to the same months of 2022/23.
- Non elective admissions also saw increases, of 20.8% compared to 2023/24 and 20.1% compared to 2022/23.



Appendix 6 – Infection Control and Prevention – May 2024

MRSA bloodstream infections	Commentary on MRSA / MSSA BSIs
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	The case of MRSA has been reviewed and source was a chronic wound present on admission. There were challenges with decolonisation compliance outside the hospital setting. Regional data for the end of April shows our Trust has one of the highest rates of MSSA bloodstream infection at 12.89 per 100,000 bed days. Reduction strategies in our Trust prioritised reducing the number of cases linked to peripheral cannulae. Reductions were achieved but work continues as improvements can still be made. The next most common source is soft tissue and bone & joint infections. As around 30% of the population are naturally colonised with this organism it can make these sources more challenging. Work continues with the Homeless Nursing service to try to improve outcomes for these patients who often have chronic or complex wounds. However, this population is not driving all our cases. The team is analysing our recent cases to identify any areas where improvements can be made.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 6 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 8 Yeovil District Hospital = 8 Community Hospitals / Mental Health = 0	Case numbers of E.coli doubled this month in comparison to April. The most common source of these infections nationally, regionally and in the Trust is urine. Two years ago, a significant proportion in the Trust were due to indwelling urinary catheters. As reported last month improvements have been made and were sustained during May. Regional data for the end of April shows our Trust has low rates of all three of these infections: • E.coli – lowest in the region at 20.62 per 100,000 occupied bed days. National rate is 36.31 per 100,000 occupied bed days. • Klebsiella – 3rd lowest in the region • Pseudomonas – one of 5 trusts which are all equal lowest in the region Regional data for May is not yet published.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 10 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0	Case numbers are above trajectory and not reducing which is inline with the regional and national picture and the reasons for this are unclear. Almost all the cases in the Trust are the result of antibiotics despite having some of the lowest overall usage levels. All Trust cases are sent for typing to determine any links between patients. Initial review of the data gives assurance that transmission is not occurring between the patients whilst in our care. Further work is needed to understand why case numbers are not reducing.

Respiratory Viral Infections - inpatients	Commentary on Respiratory Viral Infections
COVID (Trust Cases) = 87 Musgrove Park Hospital = 51 Yeovil District Hospital = 26 Community Hospitals / Mental Health = 10 **Influenza = 11 (Inpatients)** Musgrove Park Hospital = 7 Yeovil District Hospital = 4 Community Hospitals = 0	**COVID** COVID cases increased further during May, but overall levels remain relatively low. **Influenza** Levels of influenza decreased further during May. The season is technically over.
Outbreaks	**Commentary on outbreaks**
COVID = 16 Musgrove Park Hospital = 9 Yeovil District Hospital = 6 Community / Mental Health = 1 **Carbapenemase Producing Organism (CPO)** **YDH -** Since January 2022 there have been 44 cases of CPO identified on the YDH site. Typing for the most recent 5 cases is awaited to confirm if they are part of the original outbreak or a separate cluster.	**Respiratory Outbreaks** Outbreaks due to COVID-19 continue to occur. **Carbapenemase Producing Organism (CPO)** A further meeting with UKHSA has occurred to support us in managing this outbreak. The national infection control team has been contacted to see if there are any actions from other centres that might help us. The immediate review by the health protection / public health specialists have not identified any interventions that we have not already implemented. However, they will provide some epidemiological input to map the outbreak and see if more information is revealed.
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009. **Yeovil District Hospital Site** Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance	**Musgrove Park Hospital Site** • **Total Hip Replacement** Within the last year (May 2023 to April 2024) a total of 323 operations have been undertaken with no infections identified. • **Total Knee Replacement** Within the last year (May 2023 to April 2024) a total of 188 operations have been undertaken and 1 infection identified giving an infection rate of 0.53%. This is slightly higher than the national benchmark of 0.4%. • **Spinal Surgery**

was commenced on total knee replacement surgery from January 2024.	Within the last year (May 2023 to April 2024) a total of 351 operations have been undertaken and 3 infections identified giving an infection rate of 0.5%. The rate has reduced since last month and is back under the national benchmark of 1.2%. Two of the recent infections identified have the same organism (Serratia marcescens). Whilst this organism is widely found in the environment it is not the most common cause of surgical site infections. An investigation has begun to determine if the cases are linked alongside a of review practice. Initial actions include additional cleaning in theatre, maintenance of patient's body temperature, and minimising number of personnel in theatre during operations. **<u>Yeovil District Hospital Site</u>** • **Total Hip Replacement** Within the last year (May 2023 to April 2024) a total of 343 operations have been undertaken and 5 infections identified giving an infection rate of 1.46%. This is higher than the national benchmark of 0.5%. The national rate is calculated over the period April 2018 to March 2023 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide and has triggered some internal actions. The One Together framework is being used to assess, investigate, and manage increased incidence of surgical site infections, particularly on the YDH site. • **Total Knee Replacement** Surveillance began in January 2024 therefore since then a total of 129 operations have been undertaken with no infections identified.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report – Month 2
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	2 July 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Group. It includes commentary on the key issues, risks, and variances, which are affecting the financial position.
Recommendation	The Board is requested to discuss and note the report**.**

Links to Joint Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

- ☐ Obj 1 Improve health and wellbeing of population
- ☐ Obj 2 Provide the best care and support to children and adults
- ☐ Obj 3 Strengthen care and support in local communities
- ☐ Obj 4 Reduce inequalities
- ☐ Obj 5 Respond well to complex needs
- ☐ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☒ Obj 7 Live within our means and use our resources wisely
- ☐ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion

The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.

This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
n/a

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
Monthly report

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In May, the Trust recorded a deficit of £2.655m. This was £0.716m favourable compared with the plan for the month. Cumulatively, the Trust is £6.648m in deficit, which is an adverse position to plan of £0.046m.

1.2 The main headlines are:-

- Agency expenditure was £2.799m which was £0.340m over the plan for the month and £0.118m above the ceiling. The ceiling (c£27m for the year) is profiled pro-rata to the pattern of 2023/24 actual expenditure. The plan is based on detailed workforce assumptions which assume a level of substantive recruitment in the second half of the year (further analysis is provided in the report).
- CIP delivery was £2.492m in month compared with the plan of £2.573m, an under delivery of £0.081m in total. The impact of this under performance has been largely offset by operational underspends across services.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 May 2024: -

Table 1: Income and Expenditure Summary May

Statement of Comprehensive Income	Annual Plan	Current Month 2			Year to date		
	£000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	964,359	80,297	81,465	1,168	160,633	164,097	3,464
Other Operating Income	66,887	4,167	5,284	1,118	8,319	10,087	1,768
Total operating income	**1,031,246**	**84,464**	**86,750**	**2,286**	**168,952**	**174,184**	**5,232**
Operating expenses							
Employee Operating Expenses	(704,574)	(59,423)	(60,671)	(1,248)	(118,877)	(122,614)	(3,737)
Drugs Cost: Consumed/Purchased	(88,194)	(7,338)	(7,934)	(596)	(14,630)	(15,685)	(1,055)
Clinical Supp & Serv Exc-Drugs	(29,724)	(3,666)	(5,105)	(1,439)	(7,225)	(9,826)	(2,600)
Supplies & Services - General	(39,409)	(3,284)	(3,512)	(229)	(6,570)	(5,975)	596
Other Operating Expenses	(158,267)	(13,201)	(11,536)	1,665	(26,405)	(25,663)	742
Total operating expenses	**(1,020,168)**	**(86,912)**	**(88,759)**	**(1,847)**	**(173,708)**	**(179,763)**	**(6,055)**
Operating Surplus/Deficit	11,078	(2,448)	(2,009)	439	(4,756)	(5,579)	(823)
Finance Expense	(13,070)	(1,089)	(1,016)	73	(2,179)	(2,027)	152
Finance Income	2,424	202	324	122	404	739	335
Other	0	0	0	(0)	1	0	(1)
Overall Surplus/(Deficit)	432	(3,335)	(2,700)	635	(6,530)	(6,867)	(336)
Depr On Donated Assets	1,397	116	80	(37)	233	160	(73)
Donated Assets Income	(2,591)	(216)	(155)	61	(432)	(178)	253
Amortisation	9	1	1	(0)	2	1	(0)
Impairments (Reversals)	0	0	0	0	0	0	0
Other	753	63	120	57	126	236	110
Adjustments to control total	(432)	(36)	45	81	(72)	219	290
Adjusted Financial Performance	0	(3,371)	(2,655)	716	(6,601)	(6,648)	(46)

2.2 The tables below set out pay expenditure and whole time equivalent information by month. Actual performance is compared with plan in each table.

2.3 In May, overall staffing levels were 129.93 wte under our planned trajectory:- Substantive staffing was 59 under plan, Bank 90 under plan, Agency 34 over cap plan and Locums 15 under the planned level. The WTEs shown in the tables are contracted WTEs for substantive staff and actual WTEs for temporary staffing (bank and agency). The impact of enhancements/overtime on WTEs is not included in the WTE analysis below which aligns with our external workforce reporting to NHSE

Table 2: Pay expenditure information

2024/25 Monthly Pay Expenditure analysis	Actuals			F/(A) Variance £000	2024/25 Total £000	2024/25 YTD		F/(A) Variance £000
	Mar-24 £000	Apr-24 £000	May-24 £000			Plan	£000	
Temporary staff								
Bank Staff	3,554	2,090	1,927	292	4,017	4,401		384
Medical Agency	1,819	1,830	1,685	70	3,515	3,511		(5)
Medical Locums	1,409	1,152	1,032	(530)	2,184	1,004		(1,180)
Nursing Agency	966	771	618	478	1,388	2,173		784
Other Agency	466	484	497	(208)	980	573		(408)
Total Temporary Staff	**8,214**	**6,326**	**5,759**	**101**	**12,085**	**11,661**		**(424)**
Nursing	21,933	15,075	14,998	876	30,073	31,779		1,706
Support to Nursing	8,300	6,307	6,229	(994)	12,536	10,494		(2,042)
Medical	15,301	12,773	10,722	821	23,496	23,107		(388)
AHP's	13,095	8,615	8,680	212	17,295	17,792		497
Infrastructure Support	10,612	9,657	9,326	(441)	18,983	17,782		(1,202)
Other	5,196	3,191	4,956	(1,824)	8,147	6,263		(1,884)
Substantive Staff	**74,437**	**55,618**	**54,912**	**(1,350)**	**110,529**	**107,216**		**(3,313)**
Total All Staff	**82,651**	**61,943**	**60,671**	**(1,248)**	**122,614**	**118,877**		**(3,737)**
% Temporary	9.94%	10.21%	9.49%		9.86%	9.81%		

Table 3: WTE information

2024/25 Monthly Workforce analysis	Planning Month WTE	Actuals		In Month Plan WTE	F/(A) Variance WTE	Plan	F/(A) Variance WTE
		Apr-24 WTE	May-24 WTE				
Temporary staff							
Bank Staff	611.40	588.90	493.89	584.10	90.21	539.24	45.35
Medical Agency	73.21	74.57	67.68	66.37	(1.31)	60.16	(7.52)
Medical Locums	22.40	31.19	25.72	21.40	(4.32)	19.76	(5.96)
Nursing Agency	93.45	94.58	69.57	84.72	15.15	76.79	7.22
Other Agency	53.61	67.26	77.61	48.60	(29.01)	44.05	(33.56)
Total Temporary Staff	**854.07**	**856.50**	**734.47**	**805.20**	**70.73**	**740.00**	**5.53**
Nursing	3,428.00	3,380.35	3,402.66	3,465.18	62.52	3,419.62	16.96
Support to Nursing	2,179.48	2,171.87	2,153.16	2,125.29	(27.87)	2,097.34	(55.81)
Medical	1,090.19	1,079.95	1,084.89	1,104.53	19.64	1,090.01	5.12
AHP's	1,649.76	1,590.04	1,589.92	1,601.77	11.85	1,580.71	(9.21)
Infrastructure Support	2,501.85	2,484.95	2,470.55	2,540.50	69.95	2,507.10	36.55
Other	1,093.86	1,136.01	1,161.37	1,084.48	(76.89)	1,070.22	(91.15)
Substantive Staff	**11,943.12**	**11,843.17**	**11,862.55**	**11,921.75**	**59.20**	**11,765.00**	**(97.55)**
Total All Staff	**12,797.19**	**12,699.67**	**12,597.02**	**12,726.95**	**129.93**	**12,505.00**	**(92.02)**
% Temporary	6.67%	6.74%	5.83%	6.33%		5.92%	

2.4 Total agency and locum costs in month were £3.832m, a decrease of £0.404m compared with April. Nursing agency continues to show improvement, May's expenditure was £0.618m. This was £0.153m lower than in April and £0.242m lower than in the equivalent month last year.

2.5 Medical agency in May was £1.685m (£0.145m higher than April). Vacancies continue to be the largest driver of agency usage and accounted for

£1.070m (64%) of the total SFT agency spend in month. In May SHS used £0.334m to cover gaps in their workforce.

2.6 The Trust continues to explore recruitment opportunities overseas and is also investigating alternative staffing models in areas where there are national shortages in medical staff and roles are proving extremely challenging to recruit into. Strong controls exist across the Trust to authorise agency use and ensure regular reviews are undertaken where agency is being used.

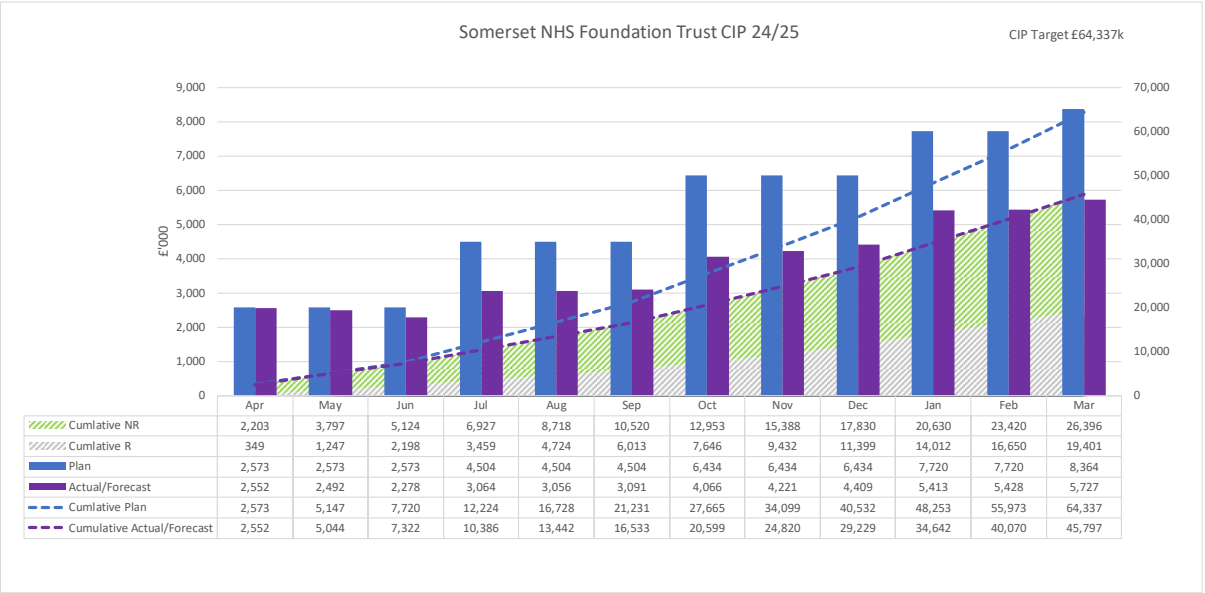
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has an annual efficiency plan of £64.337m this year, this includes £1.025m of merger savings.

3.2 In May, savings of £2.492m were delivered. This was an under delivery of £0.081m compared with plan. Recurrent savings formed £0.898m of the savings achieved (36%).

3.3 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 2024/25



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumlative NR	2,203	3,797	5,124	6,927	8,718	10,520	12,953	15,388	17,830	20,630	23,420	26,396
Cumlative R	349	1,247	2,198	3,459	4,724	6,013	7,646	9,432	11,399	14,012	16,650	19,401
Plan	2,573	2,573	2,573	4,504	4,504	4,504	6,434	6,434	6,434	7,720	7,720	8,364
Actual/Forecast	2,552	2,492	2,278	3,064	3,056	3,091	4,066	4,221	4,409	5,413	5,428	5,727
Cumlative Plan	2,573	5,147	7,720	12,224	16,728	21,231	27,665	34,099	40,532	48,253	55,973	64,337
Cumulative Actual/Forecast	2,552	5,044	7,322	10,386	13,442	16,533	20,599	24,820	29,229	34,642	40,070	45,797

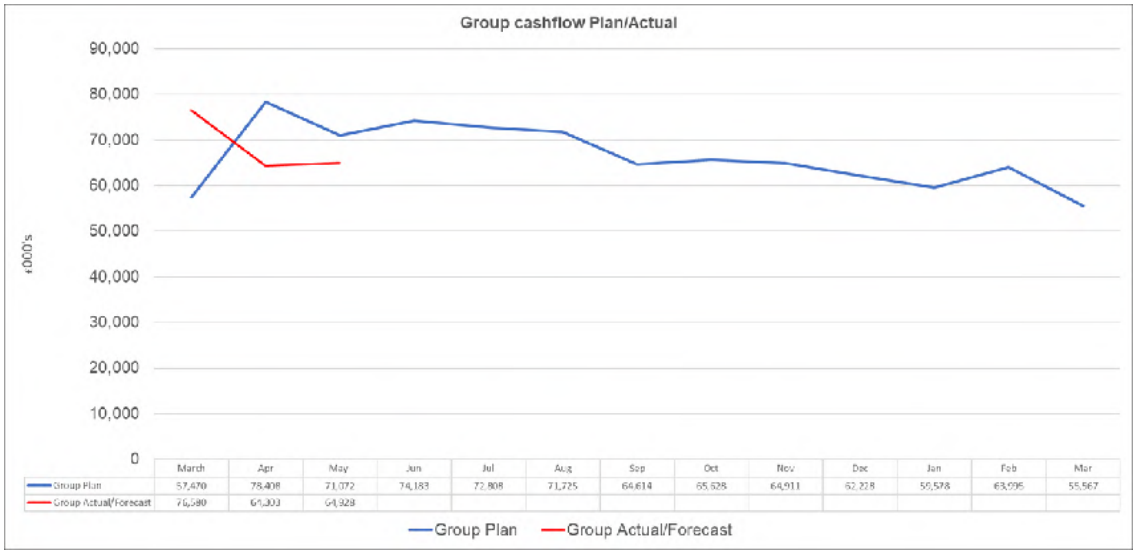
3.4 All Clinical Service Groups are implementing their Productive Care and CIP plans following reviews at the monthly performance assurance meetings. A subsequent review meeting with the Chief Medical Officer and Chief Nurse has reviewed all schemes that required a quality impact assessment.

3.5 We are continuing to scope further opportunities to close the gap in our current plans. Through our business-as-usual structures we will continue to support clinical and corporate teams to increase their delivery and work with the ICB to progress system wide opportunities set out in the Joint Forward Plan.

4. CASH

4.1 Cash balances at 31 May were £64.9m. The planned and actual cash balances are set out in Chart 2 below:-

Chart 2: Cash flow Actual/Plan



5. CAPITAL

5.1 Year to date, capital expenditure is £2.5m compared with the plan of £2.8m, resulting in an underspend of £0.3m. Further details at programme level are shown in Table 4 below:

Table 4: Capital Programme monitoring

Acute Programme MPH	Plan £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Total MPH Site Risks / Plant & Equipment	550	25	26	1
Total MPH Site and Service Development	4,823	11	35	24
Acute Programme YDH	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total YDH Main Site Budgets	2,665	82	120	38
Total - YDH Site and Service Development	5,902	36	37	1
Total - YDH Site Risks / Plant and equipment Replacement	430	45	44	(1)
Total Acute	14,370	199	262	63
Community/Mental Health Programme	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Community / Mental Health Site and Service Development	2,450	550	550	0
Total Community / Mental Health - Site Risks / Plant & Equipment	300	(6)	(6)	(0)
Total Community/Mental Health	2,750	544	544	(0)
Trustwide	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Trustwide	26,403	1,170	1,170	(0)
Total Internal Capital Envelope	43,623	1,913	1,976	63
Additional Capital Schemes	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Additional Schemes	35,732	462	470	8
IFRS Leases	15,085	375	68	(307)
TOTAL TRUST PROGRAMME	94,340	2,750	2,514	(236)

5.2 STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

Apr-24	May-24	Movement		Mar-24	May-24	Movement in Year
£000	£000	£'000		£000	£000	£000
37,297	37,536	239	Intangible Assets	37,804	37,536	(267)
391,470	390,693	(777)	Property, plant and equipment, other	390,713	390,693	(20)
28,180	28,002	(178)	On SoFP PFI assets	28,360	28,002	(358)
78,272	77,724	(548)	Right of use assets	83,020	77,724	(5,296)
14	14	(1)	Investments	14	14	(1)
14	14	0	Other investments/financial assets	14	14	0
1,718	1,697	(22)	Trade & other receivables >1yr	2,957	1,697	(1,261)
536,965	**535,680**	**(1,285)**	**Non-current assets**	**542,883**	**535,680**	**(7,202)**
11,140	11,146	6	Inventories	11,005	11,146	141
21,083	19,860	(1,223)	Trade and other receivables: NHS receivables	7,105	19,860	12,755
11,132	12,706	1,574	Trade and other receivables: non-NHS receivables	24,932	12,706	(12,226)
466	466	0	Non current assets held for sale	466	466	0
64,303	64,928	625	Cash	76,580	64,928	(11,652)
108,124	**109,106**	**982**	**Total current assets**	**120,088**	**109,106**	**(10,982)**
(82,027)	(86,614)	(4,587)	Trade and other payables: non-capital	(97,117)	(86,614)	10,503
(6,552)	(5,944)	609	Trade and other payables: capital	(14,419)	(5,944)	8,476
(26,916)	(27,638)	(721)	Deferred income	(16,364)	(27,638)	(11,274)
(14,161)	(14,042)	119	Borrowings	(14,265)	(14,042)	222
(7,846)	(7,654)	192	Provisions <1yr	(7,818)	(7,654)	164
(137,502)	**(141,892)**	**(4,389)**	**Current liabilities**	**(149,983)**	**(141,892)**	**8,091**
(29,379)	**(32,786)**	**(3,408)**	**Net current assets**	**(29,895)**	**(32,786)**	**(2,891)**
(108,201)	(107,734)	468	Borrowings >1yr	(111,011)	(107,734)	3,278
(3,003)	(3,003)	0	Provisions >1yr	(3,060)	(3,003)	57
(1,660)	(1,639)	22	Deferred income >1yr	(1,682)	(1,639)	43
(112,865)	**(112,376)**	**489**	**Total long-term liabilities**	**(115,753)**	**(112,376)**	**3,378**
394,721	**390,518**	**(4,203)**	**Net assets employed**	**397,234**	**390,518**	**(6,716)**
			Financed by:			
363,752	363,752	0	Public dividend capital	363,752	363,752	0
77,897	77,897	0	Revaluation reserve	77,897	77,897	0
(245)	(245)	(0)	Other reserves	(245)	(245)	(0)
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(45,865)	(48,565)	(2,701)	I&E reserve	(42,246)	(48,565)	(6,319)
			Other's equity			
1,653	151	(1,502)	Non-controlling Interest	548	151	(397)
394,721	**390,518**	**(4,203)**	**Total financed**	**397,234**	**390,518**	**(6,715)**

6. CONCLUSION AND RECOMMENDATION

6.1 The 2024/25 planning process was complex and challenging. We were able to agree balanced Trust and system plans that deliver the key activity and performance targets while achieving financial balance and a planned reduction in our workforce numbers. Workforce, finance and activity plans are aligned and achievable.

6.2 The Trust is slightly behind plan at month 2 but we continue to make good progress in a number of areas as we remain focussed on controlling costs and delivering within agreed budgets. The productive care approach is enabling clinical services to identify ways to raise their productivity and improve efficiency through clinical services transformation. We will bolster this programme through additional CIP schemes.

6.3 There is a further period of industrial action by post graduate doctors in training planned in early July. It not yet clear how the financial and activity of this (and any further periods) will be managed.

6.4 The Board is asked to discuss and note the financial performance for May.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Procurement amendments to SFIs and SOs
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Paul Saunders, Head of Procurement
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	2 July 2024

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
☐ For Assurance	☒ For Approval / Decision	☐ For Information

Executive Summary and Reason for presentation to Committee/Board	Changes to the Standing Financial Instructions Appendix 1 Financial Limits are required because of the findings from the Procurement internal audit undertaken by BDO (final report was issued 13 December 2023). Changes to the Annex 3 Tendering and Contract Procedure of the Trust Standing Orders have been made to align with the amendments required to the Standing Financial Instructions.
Recommendation	The Board is asked to approve the proposed changes to Standing Financial Instructions Appendix 1 and Standing Orders Annex 3.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☐ Obj 1 Improve health and wellbeing of population
☐ Obj 2 Provide the best care and support to children and adults
☐ Obj 3 Strengthen care and support in local communities
☐ Obj 4 Reduce inequalities
☐ Obj 5 Respond well to complex needs
☐ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Obj 7 Live within our means and use our resources wisely
☐ Obj 8 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
Details: N/A					

Equality and Inclusion The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.
This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
n/a

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report has been considered at the June 2024 Finance Committee meeting.

Reference to CQC domains (Please select any which are relevant to this paper)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

PROCUREMENT AMENDMENTS TO SFT STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS

1. BACKGROUND AND PURPOSE

1.1 This paper has been prepared to recommended amendments to the Trust's Standing Financial Instructions Appendix 1 Financial Limits and to the Trust's Standing Orders Annex 3 Tendering and Contract Procedure.

1.2 The changes to the Standing Financial Instructions Appendix 1 Financial Limits are required because of the findings from the Procurement internal audit undertaken by BDO for which the final report was issued 13 December 2023.

1.3 The changes to Annex 3 Tendering and Contract Procedure of the Trust Standing Orders have been made to align with the amendments required to the Standing Financial Instructions.

2. DETAIL OF CHANGES TO STANDING FINANCIAL INSTRUCTIONS APPENDIX 1 FINANCIAL LIMITS (STARTS PAGE 51 OF SFIs)

2.1 Tables 1 to 5 inclusive have been amended to clearly state that all authorisation levels are excluding VAT.

2.2 Table 3 has been retitled to read Procurement thresholds for competition. Line 3 of the table has been amended to read 'Competition in line with Public Contracts Regulations and Provider Selection Regime'.

2.3 Table 3A, Procurement Department Limits (for executing Purchase Orders) has been amended to reflect current job titles.

2.4 Table 4 'Limits for entering of <u>new</u> contracts including products/services, maintenance, leases and managed services' has been amended to

- clarify that by the lowest bidder, we mean the lowest cost bidder as opposed to lowest scored.

- amend that contracts not awarded to the lowest cost bidder for the value of above £50,000 excluding VAT and beneath £1,000,000 excluding VAT can be authorised by the Chief Executive Officer <u>and</u> Chief Finance Officer (or in their absence the Deputy Chief Financial Officer).

2.5 Table 5 'Limits for entering of <u>existing</u> contracts and covered by delegated budgets or within financial plan. Include products, services, maintenance,

leases and managed services for which the Trust already has had a contract in place' has been amended to

- clarify that by the lowest bidder, we mean the lowest cost bidder as opposed to lowest scored.

- amend that contracts not awarded to the lowest cost bidder for the value of above £1,000,000 excluding VAT are authorised by the Chief Executive Officer and Chief Finance Officer (or in their absence the Deputy Chief Financial Officer).

3. DETAIL OF CHANGES TO STANDING ORDERS ANNEX 3 TENDERING AND CONTRACT PROCEDURE (STARTS PAGE 57 OF SOs)

3.1 Amend 1.14 'Non Competitive Quotations' to mirror the permitted reasoning and approval requirements for waiving the need to obtain competitive quotations to that of waiving the need for obtaining competitive tenders.

3.2 Amend 1.16 to state that tender and quotation approvals shall be in accordance with thresholds stated in Appendix 1 of Trust Standing Financial Instructions. This saves duplication and prevents situations where the two documents don't align.

3.3 Amend 1.17.1.2 to reflect the correct £10,000 threshold.

4. RECOMMENDATION

4.1 The Board is asked to approve the proposed changes.

PAUL SAUNDERS
HEAD OF PROCUREMENT

NHS
Somerset
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

POLICY

CONTENTS

1 INTRODUCTION

1.1 The **SOMERSET NHS FOUNDATION TRUST** (the "Trust") became a Public Benefit Corporation on 1 May 2008 following approval by the Independent Regulator of NHS Foundation Trusts (the office now known as NHS England (NHSE)) pursuant to the National Health Service Act 2006 (the "2006 Act").

1.2 The principal place of business of the Trust is at the Trust Headquarters at Musgrove Park Hospital, Taunton, Somerset, TA1 5DA.

1.3 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 NHSE, which this document represents).

1.4 The NHS Oversight Framework details how NHSE oversees and supports all NHS Trusts. Additional financial guidance is included in National Audit Office – Code of Audit Practice, NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

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

1.6 The Trust has a number of wholly and partially owned corporate entities. These corporate entities are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As separate, independent corporate entities, they are subject to their own governance arrangements, which are the responsibility of the relevant entity's management structure, and therefore these Standing Financial Instructions are not applicable. For avoidance of doubt, any matter reserved to the Trust in relation to such corporate entities will be treated as an item of the Trust and will be considered in accordance with these Standing Financial Instructions. The Group expects that wholly and partially owned corporate entities will maintain adequate governance arrangements to at least an equivalent standard as those maintained by the Trust. **All financial procedures must be approved by the Chief Finance Officer** or nominated authorised deputy.

1.7 Should any difficulties arise regarding the interpretation or application of

any of the SFIs then the advice of the Chief Finance Officer or nominated authorised deputy **MUST BE SOUGHT BEFORE ANY ACTION IS TAKEN**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs), as contained in the Constitution.

1.8 Failure to comply with these SFIs may be regarded as a disciplinary matter that could result in dismissal from employment with the Trust.

1.9 **Overriding Standing Financial Instructions**
If 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 Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

2 TERMINOLOGY

2.1 Save as otherwise permitted by law, at any meeting of the Board of Directors the Chairman shall be the final authority on the interpretation of Standing Financial Instructions (on which the Chairman should be advised by the Chief Executive or Chief Finance Officer). The Chairman's decision shall be final and binding except in the case of manifest error.

2.2 Any expression to which a meaning is given in the Health Service Acts or in the Financial Directions made under the Acts, shall have the same meaning in these instructions:

"Accounting Officer"
means the officer responsible for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust it shall be the Chief Executive.

"Audit Committee"
means the Audit Committee established in accordance with the Constitution and SFI 4.1.

"Auditor"
means the auditor as appointed by the Council of Governors in accordance with the Constitution.

"Board of Directors"
means the board of directors as constituted in accordance with the Constitution.

"Budget"
means a resource, expressed in financial terms, proposed by the Board of

Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget Holder"
means the Director or officer with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

“Chairman”
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression “Chairman” shall be deemed to include the Deputy Chairman and any other Non-Executive Director appointed if the Chairman is absent from the meeting and is otherwise unavailable.

"Chief Executive"
means the Chief Executive of the Trust appointed in accordance with the Constitution.

“Constitution”
means the Constitution of the Trust as approved by the Council of Governors and the Board.

“Council of Governors”
means the Council of Governors as constituted in accordance with the Constitution, which has the same meaning as the Board of Governors in Paragraph 7 to Schedule 7 of the 2006 Act.

“Executive Director”
means a Member of the Board appointed as an Executive Director in accordance with the Constitution.

“Executive Team”
means a group of Executive Directors.

"Chief Finance Officer"
means the Chief Finance Officer of the Trust appointed in accordance with the Constitution.

“Finance Committee”
means the Finance Committee established by the Board.

“Financial Limits”
means the financial limits set out in the Appendix to the Scheme of Delegation.

"Funds held on Trust"
means those funds which the Trust holds on its date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.40 of the NHS Act 2006, as amended. Such

funds may or may not be charitable.

“Group”
means the Group Somerset NHS Foundation Trust including wholly and partially owned corporate entities.

“Internal Audit”
means the function described in SFI 4.3.

“Licence”
means the NHS Provider Licence issued by NHSE in accordance with section 100 of the Health and Social Care Act 2022.

“Local Counter Fraud Manager (LCFM)”
means the person appointed by the Trust pursuant to SFI 4.4.3 to carry out the responsibility set out in the NHS Standard contract, service condition 24.1, 24.2, as amended from time to time.

“Member of the Board”
means an Executive Director or Non-Executive Director (including for the avoidance of doubt the Chairman) or both, as the context requires.

“NHS England (NHSE)”
means the Independent Regulator of NHS Foundation Trusts established under section 31 and Schedule 8 of the 2006 Act, as amended by the Health and Care Act 2022.

"Nominated officer"
means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

“Non-Executive Director”
means a Member of the Board appointed as a Non-Executive Director in accordance with the Constitution.

“Officer”
means a officer of the Trust or any other staff member or person holding a paid appointment or office with the Trust or an agent/third party working on behalf of the Trust.

“Regulatory Framework”
means the 2006 Act, as amended by the Health and Social Care Act 2022, the Constitution and the NHS Provider Licence as issued by NHSE.

“Scheme of Delegation”
means both the document containing the Reservation of Powers to the Board of Directors and the Scheme of Delegation for the Trust. "SFIs" means these Standing Financial Instructions.

"SOs"

means the Standing Orders of the Board of Directors.

"Tendering Procedure"
means the procedure set out at Section 10 in the Standing Orders for the Board of Directors.

"Trust"
means the Somerset NHS Foundation Trust.

3 RESPONSIBILITIES AND DELEGATION

3.1 The Board of Directors

3.1.1 The Board of Directors exercises financial supervision and control by:

- formulating the financial strategy;
- requiring the submission and approval of budgets within approved allocations/overall income;
- defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
- defining specific responsibilities placed on the Board of Directors and officers as indicated in the Scheme of Delegation containing the powers of delegation and reservation as the Trust has established.

3.1.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Reservation of Powers to the Board in the Scheme of Delegation.

3.1.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by the Trust.

3.2 The Chief Executive and Chief Finance Officer

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

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

3.2.3 It is a duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within these SFIs.

3.3 The Chief Finance Officer

3.3.1 The Chief Finance Officer is responsible for:

- these SFIs and for keeping them up to date;
- implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
- 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;
- 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; and without prejudice to any other functions of the Directors and officers to the Trust. The duties of the Chief Finance Officer include:

i) the provision of financial advice to the Trust, other Board of Directors and officers;
ii) the design, implementation and supervision of systems of internal financial control; and
iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

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

3.4 Board of Directors and Officers

3.4.1 All members of the Board of Directors and officers, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding financial loss;

- exercising economy and efficiency in the use of resources and value for money; and

- conforming to the requirements of Standing Orders, Standing Financial Instructions, relevant financial procedures and the Scheme of Delegation.

3.5 Contractors and their officers

3.5.1 Any contractor or, officer 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 SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3.5.2 For any and all directors and officers who carry out a financial function, the form in which financial records are kept and the manner in which directors and officers discharge their duties must be to the satisfaction of the Chief Finance Officer.

4 AUDIT

4.1 Audit Committee

4.1.1 In accordance with the Constitution and Standing Orders, the Board of Directors shall formally establish an Audit Committee; with clearly defined terms of reference and in accordance with guidance in the FT Code of Governance issued by Monitor in 2014, the Audit Code for NHS Foundation Trusts (2007) and any other relevant directions and guidance issued by NHSE or any other relevant body, which will provide an independent objective view of internal control by:

- overseeing Internal and External Audit services;

- reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements;

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

- monitoring compliance with Standing Orders and Standing Financial Instructions;

- reviewing schedules of losses and special payments and making recommendations to the Board of Directors;

- reviewing the information prepared to support the controls assurance

statements prepared on behalf of the Board of Directors and advising the Board of Directors accordingly; and

- Reviewing reports to gain assurance that sufficient control and management mechanisms are in place in relation to counter-fraud, bribery and corruption. This will include providing assurance to the Board.

4.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit Committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Finance Officer in the first instance). Exceptionally the matter may need to be referred to NHS England (NHSE).

4.1.3 It is the responsibility of the Chief Finance Officer to ensure that an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

4.2 Chief Finance Officer

4.2.1 The Chief Finance Officer is responsible for:

- 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 is adequate and meets NHSE's mandatory audit standards;

- ensuring that there is an adequate provision of strategic management of all counter fraud, bribery and corruption work within the organisation and providing assurance to the executive board in relation to the quality and effectiveness of the work undertaken. This includes that ensuring that the NHS Counter Fraud Authorities Standards for Provider are met;

- deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, bribery or corruption; authorising a report to the police and liaising with NHSE as appropriate;

- ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors; and

- ensuring that an annual counter fraud statement of assurance is prepared for consideration by the Audit Committee.

4.2.2 The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with

current controls assurance guidance issued by NHSE including for example compliance with control criteria and standards;

- major internal financial control weaknesses discovered;
- progress on the implementation of internal audit recommendations;
- progress against plan over the previous year;
- strategic audit plan covering the coming three years; and
- a detailed plan for the coming year.

4.2.3 The Chief Finance Officer or designated auditor is entitled without necessarily giving prior notice to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises held by the Board of Directors or officers of the Trust;
- the production of any cash, stores or other property of the Trust under a Member of the Board's or officer's control; and explanations concerning any matter under investigation.

4.3 Role of Internal Audit

4.3.1 Internal audit will review, appraise and report upon:

- the extent of compliance with, and the financial effect of relevant established policies, plans and procedures;
- the adequacy and application of financial and other related management controls;
- the suitability of financial and other related management data;
- the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from waste, extravagance, inefficient administration; and poor value for money and other causes;
- the adequacy of follow-up actions by the Trust to internal audit reports;
- any investigations/project work agreed with and under terms of reference laid down by the Chief Finance Officer;
- the Trust's Annual Governance Statement and Assurance Framework;

- the Trusts' compliance with the Care Quality Commission's fundamental standards.

4.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately. In the case of alleged or suspected fraud, bribery and corruption, the LCFM must be notified.

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

4.3.4 The Head of Internal Audit shall be accountable to the Chief Executive. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Audit Code for NHS Foundation Trusts and NHS Foundation Trust Annual Reporting Manual and the NHS Foundation Trust Accounting Officer Memorandum. The reporting system shall be reviewed at least every three years.

4.4 Fraud and Corruption

4.4.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall ensure compliance with the NHS Standard Contact, Service Condition 24 which places the following responsibilities on NHS Providers:

- requires that the Trust to put in place and maintain appropriate counter fraud arrangements;

- requires that the Trust protect NHS resources against bribery and corruption and take action to comply with NHS Counter Fraud Authority functional standards;

- report any suspected cases of fraud, bribery or corruption to the LCFM and/or the NHSCFA s appropriate;

- allow access to any property, staff, premises or information for the purpose of investigating and detecting fraud, bribery or corruption within five operational days.

4.4.2 The Trust is committed to ensuring that NHS resources are appropriately protected and the Chief Finance Officer is responsible for providing strategic management for all counter fraud, bribery and corruption activity. This includes the provision of assurance to the Board in relation to the quality and effectiveness of the work undertaken.

4.4.3 The Trust has a nominated and accredited LCFM who reports directly to the Chief Finance Officer. The LCFM undertakes the full range of counter fraud, bribery and corruption work including both proactive and reactive activity.

4.4.4 The Trust's non-executive Directors or lay members and board/governing level senior management are accountable for gaining assurances that there are sufficient controls and management mechanisms in relation to fraud, bribery and corruption.

4.4.5 Any officer suspecting fraud, bribery or corruption concern/risk which may result in an actual or potential risk of any financial loss to the organisation must report these concerns immediately to the Chief Finance Officer, LCFM; 01935 384106 / 07867 526312 or the NHSCFA 0800 028 4060 (24 hours) or https://cfa.nhs.uk/reportfraud.

4.4.6 The Trust is committed to pursuing and/or supporting NHS Counter Fraud Authority in pursuing the full range of available services (criminal, civil and disciplinary) against those found to have committed fraud and/or bribery.

4.5 Security Management

4.5.1 The Chief Executive has overall responsibility for the safety and security of officers, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider and for safeguarding Trust's premises and keeping them secure.

4.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS).

4.5.3 The LSMS shall be afforded the opportunity to attend Audit Committee meetings and other meetings of the Board, or its committees, as required.

4.6 External Audit

4.6.1 The Auditor is appointed in accordance with the Constitution by the Trust, subject to approval by the Council of Governors, and paid for by the Trust.

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

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

4.7 Senior Information Risk Owner

4.7.1 The Board shall nominate an Executive Director to be responsible to the

Board for information risk management (the Senior Information Risk Owner).

4.7.2 The role of the Senior Information Risk Owner is defined in the Information Governance toolkit and is summarised in the Trust's Information Governance Policy as a Board level post. The Senior Information Risk Owner is the leading advocate for information risk to the Board, advising how risks may impact the strategic vision of the Trust.

5 ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

5.1 Preparation and approval of business plans and budgets:

5.1.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.

5.1.2 Prior to the start of the financial year, the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board of Directors. Such budgets will be in accordance with the aims and objectives set out in the Trust's Annual Business Plan and;

- accord with workload and manpower plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds and identify potential risks.

5.1.3 The Chief Finance Officer shall monitor financial performance against budget and business plan, periodically review them, and report to the Finance Committee and the Board of Directors.

5.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be complied with.

5.1.5 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

5.2 Budgetary delegation

5.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities including pooled budget arrangements under section 75 of the NHS Act 2006.

5.2.2 This delegation must be in writing and be accompanied by a clear definition

of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and
- the provision of regular reports.

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

5.2.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

5.3 Budgetary control and reporting

5.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

- monthly financial reports to the Board in a form approved by the Board containing income and expenditure to date showing trends and forecast year end position;
- movements in working capital;
- movements in cash;
- capital project spend and projected outturn;
- explanations of any material variances from plan;
- details of any corrective action where necessary and the Chief Executive's and/or the Chief Finance Officer's views of whether such actions are sufficient to correct the situation;
- the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible; and
- Investigation and reporting of variances from budgets. These reports will be monitored by the Finance Committee who will report to the Board on matters arising from their review.

5.4 Each budget holder is responsible for ensuring that:

5.4.1 Any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors.

5.4.2 The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement as set put in the Scheme of Delegation.

5.4.3 No permanent officers are appointed outside of the agreed funded establishment without prior approval from the Executive Team.

5.4.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

5.5 Capital expenditure

5.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 15).

5.6 Monitoring Returns

5.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSE and any other requisite monitoring organisation.

6 ANNUAL ACCOUNTS AND REPORTS

6.1 The Chief Finance Officer, on behalf of the Trust, will:

- prepare financial returns in accordance with the accounting policies and guidance given by NHSE, HM Treasury and the DHSC, the Trust's accounting policies, and generally accepted accounting practice;
- submit annual financial reports to NHSE certified in accordance with current guidelines; and
- submit financial returns to NHSE for each financial year in accordance with the timetable prescribed.

6.2 In accordance with the Constitution, the Trust's annual accounts must be audited by an auditor appointed by the Council of Governors and presented to a general meeting of the Council in accordance with the Constitution. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

6.3 The Trust will publish an annual report, in accordance with the Constitution and guidelines on local accountability and NHSE's NHS Foundation Trust Annual Reporting Manual and send it to NHSE and Parliament.

6.4 In accordance with paragraph 37.3 of the Constitution, the Trust shall give information prepared by the Board of Directors with regard to the Council of Governor's views as to its forward planning in respect of each financial year to NHSE.

7 BANK ACCOUNTS

7.1 General

7.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance issued from time to time by NHSE.

7.1.2 The Board of Directors shall approve the banking arrangements.

7.1.3 No Trust monies or donated funds can be held in any personal bank accounts. Any accounts linked to the Trust; either by name or address should be managed and controlled by Finance, individual accounts held by departments is strictly forbidden and will be referred to counter fraud for investigation.

7.2 Bank and Government Banking Service (GBS) Accounts

7.2.1 The Chief Finance Officer is responsible for:

- bank accounts and GBS accounts;
- establishing separate bank accounts for the Trust's non-exchequer funds;
- ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn (together with remedial action taken);
- monitoring compliance with HM Treasury guidance and any guidance issued by NHSE or any other relevant guidance on the level of cleared funds;
- managing the investment of surplus cash in accordance with the Trust's Treasury Management Policy and in compliance with the directives of the Finance Committee; and

- negotiating any appropriate loans from the Foundation Trust Financing Facility or other financial institutions in compliance with the directives of the Finance Committee and the Board.

7.3 Banking Procedures

7.3.1 The Chief Finance Officer will ensure that detailed instructions on the operation of bank and GBS accounts are prepared which must include:

- the conditions under which each bank account is to be operated; the limit to be applied at any overdraft; and those authorised to sign cheques or other orders drawn on the Trust's accounts; and

- the Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

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

8.1 Income systems

8.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

8.1.2 All such systems shall incorporate, where practicable, the principles of internal check and separation of duties.

8.1.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

8.14 An official receipt will be made out for all cash receipts when requested, showing the type of remittance and the reasons for payment.

8.2 Fees and charges

8.2.1 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation should be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the DHSC's Commercial Sponsorship – Ethical Standards in the NHS (Contained within the Code of Conduct & Managing Conflict of Interest and Personal Conduct Policy) shall be followed and must be declared.

8.2.2 All officers must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other

transactions.

8.3 Income in Dispute/in Error

8.3.1 Where an invoice is raised in error, it can only be cancelled by a credit note, appropriately authorised by Finance staff as per the Trust's authorisation list.

8.4 Debt recovery

8.4.1 The Chief Finance Officer is responsible for the appropriate financial recovery.

8.4.2 Outstanding debts will be reviewed and follow up action taken, dependent upon the value of the debt and length of time outstanding. Where applicable, debt recovery agencies will be used to recover such debts.

8.4.3 Income not received should be dealt with in accordance with losses procedures.

8.4.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

8.4.5 Any financial losses identified resulting from Fraud or bribery will be notified by the LCFM to Finance and robust action will be taken to ensure any loss is recovered in full.

8.5 Security of cash, cheques and other negotiable instruments

8.5.1 The Chief Finance Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such stationery;
- the provision of adequate facilities and systems for officers 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;
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust;
- official money shall not under any circumstances be used for the encashment of private cheques or IOUs;
- approval of Trust credit cards to initiate ordering and purchasing of immediate goods; all agreements signed by the cardholder; and

- Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported to the Chief Finance Officer.

8.5.2 Subject to the SFI clause, all cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received except under arrangements approved by the Chief Finance Officer.

8.5.3 All departments who are permitted to hold cash will be provided with a safe or lockable cash box which shall normally be deposited in a safe. The nominated officer will hold one key and shall arrange for a duplicate key to be lodged in the Trust Headquarters safe. Instructions for the release of this duplicate key should be prepared by the nominated officer and approved by the Chief Finance Officer. Loss of any key should be reported immediately to the Chief Finance Officer. During the absence of the key holder, the officer who acts in their place shall be subject to the same controls as the key holder. A written discharge of the contents of the safe or cash box on the transfer of responsibilities should be retained for audit purposes with consideration to operational practices. 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 is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.5.4 The opening of incoming post shall be undertaken by a one officer and all cash, cheques, postal orders and other forms of payment must be entered immediately in an approved form or remittance register, which should be countersigned by a senior officer. The counting and recording of the takings shall be undertaken by two members of staff together.

8.5.5 An official receipt will be made out for all cash receipts, showing the type of remittance and the reasons for payment.

8.5.6 A special receipt will be issued for all charitable fund donations which will enable the donor to express their wishes as to the purpose of the donation.

8.5.7 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Chief Finance Officer and the coin box keys shall be held by a nominated manager.

8.5.8 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash; bulk stocks of cheques will be retained by the Trust's bankers and released by them only against a requisition signed by the Chief Finance Officer or a nominated officer.

8.5.9 The use of a cheque signing machine and/or cheques with a pre-printed signature included will be subject to special security precautions by the Chief Finance Officer, as deemed appropriate.

8.5.10 Staff shall be informed on their appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

8.5.11 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedures for reporting losses and for recording incidents.

8.6 Petty Cash

8.6.1 All new floats or amendments to floats are authorised by the Assistant Director - Financial Services, they will only be approved if they are essential to the Service.

8.6.2 All Petty Cash Floats must be held in a secure place and remain under the control of the designated Float Holder/Accounting Officer. The float holders who are going off duty and coming on duty will both check the petty cash together and a formal record of the check will be documented.

8.6.3 Petty Cash disbursements should be for the purpose agreed when the float was established. Other than for re-imbursement of patients/clients' money, petty cash must not be used for the reimbursement for any item over £50. All disbursements must be supported by receipt(s). In circumstances where staff require an advance of cash to make a purchase, a record must be kept of the details and amount issued to ensure that all cash can effectively be accounted for until receipts and unspent cash are returned within 24 hours. Advances of cash need to be authorised by either the Deputy Chief Finance Officer or the Assistant Director - Financial Services prior to the advance being issued.

8.6.4 Reimbursements will not be made unless both signatories provided match the authorised signatories that is held on record for the float.

8.7 Trust Credit Card

8.7.1 The Trust administer a number of credit cards to support the procurement process in allowing more flexibility to purchase goods but limited to exceptional circumstances. Standard procurement processes must be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then the Trust's procurement processes will still need to be followed.

8.7.2 Fuel Purchasing Cards (approved by Finance) are held by the individual units, these should be kept in a secure place when not in use and documentation kept on usage.

8.7.3 Local procedures need to be in place to ensure the security of these cards and there must be robust departmental monitoring of purchases.

9 SUPPLIER INVOICE RECEIPT/APPROVAL AND BANK DETAILS

9.1 Invoice approval

9.1.1 All invoices are approved by verifying the information in accordance with the Trusts' scheme of delegation and are sent out electronically within our accounting system. Payment staff will scan the invoice received, cross checking the purchase order number from the invoice to our system.

9.2 New suppliers

9.2.1 The Chief Finance Officer shall ensure there are suitable controls for all notification of new supplier accounts. All details received on the Trust template are followed up by confirmation to another contact by telephone to validate the new details. New suppliers or bank account changes for existing suppliers will be checked using external verification software.

9.3 Inactive suppliers

9.3.1 The Chief Finance Officer shall ensure suppliers with no activity for greater than two years will be classified as "inactive" on the system. This will be reviewed on bi-annual basis.

9.4 Changes of bank details

9.4.1 The Chief Finance Officer shall ensure there are suitable controls for any changes to suppliers' bank details. Suppliers shall use the standard amendment form recommended by NHS Counter Fraud Authority in Fraud Prevention Notice 9 (FP9) of December 2010. Payment staff will confirm requests for changes using details already held and will undertake checks using external bank verification software for additional assurance. Monthly reports will be reviewed and approved by the Transactional Services Manager.

10 AGREEMENTS FOR PROVISION OF SERVICES

10.1 Foundation Trust Contracts

10.1.1 The Board of Directors of the Trust shall regularly review and; at all times maintain and ensure the capacity of the Trust to provide the commissioner requested services referred to in the Licence and other terms of authorisation and related schedules.

10.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring that the Trust enters into suitable NHS contracts with Integrated Care Boards (ICBs) and other commissioners for the provision of services.

10.1.3 The Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the

Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the Performance Assessment Framework contained within the NHS contract;
- that NHS contracts build where appropriate on existing partnership arrangements; and
- any model contracts issued by NHSE or the DHSC.

10.1.4 A good NHS 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 Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

10.1.5 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the NHS contract. This will include information on costing arrangements, which increasingly should be based upon patient clusters. Where patient clusters are unavailable for specific services, all parties should agree a common currency.

10.1.6 Where the Trust makes arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accounting Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

10.2 Contracts

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

10.2.2 Contracts should incorporate:

- a description of the service and indicative activity levels;
- the term of the agreement;
- the value of the agreement;
- lead officers;
- performance and dispute resolution procedures; and
- risk management and governance arrangements.

10.2.3 Contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement to ensure value for money and to minimise any potential loss of income.

11 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF DIRECTORS, OFFICERS, VOLUNTEERS, OFF-PAYROLL WORKERS AND COLLEAGUES

11.1 Remuneration and Terms of Service

11.1.1 In accordance with SOs the Board of Directors shall establish a Nomination and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

11.1.2 The Nomination and Remuneration Committee will decide on appropriate remuneration and terms of service of the Chief Executive and other Executive Directors (and other very senior officers) including:

- all aspects of salary (including any performance related elements/bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms; and
- and will advise the Board of Directors of any decisions made.

11.1.3 Regular reviews of the remuneration and terms of service of the Chief Executive and other Executive Directors (and other senior officers) will be carried out to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate. To decide the appropriate remuneration of the Chief Executive and other Executive Directors and advise the Board of Directors of any decisions made. Any decisions made by the Nominations and Remuneration Committee shall be recorded in the minutes of the meetings.

11.1.4 The Nomination and Remuneration Committee shall monitor and evaluate the performance of individual Executive Directors (and other senior officers).

11.1.5 The Committee shall also advise on and oversee appropriate contractual arrangements for all Directors and officers, including the proper calculation and scrutiny of termination payments taking account of such national guidance.

11.1.6 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those officers and officers not covered by the Committee.

11.1.7 The Trust will pay allowances to the Chairman and other Non- Executive Directors in accordance with the decision of the Council of Governors in accordance with the Constitution.

11.2 Funded establishment

11.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

11.2.2 The funded establishment of any department may be varied within the existing funding available.

11.3 Officer appointments

11.3.1 No officer may engage, re-engage, or re-grade officers, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

- unless within the limit of his approved budget and funded establishment.

11.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, and conditions of service for officers.

11.4 Processing of Payroll

11.4.1 The Chief Finance Officer is responsible for:

- specifying timetables for submission of properly authorised time records and other notifications;
- the final determination of pay and allowances;
- making payment on agreed dates; and
- agreeing method of payment.

11.4.2 The Chief Finance Officer will issue instructions regarding:

- verification and documentation of data;
- the timetable for receipt and preparation of payroll data and the payment of officers;
- maintenance of subsidiary records for superannuation, income tax; social security and other authorised deductions from pay;
- security and confidentiality of payroll information;
- checks to be applied to completed payroll before and after payment;
- authority to release payroll data under the provisions of the Data Protection Act 2018;
- methods of payment available to various categories of officers;
- procedures for payment by cheque, bank credit, or cash to officers;
- procedures for the recall of cheques and bank credits;
- pay advances and their recovery;
- maintenance of regular and independent reconciliation of pay control accounts;

- separation of duties of preparing records and handling cash;
- a system to ensure the recovery from leavers of sums of money and property due by them to the Trust; and
- the process of reclaiming business mileage and expenses (processed through the Trust e-expenses system).

11.4.3 Appropriately nominated managers have delegated responsibility for: submitting time records, and other notifications in accordance with agreed timetables, completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer, submitting termination forms in the prescribed form immediately upon knowing the effective date of an officer's resignation, termination or retirement. Where an officer fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

11.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and those suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.5 Contracts of Employment

11.5.1 The Chief of People and Organisational Development is responsible for ensuring that all officers are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation; and for dealing with variations to, or termination of, contracts of employment.

11.6 Expenses

11.6.1 The Trust E-Expenses system should only be used for expenses associated with officers, i.e. those paid via payroll. Budget holders are accountable for checking and authorising only appropriate expenses incurred in line with Trust business travel and Expenses policy and based upon their financial delegations set out in these SFIs. If applicable, receipts must support the claim in electronic format.

11.6.2 E-Expenses reimbursements to officers are processed via payroll and should never occur via accounts payable.

11.6.3 The E-Expenses system is only for the reimbursement of expenses associated or incurred during the course of Trust business i.e, travel and subsistence, relocation and removal allowances, and should never be used to reimburse items that should have been and could have been purchased via the Trust's purchasing systems.

11.7 Salary sacrifice schemes

11.7.1 All salary sacrifice schemes have a procedure that is applicable and provide detailed guidance. Please refer to the Trust intranet for the various scheme procedures.

11.8 Working with service users/volunteers

11.8.1 Service Users and Volunteers have a unique contribution to make to service improvement. The Trust delivers partnerships that put their views, needs, aspirations, experiences and expert knowledge central to the Trust service development.

11.9 Service user and volunteer reimbursement of expenses

11.9.1 In accordance with tax law, service users can only be reimbursed for actual expenses incurred, without the deduction of income tax and national insurance.

11.9.2 Specifically, tax law allows this reimbursement to be:

- on the basis of actual costs incurred, which require supporting receipts and should be in line with the Trusts service user standard operating procedure;

11.9.3 All reimbursement or expenses to service users should be made following the submission of an expenses claim form. This should be submitted within 3 months of the meeting/event and must include receipts for any expenses claimed. Expenses claimed must be in line with the service user standard operating procedure.

11.9.4 Honorarium 'reward' or remuneration (over and above paying expenses) is offered but brings potential complications for the service user in respect to income tax and/or benefit entitlements. It also brings complications for the Trust in relation such matters as minimum wage law. Participants would ultimately be responsible for informing the Department of Work and Pensions along with the Inland Revenue of any such reward or remuneration and this may affect their benefits or tax code.

11.10 Staff loans and advances

11.10.1 The Trust does not allow loans and advances to staff.

12 NON-PAY EXPENDITURE

12.1 Delegation of Authority

12.1.1 The level of non-pay expenditure will be determined on an annual basis as part of the budget setting process and the Chief Executive will determine the level of delegation to budget managers.

12.1.2 The Chief Executive will set out: the list of managers who are authorised to place requisitions for the supply of goods and services and the maximum level of each requisition and the system for authorisation above that level.

12.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

12.1.4 The Council of Governors will need to approve significant transactions as defined in the Constitution.

12.2 Choice, Requisitioning, Ordering, Receipt and Payment of Goods and Services Requisitioning

12.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed), must always obtain the best value for money for the Trust. In so doing, the advice of the Procurement Department shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

12.2.2 The Chief Finance Officer 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.

12.3 System of Payment and Verification

12.3.1 The Chief Finance Officer will:

- advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated in SOs and the Scheme of Delegation and regularly reviewed. These limits shall have the effect as if incorporated in these SFIs;

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

- be responsible for the prompt payment of all properly authorised accounts and claims;

- be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for;

- a list of Directors/officers (including specimens of their signatures) authorised to certify invoices;

- certification that:

a) goods have been duly received, examined and are in accordance with;

b) specification and the prices are correct;

c) 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;

d) 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 the price and the charges for the use of vehicles, plant and machinery have been examined;

e) where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

f) the account is arithmetically correct;

g) the account is in order for payment:

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

- instructions to officers regarding the handling and payment of accounts within the Finance Department;

- be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as set out at 12.4 below)

- prepare and issue procedures regarding Value Added Tax (VAT).

12.4 Prepayments

12.4.1 Prepayments other than those which are standard practice, e.g. telephone rental and annual subscriptions, are only permitted where exceptional circumstances apply. In such instances:

- prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using an appropriate rate);

- the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase.

The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

- the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

- the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

12.5 Official Orders

12.5.1 Official orders must:

- be consecutively numbered;

- be in a form approved by the Chief Finance Officer, including electronic format;

- state the Trust's terms and conditions of trade; and

- only be issued to, and used by, those duly authorised by the Chief Executive.

12.6 Duties of Officers

12.6.1 Officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

- all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability, are notified to the Chief Finance Officer in advance of any commitment being made. Contracts above specified thresholds are advertised and awarded in accordance with the EU rules on public procurement;

- where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHSE;

- If Trust officers, contractors or temporary staff have any potential or actual conflicts of interest this should be declared in line with the Trust's 'Managing Conflicts of Interest and Personal Conduct policy'. To protect against accusations of compromise staff must declare gifts, hospitality, patents, political interests, entertainment, shareholdings, secondary employment, private practice, loyalty interests and sponsorship in line

with this policy. Officers at band 8D, or above and officers working at band 7, or above working in Pharmacy, Estates or Procurement must submit a ~~'Nil'~~ return on an annual basis;

- no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

- all goods, services, or works are ordered on an official order except ~~works and services executed in accordance with a contract~~ categories of spend agreed to be exempt by Chief Finance Officer on behalf of the Chief Executive (e.g business rates, utility bills and clinical agency staffing) and purchases by purchase card or from petty cash;

- verbal orders must only be issued very exceptionally – by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

- orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

- goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

- changes to the list of Directors/officers authorised to certify invoices are notified to the Chief Finance Officer;

- purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer; and

- petty cash records are maintained in a form as determined by the Chief Finance Officer.

12.6.2 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with any DHSC guidance or other regulations relating to the EU, PFI or Procure 22 projects. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

12.6.3 Under no circumstances should goods be ordered through the Trust for personal or private use (other than approved lease car schemes).

13 JOINT FINANCE ARRANGEMENTS WITH LOCAL AUTHORITIES AND VOLUNTARY BODIES

13.1 Payments to local authorities and voluntary organisations made under the

powers of section 75 of the NHS Act 2006 shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

14 EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

14.1 External Borrowing

14.1.1 The Chief Finance Officer is responsible for ensuring that the sum of borrowing from all sources both short term and long term represents value for money, comply with any Regulatory limits and guidance and does not adversely impact on future cash flows.

14.1.2 Any application for a temporary loan or overdraft will only be made by the Chief Finance Officer or by a member of staff so delegated by them and in any event a duly authorised signatory.

14.1.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for temporary loans and overdrafts.

14.1.4 All external borrowing must be consistent with the plans outlined in the current Business Plan and be recommended by Finance Committee to the Trust Board.

14.1.5 The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.

14.2 Public Dividend Capital

14.2.1 The Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay dividend on and repay Public Dividend Capital (PDC) and any proposed new borrowing, at a rate to be determined from time to time by the Secretary of State in accordance with the 2006 and the Regulatory Framework. The Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the PDC debt and all loans and overdrafts.

14.2.2 The Board of Directors will agree the list of officers who are authorised to make short-term borrowings on behalf of the Trust. This must include the Chief Executive and the Chief Finance Officer.

14.2.3 The Chief Finance Officer must prepare detailed procedural instructions on applications for loans and overdrafts; and the operations of investment accounts and the records to be maintained.

14.2.4 All short-term borrowings should be kept to a minimum period of time possible, consistent with the over cash flow position, represent good value for money, and comply with the latest guidance issued by NHSE.

14.2.5 Any short-term borrowing must be with the authority of two members of the authorised panel, one of which must be the Chief Executive or the Chief Finance Officer. The Board of Directors must be made aware of all short-term borrowings at the next Board meeting.

14.3 Cash Investments

14.3.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by NHSE and/or the Secretary of State and in accordance with the Treasury Management policy.

14.3.2 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held and on ensuring the Trust acts in accordance with the Best Practice Guidance in Making Investments for NHS Foundation Trusts. Proposals for investments will be considered and scrutinised by the Finance Committee on behalf of the Board.

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

15.1 Capital Investment

15.1.1 The Trust will follow NHSE's Capital Regime and where applicable approval will be sought for any investment and property business cases in line with the requirements of the guidance. See NHS Improvement: 'Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.

15.1.2 The Trust will follow NHSE'S capital regime in relation to system sign off and working within Capital Departmental Expenditure Limit (CDEL) set by the Regulator.

15.1.3 The Chief Executive:

- shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
- shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support and the availability of resources to finance all revenue consequences, including capital charges.

15.1.4 The Trust shall appoint the Capital Delivery Group or other appropriate meeting structure whose responsibilities shall be:

a) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost and meet their overall purpose;

b) ensuring that capital investment is not undertaken without commissioner(s)/partner(s) written support, where required, and the availability of resources to finance all revenue consequences and capital charges;

c) to ensure that a robust financial appraisal is undertaken as appropriate for all business cases (which have been approved by the Trust's Finance committee as appropriate);

d) to ensure that appropriate project management and control arrangements are in place; and

e) that the Director of Strategy and Digital Development has certified professionally to the costs and revenue consequences detailed in business cases.

15.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

- specific authority to commit expenditure;
- authority to proceed to tender; and
- approval to accept a successful tender.

15.1.6 The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with "Protection of Assets Guidance for NHS Foundation Trusts" issued by NHSE, "Estatecode" guidance and the SOs.

15.1.7 The Chief Finance Officer shall issue the capital investment policy and procedures governing the financial management including variations to contract, of capital investment projects and valuation for accounting purposes.

These procedures shall fully take into account:

- the delegated limits for capital schemes included in Annex C of HSC 1999/246 and guidance issued by NHSE relating to the Prudential Borrowing Code which determines the limits of borrowing by an NHS Foundation Trust;

- the Trust's Investment Policy;

- the best practice advice issued by NHSE in "Risk Evaluation for Investment Decisions by Foundation Trusts"; and

- ensure the NHS Foundation Trust Annual Reporting Manual which outlines the application of International Financial reporting Standards (IFRS), to the extent that they are relevant to NHS Foundation Trusts, is followed in the production of the Trust's annual accounts and annual report.

15.2 Private Finance

15.2.1 When the Trust proposes to use finance that is to be provided other than through its allocations, the following procedures shall apply:

- the Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

- where the sum exceeds the delegated limits set out in the Scheme of Delegation a business case must be prepared and the Trust shall comply with any relevant guidance and/or best practice advice issued by NHSE;

- the proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought.

15.3 Asset Registers

15.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

15.3.2 The Trust shall maintain an asset register recording non-current assets. The asset register shall list every asset used by the Trust for the provision of commissioner requested services.

15.3.3 Additions to the non-current asset register must be clearly identified to an appropriate budget holder and be validated by reference to properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

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

15.3.5 Lease agreements in respect of assets held under a finance lease and capitalised.

15.3.6 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).

15.3.7 The Chief Finance Officer shall approve procedures for reconciling balances on non-current assets accounts in ledgers against balances on non-current asset registers with the value of each asset indexed to current values.

15.3.8 The value of each asset shall be depreciated using methods as specified in the Annual Reporting Manual issued by NHSE.

15.3.9 The Chief Finance Officer shall calculate and pay capital charges as specified in the Annual Reporting Manual issued by NHSE.

15.3.10 No assets that have been identified to hold Commissioner Requested Services in accordance with the NHSE Licence Agreement are allowed to be sold without prior consultation and agreement with NHSE in line with current guidance and approval from the Board. The Trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services.

15.3.11 The value of owned buildings shall be indexed to current values and all assets shall be depreciated using methods and rates as specified by the appropriate accounting policies in use in the Trust. Periodically non-current assets will be subject to a formal revaluation exercise as described in the relevant Trust accounting policies. The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.4 Security of Assets

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

15.4.2 Asset control procedures (including non-current assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

- recording managerial responsibility for each asset;
- identification of additions and disposals;
- identification of all repairs and maintenance expenses;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques, and

negotiable instruments.

15.4.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

15.4.4 Whilst each member of staff has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior officers in all disciplines to apply such appropriate routine security practices in relation to Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

15.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and officers in accordance with the procedure for reporting losses.

15.5.6 Where practical, assets should be marked as Trust property.

16 STORES AND RECEIPT OF GOODS

16.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- kept to a minimum;
- subjected to annual stock take; and
- valued at the lower of cost and net realisable value.

16.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stocks and stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a Designated Pharmaceutical Manager; the control of any fuel shall be the responsibility of the Designated Estates Manager.

16.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Head of Facilities. Wherever practicable, stocks should be marked as “Trust service property”.

16.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores, including records for receipt of goods, issues, and returns to stores, and losses.

16.5 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

16.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

16.7 The designated officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also SFI 17 Disposals and 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.

16.8 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy him/herself that the goods have been received before accepting the recharge.

17 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets in accordance with the Regulatory Framework and guidance issued by NHSE, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset, the Head of Facilities or Head of Procurement will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable articles shall be condemned or otherwise disposed of by a officer authorised for that purpose by the Chief Finance Officer.

17.1.4 Recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Chief Finance Officer.

17.1.5 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 Chief Finance Officer who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

17.2.2 Within limits delegated to it by NHSE, and the Treasury, the Board of Directors shall approve the writing-off of losses above the level delegated to nominated Executive Directors or other senior officers contained in the Financial Limits.

17.2.3 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.4 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

17.2.5 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded. These are presented to the Audit Committee on a quarterly basis.

17.2.6 No special payments exceeding delegated limits shall be made without the prior approval of NHSE/Treasury.

18 INFORMATION TECHNOLOGY

18.1 Responsibilities and duties of the Director of Strategy and Digital Development

18.1.1 The Director of Strategy and Digital Development, 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 protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and any subsequent legislation.

18.1.2 Ensure that adequate 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.

18.1.3 Ensure that adequate controls exist such that the computer operation separated from development, maintenance, and amendment.

18.1.4 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.

18.1.5 The Director of Strategy and Digital Development shall satisfy himself 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, assurance of adequacy will be obtained from them prior to implementation.

18.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

18.2.1 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible Directors and officers will send to the Director of Strategy and Digital Development:

- details of the outline design of the system; and
- in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

18.3 Contracts for computer services with other health bodies or outside agencies

18.3.1 The Director of Strategy and Digital Development 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.

18.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Strategy and Digital Development shall periodically seek assurances that adequate controls are in operation.

18.4 Risk Assessment

18.4.1 The Director of Strategy and Digital Development shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

18.5 Requirements for computer systems which have an impact on corporate financial systems

18.5.1 Where computer systems have an impact on corporate financial systems the Director of Strategy and Digital Development shall satisfy himself that: systems

acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy.

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

18.5.3 The Director of Strategy and Digital Development/officers have access to such data; and such computer audit reviews as are considered necessary are being carried out.

18.5.4 The Director of Strategy and Digital Development will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Trust's information strategy.

18.5.5 The Director of Strategy and Digital Development will ensure that separate control procedures are put in place for computer systems. This procedure will include:

- the decommissioning of systems containing confidential data; and in accordance with guidance issued by NHSE and the DHSC; and
- the acquisition and disposal of IT, systems and equipment.

19 PATIENTS' PROPERTY

19.1 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 possession of patients dying in hospital or dead-on arrival.

19.2 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; where applicable signed by the patient and staff member; and
- the oral advice of officers responsible for admissions into Trust premises that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. hospital admission documentation and property records; where applicable signed by the patient and staff member.

19.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to

maximise the benefits to the patient.

19.4 Where NHSE's instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

19.5 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 as amended), 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.

19.6 Officers 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.

19.7 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 donor or patient in writing.

20 FUNDS HELD ON TRUST, INCLUDING CHARITABLE FUNDS

20.1 Funds held on Trust Introduction

This Standing Financial instruction identifies the Trust's responsibilities as a corporate trustee for the management of funds it holds on Trust and defines how those responsibilities are to be discharged. It explains that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition must be given to the dual accountabilities to the Charity Commission for charitable funds held on Trust and to NHSE for all funds held on Trust.

20.1.1 The Scheme of Delegation makes clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

20.1.2 As management processes overlap most of the sections of these SFIs will apply to the management of Funds held on Trust. This section covers those instructions which are specific to the management of charitable funds held on Trust.

20.1.3 The overriding principle is that the integrity of each fund must be maintained and statutory and charity obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20.1.4 The Board is responsible for the management of charitable funds and this function is overseen by the Charitable Funds Committee which meets quarterly in accordance with the business requirements of the Trust and the Charitable Funds.

20.2 Existing Charitable Funds

20.2.1 The Chief Finance Officer shall arrange for the administration of all existing charitable funds. Chief Finance Officer shall ensure that written instructions exist for every charitable donated fund and shall produce detailed procedures covering every aspect of the financial management of funds, for the guidance of all officers. Such guidelines shall identify the restricted nature of certain funds.

20.2.2 The Chief Finance Officer shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines.

20.2.3 The Chief Finance Officer may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g, designation for specific wards or departments.

20.3 New Charitable Funds

20.3.1 The Chief Finance Officer shall arrange for the creation of a new charitable fund where funds and/or other assets, received in accordance with the Trust's policies, cannot adequately be managed as part of an existing fund.

20.3.2 The Chief Finance Officer shall present the governing document to the Board for each new charitable fund. Such a document shall clearly identify, inter alia, the objects of the new charitable fund, the capacity of the Trust to delegate powers to manage and the power to assign the residue of the charitable fund to another fund contingent upon certain conditions, e.g, discharge of original objects.

20.4 Sources of New Funds

20.4.1 In respect of Donations, the Director of Strategy and Digital Development shall:

20.4.2 Provide guidelines to officers of the Trust as to how to proceed when offered funds. These are to include:

- the identification of the donors intentions;
- where possible, the avoidance of new Trusts;
- the avoidance of impossible, undesirable or administratively difficult objects;
- sources of immediate further advice; and treatment of offers for personal gifts; and
- provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's donated funds and that the donor's intentions have been noted and accepted.

20.4.3 In respect of Fundraising, the Director of Strategy and Digital Development shall:

- deal with all arrangements for fund-raising by and/or on behalf of the Trust and ensure compliance with all statutes and regulations;

- be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge. The Director of Strategy and Digital Development shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

- be responsible for alerting the Board to any irregularities regarding the use of this Trust's name or its registration numbers; and

- be responsible for the appropriate treatment of all funds received from this source.

20.4.4 In respect of Legacies and Bequests, the Chief Finance Officer shall:

- provide guidelines to officers of the Trust covering any approach regarding;
- the wording of wills;
- the receipt of funds/other assets from executors;
- where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Trust is the beneficiary;
- be empowered, on behalf of this Body, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;
- be directly responsible for the appropriate treatment of all legacies and bequests; and
- keep a register of all enquiries.

20.4.5 No trading activities will be undertaken without the prior consent of the Trustees and the formation of a trading company.

20.4.6 In respect of Investment Income, the Chief Finance Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source.

20.5 Investment Management

20.5.1 The Director of Strategy and Digital Development shall be responsible for all aspects of the management of the investment of donated funds. Advice provided to the Board shall include:

- the formulation of investment policy within the powers of the Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;
- the appointment and agreement of the terms of appointment of advisers, brokers, and, where appropriate, fund managers, written agreements to be signed by the Chief Executive;
- the pooling of investment resources in accordance with the scheme approved by the Charity Commission;
- the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;
- that the use of Charity assets shall be appropriately authorised in writing and charges raised within policy guidelines;
- the review of the performance of brokers and fund managers;
- the reporting of investment performance; and
- all share and stock certificates and property deeds are held by the Trust's stockbroker who uses a nominee company on behalf of the Trust.

20.6 Expenditure Management

20.6.1 The exercise of this Trust's expenditure discretion shall be managed by the Chief Finance Officer in conjunction with the Board. In so doing, to be aware of the following:

- the objects of various funds and the designated objectives;
- the availability of liquid funds within each donated fund;
- the powers of delegation available to commit resources;
- the avoidance of the use of exchequer funds to discharge donated fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by donated funds at the earliest possible time;
- that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Trust; and
- the definitions of ‘charitable purposes’ as agreed by the NHS Executive with the Charity Commission.

20.7 Banking Services

20.7.1 The Chief Finance Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the Charity as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each Trust where this is deemed necessary by the Charity Commission.

20.8 Asset Management

20.8.1 Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure:

- that appropriate records of all assets owned by the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;
- that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
- that donated assets received are accounted for appropriately; and
- that all assets acquired from Charitable Funds which are intended to be retained within the Charity are appropriately accounted for.

20.9 Reporting & Accounting and Audit

20.9.1 The Chief Finance Officer shall ensure that regular reports are made to the Charitable Funds Committee with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

20.9.2 The Chief Finance Officer shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

20.9.3 The Chief Finance Officer shall prepare an annual trustees' report (separate reports for charitable and non-charitable Trusts) and the required returns to the NHS Executive and to the Charity Commission for adoption by the Board.

20.9.4 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

20.9.5 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. The Chief Finance Officer will liaise with external audit and provide them with all necessary information.

20.9.6 The Board shall be advised by the Chief Finance Officer on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Corporate Trustee.

20.10 Authorised Limits for Charitable Trust Funds

20.10.1 Limits for expenditure out of charitable funds are set out in Appendix 2.

21 ACCEPTANCES OF GIFTS AND HOSPITALITY

21.1 The Chief Executive shall ensure that all officers are made aware of the Trust policy on acceptance of gifts and other benefits in kind to officers. This policy should follow the guidance contained in NHSEs Standards of Business Conduct for NHS Staff and the NHS Foundation Trust Code of Governance, which forms part of the Trust's Code of Conduct and Managing Conflict of Interest and Personal Conduct Policy. All gifts, hospitality or sponsorship are reported in accordance with this policy. All declarations; staff at band 8D, (or equivalent) must be made online via https://spft.mydeclarations.co.uk/login.

21.2 Any Fraud, bribery and corruption concerns should be reported to the LCFM or the NHS Counter Fraud Authority.

22 RETENTION OF DOCUMENTS

22.1 The Chief Executive shall be responsible for maintaining a Policy and Procedure for the Retention, Preservation and Destruction of Records which all officers must follow.

22.2 The documents held in archives shall be capable of retrieval by authorised persons.

22.3 Documents held under the Records Management Code shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

23 FREEDOM OF INFORMATION

23.1 The Director of Corporate Services shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

24 RISK MANAGEMENT AND INSURANCE

24.1 The Chief Executive shall ensure that the Trust has a programme of risk management in accordance with current directions and guidance in relation

to assurance frameworks as issued by NHSE which will be approved and monitored by the Board of Directors.

24.2 **The programme of risk management shall include**:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of officers a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements, including internal audit, clinical audit, health and safety review;
- decision on which risks shall be insured; and
- arrangements to review the risk management programme.

24.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an annual governance statement as required by the NHS Foundation Trust Annual Reporting Manual.

24.4 The Board of Directors shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.5 The Trust may enter into insurance arrangements with commercial insurers in respect of vehicle and other insurance not covered by the NHS Resolution schemes.

24.6 Where income generation activities take place these activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Finance Officer should consult the NHS Resolution.

24.7 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

24.8 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

24.9 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

25 DOCUMENT CONTROL

Document Author	Assistant Director - Financial Services / Head of Procurement		
Lead Owner	Chief Finance Officer		
This Version	1.0	**Status**	Draft
Replaces	~~Previous Somerset and Yeovil District Hospital NHS FT's SFI's~~2023 V1.0		
Approval Date	~~***** 2022~~ 24/6/24	**Where**	Finance Committee
Ratification Date	~~***** 2022~~ 2/7/24	**Where**	Trust Board~~Policy Review Group~~
Date of issue	July~~April~~ 2024~~3~~	**Review Date**	July~~April~~ 2027~~6~~
Applies to	All Staff	**Exclusions**	

SOMERSET NHS FOUNDATION TRUST FINANCIAL LIMITS – EASY REFERENCE GUIDE

<table>
<tr><th>Financial Limit £</th><th>Ordering Goods& Services& authorising</th><th>Capital Expenditure</th><th>Charitable Funds</th><th>Sale of Equipment</th><th>Income in Dispute (credit note)</th><th>Losses Write-off/special payments</th></tr>
<tr><td>0 ↓</td><td rowspan="2">Authorised signatory</td><td rowspan="5">Capital Delivery Group</td><td rowspan="3">Charitable Fund Holder</td><td>General Managers/ Directors</td><td rowspan="6">Assistant Director - Financial Services</td><td rowspan="2">Assistant Director - Financial Services/ Deputy Chief Finance Officer</td></tr>
<tr><td>250 ↓</td><td>As above with written quotations</td></tr>
<tr><td>1,000 ↓</td><td>Budget Holders</td><td rowspan="2">As above with prior approval by Chief Finance Officer</td><td rowspan="2">Chief Finance Officer</td></tr>
<tr><td>5,000 ↓</td><td rowspan="2">Service Group Managers</td><td>Chief Finance Officer</td></tr>
<tr><td>10,000 ↓</td><td rowspan="7">Charitable Fund Committee</td><td rowspan="7">Trust Board to declare surplus followed by full tendering procedure</td><td rowspan="7">Audit Committee</td></tr>
<tr><td>50,000 ↓</td><td>Board Directors/ Assistant Director - Financial Services/ Management</td><td rowspan="3">Strategic Estates Group</td></tr>
<tr><td>100,000 ↓</td><td rowspan="3">Deputy Chief Finance Officer</td><td rowspan="3">Deputy Chief Finance Officer</td></tr>
<tr><td>150,000 ↓</td></tr>
<tr><td>500,000 ↓</td><td rowspan="2">Finance Committee</td></tr>
<tr><td>750,000 ↓</td><td rowspan="2">Chief Finance Officer/Chief Executive</td><td rowspan="2">Chief Finance Officer/ Chief Executive</td></tr>
<tr><td>1,000,000 ↓</td><td>Trust Board</td></tr>
</table>

Appendix 1:

FINANCIAL LIMITS

Paragraph 2 on page 5 under the heading Interpretation of these SFIs states that “wherever a financial limit is stipulated but no value is given, reference should be made to the Trust’s decision on Financial Limits” The approved limits are set out below. The Board periodically reviews these Financial Limits:

1) Overall Financial Limits for sign off of invoices (subject to observance of the provisions of the SFIs relating to procurement	**Up to Authorisation Level £ (excluding VAT)**
Authorised Secondary List Signatory (e.g. ward sisters)	1,000
Budget holders / other authorised main list signatories (e.g. Clinical Service Manager)	5,000
Service Group Managers or equivalent (including Pharmacy) and their nominated deputies	50,000
Board Director	100,000
Assistant Director - Financial Services/Financial Management	100,000
Deputy Chief Finance Officer	750,000
Chief Finance Officer/Chief Executive	Over 750,000

2) Authorisation Limits For ordering (iProcurement)	**Authorisation Level £ (excluding VAT)**
Requisitioner	0
Authorised Secondary List Signatory (e.g. ward sisters)	1,000
Budget holders/other authorised main list signatories (e.g. Clinical	5,000

Service Manager)	
Service Group Managers or equivalent (including Pharmacy)	50,000
Board Director	100,000
Assistant Director - Financial Services/Financial Management	100,000
Deputy Chief Finance Officer	750,000
Chief Finance Officer/Chief Executive	Over 750,000

3) Procurement ~~Limits~~ thresholds for competition	**Authorisation Level £ (excluding VAT)**
Request for quotation	10,000
Request for tender	50,000
~~Requiring advertisement in Find a Tender~~Competition in accordance with Public Contracts Regulations and Provider Selection Regime	Current limit *

*The levels are amended at a national level and set pre–VAT. Advice should be sought from the Procurement Department as to the correct limit to apply in each situation

3A) Procurement Department Limits ***(note: These amounts set out the limits applicable to Procurement staff in executing orders that have been approved in accordance with sections 1,2,3&4 of appendix 1 and Appendix 3)***	**Authorisation Level £ (excluding VAT)**
Buyer	10,000

Senior Buyer	50,000
~~Assistant~~ Contracts Manager	100,000
~~Procurement~~ Senior Contracts Manager	250,000
Head of Procurement ~~/~~and Head of Supply Chain and Procurement Systems ~~Manager~~	Unlimited

Note: In the exceptional circumstances in which an authorised signatory wishes to delegate this responsibility to a more junior member of staff, this must be authorised by the Assistant Director-Financial Services/Financial Management (or above) for levels up to £200,000 (ex VAT) or by the Chief Finance Officer / Chief Executive if this is above £200,000.

4) Limits for entering of new contracts including products/services, maintenance, leases and managed services		
Level ~~inc~~ excluding VAT	**a) If contract awarded to the lowest cost bidder**	**b) If contract is not awarded to the lowest ~~scored bid~~cost bidder**
£50,000 or below	Main List signatory	Chief Finance Officer* or Chief Executive
Above £50,000	Main List signatory and an Executive Director	Chief Executive and Chief Finance Officer* ~~air (and reported to Board)~~
Above £1m	Approval by the Board	Approval by the Board

*or in their absence Deputy Chief Finance Officer

~~**Refer to the Scheme of Delegation for Procurement policies and procedures.**~~

5) Limits for entering of existing contracts and covered by delegated budgets or within financial plan. Include products, services, maintenance, leases and managed services for which the Trust already has had a contract in place		
Level ~~inc~~ excluding VAT	**c) If contract awarded to the lowest cost bidder**	**d) If contract is not awarded to the lowest ~~scored bid~~cost bidder**
£50,000 or below	Main List signatory	Chief Finance Officer* or Chief Executive
Above £50,000	Main List signatory and an Executive Director	Chief Finance Officer* or Chief Executive
Above £1m	Main list signatory and Chief Finance Officer*	Chief Finance Officer* ~~or~~ and Chief Executive

*or in their absence Deputy Chief Finance Officer

Appendix 2:
FINANCIAL LIMITS CHARITABLE TRUST FUNDS

Authorisation Level £	**Approval process**
Up to £5,000	To be authorised by the budget holder of the charitable fund
£5,000 to £10,000	A business case must be submitted to the Chief Finance Officer or Chief Executive for approval
Over £10,000	A business case must be submitted to the Charitable Funds Committee for approval. NB if there is not a forthcoming Charitable Trust Fund Committee, the business case must be submitted by e mail to the Charitable Trust Fund members for approval followed by ratification at the new Committee meeting.
Additional rules for Staff Appointments	All applications for funding that involve staff appointments must be submitted to the Charitable Funds Committee via the Chief Finance Officer using the prescribed staff appointments form (available from Finance).

SOMERSET NHS FOUNDATION TRUST

STANDING ORDERS

SOMERSET NHS FOUNDATION TRUST

STANDING ORDERS

1. INTRODUCTION

1.1. The Somerset NHS Foundation Trust (the "Trust") (previously known as the Somerset Partnership NHS Foundation Trust) became a Public Benefit Corporation on 1 May 2008 following authorisation by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act") and this Authorisation is of unlimited duration.

1.1. The principal place of business of the Trust is currently at Yeovil District Hospital, Higher Kingston, Yeovil, Somerset, BA21 4AT.

1.2. The Trust is governed by the 2006 Act, its Constitution and the terms of its Provider Licence granted by NHS Improvement (Monitor) (the Regulatory Framework). The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Trust Board and the Council of Governors of the Trust to adopt SOs for the regulation of its proceedings and business.

1.3. The Trust applies the principles of the NHS Foundation Trust Code of Governance, most recently revised in July 2014, which is based upon the principles of the UK Corporate Governance Code issues in 2012.

1.4. The SOs, Scheme of Delegation and SFIs provide a comprehensive business framework. All Executive Directors and Non-Executive Directors, all members of staff, and Governors should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1.5. As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.6. The Trust has a number of wholly and partially owned corporate entities. These corporate entities are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As separate, independent corporate entities, they are subject to their own governance arrangements, which are the responsibility of the relevant entity's management structure, and therefore these Standing Orders are not applicable. For avoidance of doubt, any matter reserved to the Trust in relation to such corporate entitles will be treated as an item of the Trust and will be considered in accordance with these Standing Orders.

1.7. The Chairman, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for Public Service, and the Care Quality Commission's Fit and Proper Person regulations. They will also ensure that they follow the best practice advice set out in the NHS Foundation Trust Code of Governance 2006 (the "Code") published by Monitor that sets out the overarching framework for compliance with the Regulatory Framework.

1.8. The Trust shall deal with NHS England/Improvement (Monitor) in an open and co-operative manner and shall promptly notify NHS England/Improvement (Monitor) of anything relating to the Trust of which NHS England/Improvement (Monitor) would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under its Provider Licence or any financial or performance thresholds which NHS England/Improvement (Monitor) may specify from time to time.

ANNEX 1 - STANDING ORDERS FOR THE COUNCIL OF GOVERNORS

(Ref. Paragraphs 19, 20 and 21)

CONTENTS:

1. DEFINITIONS

1.1. In these Standing Orders:

Annual Meeting
means a general meeting of the Council of Governors at which the annual accounts, annual report and external auditors' opinions are presented to the Council of Governors.

Clear Day
means a day of the week not including Saturday, Sunday or a public holiday.

Code of Conduct
means any code which the Trust may publish from time to time to govern or guide the conduct of the Council of Governors, Directors and Officers of the Trust.

Appointments Panel
means the Panel established in accordance with Annex 3.

Officer
means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

Returning Officer
means an employee of the Trust or any other person holding a paid appointment or office with the Trust who is administering and counting the e-mail votes for the issue(s) to be voted upon.

2. INTERPRETATION

2.1. Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the constitution.

2.2. for the purposes of these SOs, the "board" means the Board of Directors and the "Council" means the Council of Governors.

3. THE COUNCIL OF GOVERNORS

3.1. The roles and responsibilities of the Governors as set out in paragraph 24 of the Constitution also have effect as if incorporated into the SOs. Certain powers and decisions may only be exercised by the Council of Governors in formal session. These powers and decisions are set out in paragraphs 23, 24, 26 and 50.

3.2. The roles and responsibilities of the Council are to be carried out in accordance with the Regulatory Framework include the following:

3.2.1. to hold the Board to account for the performance of the Trust;

3.2.2. to respond as appropriate when consulted by the Board in accordance with the Constitution; and

3.2.3. to prepare and from time to time review the Trust's membership strategy.

3.3. The Council and each Governor individually shall at all times seek to comply with the Trust's Code of Governance and the Code of Conduct for the Council.

4. MEETINGS OF THE COUNCIL OF GOVERNORS

4.1. Admission of the Public

4.1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from all or part of a meeting on the grounds that:

4.1.1.1. any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

4.1.1.2. for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

4.1.2. The Chairman shall give such directions as he thinks fit (including a decision to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting).

4.1.3. Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chairman.

4.1.4. Matters to be dealt with by the Board or the Council following the exclusion of the public and representatives of the press under SO 4.1.1 above shall be confidential to the Governors.

Members of the Council and others in attendance at the request of the person chairing the meeting shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chairman.

4.1.5. The Chairman (or Deputy Chairman) will decide what arrangements and terms and conditions they feel are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board or the Council (as relevant), and may change, alter or vary these terms and conditions as it deems fit.

4.2. **Calling Meetings**

4.2.1. Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least 4 (four) meetings in any year including:

4.2.1.1. an annual meeting no later than the 30 September in each year, when the Council of Governors are to receive and consider the Annual Accounts, any report by the Auditor and the Annual Report; and

4.2.1.2. any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

4.2.2. Not less than 8 (eight) Governors may by notice in writing to the Secretary requisition an extraordinary meeting of the Council of Governors and on receipt of such notice the Secretary shall cause such a meeting to be called within 5 (five) working days of receipt of the notice.

4.2.3. The Council of Governors may invite the Chief Executive, member of the Board of Directors or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

4.2.4. The Council of Governors may agree that its Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 4.16 (Quorum).

4.3. **Notice of Meetings**

4.3.1. Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be

transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf, shall be delivered to, or sent by post to the usual place of residence of every Governor, so as to be available to them at least four (4) Clear Days before the meeting save in the case of emergencies.

4.3.2. Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least four (4) Clear Days before the meeting, save in the case of emergencies.

4.3.3. Want of service of the notice on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than five Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of posting or in the case of a notice being sent electronically, on the date of transmission.

4.3.4. In the case of a meeting called by Governors in default of the Secretary, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the requisition.

4.4. **Setting the Agenda**

4.4.1. The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2. A Governor of the Council of Governors desiring a matter to be included on an agenda, including a formal proposition for discussion and voting on at a meeting, shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5. **Petitions**

4.5.1. Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

4.6. **Written Motions**

4.6.1. In urgent situations and with the consent of the Chairman, business may be effected by a Governor's written motion to deal with business otherwise required to be conducted at a meeting of the Council of Governors.

4.6.2. If all Governors of the Council of Governors have been notified of the proposal and a simple majority of Governors entitled to attend and vote at a meeting of the Council of Governors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 (five) Clear Days of dispatch then the motion will be deemed to have been resolved, notwithstanding that the Governors have not gathered in one place.

4.6.3. The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date, a Governor who has previously indicated acceptance can withdraw, and the motion shall fail.

4.6.4. Once the resolution has been passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

4.6.5. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the Governor or Director who gives it and also the signature of four (4) other Governors or Directors. When any such motion has been disposed of by the Council or the Board, it shall not be competent for any Governor or Director other than the Chairman to propose a motion to the same effect within six (6) months, however the Chairman may do so if he considers it appropriate.

4.6.6. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.7. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or Director (as relevant) to move:

4.6.7.1. An amendment to the motion.

4.6.7.2. The adjournment of the discussion or the meeting.

4.6.7.3. That the meeting proceed to the next business (*).

4.6.7.4. The appointment of an ad hoc committee to deal with a specific item of business.

4.6.7.5. That the motion be now put to a vote (*).

4.6.7.6. That the public be excluded from the meeting in relation to the discussion concerning the proposition under SO 4.1.1.

4.6.8. In the case of SOs denoted by (*) above, to ensure objectivity motions may only be put by a Governor or a Director who has not previously taken part in the debate.

4.6.9. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.6.10. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.7. **Chairman of Meeting**

4.7.1. At any meeting of the Council of Governors, the Chairman, if present, shall preside.

4.7.2. If the Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chairman shall preside.

4.7.3. If the Deputy Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director shall preside.

4.7.4. Where it has been determined by the Chair that it is inappropriate for the Chairman or any non-executive director to chair the meeting, the Lead or Deputy Lead Governor shall preside.

4.8. **Agenda**

4.8.1. Where a Governor has requested inclusion of a matter on the agenda in accordance with SO 4.4.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 4.8 shall apply in respect of the proposition.

4.8.2. The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("Standing Items").

4.8.3. Agendas will be sent to Governors before the meeting and supporting papers, whenever possible, shall accompany the

agenda, but will certainly be despatched no later than 3 (three) Clear Days before the meeting, save in the case of emergencies. It is the responsibility of the Chairman to ensure that sufficient information is provided to Governors to ensure that rational discussion can take place.

4.8.4. In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in SO 4.3 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact Governors of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

4.8.5. No business may be transacted at any meeting of the Council which is not specified in the notice of that meeting unless the Chairman, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Council as a matter of urgency. A decision by the Chairman to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

4.9. **Report from the Board of Directors**

4.9.1. Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Board of Directors is required to report to the Council of Governors on the Trust's general progress and forward planning unless it is agreed in writing they will not do so.

4.10. **Chairman's Ruling**

4.10.1. Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11. **Voting**

4.11.1. A Governor may not vote at a meeting of the Council of Governors unless, within the 12 months prior to the commencement of the meeting they have:

4.11.2. made a declaration that they are a member of the constituency which elected them; or

4.11.3. if the Governor is an Appointed Governor, they are not prevented from being a governor of the Council

of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

4.11.4. Such declaration will be in the form as set out in paragraph 18 of the Constitution.

4.11.5. Subject to SO 4.11.7 below, every question at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and the Governors present and voting on the question.

4.11.6. Whoever is Chairman of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a second or casting vote.

4.11.7. A resolution for the removal of the Chairman or a Non-Executive Director shall be passed only if three quarters of the total number of Governors vote in favour of it.

4.11.8. If at least one-third of the Governors present so request, the voting (other than by paper ballot or e-mail vote) on any question may be recorded to show how each Governor present voted or abstained.

4.11.9. If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot or e-mail vote).

4.11.10. Subject to SO 4.17, a Governor may only vote if present at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote. For the avoidance of doubt, SO 4.11.11 does not apply if an e-mail vote is required under SO 4.17.

4.11.11. In certain circumstances, the Chairman may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three quarters of the Governors, and a majority of the elected Governors, approve the resolution in writing within the timescale imposed in such a notice.

4.12. **Minutes**

4.12.1. The minutes of the proceedings of a meeting shall be drawn up by the Secretary or a Nominated Officer and submitted for agreement at the next ensuing meeting of the

Council of Governors where they will be signed by the Chairman presiding at it.

4.12.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.12.3. Minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of SO 4.1.1 above.

4.13. **Suspension of Standing Orders**

4.13.1. Except where this would contravene any statutory provision or any guidance or best practice advice issued by NHS England/Improvement (Monitor), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Governors are present, there is a majority of Governors who are members of the Public Constituency of the Trust, and that a majority of those present vote in favour of suspension.

4.13.1.1. A decision to suspend the SOs shall be recorded in the minutes of the meeting.

4.13.1.2. A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Chairman and Governors.

4.13.1.3. No formal business may be transacted while the SOs are suspended.

4.13.1.4. The Audit Committee shall review every decision to suspend SOs.

4.14. **Variation and Amendment of Standing Orders**

4.14.1. Subject always to paragraph 54 of the Constitution, these SOs shall be amended only if:

4.14.1.1. a notice of proposal under SO 4.4.2 has been given; and

4.14.1.2. no fewer than half the total number of Governors vote in favour of amendment; and

4.14.1.3. no fewer than half of the total number of Governors is present; and

4.14.1.4. the variation proposed has been approved by the Council of Governors and does not contravene a statutory provision or guidance issued by NHS England/Improvement (Monitor) or the Constitution.

4.15. **Record of Attendance**

4.15.1. The names of the Chairman and Governors present at the meeting shall be recorded in the minutes.

4.16. **Quorum**

4.16.1. No business shall be transacted at a meeting unless at least half of the Governors are present, and of these not less than half shall be Governors elected from the Public or appointed by non Health Service Bodies.

4.16.2. If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a minimum period of 5 (five) Clear Days and upon reconvening, those present shall constitute a quorum.

4.16.3. If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 6, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.16.4. At all times all questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined in the first instance by oral expression or by a show of hands, unless the Chairman uses their discretion under SO 4.17 to hold an e-mail vote. At all times, no Governor may vote by proxy.

4.16.5. Chairman's discretion to hold an e-mail vote may be exercised at any time, and for any reason in consultation with the Lead Governor.

4.16.6. If the Chairman exercises their discretion to hold an e-mail vote, then the Governors must vote by e-mail by sending their e-mail vote back to the Returning Officer by the Deadline Date (as prescribed under SO 4.17 and as agreed

with the Lead Governor). For the avoidance of doubt, if the Chairman exercises their discretion to hold an e-mail vote, this e-mail vote will form the only method of voting.

4.16.7. Individual Governor may only cast one vote on the issue(s) to be voted on unless a second further vote is required owing to any previous vote not being passed in accordance with SO 4.11.5. Once an e-mail vote has been cast by a Governor in accordance with SO 4.17, the vote cannot be revoked or altered in any way.

4.17. **Protocol for Voting by e-mail**

4.17.1. The Returning Officer is to e-mail a notice of the e-mail vote stating:

4.17.1.1. The details of the issue(s) to be voted upon.

4.17.1.2. The date and time at which the e-mail votes are required to be sent out to the Governors.

4.17.1.3. The e-mail address for return of e-mail votes including the date and time by which they must be received by the Returning Officer ("Deadline Date") and

4.17.1.4. The contact details of the Returning Officer.

4.17.2. As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Returning Officer is to e-mail to the valid e-mail address of every Governor, the following information:

4.17.2.1. A ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail.

4.17.2.2. A Declaration of Eligibility form (if required). This form may be combined with the ballot paper.

4.17.2.3. Information about the issue(s) to be voted upon.

4.17.2.4. A covering e-mail providing:

4.17.2.4.1. The e-mail address for return of the ballot paper.

4.17.2.4.2. Clear instructions instructing the voter as to how to return their e-mail vote to the Returning Officer by the

Deadline Date ("e-mail voting information").

5. COMMITTEES

5.1. Subject to any guidance as may be issued by NHS England/Improvement (Monitor), the Council of Governors may and, if directed by NHS England/Improvement (Monitor), shall appoint committees of the Council of Governors consisting wholly or partly of its members to assist it in the proper performance of its functions under the Regulatory Framework.

5.2. The Council may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors and other persons to assist the Council in carrying out its functions. The Council may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

5.3. All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting.

5.4. A committee appointed under SO 5 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.5. These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms "Chairman" to be read as a reference to the Chairman of the committee, and the term "Governor" to be read as a reference to a member of the committee as the context permits.

5.6. Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance or best practice advice issued by NHS England/Improvement (Monitor), but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.7. Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.8. Any committee or sub-committee established under this SO 5 may call upon outside advisers to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out in paragraph 53 of the Constitution.

5.9. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.10. Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with guidance issued by NHS England/Improvement (Monitor).

5.11. Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS England/Improvement (Monitor).

5.12. The Council of Governors may appoint Governors to serve on joint committees with the Board of Directors or committees of the Board of Directors.

5.13. In making any recommendations, a committee of the Council must have due regard to the established policies of the Council and shall not depart from them without due reason and consideration. Any such departure and the reason for it shall be drawn to the attention of the Council at the earliest opportunity. The Council requires its committee to refer back to them for a decision.

5.14. In consideration of any recommendation, a committee of the Council must comply with:

5.14.1. The Trust's Standing Financial Instructions, SOs and written procedures and specific reference to the relevant sections of these documents should be made.

5.14.2. Any statutory provisions or requirements.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1. Declaration of Interests

6.1.1. The Regulatory Framework requires each Governor to declare to the Secretary:

6.1.1.1. any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 6.2.1; and

6.1.1.2. any actual or potential pecuniary interest, direct or indirect, in any matter concerning the Trust, as described in SOs 6.2.3 and 6.2.4; and

6.1.1.3. any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in SO 6.2.6.

6.1.2. Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, and in a form prescribed by the Secretary which shall be included as Schedule A to these SOs.

6.1.3. In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

6.1.4. If a Governor has a pecuniary interest, whether direct or indirect, or any material non-financial interest in any contract, proposed contract or other matter which is under consideration by the Council of Governors, they shall disclose that to the rest of the Council of Governors as soon as they are aware of it.

6.1.5. At the time the interests are declared, they should be recorded in the Council of Governors meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.6. Subject to SO 6.2.5, if a Governor has declared a pecuniary interest (as described in SO 6.2.3 and 6.2.4 they shall not take part in the consideration or discussion of the matter.

6.1.7. This SO 6 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a Governor).

6.1.8. The interests of Governors in companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

6.2. **Nature of Interests**

6.2.1. Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England/Improvement (Monitor):

6.2.1.1. directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

6.2.1.2. ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; or

6.2.1.3. majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS; or

6.2.1.4. a position of authority in a charity or voluntary organisation in the field of health and social care; or

6.2.1.5. any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; or

6.2.1.6. any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

6.2.2. For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

6.2.2.1. Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange.

6.2.2.2. An employment contract held by Staff Governors.

6.2.2.3. An employment contract with the relevant local authority held by a Local Authority Governor.

6.2.2.4. An employment contract with a Partnership Organisation held by a Partnership Governor.

6.2.3. A Governor shall be treated as having indirectly a pecuniary interest in a matter, if:

6.2.3.1. They, or a nominee of them, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

6.2.3.2. They are a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.2.4. A Governor shall not be treated as having a pecuniary interest in any matter by reason only:

6.2.4.1. of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

6.2.4.2. of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.2.4.3. of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

6.2.5. Where a Governor:

6.2.5.1. has an indirect pecuniary interest in a matter by reason only of a beneficial interest in securities of a company or other body, and

6.2.5.2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

6.2.5.3. if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not

exceed one-hundredth of the total issued share capital of that class,

the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

6.2.6. A family interest is an interest of an Immediate Family Member of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of them.

6.2.7. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3. **Register of Governors**

6.3.1. The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted which may be the Secretary.

6.4. **Register of Governors' Interests**

6.4.1. The Secretary shall keep a register of interests of Governors which shall contain the names of each Governor, whether he has declared any interest, and if so, the interest declared.

7. STANDARDS OF BUSINESS CONDUCT

7.1. Governors of the Council of Governors shall comply with the NHS Foundation Trust Code of Governance, the Council of Governors' Code of Conduct and any guidance or best practice advice issued by NHS England/Improvement (Monitor).

8. APPOINTMENTS AND RECOMMENDATIONS

8.1. A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.2. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.3. Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any Governor or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4. The Chairman and every Governor shall disclose to the Chief Executive or their delegated officer any relationship between themselves and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Chief Executive or their delegated Officer to report to the Council of Governors any such disclosure made.

8.5. On appointment, Governors of the Council of Governors should disclose to the Council of Governors whether they are related to any other Governor of the Council of Governors or holder of any office in the Trust.

8.6. Where the relationship to a Governor of the Council of Governors of the Trust is disclosed, SO 6 shall apply.

9. MISCELLANEOUS

9.1. The Secretary shall provide a copy of these SOs to each Governor and endeavour to ensure that each Governor understands their responsibilities within these SOs.

9.2. These SOs including all documents having effect as if incorporated in them shall be reviewed annually by the Board of Directors and the Council of Governors.

9.3. If for any reason these SOs 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 formal meeting of the Council of Governors for action or ratification. All Governors have a duty to disclose any non-compliance with these SOs to the Chairman as soon as possible.

Schedule A

Prescribed Form of Declaration of Interests

Declaration to the Secretary of Somerset NHS Foundation Trust

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Date [insert]

To the Secretary of Somerset NHS Foundation Trust

Dear [insert]

In fulfilment of the obligations imposed on me by paragraph 16 of the Constitution of the Somerset NHS Foundation Trust and the provisions of Standing Order 6 of the Standing Orders for the Council of Governors generally, I hereby give notice to the Trust of my interest in **[**insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non pecuniary, direct, indirect, actual, potential, etc.)**]** as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's register of interests of the Governors of the Council of Governors.

Yours faithfully

[name]

ANNEX 2 - BOARD OF DIRECTORS STANDING ORDERS
(Ref. Paragraph 32)

CONTENTS:

1 INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of SOs (on which they should be advised by the Chief Executive and Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act or any regulations or orders made under the 2006 Act shall have the same meaning in these SOs and, in addition, defined terms used in these SOs have the same meaning as in the Constitution unless the context requires otherwise, or a contrary intention is evident.

1.3 Words importing the singular shall include the plural and vice-versa.

1.4 In these SOs:

"Accounting Officer"
means the Officer responsible for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust is shall be the Chief Executive.

"Board of Directors"
means the Board of Directors as constituted in accordance with the Constitution.

"Budget"
means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chairman"
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "the Chairman" shall be deemed to include the Deputy Chairman or any other non-executive appointed in accordance with paragraph 26 of the Constitution if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive"
means the Chief Executive officer of the Trust.

"Clear Days"
means a day of the week not including a Saturday, Sunday or Public Holiday.

"Concode"
means a code of procedure for building and engineering contracts for the NHS.

“Constitution”
means the Constitution of the Trust, together with the Annexes and Appendices attached hereto as approved by NHS England/Improvement (Monitor).

“Council of Governors”
means the Council of Governors as constituted in this Constitution, which has the same meaning as the “Council of Governors” in the 2006 Act.

“Director”
means a member of the Board of Directors appointed in accordance with the Constitution and includes both executive and non-executive Directors and the phrase “member of the Board” shall be construed accordingly.

“Finance Director”
means the Director of Finance of the Trust.

"Funds held on Trust"
means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Section 14 of Part 2, Schedule 4 to the 2006 Act. Such funds may or may not be charitable.

“Member”
means a member of the Trust.

"Motion”
means a formal proposition to be discussed and voted on during the course of a meeting.

“NHS England/Improvement”
means the body corporate known as NHS England/Improvement (Monitor), the successor body of Monitor, as provided by Section 61 of the 2012 Act.

"Nominated Officer"
means an Officer charged with the responsibility for discharging specific tasks within the SOs and the SFIs.

“Officer”
means an employee or any other person holding a paid appointment or office with the Trust.

“Scheme of Delegation”
means the Reservation of Powers to the Board of Directors and Delegation of Powers.

"Secretary to the Trust"
means a person appointed by the Trust to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors and the Chairman and to monitor the Trust's compliance with the Regulatory Framework, the Standing Orders, and regulatory guidance.

"SFIs"
means Standing Financial Instructions.

"SOs"
means these Standing Orders.

"the 2006 Act"
means the National Health Service Act 2006.

"Trust"
means the Somerset NHS Foundation Trust.

"Trust Headquarters"
means Musgrove Park Hospital, Taunton, Somerset, TA1 5DA

"Vice Chairman"
means a non-executive Director appointed by the Council of Governors to undertake the Chairman's duties in the event that the Chairman is absent for any reason.

2 THE TRUST BOARD

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Trust.

2.4 The Trust has the functions conferred on it by its Provider Licence issued by NHS Improvement (Monitor). Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees. Accountability for charitable Funds held on Trust is to the Charity Commission. Accountability for non-charitable Funds held on Trust is only to NHS England/Improvement (Monitor).

2.5 The powers of the Trust established under statute shall be exercised by the Board of Directors meeting in public/ private session except as otherwise provided for in SO 4.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

2.7 **Composition of the Board of Directors**

2.7.1 In accordance with the Constitution, the Board of Directors is to comprise:

2.7.1.1 The following Non-Executive Directors:

2.7.1.1.1 the Chairman, and up to a maximum of 9 (nine) other Non-Executive Directors.

2.7.1.2 the following Executive Directors:

2.7.1.2.1 the Chief Executive who shall be the Accounting Officer, the Finance Director, and up to a maximum of 6 (six) other Directors as set out in paragraph 31 of the Constitution.

2.7.2 At meetings of the Board of Directors, in the event that the number of Non-Executive Directors (including the Chairman) is equal to the number of Executive Directors, the Chairman (and in their absence, the Deputy Chairman) shall have a second or casting vote.

2.7.3 A person may only be appointed as a Non-Executive Director if:

2.7.3.1 They are a member of the Public Constituency, and

2.7.3.2 They are not eligible by virtue of paragraph 34 of the Constitution or disqualified by virtue of paragraph 35.

2.7.4 The validity of any act of the Board of Directors is not affected by any vacancy among the Directors or any defect in the appointment of a Director.

2.7.5 The Chairman (in consultation with the Council of Governors) will appoint a Non-Executive Director as the "senior independent director", for such period not exceeding the remainder of their term as a Non-Executive Director as they may specify on appointing them.

2.7.6 Any Non-Executive Director so appointed may at any time resign from the office of "senior independent director" by

giving notice in writing to the Chairman. The Chairman (in consultation with the Council of Governors) will thereupon appoint another Non-Executive Director as "senior independent director" in accordance with the provisions in SO 2.7.5.

2.7.7 The "senior independent director" shall perform the role set out in the Code of Governance.

2.8 **Register of Directors**

2.8.1 In accordance with paragraphs 41 and 42 of the Constitution, the Trust shall keep and maintain a register of Directors which shall list the names of the Directors, their capacity on the Board of Directors and an address through which they may be contacted which may be the Secretary.

2.9 **Appointment and Removal of the Chairman and other Non-Executive Directors**

2.9.1 The Chairman and other Non-Executive Directors are to be appointed by the Council of Governors following a formal, rigorous and transparent procedure. The current Chairman or a Non-Executive Director may stand for reappointment. Six months before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Council of Governors will adopt a procedure as set out in Annex 3 for appointing the Chairman and the Non-Executive Directors.

2.9.2 The provisions of paragraph 32 of the Constitution apply to the removal of the Chairman or other Non-Executive Directors.

2.10 **Remuneration and Terms of Office of the Chairman and Non-Executive Directors**

2.10.1 The Chairman and the Non-Executive Directors are to be appointed for a period of office determined by the Council of Governors at a general meeting of the Council of Governors.

2.10.2 At the general meeting of the Council of Governors referred to at SO 2.10.1 the Council of Governors shall decide the:

2.10.2.1 period of office;

2.10.2.2 remuneration and allowances; and

2.10.2.3 other terms and conditions of office, including the job description, of the Chairman and other Non-Executive Directors.

2.11 **Appointment and Powers of Deputy Chairman**

2.11.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman and in accordance with paragraph 36 of the Constitution, the Council of Governors shall appoint a Non-Executive Director to be Deputy Chairman for such period, not exceeding the remainder of their term as Non-Executive Director, as the Council of Governors may specify on appointing them.

2.11.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Council of Governors. The Council of Governors may thereupon appoint another Non-Executive Director as Deputy Chairman in accordance with the provisions of SO 2.11.1.

2.11.3 Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chairman will be "acting chairman" until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these SOs shall, so long as there is no Chairman able to perform their duties, be taken to include references to the Deputy Chairman. Where both the Chairman and Deputy Chairman are unable to perform their duties owing to illness, conflict of interest or any other cause, another Non-Executive Director as may be appointed by the Council of Governors shall act as Chairman.

2.12 **Remuneration and Terms of Office of the Chief Executive and Executive Directors**

2.12.1 The Trust shall establish a committee of Non-Executive Directors in accordance with SO 33 to decide the:

2.12.1.1 remuneration and allowances; and

2.12.1.2 the other terms and conditions of office of the Chief Executive and other Executive Directors.

2.13 **Disqualification**

2.13.1 Directors are subject to the disqualification criteria included at paragraphs 34 and 35 of the Constitution.

3 MEETINGS OF THE TRUST

3.1 Admission of the Public and the Press

3.1.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, to be determined by the Board of Directors.

3.1.2 Before holding a public meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding the meeting, the Board of Directors will send a copy of the minutes of the meeting to the Council of Governors. Want of service of the agenda and minutes of the Board meeting on any Governor shall not affect the validity of a meeting.

3.1.3 The public and representatives of the press shall be afforded facilities to attend public meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest".

3.1.4 The Chairman shall give such directions as they thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public.

3.1.5 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.1.6 Matters to be dealt with by the Board following the exclusion of the public and representatives of the press under SO 3.1.4

above shall be confidential to the Directors. Members of the Board and others in attendance at the request of the person chairing the meeting shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chairman.

3.1.7 The Chairman (or Deputy Chairman) will decide what arrangements and terms and conditions they feel are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board, and may change, alter or vary these terms and conditions as they deem fit.

3.2 **Calling Meetings**

3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.2.2 The Chairman may call a meeting of the Board of Directors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of the Directors, and this has been presented to them, or if, without so refusing, the Chairman does not call a meeting within 7 (seven) days after such requisition has been presented to them, such one third or more members of the Board of Directors may forthwith call a meeting.

3.3 **Notice of Meetings**

3.3.1 Before each meeting of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman, or by an Officer of the Trust authorised by the Chairman to sign on their behalf, shall be delivered to every Director, or sent by post and where possible by email to the usual place of residence of every Director, so as to be available to them at least 4 (four) Clear Days before the meeting.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting.

3.3.3 In the case of a meeting called by the Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Failure to serve such a notice on more than 3 (three) Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.3.5 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite 4 (four) Clear Days' notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4 **Agendas**

3.4.1 Agendas will be dispatched by post and by email to members of the Board of Directors 4 (four) Clear Days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 (three) Clear Days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after dispatch.

3.4.2 Before each meeting of the Board of Directors (where SO 3.1.2 applies), a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's Headquarters at least 3 (three) Clear Days before the meeting.

3.4.3 No business may be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chairman, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Board as a matter of urgency. A decision by the Chairman to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

3.5 **Setting the Agenda**

3.5.1 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting, subject to SO 3.3. Requests

made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman. Agendas will be sent to Directors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 (three) Clear Days before the meeting, save in the case of emergencies. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6 **Petitions**

3.6.1 Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

3.7 **Chairman of Meeting**

3.7.1 At any meeting of the Board of Directors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and they are present, shall preside. If the Chairman and Deputy Chairman are absent such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

3.7.2 If the Chairman is absent temporarily on the grounds of a declared conflict of interest, the Deputy-Chairman, if present, shall preside. If the Chairman and Deputy-Chairman are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose shall preside.

3.8 **Chairman's Ruling**

3.8.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time, and subject to SO 1.1 the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9 **Notices of Motion**

3.9.1 Subject to the provisions of SO 3.11 ('Motions: procedure at and during a meeting') and SO 3.12 ('Motion to rescind a resolution'), a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chairman.

3.9.2 The notice shall be delivered at least 10 (ten) Clear Days before the meeting. The Chairman shall include in the agenda

for the meeting all notices so received that are in order and permissible under these SOs. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10 **Emergency Motions and Written Motions**

3.10.1 **Emergency Motions**

3.10.1.1 Subject to the agreement of the Chairman, and subject also to the provision of SO 3.11 ('Motions: procedure at and during a meeting'), a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.10.2 **Written Motions**

3.10.2.1 In urgent situations and with the consent of the Chairman, business may be effected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

3.10.2.2 If all members of the Board of Directors have been notified of the proposal and a simple majority of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 (five) Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.

3.10.2.3 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a Director who has previously indicated acceptance can withdraw and the motion shall fail.

3.10.2.4 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

3.11 **Motions: Procedure at and during a meeting**

3.11.1 **Who may propose**

3.11.1.1 A motion may be proposed by the Chairman of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

3.11.2 **Contents of motions**

3.11.2.1 The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

3.11.2.1.1 the reception of a report;

3.11.2.1.2 consideration of any item of business before the Board of Directors;

3.11.2.1.3 the accuracy of minutes;

3.11.2.1.4 that the Board of Directors proceed to next business;

3.11.2.1.5 that the Board of Directors adjourn;

3.11.2.1.6 that the question be now put.

3.11.3 **Amendments to motions**

3.11.3.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

3.11.3.2 Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board of Directors.

3.11.3.3 If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.3.4 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

3.11.4 **Rights of reply to motions**

3.11.4.1 Amendments

3.11.4.1.1. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

3.11.4.2 Substantive/original motion

3.11.4.2.1. The Director who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 **Withdrawing a motion**

3.11.5.1 A motion or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.11.6 **Motions once under debate**

3.11.6.1 When a motion is under debate, no motion may be moved other than:

3.11.6.1.1. an amendment to the motion;

3.11.6.1.2. the adjournment of the discussion, or the meeting;

3.11.6.1.3. that the meeting proceed to the next business;

3.11.6.1.4. that the question should be now put;

3.11.6.1.5. the appointment of an 'ad hoc' committee to deal with a specific item of business;

3.11.6.1.6. a motion under SO 3.1.3 resolving to exclude the public (including the press); and

3.11.6.1.7. that a member be not further heard.

3.11.6.2 In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

3.11.6.3 If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.11.6.4 The mover of a motion shall have a maximum of 5 (five) minutes to move and 5 (five) minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak more than once or for more than 5 (five) minutes.

3.12 **Motion to Rescind a Resolution**

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 (six) calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of 4 (four) other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chairman to propose a motion to the same effect within 6 (six) months however the Chairman may do so if he considers it appropriate. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13 **Voting**

3.13.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the chairman of the meeting shall have a second or casting vote. For any avoidance of doubt, for voting, there must not be more Executive Directors voting than Non-Executive Directors.

3.13.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.13.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.

3.13.4 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.13.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.13.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.14 **Minutes**

3.14.1 The minutes of the proceedings of a meeting shall be drawn up by the Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained in the Chief Executive's office.

3.14.3 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.15 Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any guidance or best practice advice issued by NHS England/Improvement (Monitor), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

3.15.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

3.15.4 No formal business may be transacted while the SOs are suspended.

3.15.5 The Audit Committee shall review every decision to suspend the SOs.

3.16 Variation and Amendment of Standing Orders

3.16.1 Subject always to paragraph 38 of the Constitution, these SOs shall be amended only if:

3.16.1.1 relevant notice of a meeting has been served in accordance with SO 3.3;

3.16.1.2 a notice of motion under SO 3.9 has been given;

3.16.1.3 no fewer than half the total of the Non-Executive Directors vote in favour of amendment;

3.16.1.4 at least two-thirds of the Directors are present; and

3.16.1.5 the variation proposed does not contravene the Regulatory Framework, any statutory provisions or any guidance issued by Monitor.

3.17 Record of Attendance

3.17.1 The names of the Directors present at the meeting shall be recorded in the minutes.

3.18 **Quorum**

3.18.1 No business shall be transacted, where a vote is required, at a meeting of the Board of Directors unless at least two Executive Directors, two Non-Executive Directors and the Chairman, or nominated Deputy Chairman for the purpose of this meeting, are present and to be properly constituted the number of Non-Executive Directors (including the Chairman) voting must exceed the number of Executive Directors. This paragraph should be read in conjunction with paragraph 3.13.1.

3.18.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.18.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7)7 they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Nomination and Remuneration Committee).

3.19 **Joint Directors**

3.19.1 Where a post of Executive Director is shared by more than one person:

3.19.1.1 both persons shall be entitled to attend meetings of the Board;

3.19.1.2 either of those persons shall be eligible to vote in the case of an agreement between them;

3.19.1.3 in the case of disagreements between them no vote shall be cast; and

3.19.1.4 the presence of either or both of those person shall count as one person for the purposes of SO 3.13.

3.20 **Meetings: Electronic Communication**

3.20.1 In this SO, "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

3.20.2 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.20.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.20.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

3.20.5 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.6 and such guidance as may be issued by NHS England/Improvement (Monitor), the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 4.3 below or by a Director or an Officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2 **Emergency Powers**

4.2.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency be exercised by the Chief

Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 **Delegation to committees**

4.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or subcommittees, or joint committees, which it has formally constituted. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.3.2 When the Board is not meeting as the Trust in formal session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in formal session.

4.4 **Delegation to Officers**

4.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

4.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the Finance Director shall be accountable to the Chief Executive for operational matters.

4.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.5 **Delegation of Powers – Scheme of Delegation**

4.5.1 Under the SOs relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5.1.1 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in a separate document (the Scheme of Delegation). That document has effect as if incorporated into the SOs.

4.6 **Duty to Report Non-Compliance with Standing Orders**

4.6.1 If for any reason these SOs 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 formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and all Officers have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

5 COMMITTEES

5.1 **Appointment of Committees**

5.1.1 Subject to SO 2.6, the Regulatory Framework and such guidance issued by NHS England/Improvement (Monitor), the Board of Directors may and, if directed by NHS England/Improvement (Monitor), shall appoint committees of the Trust consisting wholly or partly of Directors or other Health Service Bodies or wholly of persons who are not Directors of the Trust or other Health Service Bodies.

5.1.2 A committee appointed under SO 5.1.1 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be issued by NHS England/Improvement (Monitor) or the Board of Directors or other Health Service Bodies in question, appoint sub-committees or sub-groups consisting wholly or partly of Directors or wholly of persons who are not Directors of the Trust, the committee of the Trust or the other Health Service Bodies in question.

5.1.3 The SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-groups established by the Board of Directors, in which case

the term “Chairman” is to be read as a reference to the Chairman of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

5.1.4 Each such committee, sub-committee or sub-group shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any legislation, and/or regulations and/or such guidance or best practice advice issued by Monitor. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees or sub-groups they may not delegate executive powers to the sub-committee/group unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.1.7 Where the Board of Directors is required to appoint persons to a committee and/or undertake statutory functions as required by the Secretary of State and/or NHS England/Improvement (Monitor), and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and guidance made by NHS England/Improvement (Monitor).

5.1.8 Where the Board determines, and legislation, regulations and directions or guidance issued by NHSI permit that persons who are not Directors of the Trust shall be appointed to a committee of the Board, the terms of such appointment shall be determined by the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses.

5.1.9 The committees established by the Board of Directors are:

5.1.9.1 Audit Committee;

5.1.9.2 Nomination and Remuneration Committee;

5.1.9.3 Charity Committee;

5.1.9.4 Finance Committee;

5.1.9.5 Quality and Governance Assurance Committee;

5.1.9.6 People Committee; and

5.1.9.7 Mental Health Act Committee

5.1.10 The terms of reference of those committees and sub-groups shall be agreed by the Board of Directors.

5.1.11 Notwithstanding the provisions of SO 5.1.9 above, the Board of Directors may establish other committees and sub-groups from time to time at its discretion.

5.2 **Confidentiality**

5.2.1 A member of a committee, sub-committee or joint committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.2.2 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6 INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution.

6.2 The Directors, having regard to the views of the Council of Governors, are to prepare the Forward Plan in respect of each Financial Year to be given to NHS England/Improvement (Monitor).

6.3 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the Auditor on them, and the Annual Report.

6.4 The Annual Report is to give:

6.4.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership;

6.4.2 information on each non-executive director determining whether each is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement, with particular reference to paragraph 40 of the Constitution; and

6.4.3 any other information which NHS England/Improvement (Monitor) requires.

6.5 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 42 – 44 of the Constitution is included on the agenda for a meeting of the Board of Directors.

6.6 If the Council of Governors so desires such a matter as described within SO 6.5 to be included on an agenda item, they shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting of the Board of Directors, subject to SO 3.3. The Chairman shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Secretary:

7.1.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter which is under

consideration concerning the Trust or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust, irrespective of whether those interests are direct or indirect, actual or potential'

7.2 Directors should declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within 7 (seven) Clear Days of becoming aware of the existence of a relevant and material interest.

7.4 If a declaration under SO 7.1 or 7.2 above provided to be, or becomes, inaccurate or incomplete, the Director must make a further declaration before the Trust enters into the transaction or arrangement. This does not require a declaration of an interest of which the Director is not aware or whether the director is not aware of the transaction or arrangement in question.

7.5 A Director need not declare an interest:

7.5.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

7.5.2 if, or to the extent that, the Directors are already aware of it;

7.5.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered by:

7.5.4 a meeting of the Board of Directors, or

7.5.5 by a committee of the Directors appointed for the purpose.

7.6 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.7 If a Director has declared a pecuniary interest in accordance with SO 7.8 below they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and

shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.8 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England/Improvement (Monitor):

7.8.1 Directorships, including Non-Executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

7.8.2 ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

7.8.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

7.8.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.8.5 any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

7.8.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

7.9 Any travelling or other expenses or allowances payable to a Director in accordance with the Constitution shall not be treated as a pecuniary interest.

7.10 Members of the Board of Directors of companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.11 A Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.11.1 they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.11.2 they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.12 For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

7.12.1.1 Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange;

7.12.1.2 An employment contract held by Staff Governors;

7.12.1.3 An employment contract with the relevant local authority held by a Local Authority Governor;

7.12.1.4 An employment contract with a Partnership Organisation held by a Partnership Governor.

7.13 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.13.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.13.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.14 Where a Director:

7.14.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

7.14.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

7.14.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from

voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

7.15 In the case of Immediate Family members, the interest of one Immediate Family member shall, if known to the other, be deemed for the purposes of the Constitution and the SOs to be also an interest of the other.

7.16 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.17 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 to Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.18 SO 7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a Director) and will need to be read in conjunction with the applicable policy.

7.19 **Register of Interests**

7.19.1 The register of interests of Directors shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

7.19.2 It is the obligation of the Director to inform the Secretary in writing within 7 (seven) Clear Days of becoming aware of the existence of a relevant or material interest. The Secretary must amend the appropriate register of interests of Directors upon receipt of new or amended information as soon as is practical and, in any event, within 14 (fourteen) days.

7.19.3 The register of interests of Directors will be available to the public and the Chairman will take reasonable steps to bring the existence of the register of interests of Directors to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the register of interests of Directors must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests.

7.19.4 The details of Directors' interests recorded in the register of interests of Directors will be kept up to date by means of a

regular review as necessary of the register of interests of Directors by the Chief Executive or Secretary during which any changes of interests recently declared will be incorporated.

8 STANDARDS OF BUSINESS CONDUCT

8.1 Policy

8.1.1 Directors and Officers should comply with the NHS Foundation Trust Code of Governance, the Nolan Principles, Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England and any guidance and best practice advice issued by NHS England/Improvement (Monitor). This section of the SOs should be read in conjunction with these documents.

8.1.2 Directors and Officers should also comply with provisions of the Trust's Fraud Response Plan and Anti Bribery Policy.

8.2 Interest of Directors and Employees in Contracts

8.2.1 If it comes to the knowledge of Director or an Officer that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Secretary of the fact that they are interested therein. In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if known to the other, be deemed to be also the interest of that Immediate Family Member.

8.2.2 A Director or Officer must also declare to the Chief Executive or Secretary any other employment or business or other relationship of their, or of an Immediate Family Member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the register of interests of Directors.

8.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

8.3.1 Canvassing of Directors or members of any committee, sub-committee or joint committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.4 **Relatives of Directors or Officers**

8.4.1 Directors and Officers shall bear in mind that candidates for any staff appointment shall when making an application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 The Directors and Officers shall disclose to the Chief Executive any relationship between themself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an Officer or another Director to a Director of the Trust is disclosed, SO 7 shall apply.

8.5 **External Consultants**

8.5.1 SO 8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Scheme of Delegation should be adhered to at all times.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal**

9.1.1 The Common Seal of the Trust shall be kept by the Secretary to the Trust or Nominated Officer in a secure place.

9.2 **Sealing of Documents**

9.2.1 The Common Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof or where the Board of Directors has delegated its powers.

9.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an Officer nominated by them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them who shall not be within the originating directorate).

9.3 **Register of Sealing**

9.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11 MISCELLANEOUS

11.1 **Standing Orders to be given to Members and Officers**

11.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and the SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be

informed in writing and shall receive copies, where appropriate, of the SOs.

11.2 **Documents having the standing of Standing Orders**

11.2.1 The SFIs and the Scheme of Delegation shall have the effect as if incorporated into the SOs.

11.3 **Review of Standing Orders**

11.3.1 The SOs shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs. For the avoidance of doubt, any changes to the SFIs and Scheme of Delegation only requires Board of Directors' approval.

11.4 **Corporate Documents**

11.4.1 Any corporate documents specific to the setting up of the Trust shall be held in a secure place by the Chief Executive.

ANNEX 3 - STANDING ORDERS

TENDERING AND CONTRACT PROCEDURE

CONTENTS*:*

1 DUTY TO COMPLY WITH STANDING ORDERS

1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and the Trust's Standing Financial Instructions (SFIs) (except where SO 3.15. (Suspension of SOs) is applied).

1.2 EU Directives and Acts Governing Public Procurement

1.2.1 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs.

1.2.2 The Bribery Act 2010, which came into effect on 1 July 2011, makes it a criminal offence to give promise or offer a bribe, and to request, agree to receive or accept a bribe, either at home or abroad. The Bribery Act 2010 shall have effect as if incorporated in these SOs.

1.2.3 The Trust shall adopt as good practice the requirements of the NHS England Business Case Approvals Process for Capital Investment, Property, Equipment and ICT 14 August 2013 Publications Gateway Reference: 00324 and Health Building Note 00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities and associated relevant guidance issued by Monitor/NHS England/Improvement (Monitor) in respect of capital investment and estate and property transactions, including the "Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts November 2016.

1.2.4 In the case of management consultancy contracts the Trust shall adopt, as far as is practicable, the NHS Executive guidance "The Procurement and Management of Consultants within the NHS". The Trust will also comply with the Guidance from NHS England/Improvement (Monitor) entitled "Best Practice in Making Investments" and the Regulatory Framework.

1.2.5 The Trust should have policies and procedures in place for the control of all tendering activity.

1.3 Formal Competitive Tendering

1.3.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and

for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health or other regulatory organisations); for the design, construction and maintenance of building and engineering works (including construction and concession contracts); and for disposals.

1.3.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

1.3.2.1 the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 excl VAT (this figure to be reviewed annually); Or

1.3.2.2 the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

1.3.2.3 where the requirement is covered by an existing national, regional or local contract or framework

1.3.2.4 where provided for in regulatory guidance.

1.3.3 Formal tendering procedures may be waived by Officers to whom powers have been delegated by the Chief Executive:

1.3.3.1 in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstance are detailed in an appropriate Trust record;

1.3.3.2 where the timescale genuinely precludes competitive tendering (failure to plan the work properly is not a justification for single tender);

1.3.3.3 where it is apparent from the specification that specialist expertise is required to meet it and the expertise is only available from one source;

1.3.3.4 where the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

1.3.3.5 where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

1.3.4 The waiving of competitive tendering procedures should not be used:

1.3.4.1 to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure;

1.3.4.2 for building and engineering construction works, and maintenance (other than in accordance with Concode or other relevant regulatory guidance) without Departmental of Health and Social Care approval.

1.3.5 Where it is decided that competitive tendering is not applicable and should be waived by virtue of SO 1.3.3.1 to SO 1.3.3.4 above the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported by the Chief Executive to the Audit Committee.

1.3.6 Except where SO 1.3.2 and SO 10.3.3, or a requirement under SO 1.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and where possible, no less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

1.3.7 Items estimated to be below the limit set in this Standing Order for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

1.3.8 The Board of Directors shall review the Tendering Procedure at least every two years.

1.4 **Invitation to tender**

1.4.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

1.4.2 All invitations to tender shall be by an e-tendering software package. The suppliers response shall be completed on-line and uploaded into a secure electronic mailbox until the opening time.

1.4.3 Every tender for goods, materials, 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 SO 1.4.4 and 1.4.5 below.

1.4.4 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

1.4.5 Every tender for building or engineering works (except for maintenance work, when Estatecode or other relevant regulatory guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical 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 Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the Department of Health and Social Care or modified and/or amplified to accord with guidance issued by NHS England~~/Improvement (Monitor)~~ and the Department of Health and Social Care and, in minor respects, to cover special features of individual projects.

1.4.6 Each significant member of Trust staff involved in the tendering process must declare any interests relating to the project they are overseeing.

1.5 Receipt and safe custody of Formal tenders

1.5.1 The tender documents will be stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the data and time the offer

documents are received.

1.6 **Opening Formal tenders**

1.6.1 Where an electronic tendering package is used the tender documents will be opened electronically by two independent professionals from the procurement service.

1.6.2 Each significant member of staff involved in the tendering process is to declare any interests relating to the project they are overseeing. Where an 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.

1.6.3 All actions by both procurement staff and suppliers shall be recorded within the system audit reports.

1.7 **Admissibility**

1.7.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

1.7.2 Where only one tender is sought and/or received, the Chief Executive and ~~Director of~~ Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

1.8 **Late tenders**

1.8.1 Tenders received after the due time and date, but before the opening of the other tenders, may be considered only if the Chief Executive or their Nominated Officer decides that there are exceptional circumstances, eg 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.

1.8.2 The Chief Executive 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 shall be reported to the Board at its next meeting.

1.8.3 Technically late tenders (ie those despatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

1.8.4 Incomplete tenders (ie those from which information necessary for the adjudication of the tender is missing) and amended tenders (ie those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) will be dealt with in the same way as late tenders.

1.8.5 Where examination of tenders reveals errors or incompleteness which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

1.8.6 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, and the process of evaluation shall not be started.

1.9 **Acceptance of formal tenders**

1.9.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

1.9.2 A tender other than the lowest whole life cost (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless for good and sufficient reason and the decision and reason recorded as a written record using the appropriate Tender Acceptance Authorisation Form.

1.9.3 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

1.9.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.

1.9.5 The use of these procedures must demonstrate that the award of the contract was:

1.9.5.1 not in excess of the going market rate/price current at the time the contract was awarded, and

1.9.5.2 achieved best value for money.

1.9.6 In considering which tender to recommend, 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. This will take the form of an official evaluation process involving a consideration of both commercial and technical aspects, any key stakeholders involved in the tender process. In cases of doubt they shall consult the Chief Executive via the completion of a Recommendation Report. The Chief Executive or ~~Director of~~ Chief Finance Officer, see SO 1.16.1.1 for authorisation levels, shall approve acceptance of the tender in writing to the responsible officer. (Larger tenders ie those exceeding a total value of £1,000,000 (inc Vat) shall be referred to the Trust Board for approval).

1.9.7 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.

1.9.8 All tenders shall be treated as confidential and shall be retained for inspection.

1.10 **Tender reports to the Trust Board**

1.10.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

1.11 **List of approved firms**

1.11.1 Building and Engineering Construction Works

1.11.1.1 Invitations to tender shall be made only to firms included on either an approved list of tenderers compiled by the Trust or by neighbouring Trusts or on the Construction Line, NHS Supply Chain or other national or regional purchasing framework list.

1.11.1.2 Firms included on approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with all relevant employment legislation and guidance.

1.11.1.3 Firms shall conform at least with the requirements of the Health and Safety at Work Act 1974 (as

amended) and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British standard code of practice issued by the British Standard Institution. Firms must provide to the appropriate Officer a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

1.11.2 Financial Standing and Technical Competence of Contractors

1.11.2.1 The ~~Director of~~ Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

1.12 **Exceptions to using approved contractors**

1.12.1 If in the opinion of the Chief Executive and the Chief ~~Director of~~ Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on a list), or where a list for whatever reason has not been prepared, the Chief Executive shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

1.12.2 An appropriate record in the contract file shall be made of the reasons for inviting a tender or quote other than from an approved list.

1.13 **Competitive Quotations**

1.13.1 Quotations are required to be obtained where formal tendering procedures have been waived under SOs 1.3.2 or 1.3.3 and where the intended expenditure or income exceeds, or is reasonably expected to exceed the limits defined in the Scheme of Delegation and/or the SFIs.

1.13.2 Where quotations are obtained under SO 1.14 they shall be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board of Directors.

1.13.3 Quotations shall be in writing.

1.13.4 All quotations shall be treated as confidential and shall be retained for inspection.

1.13.5 The Chief Executive or their Nominated Officer shall evaluate the quotations and select the one which gives value for money. If this is not the lowest quotation then this fact and the reasons why the lowest quotation was not chosen shall be recorded in a permanent record and a Quotation Acceptance Authorisation Form completed.

1.14 **Non-Competitive Quotations**

1.14.1 Formal quotation procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

1.14.2 the estimated expenditure or income does not, or is not reasonably expected to, exceed £10,000 excl VAT (this figure to be reviewed annually); Or

1.14.3 the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

1.14.4 where the requirement is covered by an existing national, regional or local contract or framework

1.14.5 where provided for in regulatory guidance.

1.14.6 Formal quotation procedures may be waived by Officers to whom powers have been delegated by the Chief Executive:

1.14.7 in very exceptional circumstances where the Chief Executive decides that formal quotation procedures would not be practicable or the estimated expenditure or income would not warrant formal competitive procedures, and the circumstance are detailed in an appropriate Trust record;

1.14.8 where the timescale genuinely precludes competitive quotations (failure to plan the work

properly is not a justification for single quotation);

1.14.9 where it is apparent from the specification that specialist expertise is required to meet it and the expertise is only available from one source;

1.14.10 where the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

1.14.11 where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competition.

1.14.12 The waiving of competitive quotation procedures should not be used:

1.14.13 to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure;

1.14.14 for building and engineering construction works, and maintenance (other than in accordance with Concode or other relevant regulatory guidance) without Departmental of Health and Social Care approval.

1.14.15 Where it is decided that competitive quotations are not required and should be waived by virtue of SO 1.14.2.1 to SO 1.14.2.5 above the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported by the Chief Executive to the Audit Committee.

Commented [PS1]: Alignment with rational for waiving competitive tendering processes

~~1.14.14 Non-competitive quotations in writing may be obtained, in exceptional circumstances, for the following purposes:~~

~~1.14.14.3 the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their Nominated Officer, possible or desirable to obtain competitive quotations;~~

~~1.14.14.5 the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts. The Trust shall use National Contracts awarded by such Government Bodies as Government Procurement or NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.~~

~~1.14.14.7 the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts, the approvals required for these courses of action will be by reference to the financial limits set out in Appendix 1 of the Standing Financial Instructions.~~

~~1.14.14.9 miscellaneous services, supplies and disposals;~~

~~1.14.14.11 where the goods or services are for building and engineering maintenance the responsible works manager must verify that the first two conditions of this Standing Order eg SO 1.14.1.1 and SO 1.14.1.2 apply)~~

~~1.14.14.13~~1.14.15.1 ~~where tenders or quotations are not required, because expenditure is below the limits set in Appendix 1 of the Standing Financial Instructions, the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.~~

Commented [PS2]: Removed and replaced to align with rational for waiving competitive tendering processes

1.15 Quotations to be within Financial Limits

1.15.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SOs except with the authorisation of either the Chief Executive or ~~Director of~~Chief Finance Officer.

1.16 Authorisation of Tenders and Competitive Quotations

~~1.16.1~~ Providing all the conditions and circumstances set out in these SOs have been fully complied with, formal authorisation and awarding of a contract may be decided ~~by the following staff to the value of the contract as follows:~~

~~Contracts **awarded to the lowest bidder.**~~

~~1.16.4.0 Below £50,000 - main list authorised signatory~~

~~1.16.6.0 £50,000 - £1,000,000 - main list authorised signatory and an Executive Director~~

~~1.16.8.0 Above £1,000,000 - Trust Board - to be recorded in minutes.~~

~~**Contracts not awarded to the lowest bidder:**~~

~~1.16.11.0 Below £50,000 - Director of Finance or Chief Executive~~

~~1.16.13.0 £50,000 - £1,000,000 Chief Executive and Chairman~~

~~1.16.15.0 Above £1,000,000 - Trust Board - to be recorded in minutes.~~

~~1.16.16~~1.16.1 ~~**Contracts above £1,000,000 incl VAT (over the full period of the contract) must be approved by the Board of Directors.**~~ in accordance with the Financial Limits set out in Tables 4 and 5 of Appendix 1 'Financial Limits' of the Trust Standing Financial Instructions.

Commented [PS3]: Remove thresholds and refer to Appendix 1 of SFIs

~~1.16.17~~1.16.2 These levels of authorisation may be varied or changed from time to time by the Board of Directors and need to be read in conjunction with the Scheme of Delegation and/or SFIs.

1.16.3 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

1.17 Instances where formal competitive tendering or competitive quotation is not required

1.17.1 Where competitive tendering or a competitive quotation is not required, the Trust should adopt one of the following alternatives:

1.17.1.1 the Trust shall use the NHS supply chain for procurement of all goods and services unless the Chief Executive or their Nominated Officer deem it inappropriate. The decision to use alternative sources must be documented;

1.17.1.2 if the Trust does not use the NHS supply chain (where tenders or quotations are not required,

because expenditure is below £10~~5~~,000 excluding VAT), the Trust shall procure goods and services in accordance with procurement procedures approved by the ~~Director of~~ Chief Finance Officer.

Commented [PS4]: Correct value £10,000 excluding VAT

1.18 **Private Partnership**

1.18.1 The Trust should normally market-test for "Private Partnership" funding when considering a capital procurement. When the Board of Directors proposes, or is required, to use finance provided by the private sector the following shall apply:

1.18.1.1 The Chief Executive and Chief Finance Officer ~~Director~~ shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

1.18.1.2 Where the sum exceeds delegated limits, a business case must be referred to NHS England~~/Improvement (Monitor)~~ and/or Department of Health and Social Care for approval or treated as per current guidelines.

1.18.1.3 The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

1.18.1.4 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

1.19 **Compliance Requirements for all Contracts (including lease contracts)**

1.19.1 The Board of Directors may only enter into contracts on behalf of the Trust within its statutory powers and within the Regulatory Framework and shall comply with:

1.19.1.1 these SOs;

1.19.1.2 the SFIs;

1.19.1.3 the Trust's Provider Licence;

1.19.1.4 statutory provisions including those giving effect to EU Directives;

1.19.1.5 such of the NHS Standard Contract Conditions as are applicable;

1.19.1.6 appropriate NHS guidance;

1.19.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

1.19.3 Contracts shall include lease and hire purchase agreements.

1.19.4 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

1.20 **Personnel and Agency or Temporary Staff Contracts**

1.20.1 The Chief Executive shall nominate Officers with delegated authority to enter into contracts for the employment of other Officers and to enter into contracts for the employment of agency staff or temporary staff service contracts.

1.21 **Healthcare Services Agreements**

1.21.1 Healthcare Services contracts made between two Health Service Bodies for the supply of healthcare services, will be legally binding contracts and are subject to the provisions of the 2006 Act and any other relevant legislation.

1.21.2 The Chief Executive shall nominate Officers with power to negotiate for the provision of healthcare services from providers of healthcare services.

1.22 **Cancellation of Contracts**

1.22.1 Except where specific provision is made in model forms of contracts or standard schedules of conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

1.22.1.1 the contractor has offered, or given or agreed to give, any person any gift or consideration of any kind

as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

1.22.1.2 the contractor has shown or foreborne favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by them or acting on their behalf (whether with or without the knowledge of the contractor); or

1.22.1.3 in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1989 and 1916,the Prevention of Corruption (Amendment) Act 2018, Bribery Act 2010, and other appropriate legislation.

1.23 **Determination of Contracts for Failure to Deliver Goods or Material**

1.23.1 There shall be inserted in every written contract for the supply of goods or materials entered into by the Trust a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may (without prejudice) determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good such default.

1.23.2 The clause referred to at SO 1.23.1 shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

1.24 **Contracts Involving Funds held on Trust**

1.24.1 Contracts involving Funds held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

1.24.2 SO 1.24.1 shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

2 DISPOSALS

2.1 **Competitive** Tendering or Quotation procedures shall not apply to the disposal of:

2.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their Nominated Officer;

2.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

2.1.3 items to be disposed of with an estimated sale value as set out in the Scheme of Delegation;

2.1.4 items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; or

2.1.5 land or buildings concerning which Department of Health and Social Care guidance has been issued but subject to compliance with such guidance; or

2.1.6 any matter which NHS England~~/Improvement (Monitor)~~ has issued alternate specific guidance and/or best practice advice in relation to.

3 IN-HOUSE SERVICES

3.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

3.2 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

3.2.1 "specification group", comprising the Chief Executive or Nominated Officer(s) and specialist(s).

3.2.2 "in-house tender group", comprising representatives of the in-house team, a nominee of the Chief Executive and appropriate technical support.

3.2.3 "evaluation group", comprising normally a specialist Officer, a

supplies Officer and ~~a Director of~~ Chief Finance Officer representative. For services having a likely annual expenditure exceeding £500,000 a non-Officer member should be a member of the evaluation team.

3.3 All groups referred to in SO 3.2.1 to 3.2.3 should work independently of each other but individual Officers may be a member of more than one group. No member of the "in-house tender group" may, however, participate in the evaluation of tenders.

3.4 The "evaluation group" shall make recommendations to the Board of Directors.

4. REVIEW OF THE TENDERING AND CONTRACT PROCEDURE

4.1 For the avoidance of doubt, the Tendering and Contracting Procedure form part of the Standing Orders but any changes to the procedure only require Board of Directors' approval.

ANNEX 4 - FURTHER PROVISIONS

1. REPRESENTATIVE MEMBERSHIP

1.1. The Trust shall at all times strive to ensure that, taken as a whole, its actual membership is representative of those eligible for membership. To this end:

1.1.1. The Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors and shall be reviewed by them from time to time at least every three years.

1.1.2. The Council of Governors shall present to each Annual Meeting:

1.1.2.1. a report on steps taken to secure that, taken as a whole, the actual membership of its constituencies and the classes of constituencies is representative of those eligible for such membership;

1.1.2.2. the progress of the membership strategy; and

1.1.2.3. any changes to the membership strategy.

2. CO-OPERATION WITH HEALTH SERVICE AND OTHER BODIES

2.1. In exercising its functions, the Trust shall co-operate with Health Service Bodies and any local authority with which the Trust has a Local Authority Partnership Agreement.

2.2. Notwithstanding the provisions of paragraph 2.1 above, the Trust shall co-operate with any specific third party body that it has a duty (statutory, contractual, or otherwise) to co-operate with.

3. RESPECTS FOR RIGHTS OF PEOPLE

3.1. In conducting its affairs, the Trust shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

4. APPOINTMENT OF CHAIRMAN AND NON-EXECUTIVE DIRECTORS

4.1. Decisions and processes regarding the appointment and reappointment of the Chairman and Non-Executive Directors of the Trust are solely within the purview of the Council of Governors.

4.2. The Nominations and Remuneration Committee has delegated powers from the Council of Governors to consider the Non-Executive Director or Chairman

vacancies due in the next 12 months and make recommendations to the Council of Governors.

4.3. The Nominations and Remuneration Committee shall:

4.3.1. recommend the re-appointment of an existing Non-Executive Director/Chairman or if applicable the recruitment process for the Chairman and Non-Executive Directors (as may be the case).

4.3.2. take advice, as necessary, from the Director of People and Organisational Development and the Trust Secretary or other internal or external sources

4.3.3. report its recommendations regarding the re-appointment of the Non-Executive Director or Chairman as an agenda item in a timely manner at a Council of Governors meeting for decision, or:

4.3.4. report its recommendations regarding the recruitment process for the Non-Executive Director or Chairman post as an agenda item in a timely manner to the Council of Governors meeting for decision.

4.3.5. make recommendations to the Council of Governors meeting in relation to pay and tenure of Non-Executive Directors/Chairman for the Council of Governors' decision. Each period of appointment (or re-appointment) will be to a maximum of three years, and any re-appointment over six years will be subject to particularly rigorous review. Any re-appointment over six years will be subject to annual re-appointment to provide assurance that the Non-Executive Director seeking re-appointment retains their independence of character and judgement.

4.3.6. ensure that a formal, rigorous and transparent procedure is followed, which takes into account the needs of the organisation, the balance of expertise and experience on the Board, eligibility of existing Non-Executive Directors or Chairman to stand for a further term, and any other relevant factors. This is not an exhaustive list of the matters which may need to be considered by the Nominations and Remuneration Committee, but is merely intended to act as a guide.

4.4. Subject to the provisions of paragraph 4.3.1 above, the process for appointing new Non-Executive Directors and the Chairman, including the potential re-appointment of the Chairman and Non-Executive Directors, will be as follows:

4.4.1. No later than six months before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Nominations and Remuneration Committee will consider, paying due regard to the provisions set out in paragraph 4.3.1, the formal performance evaluation for the Non-Executive Director or Chairman for the previous two years, skills and experience and eligibility of existing Non-Executive Directors prepared to stand for re-appointment. The

reason for considering the performance of existing Non-Executive Directors will be to inform the decisions made regarding the re-appointment of the Non-Executive Director or Chairman, or the recruitment process to be followed. However, nothing within this paragraph will preclude the Nominations and Remuneration Committee from considering other relevant circumstances when deciding on the recruitment process as outlined in paragraph 4.3.1 above. Having due regard to the needs of the composition of the Board, the Nominations and Remuneration Committee may either 1) recommend to the Council of Governors that 1) an external recruitment process is followed or 2) recommend the re-appointment, pay, length of term of an existing Non-Executive Director. For the avoidance of doubt, if the recommendation to re-appoint a Non-Executive Director or Chairman is approved by the Council of Governors, there is no requirement to set up an Appointments Panel, unless this is specifically requested by the Council of Governors.

4.4.2. Following a recommendation to follow an external recruitment process, and subject to the Council of Governors' agreement, the Council of Governors will appoint an Appointments Panel to undertake the recruitment process. The Appointments Panel will be constituted in accordance with paragraphs 4.4.4 and 4.4.5 below.

4.4.3. The current Chairman or a Non-Executive Director may stand for reappointment, subject to the conditions at paragraph 4.4 above.

4.4.4. The Appointments Panel for the Chairman will consist of the Senior Independent Director, or if the Senior Independent Director is standing for appointment a Non-Executive Director who is not standing for appointment, two Elected Governors, and one Appointed Governor. If the number of Elected/Appointed Governors prepared to serve on the Appointments Panel is greater than the number of places available, the Panel members will be selected by election by the Elected/Appointed Governors respectively. A Public Governor will chair the Appointments Panel. Each member of the Appointments Panel will have one vote. The chairman of another NHS foundation trust will be invited to act as an independent assessor to the Appointments Panel.

4.4.5. The Appointments Panel for Non-Executive Directors will consist of the Chairman, two Elected Governors, and one Appointed Governor. If the number of Elected/Appointed Governors prepared to serve on the Appointments Panel is greater than the number of places available, the Panel members will be selected by election by the Elected/Appointed Governors respectively. The Chairman will chair the Appointments Panel. Each member of the Appointments Panel will have one vote.

4.4.6. Appropriate candidates (not more than 5 (five) for each vacancy) will be identified by an Appointments Panel.

4.4.7. The Appointments Panel constituted under paragraphs 4.4.4 and 4.4.5 above will be supported by appropriate advice from the Trust's Director of People and Organisational Development on the qualifications, skills and experience required for each position. They may also work with an external organisation recognised as expert at appointments to identify the qualifications, skills and experience required for Non-Executive Directors.

4.4.8. The Council of Governors will not consider nominations for the Chairman and other Non-Executive Directors other than those made by the appropriate Appointments Panel.

4.4.9. The Appointments Panel will make recommendations to the Council of Governors meeting about the preferred candidate to be appointed to the Non-Executive Director or Chairman post for the Council of Governors' decision.