Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 29 September 2011; 1530h - 1730h

Members		
Mrs S Davis	(SD)	[Chair]
Mr R Trotman	(RT)	
Dr S Sahota	(SS)	
Mrs G Hunjan	(GH)	
Prof D Alderson	(DA)	
Mrs O Dutton	(OD)	
Mr J Adler	(JA)	
Mr D O'Donoghue	(DO'D)	
Mr R White	(RW)	
Miss R Barlow	(RB)	
Miss R Overfield	(RO)	
Mr M Sharon	(MS)	

In Attendance		
Mr G Seager	(GS)	
Miss K Dhami	(KD)	
Mrs J Kinghorn	(JK)	
Mrs C Rickards	(CR)	
Mrs C Powney	(CP)	[Sandwell LINks]

Secretariat		
Mr S Grainger-Payne	(SGP)	[Secretariat]

Item	Title		Lead
1	**Apologies**	**Verbal**	**SGP**
2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
3	**Chair's opening comments**	**Verbal**	**Chair**
4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 25 August 2011 as true and accurate records of discussions*	**SWBTB (8/11) 185**	**Chair**
5	**Update on actions arising from previous meetings**	**SWBTB (8/11) 185 (a)**	**Chair**
6	**Questions from members of the public**	**Verbal**	**Public**
	FOR APPROVAL		
7	**Single Tender Action – Krypton generator service**	**SWBTB (9/11) 190**	**RB**
8	**Annual planning process and timetable**	**SWBTB (9/11) 202** **SWBTB (9/11) 202 (a) - SWBTB (9/11) 202 (c)**	**MS**
9	**Changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation**	**SWBTB (9/11) 200** **SWBTB (9/11) 200 (a)** **SWBTB (9/11) 200 (b)**	**RW**

MATTERS FOR INFORMATION/NOTING			
10	**Safety, Quality and Governance**		
10.1	Nursing update	SWBTB (9/11) 201 SWBTB (9/11) 201 (a) - SWBTB (9/11) 201 (g)	RO
10.2	Patient experience update	SWBTB (9/11) 192 SWBTB (9/11) 192 (a)	RO
10.3	Equality and Diversity update	SWBTB (9/11) 196 SWBTB (9/11) 196 (a)	RO
10.4	Update on complaints handling	Hard copy paper	KD
10.5	Update from the Quality and Safety Committee held on 22 September 2011	Verbal	DA
11	**Performance Management**		
11.1	Monthly finance report	SWBTB (9/11) 191 SWBTB (9/11) 191 (a)	RW
11.2	Draft minutes from the Finance and Performance Management Committee meeting held on 22 September 2011	To follow	RT
11.3	Monthly performance monitoring report	SWBTB (9/11) 188 SWBTB (9/11) 188 (a)	RW
11.4	NHS Performance Framework/FT Compliance monitoring report	SWBTB (9/11) 189 SWBTB (9/11) 189 (a)	RW
12	**Strategy and Development**		
12.1	Reconfiguration		
▶	Clinical services reconfiguration update	SWBTB (9/11) 193 SWBTB (9/11) 193 (a)	MS
▶	Draft minutes from the Reconfiguration Board meeting held on 8 September 2011	To follow	GH
12.2	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (9/11) 194 SWBTB (9/11) 194 (a)	MS
12.3	Foundation Trust application programme		
▶	Programme Director's report	SWBTB (9/11) 195 SWBTB (9/11) 195 (a)	JA
12.4	Midland Metropolitan Hospital project: Programme Director's report	Verbal	GS
13	**Any other business**	**Verbal**	**All**
14	**Details of next meeting** *The next public Trust Board will be held on 27 October 2011 at 1530h in the Boardroom, Sandwell Hospital*	**Verbal**	**Chair**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Boardroom, Sandwell Hospital **Date** 25 August 2011

Present		**In Attendance**	
Mrs Sue Davis CBE	(Chair)	Miss Kam Dhami	
Mr Roger Trotman		Mr Graham Seager	
Mrs Gianjeet Hunjan		Mrs Linda Pascall	
Dr Sarindar Sahota OBE		Mr Nick Howells	
Mr Gary Clarke		Mrs Carol Powney	[Sandwell LINks]
Mr John Adler			
Mr Robert White		**Guests**	
Mr Donal O'Donoghue		Mrs Helen Shoker	[Item 7]
Miss Rachel Barlow		Dr Natasha Ratnaraja	[Items 8.1 – 8.3]
		Mrs Gayna Deakin	[Item 8.7]

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Derek Alderson, Mrs Olwen Dutton, Mr Mike Sharon, Miss Rachel Overfield and Mrs Jessamy Kinghorn. Mrs Linda Pascall was in attendance in place of Miss Overfield.	
2 Declaration of Interests	**Verbal**
There were no declarations of interest raised.	
3 Chair's Opening Comments	**Verbal**

The Chair welcomed Miss Barlow, the newly appointed Chief Operating Officer to her first meeting of the Trust Board. Mrs Powney, representing Sandwell LINks was introduced to the Board. The Chair advised that the meeting would be the last that Mr Clarke would attend as a Non Executive Director of the Trust. She thanked him for his valuable contributions, his companionship and for the searching questions he had posed at the Board and Committee meetings. Mr Clarke, in turn thanked the Board for its support during his time as a member. The Chair thanked the teams that had dealt with the difficult issues arising from the national and local unrest recently, particularly for the management of the front line operations. It was agreed that these sentiments should be included in the next edition of the 'Hot Topics' briefing to managers to allow the messages to be cascaded to the relevant members of staff.	
ACTION: **Mr Howells to arrange for the thanks from the Board for the effective management of operations during the recent unrest to be included within the next 'Hot Topics' bulletin**	
4 Minutes of the previous meeting	**SWBTB (7/11) 169**
The minutes of the previous meeting were presented for approval and were accepted as a true and accurate reflection of discussions held on 28 July 2011.	
AGREEMENT: **The Trust Board approved the minutes of the last meeting**	
5 Update on actions arising from previous meetings	**SWBTB (7/11) 169 (a)**
The updated actions list was reviewed and it was noted that there were no outstanding actions requiring discussion or escalation.	
6 Questions from members of the public	**Verbal**
No questions were raised by members of the public present.	
Items for Approval	
7 Trauma and Orthopaedics staffing options	**SWBTB (8/11) 178** **SWBTB (8/11) 178 (a)**
Mrs Pascall presented a proposal to increase the level of nurse staffing in the Trust's trauma unit. She advised that the level of nurse staffing had been set in 2009 according to the acuity of patients at the time, however the level of acuity had increased since and therefore there was a need to increase the staffing in line with the revised level of dependency. The Board was asked to support the proposed investment of £199k for this purpose.	

Mr Trotman advised that at the recent meeting of the Finance and Performance Management Committee a presentation had been given by the Surgery, Anaesthetics and Critical Care division which highlighted that the delivery of the division's recovery plan and Cost Improvement Programme (CIP), included a dependency on changes in the Trauma and Orthopaedics services. Mr Adler highlighted however, that the CIP did not include any schemes impacting on nurse staffing levels and that the recovery plan measures concerned the functioning of the surgical services. Mr Trotman asked whether the proposed investment had been factored into the financial plans of the Surgery, Anaesthetics and Critical Care division. Mr Adler advised that the investment was an unfunded cost pressure, hence the need to bring the proposal to the Board for consideration. Mr O'Donoghue reported that at the time of the surgical reconfiguration exercise there were few tools available with which to assess the acuity level of the ward. Since then however, the Board was advised that the situation had become clearer and the proposed investment would address the issues. Mr White reported that in terms of affordability, the cost of the plan would need to be met non-recurrently, although this would need to be funded recurrently in future years. It was noted that the Service Line Reporting position of the Trauma and Orthopaedics speciality would also be influenced adversely by the plans. The Chair noted that the proposed investment of £199k represented a full year effect and asked what proportion of this needed to be identified for the remainder of the financial year. She was advised that this was approximately £100k. Mr Adler reminded the Board that the issues with nurse staffing on the Trauma and Orthopaedics wards had been highlighted previously as part of the nursing reported presented by Miss Overfield. He advised that agreement of the proposal would address these issues. Mr Clarke asked whether the proposed level of investment was sufficient to address completely all the issues. Mrs Pascall advised that the investment, together with measures to improve productivity and deliver efficiencies in the area would be sufficient to deal with the issues. The Trust Board unanimously supported the proposed investment to address the nurse staffing issues in the Trauma and Orthopaedics area.	
AGREEMENT: The Trust Board unanimously supported the proposed investment of £199,410 to address the nurse staffing issues in the Trauma and Orthopaedics area	
8 Safety, Quality and Governance	
8.1 Infection Control quarterly update	**SWBTB (8/11) 176** **SWBTB (8/11) 176 (a)**

Dr Ratnaraja joined the meeting to present the quarterly update on progress with infection control and prevention. The Board was advised that the report had been updated to reflect community services infection control activity. It was pointed out that the level of infections in the Trust was within local and the internal stretch targets. It was noted that there had been a slight increase in *C difficile* infections in May and June, which it was reported appeared to have been linked to the outbreaks of Norovirus. Surveillance of MSSA and *E coli* bacteria infections was highlighted to be continuing. The Board was informed that the number of contaminated blood cultures had increased, although training had been undertaken in an attempt to reduce the numbers in future. Dr Ratnaraja was asked what impact had been seen on infection control rates as a consequence of the transfer of community staff into the Trust. The Board was advised that the transfer had prompted even closer working with Sandwell PCT and it could facilitate a number of joint initiatives in the community. Mr O'Donoghue asked whether there was a possibility that there could be improved engagement with Heart of Birmingham tPCT. He was advised that there was already regular engagement with this PCT through the Birmingham Cluster meetings and joint initiatives were undertaken where possible.	
8.2 Tuberculosis (TB) update	**SWBTB (8/11) 175** **SWBTB (8/11) 175 (a)**
Dr Ratnaraja reported that tuberculosis (TB) was an increasingly prevalent infection that was being treated within the Trust and that infection rates in the local region were higher than in many other areas of the country. Mr O'Donoghue advised that TB vaccinations have only limited effectiveness, particularly in highly mobile populations with high rates of new TB coming into the community. He said that raising the level of neonatal vaccination would help to compensate for this effect, but the scientific consensus was that mass vaccination programmes were unlikely to be useful for our populations. Dr Ratnaraja confirmed that this was indeed, the scientific consensus. Mr O'Donoghue further advised that the Trust would need to be prepared for an increase in the importance of Infectious Diseases, particularly multi-drug resistant conditions in the next five to ten years. He assured the Board that elements of the new hospital specification had been designed with this possibility in mind and that future consultant recruitments in a number of disciplines would look for Infectious Disease capabilities. Mrs Powney asked whether the reports on infection control and prevention were shared with GPs. Dr Ratnaraja advised that this was the case as part of joint working between the Trust and Primary Care. Mrs Powney asked whether the clusters had been approached formally to discuss infection control plans. Dr Ratnaraja reported that this was not yet the case, although the new Black Country	

Cluster had been approached to pilot an approach on infection control. Dr Sahota noted that the TB issue was a community based problem, in addition to being an issue for the Trust. He therefore suggested that awareness of the infection needed to be raised in the community in an attempt to avoid TB admissions into the Trust where possible. Dr Ratnaraja agreed and advised that a joint strategy was being developed which would address this suggestion. Mr Adler added that discussions would be held with the commissioning groups to discuss such matters when they had stabilised. Dr Ratnaraja was asked whether the interface with the Birmingham Chest Clinic would be factored into the infectious diseases strategy that was being developed. The Board was informed that a Multi Disciplinary Team (MDT) approach was currently taken with the Birmingham Chest Clinic, however it was confirmed that the interface would form part of the strategy. Mr O'Donoghue advised that some patients with TB are required to be kept in isolation for a number of weeks and therefore thought needed to be given to introducing enhanced facilities to support this group of individuals. Mrs Powney asked whether charitable funds could be used for this purpose. The Chair confirmed that this was a possibility if required. Mr Trotman observed that in 90% of cases, the test results for TB prove to be negative. Dr Ratnaraja advised that a greater number of cases needed to be tested, however the Trust had one of the highest confirmation rates in the country.	
8.3 Cleanliness and PEAT update	**SWBTB (8/11) 171** **SWBTB (8/11) 171 (a)**
Dr Ratnaraja presented the quarterly update on the outcome of PEAT audits and cleanliness measures. The Board was advised that the operation of the discharge cleaning team had been reviewed. It was noted however, that the level of cleaning by the discharge team was disappointing. Mrs Pascall offered to clarify the reasons for this position, although she suggested that it may be reflective of the protected mealtime enforcement.	
ACTION: Mrs Pascall to determine the reason for the decline in cleaning by the discharge teams	
8.4 Newton 4 progress report and future plans	**SWBTB (8/11) 177** **SWBTB (8/11) 177 (a)** **SWBTB (8/11) 177 (b)**
Mrs Pascall reminded the Board that following a visit in March 2011 to ward Newton 4 at Sandwell Hospital, the Care Quality Commission (CQC) had reported major concerns in relation to compliance with the standard concerning nutrition. The ward was reported have been revisited by the CQC recently during which concerns were raised on the speed of progress with the delivery of the action plan to address the issues raised in the first visit. It was noted that the second visit also focussed on a different set of indicators to that reviewed in the first visit.	

A summary of the measures taken or underway to improve compliance with the privacy, dignity and nutrition standards was given. The Board was advised that the opportunity had been taken to gain external assurance on the situation on Newton 4 through a series of visits by Sandwell PCT, Cluster nurses, West Midlands Quality Review Group and the Director of Nursing from NHS West Midlands. It was reported that Newton 4 remained in 'special measures', although the leadership of the ward was noted to have now been changed. In terms of future plans for the ward, the Board was advised that Newton 4 would be included within the plans to establish a single acute stroke unit. Dr Sahota remarked that it was pleasing to see the level of sickness absence on the ward declining. Mrs Hunjan asked whether a third visit from the CQC was expected. Miss Dhami advised that a wider visit to assess compliance with the suite of CQC essential standards was expected in due course and that a further visit to Newton 4 was likely. The Board was informed that the report from the CQC on the outcome of the second visit remained awaited. Mr Clarke asked how the progress with the actions needed to address the recommendations was being reviewed. Mr Adler advised that a further action plan would be developed and closely monitored. The Chair emphasised the need for a balanced level of resources to be deployed to address the recommendations to ensure that sufficient focus remains on the other parts of the Trust. Mr O'Donoghue reported that a ward review process was in place which would provide good assurance on the status of the ward. It was noted that Newton 4 had been highlighted as a 'worry ward' as part of this process in advance of the CQC inspections. The Chair asked whether it was felt that the pace of delivery of the remedial action was sufficient. Mr O'Donoghue advised that the matter was being given a good level of focus by the Chief Nurse and the Assistant Directors of Nursing. The Chair advised that there was a need to ensure that there was sufficient resource and open dialogue around the capacity required to address the issues raised by the CQC reviews and to influence the cultural changes required to rectify the issues identified through the ward reviews. Mrs Pascall advised that the Patient Experience Professional Advisory Group (PEPAG) and the Heads of Nursing take responsibility for overseeing the outcomes from the ward reviews.	
8.5 Annual Risk Report	**SWBTB (8/11) 172** **SWBTB (8/11) 172 (a)**
Miss Dhami highlighted that the electronic incident reporting system was currently being implemented, which it was hoped would improve the robustness of the Trust's incident reporting. The Board was informed that the system had	

been introduced into the majority of clinical areas. A mechanism for feeding back to the member of staff reporting the incident was also reported to be planned. The Board was advised that there had been an increase in the number of red incidents reported, which it was explained reflected in part, the change to the reporting criteria to include pressure sores and fractures following falls. Mr White asked whether the electronic incident reporting had been implemented in all parts of the Trust. He was advised that it was yet to be rolled out into some areas, although it was being introduced according to a prioritised plan.	
8.6 Update on Complaints Handling	**Hard copy paper**
Miss Dhami reported that the total number of complaints being handled had reduced by one, with the backlog standing at 60 complaints. The Board was advised that 24 of the overdue complaints had received a response, however some previously within the failsafe timeframe had now slipped into the backlog. It was noted that the number of incoming complaints had reduced. Miss Dhami advised that the number of responses issued was short of the trajectory, with 56 having been issued against a target of 95 within the 21 working day period. Reasons for this shortfall were reported to concern the high number of complaints received in June and the significant turnover of temporary staff in the Complaints Team. In order to address the position and eliminate the backlog by December 2011 as planned, dedicated members of the Complaints Team were reported to have been assigned to different categories of complaints, including a member of staff specifically to handle the complaints backlog. It was also explained that more realistic deadlines would be set for a response to be issued in connection with a red or amber complaints, including making it clear to the complainant when a response may be issued that would fall outside the 75-day failsafe target. Dr Sahota emphasised the need to aim for a response to be issued as timely as possible, with the timeframe being extended only in exceptional circumstances. It was further agreed that there should be no plan to answer responses outside of the 75 working day failsafe limit, however should this be the case, then these should specifically be brought to the attention of the Board. The Chair added that the need to co-operate and contribute to complaints responses should be clarified with clinicians.	
8.7 Health and Wellbeing update	**SWBTB (8/11) 182** **SWBTB (8/11) 182 (a)**
Mrs Deakin joined the meeting to present an update on progress with the delivery of the actions raised in line with the Boorman Health and Wellbeing review, which aimed to improve the Trust's performance against sickness absence target and staff satisfaction. In terms of sickness absence, the Board was advised that the internal target and the regional targets were likely to be met for the current year.	

Mrs Deakin reported that a range of activities to promote the health and wellbeing agenda had been introduced and participation was encouraged through the daily staff communication bulletin. The Occupational Health department was reported to be embracing the Health and Wellbeing agenda and a Health and Wellbeing Committee was highlighted to have been established within the Trust which was meeting regularly. The Chair asked what uptake of the various exercises and activities offered had been seen to date. Mrs Deakin advised that there had been mixed uptake in some areas which had been disappointing. It was reported however, that there had been a good uptake of the weight reduction programme. Mr Clarke remarked that it was challenging to achieve a change to poor habits, however he suggested that work could be undertaken jointly with the PCTs to encourage smoking cessation. Mrs Deakin advised that this was already in place. It was suggested that a web-based solution should be introduced to enable staff to identify exercise and health lifestyle events local to their home. Mrs Deakin was asked what review of the 'Slimwell' Programme had been undertaken prior to its introduction. She advised that the programme had been tested by the Occupational Health department. Mrs Deakin was asked to include details of the uptake of the activities within the next update.	
8.8 Draft minutes of the Quality and Safety Committee meeting held on 21 July 2011	**SWBQS (7/11) 027**
The Trust Board received and noted the draft minutes of the Quality and safety Committee that had been held on 21 July 2011.	
9 Performance Management	
9.1 Monthly finance report	**SWBTB (8/11) 180** **SWBTB (8/11) 180 (a)**
Mr White reported that during the month a surplus of £72k had been achieved. The Board was asked to note that the overspend by the Surgery, Anaesthetics and Critical Care division had reduced. The overall pay bill was noted to have exceeded the budget by £24k however, although agency staff costs were noted to have fallen in July. The Wholetime Equivalent (WTEs) position was reported to have fallen below plan, predominantly due a reduction in non-clinical areas. The Board was pleased to note an improvement in the delivery of the Cost Improvement Programme to 90.8% of plan. Mr White advised that there had been good progress made with delivering the recovery plan actions, however there was a need to maintain focus on the Trust's overall position.	
9.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 18 August 2011	**Hard copy paper**
Mr Trotman asked the Trust Board to receive and note the draft minutes from the meeting of the Finance and Performance Management Committee held on 18	

August 2011.

The Board was advised that the Divisional General Manager (DGM) for the Surgery, Anaesthetics and Critical Care division had attended the meeting to report on the current situation and the plans for recovery during the remainder of the financial year. The Committee had been informed that in July, an overspend of £42k had been incurred, which was a significant improvement, given the overspend in the first quarter had reached £474k.

The details of the plan for the remaining eight months of the year and actions to be taken were reported to have been tabled, which should ensure that the division remained at breakeven for the period. Given the past record, the Committee had sought and was given reassurance that whilst the plan was ambitious, it was realistic and deliverable.

The Board was asked to note that the full minutes from the meeting detailed a discussion showing that there was rigorous checking that the proposed savings planned by the division had little impact on safety and quality of care, as well as questioning some other aspects of the planned savings.

In conclusion, the DGM had advised the Committee that the division was fully engaged with the programme and with appropriate support from the Executive Team and the Atos consultants it would deliver the plan. The division was reported to have been asked to attend another meeting of the Finance and Performance Management Committee later in the year.

The Committee was reported to have been pleased to note an improved Trust performance in the month and a reduction in the use of bank and agency staff. Concern had been expressed however, over the deficit in the Women and Child Health division and Miss Barlow had agreed to provide greater detail at a future meeting.

Other items discussed at the meeting were reported to have included the financial recovery plan, the Cost Improvement Programme, the Atos consultancy work and the plans to establish a Transformation Support Office.

The Chair asked whether there was a good level of engagement with the actions being taken to recover the financial position. Mr White advised that the issues are clearly communicated through the Chief Executive's 'Hot Topics' bulletin. Mr Adler added that the matters are also being reported prominently in the staff newspaper, 'Heartbeat' and would be outlined at the forthcoming Consultant Conference. Miss Barlow advised that there was much proactive planning underway to support the recovery plan, which was reassuring. Mr O'Donoghue confirmed that the issues would be clearly articulated at the Consultant Conference, together with the links between finance and quality.

Mr Trotman reported that during a recent Trust Board walkabout, it was not obvious that the work of the Atos consultants was clearly understood by frontline

staff, therefore he encouraged greater effort to be given to reinforcing the messages.	
9.3 Monthly performance monitoring report	**SWBTB (8/11) 183** **SWBTB (8/11) 183 (a)**
Mr White reported that cancelled operations had fallen to 0.6%, however Delayed Transfers of Care had increased. Therefore there had been robust engagement with Social Services to address the position. Performance against the stroke care targets was reported to be on the threshold of compliance. Performance against the Accident and Emergency Care target was reported to be 96.8%. The Board was advised that five new indicators concerning Accident and Emergency Care had been introduced, which were divided into two categories: timeliness and impact on patients. No MRSA bacteraemia infections were noted to have been reported and the number of *C difficile* infections had fallen. In terms of performance against the CQuIN targets, the Board was advised that there was an improving trend of achievement. Regarding the position relating to activity, Mr White highlighted that performance was above the Local Delivery Plan in some areas. Dr Sahota encouraged further work to be undertaken to address the poor performance against the Delayed Transfers of Care target. Miss Barlow reported that she had met with Social services and a detailed plan to work collaboratively had been developed to improve the position, which included the introduction of an escalation policy. As a result, a 1% decline in the number of Delayed Transfers of Care had been seen, with a trajectory for further improvement having been agreed with Sandwell Social Services. The Board was advised that a meeting with Birmingham Social Services was planned shortly. The Chair congratulated Miss Barlow on this work.	
9.4 NHS Performance Framework/FT Compliance monitoring report	**SWBTB (8/11) 184** **SWBTB (8/11) 184 (a)**
Mr White presented the NHS Performance Framework update for information. It was reported that there had been a concern that the current reviews into the Trust's compliance with the Care Quality Commission's essential standards of quality and safety may have impacted on the assessment against the NHS Performance Framework, however on investigation it had been determined that this was not the case unless a warning notice was issued.	
10 Strategy and Development	
10.1 'Right Care, Right Here' programme: progress report	**SWBTB (8/11) 179** **SWBTB (8/11) 179 (a)**

Mr Adler presented the latest 'Right Care, Right Here' programme progress report, which the Board received and noted. The Board was advised that the data on activity levels as at the end of June 2011 suggested that the Trust was meeting the trajectory planned to reach the target in 2015/16. It was agreed that this was a positive situation. Mr Adler informed the Board that there had been much activity undertaken on pathway redesign. There was also a plan to discuss and agree the combined governance arrangements and therefore a workshop had been organised to ratify them. The Board was advised that Mr Les Williams was stepping down as Programme Director to work for the Black Country Cluster and an interim Programme Director would be appointed in his place until a substantive appointment was made.	
10.2 Foundation Trust application: progress update	
Programme Director's report	**SWBTB (8/11) 179** **SWBTB (8/11) 179 (a)**
Mr Adler advised that the approval of the Outline Business Case (OBC) remained awaited and that the Tripartite Formal Agreement had not yet been approved by the Department of Health. As a consequence, the Board was informed that the planned Historical Due Diligence exercise and the public engagement phase had been delayed until the necessary approvals had been received. The delay at this stage was highlighted to potentially impact on the overall Foundation Trust application timetable.	
Draft minutes from the Foundation Trust Programme Board meeting held on 28 July 2011	**SWBFT (7/11) 047**
The tabled minutes of the FT Programme Board held on 28 July 2011 were received and noted.	
10.3 Midland Metropolitan Hospital project: progress report	**Verbal**
Mr Seager reported that the Deed of Safeguard issue had been resolved at a national level and reiterated that the approval of the OBC remained awaited, although it was being reviewed. As such, clarification on a number of matters had been sought by the Department of Health, which had appeared to have been answered satisfactorily. As part of the review, the Board was advised that reconfirmation of the support for the new hospital plans had needed to be requested from the PCTs and local commissioning groups. The response to the requests was reported to have been very positive. The Board was informed that the commercial documentation for the Midland Metropolitan Hospital continued to be developed.	

Mr Seager reported that visits to a number of other Private Finance Initiative (PFI) schemes had been undertaken during the period.	
10.4 Trauma Unit self-assessment	**SWBTB (8/11) 174** **SWBTB (8/11) 174 (a)** **SWBTB (8/11) 174 (b)**
The Trust Board was presented with a proposal to apply to the West Midlands Specialised Commissioning Group to become a Trauma Unit. It was reported that a self-assessment had been undertaken which would accompany the application. It was noted that there was an expectation that the Trust would be required to assemble a portfolio of evidence to support the self-assessment and to develop action plans to ensure full compliance with the required standards by June 2012. It was agreed that the Trust was committed to the delivery of high quality trauma services and therefore the Trust Board unanimously supported the self-assessment and application to become a Trauma Unit.	
AGREEMENT: The Trust Board supported the Trust's application to become a Trauma Unit	
11 Any other business	**Verbal**
There was none.	
12 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 29 September 2011 and would be held in the Anne Gibson Boardrooms at City Hospital.	

Signed: …….

Name: …….

Date: …….

Next Meeting: 29 September 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

25 August 2011, Boardroom @ Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr G Clarke (GC), Mr J Adler (JA), Mr R White (RW), Mr Donal O'Donoghue (DO'D), Miss R Barlow (RB)

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mrs L Pascall (LP), Mr N Howells (NH), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson (DA), Mrs O Dutton, Mr M Sharon (MS), Miss R Overfield (RO), Mrs J Kinghorn (JK)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 22 September 2011

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	~~31/07/2011~~ ~~22/09/2011~~ 15/12/2011	Process flow of complaints process being developed at as part of the revised Complaints Handling strategy which will be shared the the Trust Board in December 2011	G
SWBTBACT.208	Sustainability update and Sustainability & Environment policy	SWBTB (7/11) 149 SWBTB (7/11) 149 (a) - SWBTB (7/11) 149 (c)	28-Jul-11	Arrange for the anticipated position in respect of the Trust's carbon credit allocation to be presented at a future meeting of the Finance and Performance Management Committee	GS	20/10/11	Scheduled for October 2011	G
SWBTBACT.196	Right Care, Right Here' programme: progress report	SWBTB (4/11) 094 SWBTB (4/11) 094 (a)	28-Apr-11	Present an update on delivery of the decommissioning plan at a future meeting of the Trust Board	MS	~~25/08/2011~~ 29/09/2011	Includes as part of the update on the 'Right Care, Right Here' programme update on the agenda of the September 2011 meeting	B
SWBTBACT.211	Chair's Opening Comments	Verbal	25-Aug-11	Arrange for the thanks from the Board for the effective management of operations during the recent unrest to be included within the next 'Hot Topics' bulletin	NH	05/09/11	Included as requested	B
SWBTBACT.212	Cleanliness & PEAT update	SWBTB (8/11) 171 SWBTB (8/11) 171 (a)	25-Aug-11	Determine the reason for the decline in cleaning by the discharge teams	LP	29/09/11	Due to a reduction in the number of cleans undertaken at weekends as part of the Trust's Cost improvement Programme - there has not been an increase in *C difficile* infections since this decision however	B

KEY:

R	Outstanding action due for completion more than 6 months ago. Completion has been deferred more than once or there is no firm evidence that it is being progressed towards completion
A	Oustanding action due for completion more than 6 months ago. Completion has been deferred more than once but there is substantive evidence that work is progressing towards completion
Y	Outstanding action raised more than 3 months ago which has been deferred more than once
G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

Next Meeting: 29 September 2011, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

25 August 2011, Boardroom @ Sandwell Hospital

Members present: Mrs S Davis (SD), Mr R Trotman (RT), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr G Clarke (GC), Mr J Adler (JA), Mr R White (RW), Mr Donal O'Donoghue (DO'D), Miss R Barlow (RB)

In Attendance: Mr G Seager (GS), Miss K Dhami (KD), Mrs L Pascall (LP), Mr N Howells (NH), Mrs C Powney (CP) [Sandwell LINks]

Apologies: Prof D Alderson (DA), Mrs O Dutton, Mr M Sharon (MS), Miss R Overfield (RO), Mrs J Kinghorn (JK)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 22 September 2011

Reference No	Item	Paper Ref	Date	Agreement
SWBTBAGR.242	Minutes of the previous meeting	SWBTB (8/11) 185	25/08/2011	The Trust Board approved the minutes of the previous meetings as a true and accurate records of discussions held
SWBTBAGR.243	Trauma and Orthopaedics staffing options	SWBTB (8/11) 178 SWBTB (8/11) 178 (a)	25/08/2011	The Trust Board unanimously supported the proposed investment of £199,410 to address the nurse staffing issues in the Trauma and Orthopaedics area
SWBTBAGR.244	Trauma Unit self-assessment	SWBTB (8/11) 174 SWBTB (8/11) 174 (a) SWBTB (8/11) 174 (b)	25/08/2011	The Trust Board supported the Trust's application to become a Trauma Unit

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Single Tender Action – Krypton Generator service
SPONSORING DIRECTOR:	Rachel Barlow, Chief operating Officer
AUTHOR:	Dr Bill Thomson, Consultant Physicist and Radiation Protection Adviser
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The Trust Board is asked to support a single tender action arrangement in respect of two purchases: £150k for the delivery of radioactive krypton generators and £480k for the provision of Rb81 solution.

The Krypton generator service has been operational from the Physics and Nuclear Medicine department since 1979. It operates in conjunction with the University of Birmingham Cyclotron Unit, which is a commercial venture called Alta Cyclotron Ltd. Krypton generators are used in nuclear medicine to supply the very short lived radioactive gas Kr81m (13second half-life). This is a very effective agent for imaging the ventilation of the lungs, which in conjunction with a Tc99m perfusion agent can help diagnose pulmonary embolus.

The generators rely on a radioactive product Rb81 being loaded onto the generator. Rb81 has a half-life of 4.6 hours and is produced in a specialist cyclotron. Because of the relatively short half-life of Rb81, generators can only be used by departments on the day of supply. We have a generator production laboratory within the cyclotron unit at the University of Birmingham. The University cyclotron produces Rb81 solution during the afternoon production takes place the evening before, and the generators are picked up at 11pm by the transport company and transported overnight to arrive at the hospitals before 9am. We currently supply 3100 generators to 31 hospitals in England.

The production of the Rb81 solution requires specialist targetry and cyclotron facilities. There is no other cyclotron in the UK producing Rb81. In previous years we had established a back-up supply from a facility in Holland (the next nearest production unit). However this had to be air-freighted overnight and the costs and logistics are very high and impractical for routine production. In practice, the new facility at the University of Birmingham has had only one days lost production in 2 years, and only needs 1 week a year closure for maintenance.

Therefore we can only continue the current Kr81m generator service with supply from the Alta Cyclotron Group at the University of Birmingham and this is the reason for the Single Tender request submission. It should be noted that although the annual cost is high, the basis of the supply agreement is that we are only charged for the Rb81 solution we require for our generators on each day. Therefore there is no inherent risk associated with the agreement for this annual call-off sum.

In conjunction with producing the generators, the transport infra-structure for collection of the prepared generators, delivery to hospitals overnight and return of the 'spent' generators is vital. This is a specialist service which not only has to deliver overnight but also has to comply fully with the Radioactive Transport Regulations. In 2009, the only company who could operate our current delivery schedule at a competitive price was DSB Active Ltd. They supply over 90% of our customers for other radiopharmaceutical companies and we have agreement with them to supply the generators to hospitals on a day-by-day basis.

The Single Tender value is for a call-off order for the year and has no inherent risk associated with this total figure. We do however recognise that this agreement will need to be subject to a formal re-tendering exercise and will be working towards that taking place.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to APPROVE single tender arrangement.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	x	
Business and market share		
Clinical	x	
Workforce		
Environmental		
Legal & Policy	x	Approval for Single Tender Action requested to ensure compliance with SFIs
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

None.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Planning Process 2012/13
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy and Organisational Development
AUTHOR:	Anne Charlesworth, Head of Corporate Planning
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

This paper sets out proposed revisions to the annual planning process together with a timetable for completion.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to **approve** the planning process and timetable.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Supports the delivery of all Strategic Objectives
Annual priorities	Supports the delivery of annual priorities
NHS LA standards	Supports the achievement of NHSLA standards
CQC Essential Standards Quality and Safety	Supports the achievement of CQC Essential Standards
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**Y**	
Business and market share	**Y**	
Clinical	**Y**	
Workforce	**Y**	
Environmental	**Y**	
Legal & Policy	**Y**	
Equality and Diversity	**Y**	
Patient Experience	**Y**	
Communications & Media	**Y**	
Risks		Risk that the Divisions and Directorates are not able to meet the required timescales

PREVIOUS CONSIDERATION:

Annual update to Trust Board

TRUST ANNUAL PLAN AND FINANCIAL PLANNING 2012/13 PROCESS AND TIMETABLE

INTRODUCTION

This paper presents the proposed timetable for developing the Trust's Annual Plan 2012/13 – 2014/15 for approval by the Trust Board. As in previous years the timetable for Board consideration of the draft and final annual plan is consistent with the financial planning timetable. Consequently, this report highlights the key events in the lead-up to presenting the annual budget and medium-term financial plan.

The work with ATOS and the development of the Integrated Business Plan have highlighted the need to develop clear specialty service strategies and to progress the development of more detailed plans to achieve the Right Care Right Here activity and capacity projections.

PROCESS AND TIMETABLE – Annual Plan

This year, therefore, it is proposed that some changes should be made to the process and timetable from that adopted in the last few years.

The aim is:

- To develop the 5-Year Specialty based Service Strategies to deliver the objectives of 'Right Care Right Here' (RCRH) and the opening of the Midland Metropolitan Hospital in 2016/17.
- To develop Transition Plans at Clinical Directorate level that can be brought together to form Divisional Plans.
- To ask Clinical Directorates to produce annual plans that describe years one and two activities required to deliver the Strategies and Transition
- To improve the process for "Sign-off" and ongoing Monitoring of the Divisional/ Directorate Annual Plans.
- To improve the workforce planning information generated by the planning process
- To avoid as far as possible duplication of effort, while ensuring that the standards required by Monitor of a Foundation Trust are met.

Key aspects of the process include:

<u>Trust Strategic Objectives</u>
At the July Trust Board the draft IBP was discussed including a review of the Trust's Strategic Objectives and an assessment of risks associated with those longer term objectives. It is proposed that the risk assessment will be revisited/reviewed on a half yearly basis.

<u>Trust Corporate Objectives 2012/13</u>
As in recent years the Trust's Corporate Objectives will be formulated in order to deliver the agreed Strategic Objectives. There is a need to ensure that the objectives are "SMART". A Member event was held in September offering the opportunity for members to give their views on the priorities for the Trust for the year ahead. Staff views will be sought via Hot Topics in October. Corporate Objectives will be finalised by the Trust Board in January 2012.

Service Strategies

Each Directorate is being asked to produce (or refresh) a strategy for their service that takes into account the strategic direction of the Trust. This will help the Trust to prioritise service developments in the longer term as well as providing Directorates with an opportunity to identify and articulate the long term priorities for their service

Transition Plans

Each Clinical Directorate is being asked to produce a Transition Plan. The Transition Plan will a describe how services will plan to deliver the activity and capacity assumptions for 2016/17 that are set out in the Outline Business Case for the new hospital.

Annual Plans

Each Clinical Directorate is being asked to produce an Annual Plan that sets out in detail for year one and in outline for a further two years. Divisions are asked to produce a Divisional Plan that summarises the Directorate plans and provides cross cutting analysis and objectives.

In September a series of half away-days are being held with each Division to launch this exercise. The intention is that "bottom up" Directorate plans should be developed set within a framework comprising:

- RCRH Strategy
- A&C Model Trajectories
- OBC assumptions for the new hospital
- The Integrated Business Plan (IBP)
- Financial context including the LTFM
- Progress on Decommissioning Plans in the current year
- The Trust's Strategic Objectives

Any service issues requiring 6 months notification to commissioners will need to be identified during September in order for the Trust to inform commissioners by the end of September 2011. Divisions were asked to provide this information to Finance by 16 September.

Work will then continue with Divisions/Clinical Directorates to prepare a first cut of the integrated plans for each service by the end of November/early December 2011.

Financial Planning

Detailed financial planning will form part of the process. Progress on the Decommissioning Plan for 2011/12 will be reviewed and assumptions made for decommissioning in 2012/13 and beyond. The Long Term Financial Model (LTFM) prepared as part of RCRH will provide the basis for planning. ATOS will be completing their work with the Trust in October and this should lead to plans for efficiencies, service improvements and cost savings to feature in draft 3 year Divisional savings and efficiency programmes (2012/13-2014/15). The efficiencies to be applied to budgets will be developed from October and refined through to January. They will form part of the Divisional Annual Plans signed-off by February 2012.

The Long Term Financial Model developed for the Integrated Business Plan suggests that the cost reduction programme required by the Trust will be around 5.5% per annum for the next five years. This figure includes national efficiency requirements, new hospital financing requirements and cost reductions required as a result of reducing activity.

It is proposed that the previous, current and future relationship between 'enabling', QuEP and transformation project charters respectively, is brought together into a single change programme

that encompasses the range of interrelated actions as well as what we know at present to be the line by line Cost Improvement Programme. The system to monitor and manage all of these activities is being progressed as it presents additional complexities, albeit necessary ones in order that accountability is established for actions in one department that affect another whilst maintaining the rigour of monitoring financial savings by operational or functional unit (i.e. as part of overall Divisional responsibilities).

Consequently, the savings associated with the transformation programme, including individual project charters are being analysed in order to identify divisional contributions to any scheme. However, at the same time and in order to provide assurance regarding delivery of the overall savings target, the relative makeup of the cost reduction within the LTFM will be broken down by division and corporate department based on:

- relative shares of baseline efficiency
- brought forward schemes from 11/12 to balance off the recurrent underlying position, if any
- RCRH activity related marginal cost savings linked to reductions in activity
- 'Distance from target' movements based on Service Line Positions and other benchmarking data

To inform Divisions and corporate departments of their theoretical contribution this calculation will be issued to Divisions and corporate departments by (date to be confirmed)

By creating a single efficiency programme, the risk of non-delivery of key elements of the transformation programme that could adversely affect the financial savings is reduced.

Within external bodies, the language of 'CIPs' is deeply embedded. Indeed, monitoring returns use this label when asking for annual plans and in-year progress updates. The Foundation Trust environment equally demands information on CIPs. The Trust can deal with this through a simple conversion.

For now it is proposed that the overarching vehicle for delivery of efficiency is known as the Transformation Programme and that each individual scheme (what might have been known as one line in the CIP) becomes a TSS (Transformation Savings Scheme). Each of these will comprise a description of the key actions, deliverables, financial benefits and accountable officers (described further in the next paragraph). They will be explicitly link to the Project Charters for each transformation project.

Aside from improving transparency and delivery, it has been observed by our auditors that whilst we have a tight process for monitoring the delivery value of CIPs, we do not hold a commencing 1 side of A4 summary of each scheme that captures 1) Purpose/Objectives 2) Key actions 3) Clarity regarding 'who' 4) Value 5) monthly phasing 6) Milestones 7) risk assessment, etc. This is not dissimilar to the sort of 'project initiation document' summary used for QuEP.

In summary, the approach described above seeks to take costed savings assigned to the ATOS projects, determine the extent to which these can be disaggregated to contributing departments (in order to identify ownership of constituent actions), measure all of this against overall cost reduction targets and ensure that any residual saving requirement is captured as part of TSS submissions.

A timetable of events is attached**.**

LDP Negotiating Strategy

At the time of writing, commissioners have not issued intentions for 2012/13. This extends to GP Commissioning Consortia, PCTs (via Clusters, they remain separate statutory bodies during 2012/13) nor have either the Clusters or SHA issued over-arching system planning documents. Much of this will be consistent with previous years and the RCRH programme provides a framework for commencing discussions.

In order to meet Monitor expectations, an LDP Negotiating (Contract) Strategy will be prepared for sign-off by the Trust Board in November, in advance of detailed LDP negotiations taking place in January and February 2012. Final contract sign-off is expected by 29th February 2012.

Executive Review of Divisional/Directorate Plans

A robust, critical review of the Divisional and Directorate Plans will need to be undertaken by the Executive Team during December/early January to provide assurance that the Plans are realistic and should deliver expectations on service quality, activity levels, financial performance etc. This will include Quality & Safety review of CIPs and assessment of risk. Any concerns can then be addressed before the plans are signed-off.

Formal Sign-Off of Plans

If the same approach is taken nationally as in recent years the Department of Health will issue an Operating Framework for 2012/13 during December 2012. Any final adjustments then required to Annual Plans may be made during January before they are signed-off (subject to final LDP agreement) at Divisional Review meetings at the end of January/early February 2012.

Monitoring of Annual Plans

In order to strengthen the ongoing monitoring of Annual Plans, a wider approach than that currently adopted will be taken to future monitoring throughout the year via Divisional Review meetings.

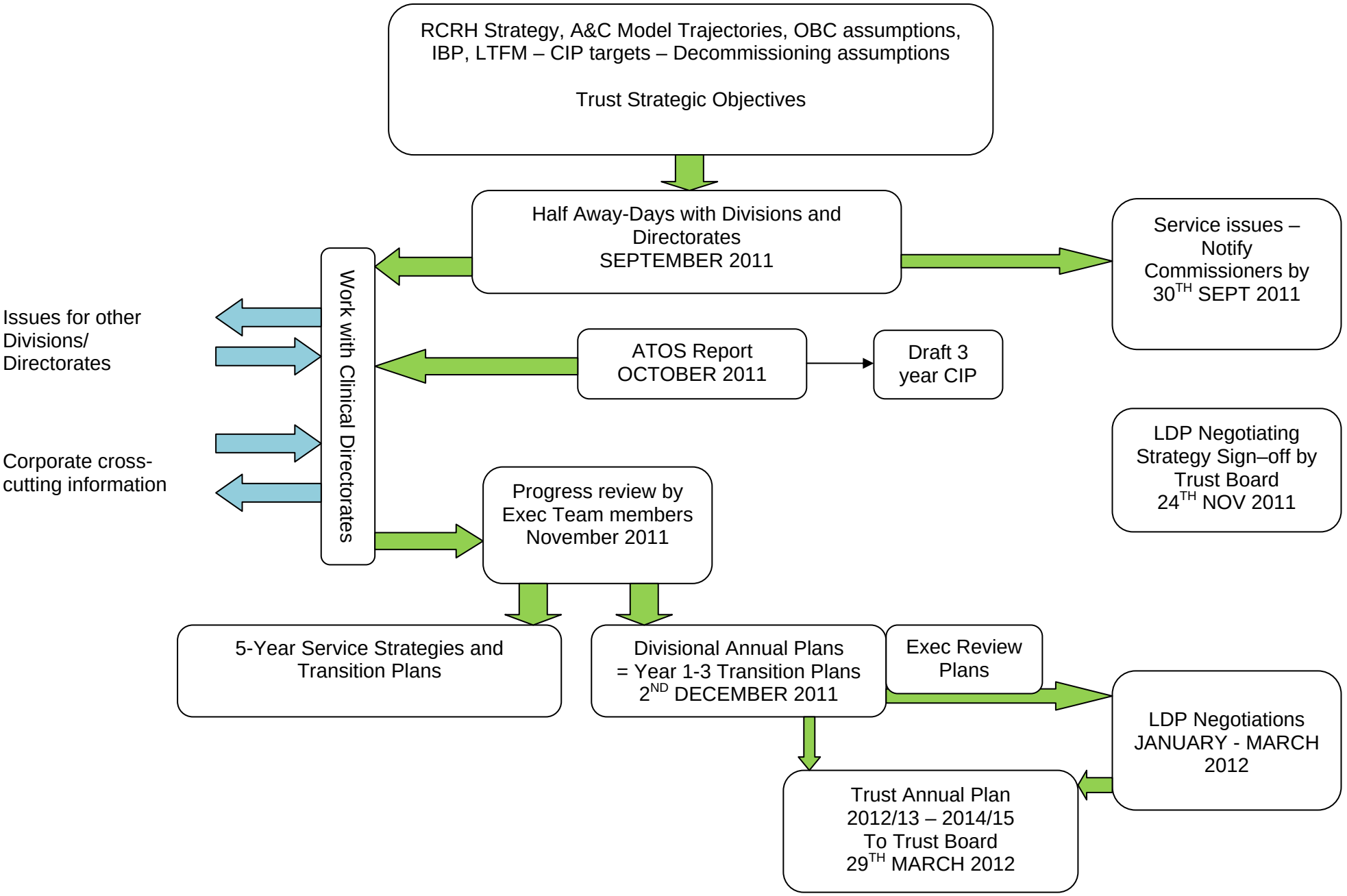
A Diagram illustrating the process is included at Attachment 1 and a Timetable by month at Attachment 2.

From the information produced it is anticipated that the corporate Trust Annual Plan 2012/13 – 2014/15 can be prepared for Trust Board approval on 29th March 2012.

RECOMMENDATION

The Trust Board is recommended to:

- APPROVE the process and timetable for the production of the 3 year Annual Plan 2012/13 - 2014/15.


RCRH Strategy, A&C Model Trajectories, OBC assumptions, IBP, LTFM – CIP targets – Decommissioning assumptions
Trust Strategic Objectives
Half Away-Days with Divisions and Directorates SEPTEMBER 2011
Service issues – Notify Commissioners by 30TH SEPT 2011
Issues for other Divisions/ Directorates
Work with Clinical Directorates
ATOS Report OCTOBER 2011
Draft 3 year CIP
Corporate cross-cutting information
LDP Negotiating Strategy Sign–off by Trust Board 24TH NOV 2011
Progress review by Exec Team members November 2011
5-Year Service Strategies and Transition Plans
Divisional Annual Plans = Year 1-3 Transition Plans 2ND DECEMBER 2011
Exec Review Plans
LDP Negotiations JANUARY - MARCH 2012
Trust Annual Plan 2012/13 – 2014/15 To Trust Board 29TH MARCH 2012

Draft Financial Planning and Contracting Timetable

Date	Description	Committee
06-Sep-11	Request Divisions to declare notifiable changes, Coding, Counting, regulatory changes, repatriation of activity, RCRH pathway changes, non-tariff pricing changes & any legitimate LDP related cost changes	Exec Team/ PMB
w/e 09-Sep-11	Provide high level indicative savings targets (excl adjustments)	Planning sessions
16-Sep-11	Divisions provide all notifiable changes	
19-Sep-11	Changes summarised for discussion at PMB	
20-Sep-11	PMB consider submission to commissioners	PMB
22-Sep-11	Assumed Contract Launch Discussions (Finance & Capacity)	
27-Sep-11	Review draft final submission re Notifications	PMB
30-Sep-11	Conclude ATOS costing work on Projects	
30-Sep-11	Final 30th Sept Notification to commissioners	
04-Oct-11	ATOS stage 2 presentation - quantified project values	Exec Team
18-Oct-11	Confirm LTFM metrics (incl I&E), further clarification on outline transformation/savings targets split by division and corporate dept, based on required efficiencies, RCRH activity related changes and direct link to Transformation Programme projects	PMB
20-Oct-11	Present summarised high level financial plan metrics and external context based on emerging national guidance and local commissioning intentions	F&PMC
27-Oct-11	Assumed Contract Meeting	
28-Oct-11	First Cut Transformation Savings Schedules (TSS) based on costed ATOS stage 2 output and reconciled to gross cost reduction requirement	
01-Nov-11	Planning position reviewed (annual and FinPlan)	Exec Team
11-Nov-11	Feedback and refinement following first cut	COO/Directors
15-Nov-11	Review of Activity targets and agreement of Contract strategy. Divisions to have identified allowable cost pressures and detailed developments	PMB
17-Nov-11	Summary position reported to FPC	F&PMC
24-Nov-11	Assumed Contract Meeting	
30-Nov-11	2nd Cut detailed TSS identifiying direct linkage of supporting saving activity to transformation programme	
09-Dec-11	Feedback and refinement following 2nd cut	
13-Dec-11	Further refinement of detailed 3 year TSS	
15-Dec-11	Assumed Contract Meeting	
15-Dec-11	Divisions/Corp to start process of assessing TPSS for Quality and Safety risks	
15-Dec-11	Summary position reported to FPC	FPC
22-Dec-11	Finance Team finalise 1st cut plan	
06-Jan-12	Complete Q&S assessments of TSS to date	
11-Jan-12	Issue indicative activity targets (either RCRH, LDP or combo)	to Divisions
17-Jan-12	Consider TSS in detail (progress and remedial action)	PMB

19-Jan-12	Consider TSS in detail and first cut Finplan	F&PMC
19-Jan-12	Q&S committee to consider 1st cut Risk assessment	
26-Jan-12	Assumed Contract meeting	
26-Jan-12	TB to consider Q&S review of TSS	TB
26-Jan-12	Consider TSS in detail and first cut Finplan (Private Session)	TB
06-Feb-12	LDP planning meeting - gap analysis	Cluster/CCGs
09-Feb-12	LDP planning meeting - gap analysis	Cluster/CCGs
14-Feb-12	2nd draft plan or reported update	PMB
16-Feb-12	2nd draft plan or reported update	F&PMC
20-Feb-12	LDP meeting	Cluster/CCGs
22-Feb-12	LDP meeting	Cluster/CCGs
23-Feb-12	Closure meeting on high level control totals and activity	Cluster/CCGs
23-Feb-12	Progress report to Board	TB
24-Feb-12	Complete Substantive negotiations and P*A schedules	Cluster/CCGs
29-Feb-12	Final Contract sign-off no TFF, Activity, LDP	Cluster/CCGs
20-Mar-12	Determination of cost pressure funding, TPSS, Activity targets and overall plan for tabling at F&PMC	PMB
22-Mar-12	Final Financial plan and detailed TSS	F&PMC
23-Mar-12	Sign-off of Budget, workforce and activity by CDs and Divisions	Divisions
29-Mar-12	Final TB committee review of detailed impact of TSS	TB
29-Mar-12	Final Financial plan and detailed TPSS	TB
29-Mar-12	Final Q&S committee review of detailed impact of TSS	Q&S

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Division

Clinical Directorate

Transition
&
Annual Plan

Speciality

September 2011

Document Development/Distribution and History				
Name	**Designation**	**Date of issue/ meeting**	**Version**	**Comments**
Mike Sharon Angela Thomas Ann Charlesworth Jayne Dunn	Director of Strategy & OD Deputy Redesign Director Head of Corporate Planning	5&9/8/11	V0.00	To integrate annual planning requirements into template
Mike Sharon Rachel Barlow Rob Banks Linda Pascal Jayne Dunn Rod Knight Ian Kendal Gayna Deakin Rob Ashley Ann Charlesworht Angela Thomas	Director of Strategy & OD Chief Operating Officer Head of Estates Assistant Director of Nursing Redesign DirectorSenior Head of Financial Projects Head of Financial Planning Deputy Director of Workforce DGM – Pathology Head of Corporate Planning Gofer	10/8/11	V0.01	First draft reviewed and first set of amendments incorporated throughout the document.
Ann Charlesworth	Head of Corporate Planning	22/8/11 & 8/9/11	V0.02	Amendments made to the annual planning section to incorporate 2nd and 3rd year planning and sign off.
Gayna Deakin Gill Gadd	Deputy Director of Workforce Service Redesign Project Manager	8/9/11/09/11	V0.03	Following first meeting with W&C's & Redesign team meeting section on Links to other Services and under workforce duplication of table from annual planning workforce section
Divisional Meetings Angela Thomas	W&C's; Surgery B, Community and Surgery A	September	V0.04	Inclusion of assumptions regarding Emergency Care, Intermediate Care. Maternity Theatre Capacity, breakdown of theatres across site; inclusion of the number of endoscopy rooms. In addition, included assumptions for upper decile calculation and comparison table
Redesign Team Meeting		19th September	V0.04	Further amendments to headings to indicate sections for Divisions/Directorates.Specialities to complete. Inclusion of appendix 4 Activity and Capacity Assumptions...
Circulated to Divisions for completion		Sept/Oct	V0.05	

Contents

7. Speciality……

Service Philosophy and Description - speciality to complete

Include:
Aims of Service

Overview of the Service - what the service provides across the Trust e.g. inpatients – Sandwell & City, daycases – BTC, City & Sandwell, OPD – Rowley, Sandwell, Neptune, BTC- other community locations.

Number of inpt and daycase theatre sessions, opd sessions, endoscopy sessions held.

? number of PAs within speciality and allocation

Staffing – in post and budgeted

Include current performance indicators - LOS, N:R ratio, throughput per opd, throughput per operating list, caesarians, daycase% etc.

Service Swot Analysis speciality to complete – service redesign team to provide 2007 FT swot if available (appendix 1)

Strengths	**Weaknesses**
Divisions might consider: • *SLR and SLM positon* • *Service Quality* • *Patient Surveys* • *Complaints* • *Staff engagement e.g. LIA* • *externals reports* • *audits* • *Future technologies* • *reconfigurations*	• Are there national, regional or local requirements driving service change? • Nice recommendations? • CQC
Opportunities	**Threats**

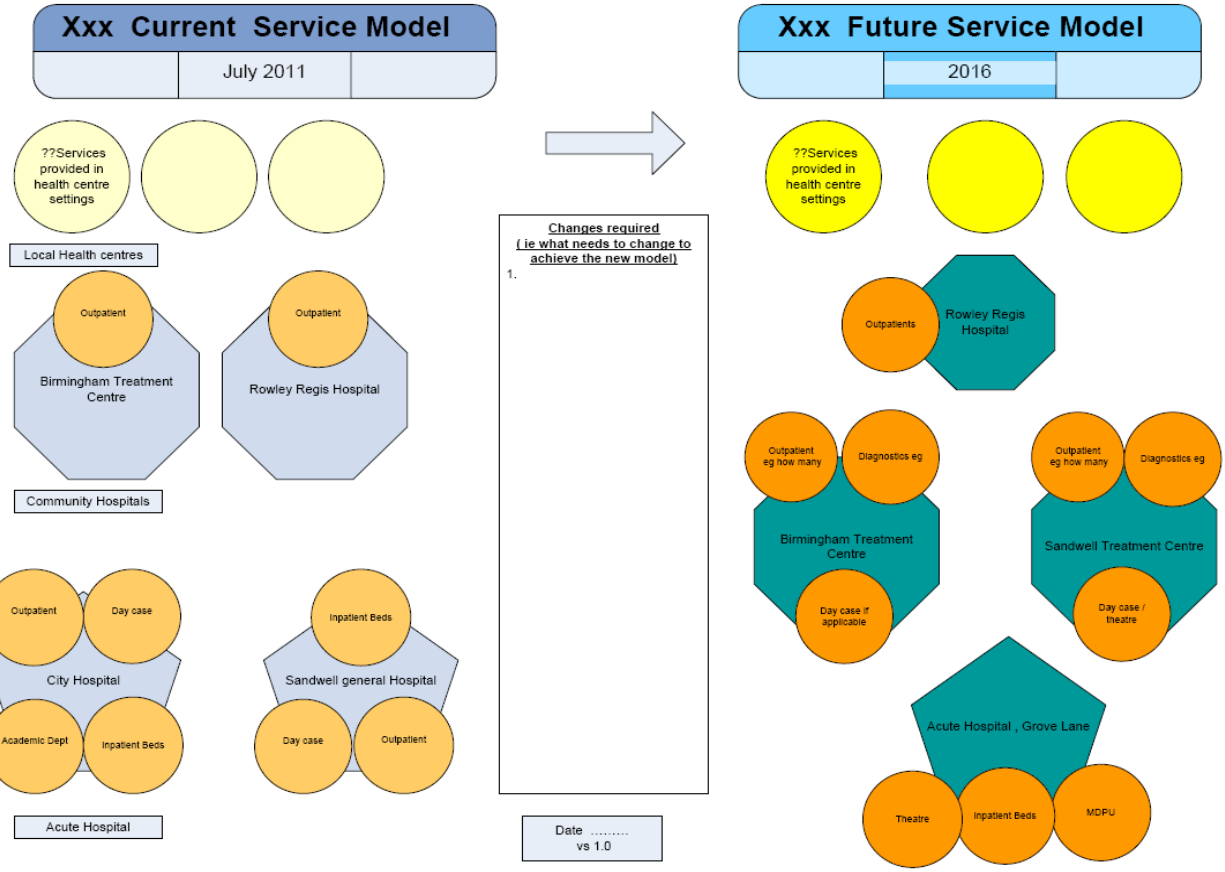
Proposed Clinical Developments/Changes next 5 years.

Market Assessment

May not be able to input for all specialities – analysis undertaken for the main specs..
Some specialities e.g. imaging and pathology understand their own share and opportunities

Circulated to DGMs by Mike Sharon 15th September 2011

Future Service Model Locations provided by redesign team – please comment if changes required



Appendix 2 – SWBH Service Model by Site 2016/17

Future Service Model – Annual Activity Levels to 2016 - provided in excel at Divisional and speciality level

See Appendix 3 – RCRH Activity and Capacity Modelling to 2016 - speciality to feedback on activity including errors or concerns regarding achievability.

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Key Underlying Assumptions for Activity and Productivity Modelling to 2016

– – see appendix 4 for additional detail on Activity and Capacity Modelling

Admitted Patient Care	
Growth ➢ Demography – approx. 1% ➢ Elective Demand – 0.5% p.a ➢ Emergency Demand – 2% for stays < 2 days ***Catchement*** ➢ 10% loss due to choice and independent sector	***Productivity Gains*** ➢ Day case rates @ 88% ➢ Reduction in bed days over HRG trim points - 75% reprovided : SPCT - 37.5% community beds & 37.5% as community services

Bed Occupancy • Acute – average 85% • Community – average 95% • ***Admission Avoidance*** • Management of long term conditions	HOBPCT – 75% as community services • Best practice adopted • Rehabilitation: 75% reprovided, 60% as community beds; 15% as other community services • Reduction in procedures of limited value • Reprovision = 129 Intermediate Care beds and 220 virtual beds.

Outpatients	
New Models of Care • Reduce follow ups to National Top Decile • Shift 52% of outpatients to community settings • Referral management for selected specialities • 60% reduction in Con to Con	***Growth*** • Demography circa 1%

A&E & Urgent Care
Growth • 2% per annum ***New Models of Care*** • 70% of low cost HRGs will be reprovided in Primary Care (30%) & Urgent Care Centres (70)% This represents a 35% shift of A&E total activity.

Capacity Assumptions of Modelling

Theatres		
Emergency MMH	***Elective***	***Community***
• 52 wks/yr • 14 sessions per week • 10% cancellation • 60% utilisation • 24/7 access to an emergency theatre Total - 6 emergency theatres. - 2 trauma theatres, - 2 emergency theatres - 2 maternity theatres	• 44 wks/yr • 10 sessions/wk • 15% cancellations • 80% utilisation Total – 8 elective theatres	• 48 wks/yr • 10 sessions/wk • 10% cancellations • 80% utilisation Total – 11 across community - 3 BMEC - 5 BTC + 1 minors ……..- 3 Sandwell + 1 minors

Outpatients	
MMH	***Community***
• 48 weeks per year • 16 sessions per week • 30 minute new appointment • 20 minute review appointment	• 46 weeks per year • 10 sessions per week • New range from 15 – 60 minutes • Review range from 10 – 60 minutes *Slots vary dependent on speciality and is an outcome of meetings to identify number of clinicians seeing patients and time slots per patient at clinic level. Representation is an average at speciality level.*

Endoscopy	
MMH • 44 weeks per year • 10 sessions per week • 10% utilisation • 80% utilisation • emergency access 24/7 Total 3 rooms	***Community*** • 44 weeks per year • 10 sessions per week • 10% cancellations • 80% utilisation Total - 6 rooms

Additional Targets in Support of the IBP– New Acute Hospital A&C assumptions based on upper quartile, IBP requires upper decile

Dr Foster is used to determine upper decile for LOS and Daycase rates and incorporates
- comparison with National Peer
- exclusion of Private Sector Providers
- exclusion of Providers with spells < 10
Indicators for new to review ratio uses

Speciality……insert

Year 10/11	*El LOS*	*Em LOS*	*Combined LOS*	*Daycase rate*	*Follow up to New ratio*
National Upper Decile					
SWBH					
Variance					

Corporate Teams to provide

Key Milestones For Service Change– speciality to complete

E.G reconfiguration of services, developing treatments and potential impact on future delivery e.g. medication negating requirements for frequent blood monitoring, change in care pathways, new roles, etc

Cross reference to SWOT analysis if appropriate

Links/Impact on Other Services– speciality to complete

Incorporate impact on other services of the key milestones e.g.

** Opportunities in redesigning care pathways with the Community Division*
** Diagnostics*
** Facilities Management*
** Theatres*
Etc.

Financial Analysis – including future income and expenditure– speciality to complete

SLR issued.to CDs and GMs in September by Ian Kendall

Consider number of locations, sessions (minutes) & staffing requirements

Workforce Implications - speciality to complete

Current budgets by staff group versus future workforce.

This section should reflect the schemes identified from the Service's strategies incorporating the financial affordability envelope, ESR, Future work patterns if working across site,Staffing projected by Division/Directorate

Divisions to consider:

Staff working in different locations:
Increased staff flexibility (extended day/weekend working, 24/7)
New/redesigned roles/new ways of working
Changes to existing skill mix
Requirement for training for new skills
Increases/decreases to WTEs by Staff Group (including or referenced to CIP)
Other

Risk Assessment and Mitigation- speciality to complete

Annual Planning
Specialities to Complete

Priorities for 2012-2014

Annual Plans should address the next 3 years; the first year in detail and the following 2 years in outline where possible.

Priorities should be specific and measurable and show how the Directorate/Division will contribute to the delivery of the six Trust corporate objectives. This could include continued work on priorities originally identified in 2011/12 where appropriate

Strategic & Directorate Objectives	Key Actions	Lead	By When
SO1 - Accessible and Responsive Care			
Division to insert their own objectives relating to the Trust's Corporate Objectives. *Priorities for this objective including (a) access targets (b) Equality and Diversity activity and (c) improving patient experience / patient survey results]* *etc.*	*Key actions required to deliver directorate objective*		
SO2 - High Quality Care			
Priorities including (a) key clinical priorities (b) any major service reconfigurations/redesign (c) any plans to improve measurement of quality / outcomes and (d) infection control]			
SO3 - Care Closer to Home			
Priorities for contributing to the delivery of the RCRH service model including (a) RCRH projects (b) making full use of Rowley and (c) supporting intermediate care provision			
SO4 - Good Use of Resources			
Priorities including (a) ensuring break even and delivering CIP and (b) priorities for productivity improvement]			
SO5 – 21st Century Facilities			
Any major priorities for improving facilities			
SO6 – An Effective Organisation			
Priorities for ensuring an effective organisation including (a) reviewing the service/divisional workforce (b) using Listening into Action within the Team/ Division (c) supporting education and research (d) ensuring mandatory training, appraisals and use of KSF			

Major Developments for 2012-13

Summary of your top priority developments proposed by the Service/Division for 2012/13 that will need corporate consideration including any developments requiring capital, consultant replacements or appointments or business cases for new services. This should include the expected date of the presentation of the case to SIRG. Developments not identified here will only be prioritised for SIRG in 2012/13 where it is clear that the Service/ Division could not have been expected to identify them as part of the planning process (e.g. an unexpected resignation)]

Please ensure that the information you provide here is the same as that submitted via the Senior Finance Managers route

Service Developments/Changes 2012/13

Service Developments/Changes	Cost Estimate £	Business Case to SIRG (proposed date)
Capital Developments [1]		

[1] *N.B. These should be in priority order. For equipment proposals this does not remove the need to submit completed Capital Equipment Forms*

Narrative may be included outlining service developments/changes to be considered for 2013/14 or 2014/15.

Cost Pressures	£
Total	

Financial Plan – Income & Expenditure

First cut to include summary of key elements of Service/Divisional CIP plus any other key financial assumptions being made by Service/Division. Final version to include summary income / expenditure and CIP plan for the Division

	Budget 2011/12 £,000s	Variance at month x £,000s	Forecast Outturn 2011/12 £,000s	Budget 2012/13 £,000s	2013/14 Forecast £,000s	2014/15 Forecast £,000s
Contract Income						
Pay						
Non-pay						
Net Budget						

brief narrative on key issues for 2012/13

work required to improve SLR and move to SLM

Cost Improvement Plan

CIP 2012/13

Initial CIP Target £000	Pay £000	Non-Pay £000	Income £000	Total £000

brief narrative on key components of CIP

CIP 2013/14 (Outline)

Initial CIP Target £000	Pay £000	Non-Pay £000	Income £000	Total £000

brief narrative on key components of CIP

CIP 2014/15 (Outline)

Initial CIP Target £000	Pay £000	Non-Pay £000	Income £000	Total £000

brief narrative on key components of CIP

Summary Activity Plan

This should include highlights of decommissioning plans with appendices for detail.

Activity	11/12 Plan	11/12 Forecast Outturn	12/13 RCRH Trajectory	12/13 Plan	13/14 Plan	14/15 Plan
Day Case						
Elective						
Emergency						

Outpatient first attendance						
Outpatient follow up						
Outpatient + procedure						
Divisional Total						

Summary of Workforce Plan

Management of Bank and Agency to be included
First cut to include completed 11/12 plan and 11/12 forecast information plus short narrative highlighting any issues arising from 2011/12 position that are likely to affect Service/Divisional planning for 2012/13. Remaining columns to be completed before sign-off of the plan in Feb 2012.

WTE by Staff Group

Staff Group	August 2011 [4] Budgeted Establishment	August 2011 Actual [5]	April 2012 Projected	March 2013 Projected	March 2014 Projected	March 2015 Projected
Medical						
Managers						
Administration & Estates						
Healthcare Assistants & Support						
Nursing & Midwifery						
Scientific Therapeutic & Technical						
Bank						
Agency						
TOTAL (WTE)						

N.B.
[4] *Source – Monthly Budget Report*
[5] *Source – Monthly Budget Report*

Brief summary of the main workforce implications arising from the key priorities and major developments (including RCRH trajectory) listed above, as applicable.
Delete as appropriate……..

Staff working in different locations:
Increased staff flexibility (extended day/weekend working, 24/7)
New/redesigned roles/new ways of working
Changes to existing skill mix
Requirement for training for new skills

Increases/decreases to WTEs by Staff Group (including or referenced to CIP)
Other

	2010/11 **£000**	**2011/12** **£000**	**2012/13 Projected £000**
Nurse Bank			

Agency Staff Group	**2010/11** **£000**	**£2011/12 000**	**2012/13 Projected £000**
Nursing			
Medical			
Other			
Total			
% Total Pay Spend			
Saving if reduced to 1.5% of total			

Key Risks and Risk Management

Summary of c. 5 main risks to delivery of divisional priorities for 2012/13 and Divisional approach to risk management. These should link to the main entries on the Divisional risk register.]

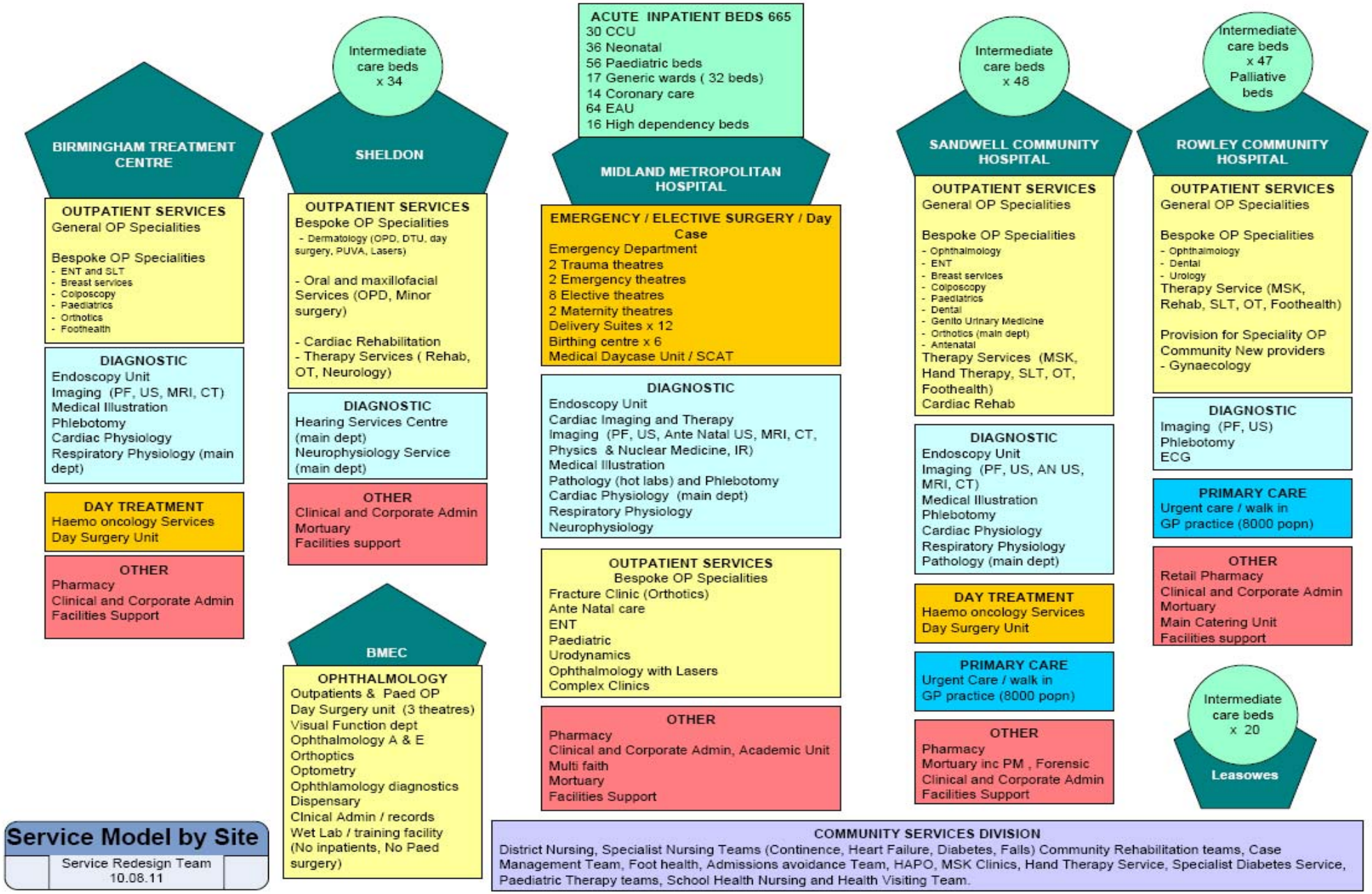
Service/Divisional Risks 2012/13

Main Risks to Divisional Plan	**Risk Score (Probability x Impact)**	**Approach to managing Risk**
1.		
2.		
3.		
4.		
5.		

SIGN OFF *[Plans to be formally signed off by Feb 2012]*	Divisional Director Divisional General Mgr Clinical Director	

	Chief Operating Officer Director of Finance Director of Strategy and Org. Development Chief Nurse/Exec Lead for Workforce		

Appendix 2 - Service Model By Site - 2016



APPENDIX 4

Sandwell and West Birmingham Hospitals NHS Trust

New Acute Hospital Project

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ACTIVITY, PERFORMANCE & CAPACITY ASSUMPTIONS

August 2010

Version 1

DOCUMENT HISTORY

Document Location:

Revision History:

Version	Date	Author	Summary of Changes
V1	5/08/10	Jayne Dunn Redesign Director Right Care Right Here	Version used for OBC refresh
V1 draft 1	30/7/10	Jayne Dunn Redesign Director Right Care Right Here	First draft to capture what is already agreed for the RCRH Programme, OBC and OBC refresh - service model and Activity and Capacity Model version 5.3.

Distribution:

Name	Date of issue	Version
New Acute Hospital Project Finance Team	05/08/10	Version 1
Service Redesign Team	05/08/10	Version 1
Core Team	05/08/10	Version 1

Approvals:

Version	Name	Title	Date
V1	Version used in the OBC refresh		
Version 1	Core Team	As per core team membership	August 2010

CONTENTS

1. INTRODUCTION

The purpose of this paper is to summarise assumed activity, performance indicators and capacity for the New Acute Hospital and also for the services it is planned that the Trust will provide in Community Hospitals.

2. BACKGROUND

The *Right Care Right Here (RCRH) Programme* (formerly the Towards 2010 Programme) developed a jointly owned forecast of future activity for the local health economy in the form of an Activity and Capacity Model. The aim was for the model to provide future forecasts of activity and capacity that would be used by partners to underpin future health care development and associated business cases. In this context the model has been used as the basis for activity assumptions for planning the New Acute Hospital.

The Activity and Capacity Model makes forecasts about:

- Activity for the population of Sandwell and West Birmingham Hospitals (SWBH) NHS Trust (a catchment of circa 500 000 people in Sandwell and western and central Birmingham) regardless of commissioner; and
- Activity for the registered populations of Sandwell and Heart of Birmingham teaching PCTs (circa 620 000 people) regardless of provider.

The activity the model covers is all consultant inpatients, day cases, outpatient attendances and A&E attendances. The model functions at HRG level. This has been supplemented by additional analysis and modelling for areas such as non contracted activity, Pathology and Imaging.

The Model starts from the baseline actual activity in the most recent year available and produces a year by year forecast for ten years in detail but can be extended to twenty years.

The current version (version 5.3, see below) of the *RCRH* Activity and Capacity Model comprises three main sections:

- *Past Trends and Current Plans (2 years: 2009/10- 2010/11):* The model includes outturn activity for 2009/10 and LDP plans for 2010/11. LDP plan for 2010/11 is used as the baseline year.
- *Forecast to Opening of New Acute Hospital (6 years: 2011/12 – 2016/17):* The model includes a forecast of the impact of major changes in models of care and service provision planned for this period.
- *Forecast After Opening of New Acute Hospital (10 years: 2017/18- 2026/27):* In line with requirements of the OBC for the new acute hospital and SWBH NHST's Foundation Trust application, the model includes a longer-term forecast of activity levels once the new models of care are fully delivered.

The local health economy have agreed a set of assumptions that form the basis of the modelling. These include:

- Assumptions about activity demand including Population Growth
- Assumptions about planned health care changes including admission avoidance, improved productivity, shifts in location
- Assumptions about future provider of health care services.

Further more detailed analysis has then been undertaken to predict capacity requirements in the New Acute Hospital for example theatre minutes.

The *RCRH* Activity and Capacity Model was first developed in 2004 for the Programme Strategic Outline Case and has then been developed through a series of versions. For the New Acute Hospital Outline Business Case Version 4.2 (2008) was used.

As a result of the change in financial conditions within the NHS a review of the *RCRH Programme* was undertaken in 2009. This included an update of the *RCRH* Activity and Capacity Model resulting in version 5.1 which also included revised forecast activity and capacity for the new Acute Hospital. The *RCRH Programme* has produced a range of detailed reports from the model e.g. at PCT level, Provider Level, Speciality Level.

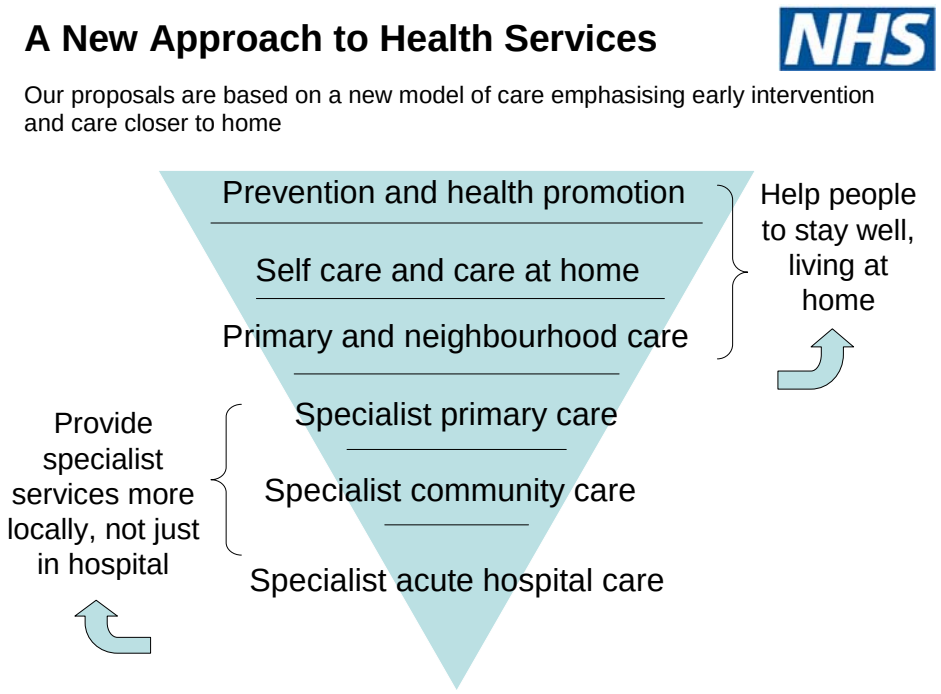
Following approval of version 5.1 of the *RCRH* Activity and Capacity Model a value engineering exercise for the new Acute Hospital was undertaken to recognise the changes in version 5.1 and also given the changes to the NHS financial conditions to reduce the size of the new Acute Hospital and improve affordability. This has resulted in further changes to the Activity and Capacity Model and in particular the split of activity between the new Acute Hospital and the community hospitals linked to retained estate. The outputs of this are captured in version 5.3 of the Activity and Capacity Model although at this stage this has not been formally signed off by the *RCRH Programme.*

The Refreshed Outline Business Case is based on Version 5.3 of the *RCRH* Activity and Capacity Model. Version 5.3 is also used as the basis for this report.

3. SERVICE MODEL

The purpose of the *RCRH Programme* is to deliver redesigned acute, primary, community and social care services in the Sandwell and Heart of Birmingham areas.

This will require a fundamental redesign and re-provision of the health and social care system and a new model of care. This is summarised in the diagram below:



This vision requires a major step change in service provision across the health economy through service redesign and investment with a re-balancing of capacity to reflect a greater focus on delivering care in community and primary care settings and a new single site Acute Hospital operating at maximum productivity.

Within the context of the *Right Care Right Here (RCRH)* model of care the Trust will provide services in community locations and support services in primary care as well as providing services within the Acute Hospital.

As part of the new Acute Hospital project an *Acute and Community Hospital Clinical Service Model* has been produced. This provides a blueprint for the development of a new service model for the Trust post opening of the new Acute Hospital and includes Trust provided services within community hospitals and other retained estate as well as the new Acute Hospital. In addition to providing services in the new Acute Hospital the Trust will also be providing clinical services in three community hospital locations (Rowley Regis Hospital, Sandwell Community Hospital, the Birmingham Treatment Centre) and other retained estate, i.e. Birmingham and Midlands Eye Centre (BMEC) and the adjacent Sheldon Block.

For the Trust the implications of the *RCRH* vision can be summarised as:

- The majority of outpatient attendances and planned diagnostics will be provided outside of the acute hospital in community locations by a mixture of secondary care specialists and primary care professionals. Only 16% of outpatient attendances will take place in the new Acute Hospital. A further 65% will be provided by SWBH in community locations, with 20% being Ophthalmology outpatient attendances taking place in BMEC. 12% of outpatient attendances will be provided by new providers (other than SWBH) in community locations and 8% will be absorbed in to primary care as part of routine working in primary care.

- A significant reduction in the average length of stay in the acute setting to 3.41 days but with some of the reduction being delivered through new bed capacity in community locations giving a Trust overall average length of stay of 4.03 days. The Trust will be the provider of intermediate care in circa 129 community beds in Rowley Regis Hospital (47 beds), Sandwell Community Hospital (48 beds) and Sheldon Block (34 beds) on the current City Hospital site.

- A catchment loss for emergency inpatient activity related to a change in location of the new Acute Hospital.

- Increased community-based urgent care and out-of-hours services to provide alternatives to attending the acute hospital Emergency Department for about 45% of patients requiring this type of care. A further 21% of emergency attendances will be for ophthalmic conditions and will take place in the Eye Emergency Department at BMEC. 34% of emergency attendances will take place in the Emergency Department within the new Acute Hospital.

- Increased day surgery rates (to 88%) with the majority of day surgery being provided in dedicated day surgery units in three community locations (Birmingham Treatment Centre, the Sandwell Community Hospital and BMEC).

- Better physical environments for service users and staff which encourage more rapid recovery and provide greater privacy and dignity.

The development of a new single site Acute Hospital will bring together clinical teams from the two current acute hospitals within the Trust and will result in:

- o A greater critical mass of services within larger clinical teams so reducing professional isolation and enabling the delivery of high quality care through greater sub-specialisation, robust 24 hour senior cover and on-going service development.

- o Emergency and inpatient services being available 24 hours, 7 days a week, and the majority of other services being operational for at least 12 hours a day during the week and for sometime at the weekend thereby offering patients greater choice of appointment times and making efficient use of facilities and equipment.

The Trust provided services from an activity and capacity perspective are divided into acute hospital and community hospital locations with the latter including Sandwell Community Hospital, Birmingham Treatment Centre (BTC), Rowley Regis Hospital and retained estate in Sheldon Block (on the current City Hospital site) and the Birmingham Midlands Eye Centre (BMEC – on the current City Hospital site).

4. ACTIVITY MODELLING ASSUMPTIONS

The assumptions outlined below are those that are in version 5.3 of the RCRH Activity and Capacity Model.

4.1 Admitted Patient Care

Figure 1 below shows the key assumptions that have been applied to admitted patient care in the period of major change up to the opening of the new acute hospital.

Figure 1: Activity Modelling Assumptions – Admitted Patient Care

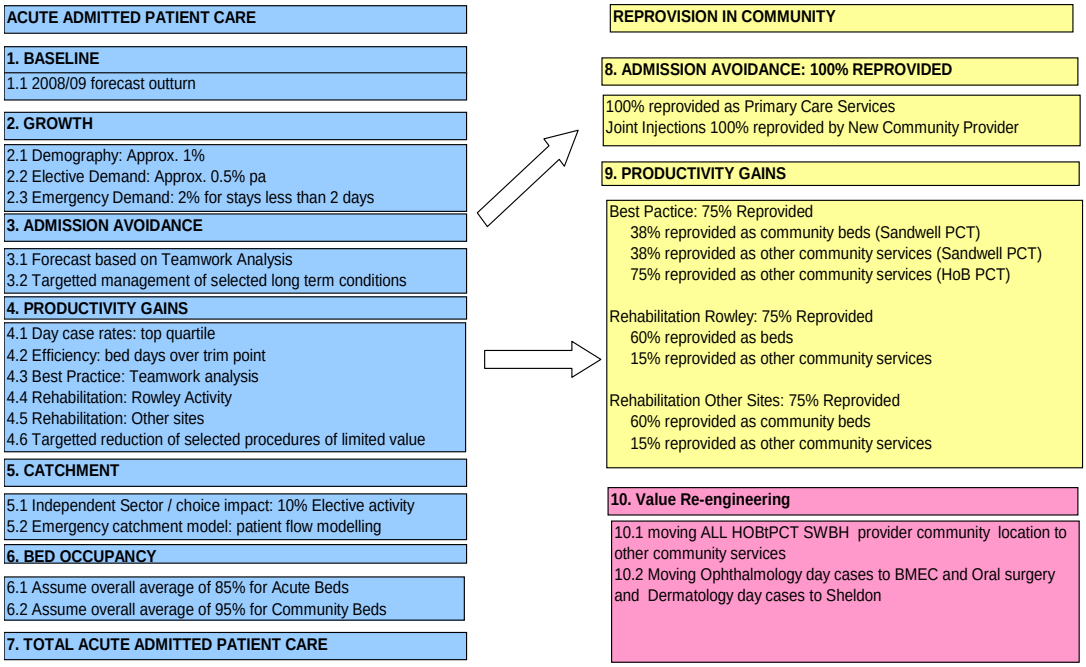


Table 1 below sets out the key assumptions applied within the model for admitted patient care in each of the modelling periods i.e. up to the opening of the new acute hospital and afterwards.

Table 1: Admitted Patient Care

Assumption	To Opening of New Acute Hospital (2009/10-2016/17)	After Opening of New Acute Hospital (2017/18-2026/27)
Growth in Demand	Impact of ONS forecast levels of population change in Birmingham and Sandwell on demand. Approx. 1% a year. 3% a year increase up to 2015/16 in elective demand in T&O, Ophthalmology, Rheumatology, Neurology and Gynae Oncology in recognition of current access rates, reduction in waiting times and increased patient presentations as electives not emergencies. 2% a year (up to 2015/16) increase in emergency spells with a length of stay less than 2 days.	Impact of ONS forecast levels of population change in Birmingham and Sandwell on demand. No additional growth in elective demand in response to improvements in primary care. 1% a year increase in demand for shorter-stay emergencies. 2% a year increase in intermediate care
Admission Avoidance	HRG level assumptions about impact of admission avoidance based on Teamwork consultancy review of evidence. This activity is re-provided as either community beds (20%) or community alternatives to beds e.g.	Existing admission avoidance continues. In addition there will be some further increase in the proportion of short stay hospital activity that can be dealt with in the community.

	hospital at home teams (80%). 100% of joint injections transferred to a new provider in a community location. Selected procedures of limited clinical value removed or reduced at HRG level. Not re-provided.	
Productivity Gains	Day case rates: modelled at 2006/7 top quartile (England) of 85%. The majority of this undertaken in the community. Efficiency: improved hospital efficiency reduces length of stay by equivalent of 75% excess bed days. Re-provided in the community. Best practice: further reduction in hospital bed days based HRG-level analysis undertaken by Teamwork consultancy. 75% of this re-provided in the community. Reduction in Caesarean Section rates to national best practice level (19%). Intermediate Care: 75% of activity at Rowley Regis Hospital re-provided as Intermediate Care in the community (60% beds, 15% community equivalents). 25% is not re-provided. All bed days over 21 days for any inpatients staying longer than 28 days are converted to Intermediate Care. 75% are re-provided in the community. 25% not re-provided.	Continued gradual reductions in length of hospital stays as a result of further incremental improvements in patient pathways.
Catchment	Patient choice impact: possible loss of activity as a result if patient choice equal to 10% of baseline elective inpatient cases (except for Ophthalmology and Gynaecology Oncology because of the tertiary nature of their work). Emergency catchment: postcode level modelling of patient flows predicting catchment of new acute hospital. The changes to the emergency catchment equate to a reduction of C. 60 beds in the capacity required in the new acute hospital. The majority of this activity is lost to Walsall (with some to Dudley, HEFT and UHBFT). The modelling assumptions have been shared with	Catchment stable after opening of new acute hospital.

	Walsall Hospitals NHS Trust. This catchment loss occurs in 2015/16 (50%) and 2016/17 (50%).	
Bed Occupancy	Average future bed occupancy of 85% (lower for specialist and assessment beds; higher for generic beds).	Bed occupancy stable after opening of new acute hospital.

The value engineering work undertaken for the new Acute Hospital has resulted in a bigger shift of day case activity from the acute hospital to community locations. In particular the decision to retain BMEC has meant the majority of Ophthalmology adult day case activity will take place in a community location even though much of this activity involves tertiary referrals. In version 5.3 endoscopy activity forecast for Sandwell Community Hospital and the BTC is also shown as day case activity in community locations.

4.2 Outpatient Care

Figure 2 below shows the key assumptions that have been applied to outpatient care in the period of major change up to the opening of the new acute hospital.

Figure 2: Outpatients

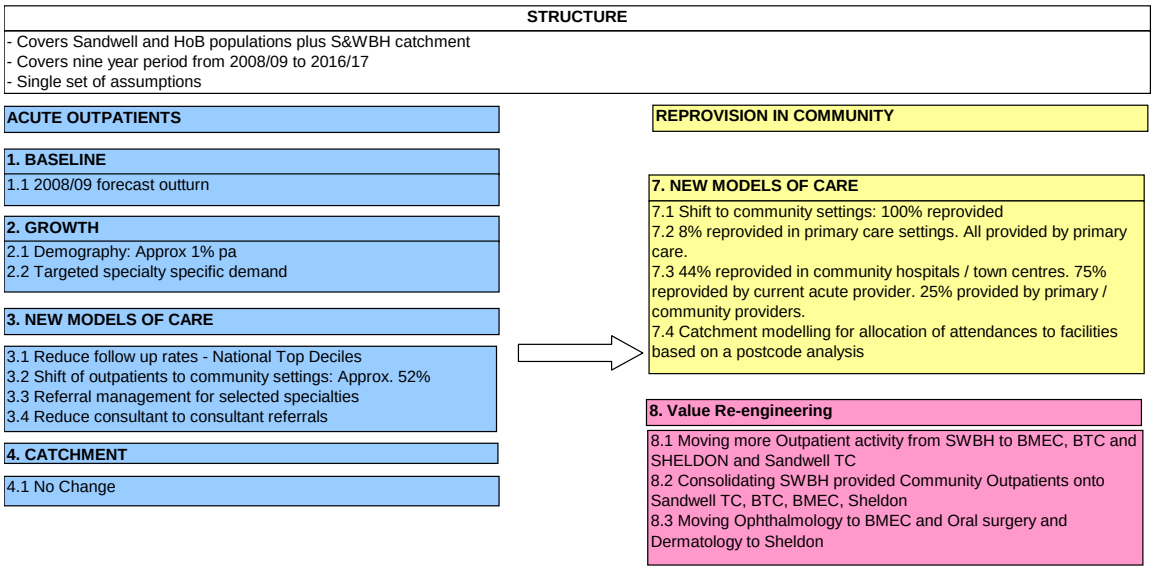


Table 2 below sets out the key assumptions applied within the model for outpatient care in each of the modelling periods i.e. up to the opening of the new Acute Hospital and afterwards.

Table 2: Outpatient Care

Assumption	To Opening of New Acute Hospital (2009/10-2016/17)	After Opening of New Acute Hospital (2017/18-2026/27)
Growth	Impact of ONS forecast levels of population change in Birmingham and Sandwell on demand. Approx. 1% a year. 1% a year increase in elective demand up to 2015/16 in recognition	Impact of ONS forecast levels of population change in Birmingham and Sandwell on demand. No additional growth in elective demand in response

	of current access rates, reduction in waiting times and increased patient presentations as electives not emergencies. This as an average percentage and so there are variations between specialities based on recent historical trends.	to improvements in primary care. .
New Models of Care	Follow-up rates: reduction of new to follow-up ratio to England upper decile. Referral Management: attendances reduced by 0.3% in selected specialities as a result of improved referral management. 60% reduction in consultant to consultant referrals based on improved referral systems. Shift to community: major shift of activity to the community. Activity re-provided in a range of settings according to specialty including primary care and new community hospitals. Postcode catchment modelling undertaken to attribute activity to new community locations.	
Catchment	No change in catchment assumed.	No change in catchment assumed.

The value engineering work undertaken for the new Acute Hospital has resulted in a bigger shift of outpatient activity from the acute hospital to community locations. In particular the decision to retain BMEC has meant the majority of Ophthalmology outpatient activity will take place in a community location even though the much of this activity involves tertiary referrals.

4.3 A&E and Urgent Care

Figure 3 below shows the key assumptions that have been applied to Accident and Emergency and Urgent Care services in the period of major change up to the opening of the new Acute Hospital.

Figure 3: Activity Modelling Assumptions – A&E and Urgent Care

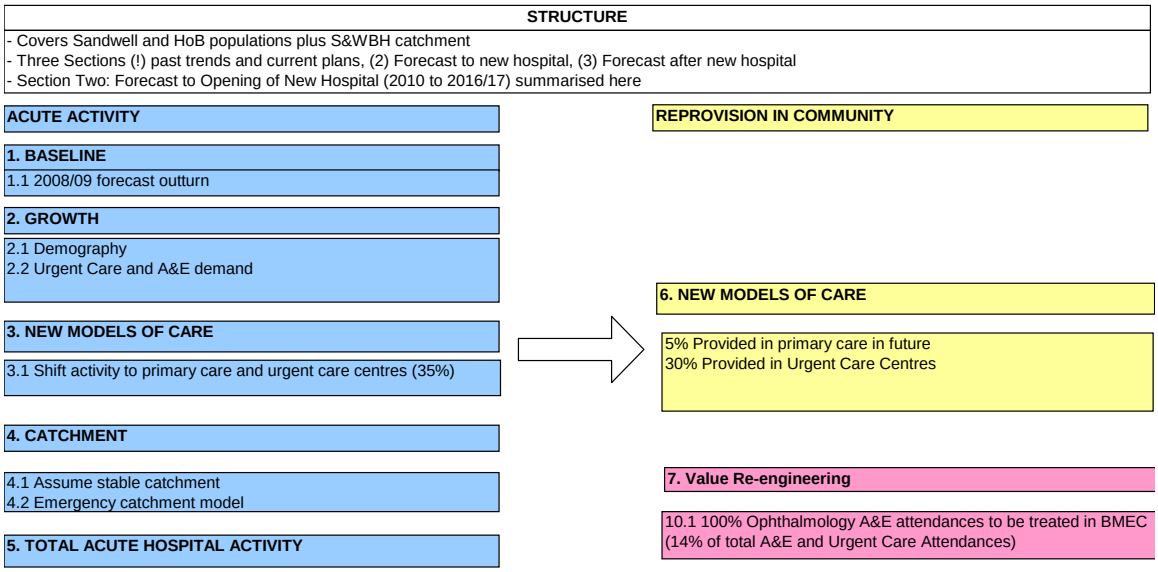


Table 3 below sets out the key assumptions applied within the model to A&E and urgent care centre activity in each of the modelling periods i.e. up to the opening of the new Acute Hospital and afterwards.

Table 3: A&E and Urgent Care

Assumption	To Opening of New Acute Hospital (2009/10-2016/17)	After Opening of New Acute Hospital (2017/18-2026/27)
Growth	Impact of ONS forecast levels of population change in Birmingham and Sandwell on demand. Approx. 1% a year. 2% a year growth in A&E and urgent care attendances prior to changes in location or model of care.	Impact of ONS forecast levels of population change in Birmingham and Sandwell on demand. 2% a year growth in A&E and urgent care attendances prior to changes in location or model of care.
New Models of Care	Assumed that in future 70 % of low cost A&E HRGs reprovided as urgent care with 30% of these treated in improved primary care services and 70% in Urgent Care centres. Ophthalmology A&E attendances will be treated in the Eye A&E in BMEC.	
Catchment	No change in catchment assumed.	No change in catchment assumed.

The value engineering work undertaken for the new Acute Hospital has resulted in a shift of ophthalmology A&E activity from the acute hospital to BMEC which for modelling purposes is identified as a community location although not an urgent care centre. This has reduced the % of emergency attendances taking place in the new Acute Hospital.

4.4 Summary of Activity

Table 4 below summarises the main changes identified by the model for the period up to the opening of the new Acute Hospital. It includes all activity that will be delivered by the Trust, including activity delivered outside of the new acute hospital.

Table 4: Summary of Activity, Productivity and Capacity Changes

Category	Type	Outturn 2008 / 09	Outturn 2009 / 10	Plan 2010 / 11	Forecast 2016 / 17	Forecast 2020 / 21	Forecast 2026 / 27
Admitted Patient Care	Elective Inpatients	13,120	13,150	12,653	6,589	6,800	7,159
	Day Cases	50,936	52,583	45,622	49,004	50,420	52,868
	Emergencies	69,494	66,299	63,084	52,774	56,496	62,988
Outpatients	New Outpatients	155,584	168,745	181,128	169,513	173,268	179,853
	Review Outpatients	380,578	429,156	371,874	291,262	300,183	315,408
Other	A&E Attendances	226,796	224,920	226,978	249,815	258,564	267,917
	OBDs	342,793	328,919	310,523	239,317	246,480	259,794
Productivity	Length of Stay	4.15	4.14	4.10	4.03	3.8	3.65
	Day Case Rates	80%	80%	78%	88%	88%	88%
	Bed Occupancy	87%	85%	87%	85%	85%	85%
	New to Review Ratios	2.45	2.54	2.05	1.72	1.74	1.75
Capacity	Beds	1079	1056	978	795	795	795

Table 5 below shows the future forecast SWBH NHST activity by location i.e. separating activity forecast for the new Acute Hospital from that forecast for the community hospitals.

Table 5: Projected Trust Activity in 2016/17 by Location

Category	Type	New Acute Hospital	Community Hospital	Total
Admitted Patient Care	Elective Inpatients	6,589	0	6,589
	Day Cases	14,773	34,231	49,004
	Emergencies	51,809	966	52,774
Outpatients	New Outpatients	47,916	121,597	169,513
	Review Outpatients	41,618	249,644	291,262
Other	A&E Attendances	137,203	112,612	249,815
	OBDs	198,260	41,057	239,317
Capacity	Beds	666	129	795

Additional activity (not forecast to be delivered by the Trust) will be undertaken in community bed equivalents i.e. care provided in patients' own homes.

4.5 Activity Changes 2008/09 – 2026/27

The model also includes a set of shared assumptions about the likely speed of transition to the new models of care and therefore changes in activity volumes and location of activity. The tables below summarise this for Trust delivered activity in the new Acute Hospital (table 6), community hospitals (table 7) and Trust total activity (table 8).

Table 6: Change in Activity Over Time (Acute Hospital Based Activity)

	2008/09	2009/10	2010/11	2012/13	2016/17	2020/21	2026/27
Admitted Patient Care	133,550	132,032	121,360	109,916	73,171	77,404	84,753

OBDs	342,793	328,919	310,523	288,050	198,260	199,988	203,417
Outpatients	536,162	597,901	537,884	443,831	89,534	91,095	93,841

Table 7: Change in Activity Over Time (Community Hospital Based Activity)

	2008/09	2009/10	2010/11	2012/13	2016/17	2020/21	2026/27
Admitted Patient Care	0	0	0	462	35,197	36,313	38,262
OBDs	0	0	0	18,392	41,057	42,678	52,563
Outpatients	0	0	15,117	68,308	371,241	382,356	401,420

Table 8: Change in Activity Overtime (Total SWBH NHST Activity)

	2008/09	2009/10	2010/11	2012/13	2016/17	2020/21	2026/27
Admitted Patient Care	133,550	128,080	121,360	110,377	108,367	113,717	123,015
OBDs	342,793	328,919	310,523	306,442	239,317	242,666	255,980
Outpatients	536,162	502,051	553,002	512,139	460,775	473,451	495,261

4.6 Diagnostics

Additional modelling work has been undertaken outside of the *RCRH* Activity and Capacity Model but in liaison with PCTs to forecast changes in activity and therefore capacity requirements in Imaging and Pathology. Table 9 below summarises the activity changes between 2009/10 and 2016/17 by modality whilst table 10 summarise the activity changes for Pathology.

Table 9: Trust Imaging Activity by Modality

	Base Year 2009-10			Forecast Year 2016-17		
Imaging Modalities	2009-10 Outturn	2009/10 Acute	2009/10 Community	2016-17 Plan	2016/17 Acute	2016/17 Community
Angiography	4,766	4760	6	4,205	3,997	208
Breast	3,849	3,656	193	5,415	4	5,411
MRI	12,389	11,725	664	15,979	4,776	11,204
CT	21,243	20,374	869	31,963	16,915	15,048
Fluroscopy	5,950	5,746	204	4,725	4,511	214
Nuclear Medicine	8,525	8,525		11,157	11,157	
Obs Ultrasound	28,329	27,895	434	21,962	6,062	15,900
Radiology (Plain Film)	176,544	133,372	43,172	171,858	106,471	65,386
US Gen	40,177	25,239	14,938	52,899	16,758	36,141
Neurophysiology	632	540	92	1,608	416	1,191

Table 10: Trust Pathology Activity

	Base Year 2009-10			Forecast Year 2016-17		
Pathology Tests by Patient Type	2009-10 Outturn	2009/10 Acute	2009/10 Community	2016-17 Plan	2016/17 Acute	2016/17 Community
BLOOD BANK	69,285	69,185	100	57,887	56,104	1,783
CLINICAL CHEMISTRY	3,480,655	1,204,421	2,276,234	5,448,777	806,924	4,641,853
CYTOPATHOLOGY	41,580	1,705	39,875	78,970	591	78,379
HAEMATOLOGY	899,356	522,319	377,036	1,172,293	357,004	815,289
HISTOPATHOLOGY	99,044	95,202	3,842	83,140	57,480	25,659
IMMUNOLOGY	143,003	112,784	30,219	168,234	92,261	75,973
MICROBIOLOGY	296,752	150,377	146,375	407,006	97,035	309,971
TOXICOLOGY	33,233	32,373	860	36,578	34,738	1,841
Total Base Diagnostic Tests Future SWBH	5,062,907	2,188,366	2,874,541	7,452,886	1,502,137	5,950,749

5 PERFORMANCE ASSUMPTIONS

Within the *RCRH* Activity and Capacity Model a number of high level performance assumptions are included within the activity modelling assumptions outlined in the above section of this report. These were used as a starting point for the capacity modelling for the new Acute Hospital and Community Hospitals and built upon with more detailed assumptions for specific categories of activity. The purpose of this section of the report is to outline these performance assumptions (the high level assumptions outlined above have been included for completeness).

5.1 Admitted Patient Care

5.1.1 Length of Stay

Within the *RCRH a*ctivity and capacity modelling assumptions a number of performance assumptions were applied to length of stay. These include:

- *Efficiency:* it was assumed that improved hospital efficiency in the new Acute Hospital particularly in relation to discharge processes generally and in particular the number of delayed discharges, reduces length of stay by the equivalent of 75% excess bed days. These excess bed days are assumed to be re-provided in the community with for Sandwell PCT half re-provided in community beds and half in community services/bed equivalents and for HoBtPCT all re-provided in community services/bed equivalents.

- *Best Practice*: a benchmark exercise was undertaken at HRG level by Teamwork Consultancy and a further reduction in hospital bed days was assumed on this basis. 75% of this bed day reduction is assumed to be re-provided in the community with for Sandwell PCT half re-provided in community beds and half in community services/bed equivalents and for HoBtPCT all re-provided in community services/bed equivalents.

- *Rehabilitation/Intermediate Care:* several assumptions were applied here. The first being, as a result of local managerial and clinical discussion all admitted patient care at Rowley Regis Hospital was assumed to be non-acute activity with 75% of this activity being re-provided as Intermediate Care in the community (60% in community beds and 15% community services/bed equivalents). The remaining 25% of activity is not re-provided on the assumption that it will not be required as a result of improved efficiency e.g. in discharge processes. All bed days over 21 days for any inpatients (excluding neonates) staying longer than 28 days in the acute hospital are converted to Intermediate Care. Of these 75% are re-provided in the community (60% in community beds and 15% community services/bed equivalents) and 25% are not re-provided on the assumption that they will not be required as a result of improved efficiency e.g. in discharge processes.

- *Elective Inpatients:* in addition to an assumption about day case rates being equivalent to the upper quartiles (see below) assumptions have been applied to short stay patients undergoing elective surgery. These are in line with best practice.

- *Adult Acute Assessment:* in order to determine the bed capacity required in the adult acute assessment a 0.5 day length of stay has been added to all adult emergency admissions (excluding Obstetrics) with an otherwise 0 day length of stay. The average length of stay assumptions for the adult acute assessment unit are:

    - 0.5 days for emergency adults with an overall length of stay of 0 days in the acute hospital
    - 1 day for emergency adults with an overall length of stay of 1-2 days in the acute hospital
    - 0.25 days for emergency adults with an overall length of stay of more than 2 days in the acute hospital.

- *Intermediate Care:* an average length of stay in the Trust provided community beds of 42.51 days.

The impact of these assumptions in terms of average length of stay has been:

- Total Trust average length of stay of 4.03 days
- New Acute Hospital average length of stay of 3.41 days with and average length of stay of 3.5 days for elective inpatients and 3.4 days for emergency inpatients.
- Community Hospital average length of stay of 42.51 days.

Table 10 below, sets out the average length of stay in the new Acute Hospital by speciality (for specialities with significant volumes of admitted patient care) and by elective and emergency activity.

Table 10: New Acute Hospital Average Length of Stay by Speciality

	2010/11							2016/17					
Specialty	Elective IP		Average LOS Elective IP	Emergency		Average LOS Emergency		Elective IP		Average LOS Elective IP	Emergency		Average LOS Emergency
	Cases	Bed Days	Days	Cases	Bed Days	Days		Cases	Bed Days	Days	Cases	Bed Days	Days
100 - General Surgery	1,671	6,385	3.82	4,780	25,666	5.37		877	3,975	4.53	4,938	17,586	3.56
101 - Urology	1,754	3,799	2.17	874	5,473	6.26		897	2,840	3.17	317	1,281	4.05
107 - Vascular Surgery	263	1,628	6.19	226	5,349	23.70		258	1,745	6.76	124	771	6.21
110 - Trauma & Orthopaedics	2,135	8,684	4.07	3,143	26,600	8.46		1,638	5,208	3.18	3,547	17,798	5.02
120 - ENT	705	1,407	2.00	693	2,845	4.10		239	687	2.87	598	1,121	1.88
130 - Ophthal	1,312	1,133	0.86	790	2,159	2.73		606	605	1.00	841	1,836	2.18
160 - Plastic surgery	543	1,295	2.38	207	760	3.68		256	891	3.48	168	233	1.39
180 - Accident & Emergency	2	17	9.76	926	3,155	3.41		-	-	-	1,222	3,509	2.87
300 - General Medicine	272	1,046	3.84	17,991	96,598	5.37		125	699	5.57	16,371	68,556	4.19
301 - Gastroenterology	115	703	6.13	1,932	14,027	7.26		71	339	4.76	-	-	-
303 - Haematology (clinical)	266	1,226	4.60	230	2,061	8.95		170	1,235	7.29	119	841	7.07
314 - Rehabilitation	11	373	32.44	457	20,885	45.68		3	32	9.32	- 3	- 1,229	437.91
320 - Cardiology	620	1,690	2.73	1,859	12,232	6.58		244	511	2.10	1,222	4,102	3.36
330 - Dermatology	71	488	6.90	45	448	9.94		42	368	8.68	27	237	8.86
340 - Thoracic Medicine	42	450	10.75	906	4,900	5.41		13	66	5.03	-	-	-
361 - Nephrology	14	24	1.76	36	322	9.00		8	28	3.58	3	2	0.62
370 - Medical Oncology	46	98	2.14	2	13	7.89		3	3	1.07	12	55	4.51
400 - Neurology	47	2,052	44.11	153	1,931	12.64		11	46	4.06	14	123	8.74
410 - Rheumatology	53	142	2.66	42	384	9.04		33	209	6.41	26	71	2.75
420 - Paediatrics	217	325	1.50	6,485	11,614	1.79		205	237	1.16	5,724	9,714	1.70
422 - Neonatology	-	-	-	412	8,787	21.31		-	-	-	438	9,314	21.28
430 - Geriatric Medicine	13	33	2.43	4,850	39,311	8.11		16	85	5.31	4,197	17,996	4.29
501 - Obstetrics using Bed or Delivery	197	296	1.50	10,162	14,895	1.47		7	15	2.10	9,628	16,312	1.69
502 - Gynaecology	1,052	2,311	2.20	2,320	4,025	1.74		452	1,105	2.44	2,100	3,211	1.53
503 - Gynaecological Oncology	623	2,766	4.44	119	1,112	9.34		367	1,630	4.44	75	473	6.33

5.1.2 Occupancy

In order to find a balance in managing peaks and troughs in demand for inpatient admission the overall bed occupancy for the new Acute Hospital has been modelled at 85%. This is in line with findings from the National Bed Inquiry which concluded that levels greater than 85% create problems in handling peaks in demand particularly for emergency admissions. However it is recognised that services with high levels of emergency demand and/or requiring bespoke bed types that cannot be provided by other more generic areas will require a lower average occupancy in order to accommodate peaks in demand and maintain a smooth patient flow. As a result within the overall 85% occupancy there are variations with bespoke bed areas and high emergency demand areas having a lower occupancy than more generic areas. Table 11 below shows the occupancy rates by area.

Table 11: New Acute Hospital Bed Occupancy

Area	**Occupancy %**
Generic Adult Wards	91%
Adult Acute Assessment Unit	78%
Maternity	78%
Neonatal Unit	71%
Children's Inpatient Unit	65%
Critical Care Unit (ICCU)	75%
Acute Hospital	***85%***

The bed occupancy for community hospital beds is assumed to be 95 %.

5.1.3 Day Case Rates

Within the *RCRH a*ctivity and capacity modelling assumptions, day case rates have been modelled on the 2006/7 top quartile (England) of 85%. A further more detailed analysis has since been undertaken by speciality and the overall day case rate for

the Trust is now forecast as 88% for 2016/17 and includes 23 hour stay surgical cases. Table 12 shows the forecast day case rate by speciality (for specialities with significant volumes of day cases) for the Trust in 2016/17 compared to 2010/11.

Table 12: Trust Day Case Rate by Speciality

Specialty	2010/11			2016/17		
	Elective IP	Day Cases and 23hr Stay	Day Case %	Elective IP	Day Cases and 23hr Stay	Day Case %
All Specialties	12,653	45,622	78	6,589	49,004	88
100 - General Surgery	1,671	6,859	80	877	5,628	87
101 - Urology	1,754	4,813	73	897	5,829	87
107 - Vascular Surgery	263	94	26	258	200	44
110 - Trauma & Orthopaedics	2,135	1,957	48	1,638	3,676	69
120 - ENT	705	707	50	239	1,522	86
130 - Ophthal	1,312	6,208	83	606	6,475	91
140 - Oral surgery	43	1,786	98	10	1,529	99
160 - Plastic surgery	543	829	60	256	965	79
191 - Pain Management	26	2,038	99	3	891	100
300 - General Medicine	272	3,556	93	125	895	88
301 - Gastroenterology	115	212	65	71	2,195	97
303 - Haematology (clinical)	266	3,040	92	170	2,644	94
316 - Clinical Immunology	9	95	92	6	231	98
320 - Cardiology	620	990	61	244	1,561	86
330 - Dermatology	71	1,249	95	42	709	94
340 - Thoracic Medicine	42	250	86	13	164	93
370 - Medical Oncology	46	3,580	99	3	3,035	100
400 - Neurology	47	616	93	11	506	98
410 - Rheumatology	53	2,501	98	33	2,092	98
420 - Paediatrics	217	102	32	205	390	66
502 - Gynaecology	1,052	1,966	65	452	2,154	83
503 - Gynaecological Oncology	623	246	28	357	263	42
800 - Clinical Oncology	62	405	87	25	5,389	100

The majority of adult surgical day cases will take place in the community locations of Sandwell Community Hospital, BTC and BMEC. 23 hour stay surgery will be undertaken in the new Acute Hospital in order to have robust out of hours emergency cover and children's surgical day cases will be undertaken in the new Acute Hospital in order to have full paediatric service back up.

5.2 Theatres

5.2.1 Theatre Minutes

Within the *RCRH* Activity and Capacity Model theatre minutes have been assigned to HRGs with a procedure. These minutes are cutting times (knife to skin to recovery) and were initially based on a bench mark exercise undertaken by Teamwork Consultancy. The theatre minutes have subsequently been tested with local clinicians and have been used along with number of cases per each relevant HRG to derive demand for theatre time.

5.2.2 Theatre Utilisation

In order to identify theatre capacity assumptions have been made about utilisation, cancellation rates, session times and sessions per week. In summary these are:

New Acute Hospital Elective Theatres:

- 10 sessions per week
- Each list held 44 weeks/year
- Cancellation rate 15%
- Utilisation rate 80%

New Acute Hospital Maternity Theatres:

- 14 sessions per week
- Each list held 52 weeks/year
- Cancellation rate 10%
- Utilisation rate 60%

New Acute Hospital Emergency Theatres:

- 14 sessions per week
- Each list held 52 weeks/year
- Cancellation rate 10%
- Utilisation rate 60%

Community Hospitals Day Surgery:

- 10 sessions per week
- Each list held 48 weeks/year
- Cancellation rate 10%
- Utilisation rate 80%

5.3 Outpatients

5.3.1 New to Review Ratios

Within the *RCRH a*ctivity and capacity modelling assumptions, outpatient new to review ratios have been modelled on the upper decile for England.

Assumptions were made in discussion with clinicians about the level of activity that could transfer from acute to community locations and from secondary care to primary care or provision by a new community based provider.

In addition as part of developing version 5.3 of the *RCRH* Activity and Capacity Model a detailed analysis of clinic types was undertaken with clinicians to identify which clinics must take place in the new Acute Hospital and which could take place in community hospitals.

Table 13 below summarises the changes in new to review ratios.

Table 13: Trust New to Review Ratio

Location	**2010/11**	**2016/17**
Acute Hospital	2.06	0.87
Community Hospitals	1.70	2.05
Trust Total	***2.05***	***1.72***

NB: Tertiary Ophthalmology outpatients are modelled in 2016/17 to take place in BMEC and therefore are within the community hospital activity.

Trust modelled new to review ratio by speciality for 2016/17 is set out in table 14.

Table 14: Trust New to Review Ratio by Speciality

Specialty	2010/11 New to Review Ratio	2016/17 New to Review Ratio
All Specialties	**2.05**	**1.72**
100 - General Surgery	1.31	1.00
101 - Urology	1.71	1.69
103 - Breast Surgery	1.55	1.14
110 - Trauma & Orthopaedics	1.98	1.51
120 - ENT	0.59	0.60
130 - Ophthal	1.96	2.22
140 - Oral surgery	1.07	0.56
160 - Plastic surgery	2.22	1.75
170 - Cardiothoracic Surgery	2.91	2.20
180 - Accident & Emergency	0.01	-
191 - Pain Management	3.11	5.60
211 - Paediatric Urology	0.79	0.76
213 - Paediatric Gastrointestinal Surgery	-	40.25
214 - Paediatric Trauma and Orthopaedics	1.25	1.40
215 - Paediatric ENT	0.48	0.84
216 - Paediatric Ophthalmology	1.54	1.62
219 - Paediatric Plastic Surgery	1.85	1.84
251 - Paediatric Gastroenterology	1.83	1.21
252 - Paediatric Endocrinology	3.22	1.89
253 - Paediatric Clinical Haematology	1.65	0.87
258 - Paediatric Respiratory Medicine	1.19	1.06
300 - General Medicine	1.90	2.51
301 - Gastroenterology	1.84	1.23
302 - Endocrinology	3.19	3.96
303 - Haematology (clinical)	7.20	4.29
307 - Diabetic Medicine	9.77	8.24
314 - Rehabilitation	2.54	2.54
316 - Clinical Immunology	0.55	0.60
320 - Cardiology	1.95	0.68
324 - Anticoagulant Service	49.63	36.14
330 - Dermatology	1.94	2.03
340 - Thoracic Medicine	1.57	1.07
360 - Genito-Urinary Medicine	0.68	0.85
361 - Nephrology	2.80	2.76
370 - Medical Oncology	9.93	6.67
400 - Neurology	1.76	1.76
401 - Clinical Neuro-Physiology	0.33	2.08
410 - Rheumatology	4.99	6.01
420 - Paediatrics	2.55	0.98
430 - Geriatric Medicine	3.41	3.44
501 - Obstetrics using Bed or Delivery	1.81	0.47
502 - Gynaecology	0.88	0.84
503 - Gynaecological Oncology	2.49	3.43
710 - Mental Illness	6.00	2.76
800 - Clinical Oncology	8.72	9.17
822 - Chemical Pathology	3.22	9.84

5.3.2 Outpatient Throughput

In order to identify the outpatient capacity requirements assumptions were made about length of appointment times, numbers of sessions per week, etc. Whist there is some variation between specialties, in summary for Trust provided outpatients, in 2016/17 these assumptions are:

New Acute Hospital:

- 16 sessions per week (8am – 8 pm Monday to Friday & 8am – 12noon Saturday)
- Each clinic held 49 weeks/year
- New outpatient appointments – 30 minutes
- Review outpatient appointments – 20 minutes

Community Hospitals:

- 10 sessions per week
- Each clinic held 46 weeks/year
- New outpatient appointments range 15-60 minutes
- Review outpatient appointments range 10– 60 minutes

(NB: upper end of these ranges primarily reflect times for tertiary Ophthalmology appointments).

5.4 Diagnostics - Imaging

The following utilisation assumptions were made for trust provided Imaging services in 2016/17:

New Acute Hospital:

- 16 sessions per week (8am – 8 pm Monday – Friday & 8am – 12pm Saturday)
- Utilisation rate 85%

Community Hospitals:

- 10 sessions per week
- Utilisation rate 85%

Activity throughput assumptions were made for each modality based on national evidence and local clinical knowledge. These are outlined in table 15 below.

Table 15: Imaging Throughput by Modality for 2016/17

	Throughputs	
Imaging Modalities	**Acute**	**Community**
Angiography	4,000	4,000
Breast	4,000	4,000
MRI	6,000	6,000
CT	8,000	8,000
Fluroscopy	4,000	4,000
Nuclear Medicine	2,500	0
Obs Ultrasound	6,000	4,000
Radiology (Plain Film)	20,000	12,500
US Gen	6,000	5,000
Neurophysiology	1,500	1,500

6 CAPACITY ASSUMPTIONS

The activity and performance assumptions described above were used as the basis for modelling capacity requirements in the new Acute Hospital. The purpose of this section of the report is to outline the capacity included in the OBC refresh (key performance factors have been included for completeness).

6.1 Admitted Patient Care

6.1.1 Beds

The *RCRH* Activity and Capacity Model (version 5.3) forecasts a requirement for 666 beds in the New Acute Hospital supported by 129 beds in community

hospitals (provided by the Trust) and 128 community bed equivalent services (provided by primary care and community providers). Table 16 below summarises inpatient beds within the new Acute Hospital and compares these to acute beds open within the Trust at the end of 2009/10.

Table 16: Inpatient Beds in the new Acute Hospital (2016/17)

	2009/10	2016/17	Key Performance Factors	Other
Total Bed Numbers	**1056**	**666**	85% occupancy Average Length of Stay 3.41 days	129community beds comprising • *47 at Rowley Regis Hospital* • *48 at Sandwell Community Hospital* • *34 in Sheldon Block* 128 community bed equivalents
Critical Care (levels 2 &3)	28	30	75% occupancy	Bed day activity included within speciality bed days
Children's Beds	64 (40 inpatient, 12 day surgery, 12 PAU)	56	65% occupancy	Includes capacity for children in all specialities including day cases. Includes Paediatric Assessment Unit beds & adolescent beds (up to the age of 16)
Neonatal Beds	37	36	71% occupancy	
Medical Adult Beds	528 (includes rehabilitation & 19 CCU beds& 20 Continuing Care beds)	224 (includes 14 CCU beds)	91% Occupancy	Excludes beds for 0 day length of stay elective patients as assumed to remain on Medical Day Procedures Unit, Endoscopy or Cardiac Interventional Suite
Surgical Adult Beds	285 (incl.19 SAU trollies)	192	91% Occupancy	Excludes beds for 0 day length of stay elective patients as assumed to remain in operating theatre suite (on central admissions unit or in stage 2 recovery)
Maternity	42	64	78% Occupancy	Excludes beds for 0 day length of stay patients as assumed to remain on delivery suite
Adult Acute Assessment Beds	72 (incl. 4 trollies and	64	78 % Occupancy 0.5 day average length of stay	Bed day activity included within speciality beds days

	2009/10	2016/17	Key Performance Factors	Other
	12 chairs)			
Level 1 Critical Care Beds	0	16 on generic wards included in medical and surgical bed numbers above		Bed day activity included within speciality bed days

For the new Acute Hospital a decision was made to group adult beds by condition rather than traditional specialities in order to facilitate delivery of the new service model. This was done by analyzing the admitted patient care by HRG Chapter. The beds derived from this analysis were then grouped into units of 32 and where one group of conditions required less then 32 beds consideration was given to the most appropriate co-location with other groups of conditions. This process was also used in determining how the 32 bed units should be grouped into clusters of 3 (in line with the design vision). Table 17 below summarises the grouping of adult generic beds by condition and shows bespoke beds for completeness.

Table 17: New Acute Hospital Inpatient Beds by Condition Group

Condition Groupings	Specialties	Bed Numbers from A&C Model	Wards & Clusters
Respiratory	Includes 4 level 1 beds	32	6 wards in 2 clusters (B&C)
Acute Elderly	Includes acute elderly & mental illness	32	
GI	Includes medical, facilities to manage acute GI bleeding, poisons unit beds (10), 4 level 1 beds	32	
Musculoskeletal	Orthopaedics & Trauma	64	
Haematology, oncology & Rheumatology	Haematological oncology, complex inpatient chemotherapy cases, other Haematology (e.g. sickle cell disease), Rheumatology	32	
Maternity	Includes Obstetrics ante- and post-natal, Antenatal Day Assessment Unit and Transfer Lounge	64	3 wards in 1 cluster (D)
Womens	Includes Gynaecology (inc. EPAU), Gynae-oncology, Breast Surgery , other female surgery (inc urology and plastic surgery)	32	
Surgical Specialities	Colorectal Surgery includes 4 level 1 beds	32	2 wards in 1 cluster (E) with critical care
Surgical Specialities	Male Urology, ENT,	32	

Condition Groupings	Specialties	Bed Numbers from A&C Model	Wards & Clusters
	Interventional Radiology, Vascular Surgery, Male Plastics, Ophthalmology		
Short Stay Surgery	Includes dermatology	32	1 ward adjacent to operating theatres
Adult Acute Assessment	Includes all adult emergency inpatients (except maternity) Includes 20 monitored beds	64	2 wards operating as 1 unit
Stroke, neurology, rehab.	Includes 4 level 1 beds	32	1 cluster of 3 wards (G)
Medical Short Stay	Acute Medical Short stay patients	32	
Cardiology	Includes 14 CCU beds & cardiology step down beds	32	
Sub Total		***544***	***17 wards in 6 clusters***
Critical Care (ICCU) level 2 & 3	All adult	30	Bespoke
Neonatal	Intensive Care, High Dependency and Special Care	36	Bespoke
Children	Includes Paediatric Assessment Unit, Adolescents	56	Bespoke
Sub Total		***122***	***Bespoke***
Total		**666**	

It should be noted that at an operational level there will be some flexibility in use of these beds.

6.1.2 Theatres

The number of theatres in the new Acute Hospital was derived using the theatre cases for 2016/17, analysed by emergency, inpatient elective and day case procedures. The performance assumptions outlined in section 5 above (cutting minutes, cancellation rates, utilisation rate etc) were applied. For emergency and dedicated specialist theatres (e.g. ophthalmology and obstetrics) a rounding up of capacity was made to ensure capacity and availability to deal with demand. The elective inpatient analysis also included the day cases that will take place at the new Acute Hospital (i.e. children and 23 hour stay surgery). Table 17 below shows theatre capacity in the new Acute Hospital and Community Hospitals and compares this to the current position.

Table 17: Theatre Capacity

	2009/10	2016/17	Key Performance Factors	Other
Acute Hospital				
Emergency	3 & sessions in other theatres	4	52 weeks/year 14 sessions/week 10% cancellation	Includes 2 trauma+ 1 Laproscopic

	including Ophthalmology		60% utilisation	
Obstetric	2	2	52 weeks/year 14 sessions/week 10% cancellation 60% utilisation	Located in Delivery Suite
Elective Inpatient	16	8	44 weeks/year 10 sessions/week 15% cancellations 80% utilisation	Includes: 1 Ophthalmology 2 Orthopaedic 3 Laproscopic 1 Vascular/IR I gynae-oncology
Sub-Total Acute	***21***	***14***		
Community Hospitals				
Day Case BTC	6	5	48 weeks/year 10 sessions/week 10% cancellations 80% utilisation	5 day case + 1 minor ops
Day Case Sandwell	3 (Surgical Day Unit)	3	48 weeks/year 10 sessions/week 10% cancellations 80% utilisation	3 + 1 minor ops
BMEC	1	3	48 weeks/year 10 sessions/week 10% cancellations 80% utilisation	
Sub-total Community:	***10***	***11***		
Total	**31**	**25**		

6.2 Outpatient Rooms

Table 18 below summarises the generic and bespoke consulting rooms but it should be noted that in addition there will be a range of other supporting rooms such as counselling and treatment rooms.

Table 18: Outpatient Consulting Rooms

Specialty	2006/07	2016/17	Other	Community Locations
General performance factors and other issues		16 sessions per week 49 weeks per year 30 minute New appointments	All areas also include a range of other support accommodation e.g. treatment rooms, counselling rooms	KPIs based on 10 sessions per week, 46 weeks per year. Appointment slots vary dependent on speciality and as agreed with clinicians; New appointments range from 15-60 minutes

Specialty	2006/07	2016/17	Other	Community Locations
		20 minute Review appointments		Review appointments range from 10-60 mins.
Generic:				
Generic Adult	72	12		BTC, Sandwell CH & Rowley Regis CH will have suites of generic adult consulting rooms for use by all specialities (apart from those requiring bespoke accommodation)
Bespoke:				
ENT	8	2	Supporting accommodation for Audiology, specialist treatment rooms	Bespoke accommodation available within 2 community sites (BTC & Sandwell CH)
Oral Surgery	4	0		Bespoke accommodation within Sheldon
Dermatology	6	Use generic consulting rooms	Range of bespoke treatment rooms	Bespoke accommodation within Sheldon
Infertility	1	0	Access to generic consulting room	
Antenatal	10	6	Supporting ultrasound rooms	
Ophthalmology	27	2	Accommodation to support inpatient requirements	Maintain BMEC
Children's	10	6	Will accommodate children from all specialities with the exceptions of ENT and Ophthalmology	Bespoke areas in BTC and Sandwell CH
Urodynamics	1	1	Supporting treatment rooms	

There are a number of specialities where all outpatient activity will be undertaken in community hospitals with no outpatient activity in the new Acute Hospital. These include Breast Surgery, Oral Surgery, Dermatology, Gynaecology (except infertility), Gynae-Oncology and Oncology.

6.3 Diagnostics - Imaging

Table 19 summarises Imaging rooms by modality for the new Acute Hospital and Community Hospitals in 2016/17.

Table 19: Imaging Rooms

Modality	2006/07	2016/17 New Acute Hospital	Key Performance Factors	Community Sites
General performance factors across all modalities			16 sessions per week 85% utilisation	10 sessions per week 85% utilisation
Plain X-ray	14 4 Emergency Department	3 Main Dept 2 Emergency Department	20 000 cases per year per machine *	Community Hospitals will also have 6 Plain X- ray machines across 3 sites
Ultrasound	14 Ultrasound Facilities also in other areas e.g. antenatal clinic	5 Main Department Ultrasound Facilities also 4 in antenatal clinic and 1 in EPAU	6 000 cases per year per machine *	Community Hospitals will also have 11 Ultrasound machines across 3 sites
CT	3	2	8 000 cases per year per machine*	2 (1 in BTC and 1 at Sandwell CH)
MRI	2	2	6 000 cases per year per machine*	2 (1 in BTC and 1 at Sandwell CH)
Interventional Radiology (includes Angiography & Fluoroscopy)	4	3	1 600 cases per year per machine *	
Physics and Nuclear Medicine	4	4 Gamma Cameras 1 Neurovascular Room	1 500 cases per year per machine *	
Mammography	3 & 4 mobiles	0		To be provided in BTC and Sandwell Community Hospital
Dexa Scans	1	0		1 in the BTC

NB: * = workload estimates but future changes in technology may change these.

6.4 Other

Table 20 below outlines capacity in several other inpatient and diagnostic areas within the new Acute Hospital.

Table 20: Capacity in Other Services in the New Acute Hospital

Service	2009/10	2016/17 New Acute Hospital	Key Performance Factors	Community Sites
Endoscopy	7	2	16 sessions per week & 24 hour access for emergencies	6 endoscopy rooms: • 3 in BTC • 3 in Sandwell CH 10 sessions per week
Cardiac Interventional rooms	2 & access to interventional imaging room	3	16 sessions per week & 24 hour access for emergencies	
Birth Rooms	20	18 (12 high risk & 6 midwifery led)	In addition within Delivery Suite there are: 6 Induction spaces	3 birth rooms in stand alone midwifery led centre in Sandwell (Leasowes site)

SWBTB (9/11) 202 (b)

PROPOSED TRUST ANNUAL PLAN 2012/13 - 2014/15 - PROCESS & TIMETABLE

Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12
Trust Board review Strategic Objectives and assess risks (Part of IBP)		Draft Corporate Objectives 2012/13 ? Member event?			Trust Board 6-monthly review of Strategic Objectives and risk assessment	Corporate Objectives 2012/13 agreed by Trust Board			
		Half Away-Days with Divisions to launch work on Transformation Strategy							
		Work with Clinical Directorates on development of 5-Year Transition Plans. Corporate and cross-cutting information shared between Divisions/Directorates.			Transformation Strategy Draft 5-Year Transition Plans by Clinical Directorate				
		Notify Commissioners (6 months notice) of proposed service changes by 30th Sept		LDP Negotiating Strategy Sign-off by Trust Board - 24th Nov		LDP Negotiations leading to Agreements with Commissioners by 29th February			
			ATOS report 4th Oct. First cut CIPs 28th Oct.	Second cut CIPs 30th Nov.	Further refinement of 3 year CIPs	Q&S review of CIPs to Trust Board 26th Jan.		Final financial plan & detailed CIP to Trust Board 29th March	
				Divisional Planning "Blitz" Away Days - to produce Directorate Transition Plans and Annual Plans	Draft Divisional Annual Plans = Years 1-3 of Clinical Directorates' Transition Plans by 2nd Dec.	Executive Team Critically Review Plans	Divisional/ Clinical Directorate Annual Plans Signed-off at Divisional Reviews end January/early February		Monitoring of Divisonal/ Directorate Annual Plans throughout 2012/13
		Annual Plan 2012/13 - 2014/15 Process and Timetable presented to Trust Board			National Operating Framework published ?	Preparation of Trust's corporate Annual Plan 2012/13 - 2014/15. First Draft by end of Feb.		Trust Annual Plan 2012/13 - 2014/15 approved by Trust Board 29th March	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Review of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation
SPONSORING DIRECTOR:	Robert White, Director of Finance & Performance Management
AUTHOR:	Robert White, Director of Finance & Performance Management, Deputy Finance Director and Trust Secretary
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

A review of the standing financial instructions, standing orders and scheme of delegation has been undertaken. The review was undertaken by the Trust Secretary, Deputy Director of Finance, Director of Finance & Performance Management and the Director of Governance.

The documents attached provide a 'tracked changes' version of the SOs/SFI & SoD, together with a guide to the sections amended, including notes of the key changes. These have largely followed changes in regulations, legislation, Trust policies, Board composition and the like.

The Audit Committee, at its meeting on 8 September 2011, considered and supported the amendments as part of its annual cycle of business.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
X		

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is requested to review and accept the Audit Committee's recommendation that the proposed changes should be approved.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	None specifically
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy	**X**	
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Audit Committee on 8 September 2011.

SUMMARY OF CHANGES TO THE TRUST'S STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS AND SCHEME OF DELEGATION

A review of the standing financial instructions, standing orders and scheme of delegation has been undertaken. The was undertaken by the Trust Secretary, Deputy Director of Finance, Director of Finance & Performance Management and the Director of Governance.

The document before the Trust Board today contains 'tracked changes', but as a guide to the sections amended, notes are provided below of the key changes. These have largely followed changes in regulations, legislation, Trust policies, changes in Board composition and the like.

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Section 1.2 Definitions

- 1.2.3 has been amended to remove the reference to 'officers' to reflect that the composition of the Board includes Executive Directors, in addition to Non Executive Directors
- 1.2.8 the reference to the Governance and Risk Management Committee has been updated to reflect that this has now been succeeded by the Quality and Safety Committee
- 1.2.13 the description of the Director of Finance has been amended to require this post to be a Qualified Accountant
- 1.2.20 the roles that are classified as Executive Directors have been clarified
- 1.2.21 the roles that are classified as Advising Directors have been clarified

STANDING ORDERS

Section 1.1 Statutory Framework

- (1) the principal places of business have been updated to include the delivery of community services from a number of locations, in line with the amendments made to the Trust's Establishment Order

Section 2.1 Composition of the Membership of the Trust Board

- (3) the number of Executive Directors included within the Trust Board membership has been raised from five to six, in line with the amendments made to the Trust's Establishment Order

Section 2.6 Patient and Public Involvement Forum

- Has been removed to reflect that this body no longer exists

Section 3.2 Notice of Meetings and the Business to be Transacted

- (1) the requirement to provide a written notice, signed by the Chair or Chief Executive, listing the business to be transacted at the Trust Board meeting has been removed, given that the agenda detailing this information is issued to Board members with the papers for consideration
- (3) updated to reflect the discussions about the agenda between the Chair and the Trust Secretary in advance of the meeting

Section 3.11 Quorum

- (ii) updated to replace the reference to 'officer' with nominated manager

Section 3.17 Admission of the public and press

- (i) updated to reflect that the Trust Secretary is the Freedom of Information Lead
- (iii) updated to require that the content of the items marked as for discussion in the private section of the Trust Board meetings shall not be disclosed outside of the Trust

Section 4.8 Committees established by the Trust Board

- updated to replace the Governance and Risk Management Committee with the Quality and Safety Committee and to remove the reference to the PPI Forum

Section 5.1 Delegation of Functions to Committees, Officer or other bodies

- 5.1.1 replacement of term 'officer' with employee of the Trust

Section 6.1 Policy statements: general principles

- Updated to reflect that the Board is only required to approve policies (which can include procedures within them)

Section 6.2 Specific policy statements

- Amended to reflect the updated name of the Disciplinary and Grievance policy

Section 6.4 Specific guidance

- Replaced the Human Rights Act 1998 with the new Equality Act 2010

Section 7.1 Declaration of interest

- 7.1.3 Amended to reflect that in reality declarations of interest are discussed with the Trust Secretary

Section 7.2 Register of Interest

- 7.2.1 Amended to clarify that in reality a register of interest is maintained by the Trust Secretary, which encompasses declarations made by the Executive, Non Executive and Advising Directors
- 7.2.3 Amended to clarify that in reality, responsibility for publishing the register of interest is taken by the Trust Secretary

Section 8.3 Register of Sealing

- Amended to clarify that in reality the Register of Sealing is maintained by the Trust Secretary and that the list of documents sealed is presented to the Trust Board annually as part of its cycle of business

DECISIONS RESERVED TO THE BOARD

Regulations and control

- 8 Amended to reflect that in line with current practice, the Board takes responsibility for approving the incident reporting and risk management policies
- 14 Removed as arrangements relating to discharge of the Trust's responsibilities as a bailer for patients' property are no longer approved by the Trust Board
- 17 Added to reflect that the Trust Board is required to approve declarations demonstrating compliance with regulatory requirements, such as CQC registration, Same Sex Accommodation guidance, etc.

Strategy, Plans and Budgets

- 2 Clause widened to cover all governance arrangements, rather that solely clinical governance
- 3 Removed duplicate clause relating to approval of risk management policies and procedures
- 11 Clarified that approval of compensation payments relates to only those not delegated to an external authority
- 12 Removed requirement for the approval of proposals for action on litigation against the Trust as in reality this is handled by other parts of the Trust, including finance, complaints & litigation, etc.

Policy Determination

- Amended to reflect that in new Policy on Policies, there will be no stipulated list of policies requiring approval by the Trust Board; instead the relevant accountable Executive Leads will use their judgement to determine whether the policy would benefit from Trust Board approval

Annual Report and Accounts

- 3 Added to reflect that the Trust Board takes responsibility for approval of the Quality Account

Monitoring

- 2 Deletion of the clause requiring that all monitoring returns required by the Department of Health and the Charities Commission to be reported to the Board, given that in reality the Trust Board does not see each and every return submitted

- 3 Reference to the Local Delivery Plan amended to clarify that this refers to Service Level Agreements

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

- All duties updates to reflect the current duties and responsibilities listed within the Terms of Reference for the various Committees
- The section related to the PPI Forum has been deleted

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

- Replacement of the term 'officer' with an appropriate substitute group of staff
- 25.3.1 Replacement of NHS Supplies with the updated name NHS Logistics
- 27.1.3 Clarification that the Trust Secretary takes responsibility for publishing the Freedom of Information scheme
- 27.3 (and thereafter) all appropriate references to the Director of IM & T have been replaced with Director with responsibility for IM & T; NOTE - all appropriate references to the Director of Workforce have been replaced with Director with responsibility for HR; all appropriate references to Director of Facilities replaced with Director with responsibility for Estates
- 30 Amendment to reflect that the Director of Governance has responsibility for the Gifts and Hospitality Policy

SCHEDULE OF DELEGATED AUTHORITY AND AUTHORISATION LIMITS

Section 1 General Conditions

- Amendment of the title of the Head of Procurement from Supplies Manager

Section 2 Management of Budgets

- Addition of a section dealing with virement of budgets, in line with recommendations from a review undertaken by Internal Audit

Section 3 Requisitions and Invoices

- Replacement of the term 'officer' with staff or Directors as appropriate (and thereafter)
- Inclusion of a new clause advising that orders placed and receipted through iPROC will not require separate authorisation

Section 7 Agreements and Leases

- Reallocation of the responsibility for letting of premises to outside organisations to the Director of Estates

Section 9 Condemnation, Disposal, Write Offs, Losses and Compensation

- 9.1 Increased limits of the estimated current value for items which are obsolete, redundant, irreparable or cannot be repaired cost effectively
- 9.3 Value of ex-gratia payments to staff and patients for loss of or damage to personal effects raised to £1000

Section 10 Reporting of Incidents to the Police

- Amended the responsibility for the reporting of criminal offences of a violent nature and other criminal offences from being allocated to the Chief Operating Officer/Deputy Chief Operating office to the Local Security Management Specialist and/or the Executive Director on call

Section 12 Personnel and Pay

- Amended to reflect that the Chief Nurse has responsibility for some tasks previously delegated to the Director of Workforce
- 12.2 Amended the term 'authorised to sign' to 'permitted to authorise' payroll documentation

Section 13 Patients and Relatives Complaints

- Title of Director of Governance amended to omit 'Development' (and thereafter)

Section 14 Relationship with the Press

- Title of Head of Communications amended to add 'and Engagement' (and thereafter)

Section 15 Patient services

- Amended to reflect that the Chief Nurse has responsibility for some task previously delegated to the Director of Infection Prevention and Control

STANDING FINANCIAL INSTRUCTIONS

Section 11.5 Fraud and Corruption

- 11.5.3 has been amended to describe the national counter fraud agency as 'NHS Protect' as amended from the Counter Fraud and Security Management Service

Section 13 Allocations, Planning, etc

- 13.1.1 All references to the Local Delivery Plan (LDP) have been changed to Annual Plan as the LDP is commonly used to describe the annual service agreement negotiated by the Trust and its commissioners

Section 15 Bank and OPG Accounts

- 15.1.1 references to OPG (office of the paymaster general) have been removed now that the GBS (government banking service) has effectively outsourced banking services to Citibank and RBS.

Section 17 Tendering and Contracting Procedure

- 17.5.3 the limit above which tenders must be advertised in the European Journal has been changed to reflect the increase in VAT to 20%.
- 17.5.6 reference to Concorde (the guidance concerning contracts) has been altered and described as 'DH Estates and Facilities' guidance
- 17.6.1 contains a complete replacement of the previous section introducing other contract requirements such as NEC-ECC.
- 17.6.3 (ii) has inserted 'the Equality Act 2010' which replaces references to other equality related acts such as 'Race Relations' and 'Sex Discrimination'

Section 18 NHS Service Agreements

- 18.3 has been brought up to date with references to the Health and Social Care Bill 2011 and introduces GP led commissioning bodies

Section 19 Commissioning

- 19.1.1 refers to GPs and NHS Clusters

Section 21 Non Pay Expenditure

- 21.2.6 (d) now includes reference to the 'Bribery Act 2010'
- 21.2.7 includes estate related guidance references 'NEC-ECC

Section 24 Capital Investment

- 24.1.3/4 amended to include 'Estatecode' and 'industry tax deduction scheme' respectively

Section 27 Information Technology

- 27.1.3 as we have no named Director of IM&T, this has been amended to refer to the 'Director with responsibility for…'

Sandwell and West Birmingham Hospitals NHS
NHS Trust

STANDING ORDERS, RESERVATION AND DELEGATION of POWERS and STANDING FINANCIAL INSTRUCTIONS

~~November 2009~~September 2011

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS AND STANDING FINANCIAL INSTRUCTIONS

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Sandwell & West Birmingham Hospitals NHS Trust.

1.2.3 **"Board"** means the Chair, Executive~~officer~~ and Nn~~n~~on-Ee~~e~~xecutive directors of the Trust collectively as a body

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust

1.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation

1.2.6 **"Chair of the Board (or Trust)"** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable

1.2.7 **"Chief Executive"** means the chief officer of the Trust.

1.2.8 **"Clinical Governance Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality of healthcare for which the Sandwell and West Birmingham Hospitals NHS Trust has responsibility. For this Trust this refers to the ~~Governance and Risk Management Sub-~~Quality and Safety Committee

1.2.9 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.10 **"Committee"** means a committee or sub-committee created and appointed by the Board.

1.2.11 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.12 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets

~~1.2.13~~ **"Director of Finance"** means the member of the Trust Board with responsibility for ensuring the discharge of obligations under relevant Financial directions. The Director of Finance will be a qualified accountant. ~~Chief Financial Officer of the Trust.~~

~~1.2.14~~1.2.13

~~1.2.15~~1.2.14 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable

~~1.2.16~~1.2.15 **"Member"** means executive~~officer~~ or non-executive director of the Board as the context permits. Member in relation to the Board does not include its Chair

~~1.2.17 **"Advising Director"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record~~

~~1.2.18~~1.2.16 **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

~~1.2.19~~1.2.17 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

~~1.2.20~~1.2.18 **"Non-Executive Director"** means a member of the Trust who is not appointed by the ~~n officer of the~~ Trust and is not to be treated as an employee~~officer~~ by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

~~1.2.21~~1.2.19 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.20 **"Executive Director**" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member). Executive Directors of the Trust are the Chief Executive, Director of Finance & Performance Management, Medical Director, Chief Nurse, Chief Operating Officer and Director of Strategy & Organisational Development

1.2.21 **"Advising Director"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record. Advising Directors are the Director of Governance and the Director of Estates/New Hospital Project Director.

1.2.22 **" Trust Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

1.2.23 **"SFIs"** means Standing Financial Instructions.

1.2.24 **"SOs"** means Standing Orders

1.2.25 **"Vice-Chair"** means the non-executive director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

~~1.2.26 **"Advising Director"** is made up of the Director of Governance, Director of Workforce and Director of Estates/New Hospital Project.~~

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Sandwell and West Birmingham Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 22 March 2002 under The Sandwell and West Birmingham Hospitals NHS Trust (Establishment) Order 2002 No 1364 (the Establishment Order). This was amended by The Sandwell and West Birmingham Hospitals National Health Service Trust (Establishment) Amendment Order 2003 No 2345, which came into force on 29 September 2003.

(1) The principal places of business of the Trust are Sandwell General Hospital, City Hospital and Rowley Regis ~~Hospital.~~Hospital. The Trust also delivers community services from a number of locations.

(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 and the Health Act 1999.

(3) The functions of the Trust are conferred by this legislation.

(4) As a statutory body, the Trust has specified 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 as well as to the Secretary of State for Health.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

(6) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint

committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Scheme of Reservation and Delegation). (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.) This document has effect as if incorporated into the Standing Orders.

1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance has been issued and will be incorporated in the Trust's Governance Strategy (see Integrated Governance Handbook 2006). Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chair of the Trust (Appointed by the NHS Appointments Commission);

(2) Up to 6 non-executive directors (appointed by the NHS Appointments Commission); One of the non-executive directors shall be nominated by the University of Birmingham

(3) Up to 6~~5~~ Executive Directors (but not exceeding the number of non-executive directors) including:

- the Chief Executive;
- the Director of Finance;
- a medical or dental practitioner;
- a registered nurse or midwife;

The Trust shall have not more than 12~~1~~ and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of Chair and Members of the Trust

(1) Appointment of the Chair and Members of the Trust - Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chair and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chair and Members

(1) The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

2.4 Appointment and Powers of Vice-Chair

(1) Subject to Standing Order 2.4 (2) below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive Director, to be Vice-Chair, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4 (1).

(3) Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

~~**2.6 Patient and Public Involvement Forum**~~

~~Section 11 of the Health and Social Care Act 2001 requires a PCT to establish a Patient and Public Involvement Forum. Further guidance can be obtained from www.cppih.org. The Trust will cooperate with the appointed PPI Forum for Sandwell and West Birmingham Hospitals NHS Trust.~~

2.6~~7~~ Role of Members

The Board will function as a corporate decision-making body, Executive~~Officer~~ and Non-Executive Directors will be full and equal members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Directors**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Reservation and ~~-~~Delegation.

(2) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial d~~D~~irections.

(4) **Non-Executive Members**

The Non Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chair**

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the NHS Appointments Commission over the appointment of Non Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.8 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) ~~(3)~~ The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

~~(3)~~(4)

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.9 Schedule of Matters reserved to the Board and Scheme of Reservation and - Delegation

(1) The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Decisions Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Reservation and Delegation.

2.10 Lead Roles for Board Members

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

(2) The Chair of the Trust may call a meeting of the Board at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 ~~Notice of Meetings and the~~ Business to be transacted

~~(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of~~

~~each member, so as to be available to members at least six clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.~~

(1~~2~~) In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

(2~~3~~) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(3~~4~~) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Trust Secretary ~~Chair~~ at least **10** clear days before the meeting who will seek the Chair's authority to add it to the matters for consideration at the next 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** days before a meeting may be included on the agenda at the discretion of the Chair.

(4~~5~~) Before each meeting of the Board 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 principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.3 Agenda and Supporting Papers

The a~~A~~genda will be sent to members six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least 1~~!~~5 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board 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 Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

The Chair 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:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

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.

iv) **Rights of reply to motions**

a) Amendments

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.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order 3.17).

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 who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair 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.

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Trust Board it shall not be competent for any member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of meeting

(1) At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair (if the Board has appointed one), if present, shall preside.

(2) If the Chair and Vice-Chair are absent, such member (who is not also an Executive Director of the Trust) as the members present shall choose shall preside.

3.10 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one member who is not) is present.

(ii) A nominated manager~~n Officer~~ in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person 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.

3.12 Voting

(i) Save as provided in Standing Orders 3.I3 - Suspension of Standing Orders and 3.I4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting) shall have a second, and casting vote.

(ii) At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(iv) If a member so requests, their vote shall be recorded by name.

(v) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(vi) A manager who has been formally appointed 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.

(vii) A manager attending the Trust Board meeting 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.

(viii) For the voting rules relating to joint members see Standing Order 2.5.

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Executive Director of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

The names of the Chair and members present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

3.17 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board 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 on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

- Guidance should be sought from the NHS Trust~~'s Freedom of Information Lead~~ Secretary to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chair (or Vice-Chair if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's 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 Trust Board resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members ~~and Officers~~ or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked ~~'In Confidence' or minutes headed 'Items Taken in Private'~~as for discussion in private outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.18 Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other Strategic Health Authorities, or other Trusts consisting of, wholly or partly of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(ii) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board 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.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Committees established by the Trust Board

The committees~~, sub-committees, and joint-committees~~ established by the Board are:

4.8.1 Audit Committee
4.8.2 Remuneration and Terms of Service ~~Sub-~~Committee
4.8.3 Charitable Funds ~~Sub-~~Committee
4.8.4 Finance and Performance Management ~~Sub-~~Committee
4.8.5 ~~Governance and Risk Management Sub-~~Quality and Safety Committee
~~4.8.6 Patient and Public Involvement Sub-Committee~~

~~4.8.7 **Other Committees**~~

The Board may also establish such other committees on an interim basis as required to discharge the Trust's responsibilities.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by ~~an officer of the Trust~~an employee of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS trusts, Strategic Health Authorities or PCTs;

(iii) by arrangement with the appropriate Trust or PCT, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more Strategic Health Authorities, ~~SHAs,~~ NHS Trusts or PCT.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Reservation and Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Reservation and Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Specified in the Scheme of Reservation and Delegation

5.5.1 The arrangements made by the Board as set out in the "Scheme of Reservation and Delegation" shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders and the Standing Financial Instructions are not complied with, full details of **any significant and material breaches** and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. **Full details of any non-compliance will periodically be reported to the Audit Committee.** All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve pPoliciesy statements/ procedures which will apply to all or specific groups of staff employed by Sandwell and West Birmingham Hospitals NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Hospitality Policy
- the staff the Disciplinary and Appeals Procedures adopted by the TrustGrievance Policy

both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998Equality Act 2010;

- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of Authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Research funding/grants that may be received by an individual or their department;

g) Interests in pooled funds that are under separate management.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the ~~Director of Governance Development~~Trust Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that 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.

7.1.4 Recording of Interests in Trust Board minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting ~~-~~following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Chief Executive via the Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by ~~both officer~~ executive, ~~and~~ non executive and advising directors of the Trust Board.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive via the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chair and Members in proceedings on account of pecuniary interest

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 **Exclusion in proceedings of the Trust Board**

(i) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(iii) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(1) <u>Power of the Secretary of State to make waivers</u>

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chair' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant Chair" is –

(a) at a meeting of the Trust, the Chair of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chair of that Committee, the Chair of the Trust;

(ii) in the case of any other member, the Chair of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of Sandwell and West Birmingham Hospitals NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) <u>Conditions which apply to the waiver and the removal of having a pecuniary interest</u>

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Business Conduct articulated in these standing orders and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff'.

7.4.2 Interest of Officers in Contracts

i) Any ~~officer or~~ employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or ~~Director of Governance Development~~Trust Secretary as soon as practicable.

ii) An ~~Officer~~ employee should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 Relatives of Members or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, members (and prior to acceptance of an appointment in the case of non executive directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 Register of Sealing

The Chief Executive via the Trust Secretary shall keep a register in which he/she, ~~or another manager of the Authority authorised by him/her,~~ shall enter a record of the sealing of every document. A list of documents sealed shall be presented to the Trust Board annually, as part of its cycle of business.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any ~~Officer~~Executive or Advising Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Reservation and Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 21.3.

DECISIONS RESERVED TO THE BOARD

General Enabling Provision

The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

Regulations and Control

1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.
2. Suspend Standing Orders.
3. Vary or amend the Standing Orders.
4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2.
5. Approve a scheme of delegation of powers from the Board to committees**.**
6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.
7. Require and receive the declaration of ~~officers'~~ employees' interests that may conflict with those of the Trust.
8. Approve arrangements for dealing with complaints, incident reporting and risk management~~s.~~
9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on.
11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.
12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.
14. ~~Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.~~
15. ~~14.~~ Authorise use of the seal.
16. ~~15.~~ Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6.
16. Discipline members of the Board ~~or employees~~ who are in breach of statutory requirements or SOs.
17. Approve the declarations made demonstrating compliance or otherwise with regulatory requirements, national guidance and legislation

Appointments/ Dismissal

1. Appoint the Vice Chair of the Board.
2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.
3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
4. Approve proposals of the Remuneration Committee regarding officer and associate members and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.

Strategy, Plans and Budgets

1. Define the strategic aims and objectives of the Trust.
2. Approve proposals for ensuring quality and developing ~~clinical~~ governance arrangements in respect of services provided by the Trust, having regard

to any guidance issued by the Secretary of State.

~~3. Approve the Trust's policies and procedures for the management of risk.~~

~~4.~~3. Approve Outline and Final Business Cases for Capital Investment where the value of the business case is greater than limits set by the Board.

~~5.~~4. Approve budgets.

~~6.~~5. Approve annually Trust's proposed organisational development proposals.

~~7.~~6. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

~~8.~~7. Approve PFI proposals.

~~9.~~8. Approve the opening of bank accounts.

~~10.~~9. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a 3 year period or the period of the contract if longer.

~~11.~~10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

~~12.~~11. Approve individual compensation payments above the level approved by the Board where these are not delegated to an external authority (including the NHS Litigation Authority) .

~~13.~~12. Approve proposals for action on litigation ~~against or~~ on behalf of the Trust.

~~14.~~13. Review use of NHSLA risk pooling schemes ~~(LPST/CNST/RPST).~~

Policy Determination

1. ~~Approve~~ Approve management ~~policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.~~policies as so determined as warranting this level of ratification by the Chair and Accountable Executive Lead

Audit

1. *Approve the appointment (and where necessary dismissal) of External Auditors and advise the Audit Commission on the appointment. Approval of external auditors' arrangements for the separate audit of funds held on trust, and the submission of reports to the Audit Committee meetings who will take appropriate action.*
2. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

Annual Reports and Accounts

1. Receipt and approval of the Trust's Annual Report and Annual Accounts.
2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
3. Receipt and approval of the Trust's Quality Account

Monitoring

1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.
2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from officerexecutive/associate members, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.
3. Receive reports from DoF on financial performance against budget and Local Delivery PlanSLAs.
4. Receive reports from DoF on actual and forecast income from SLAs.

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11	AUDIT COMMITTEE	The Committee will:- • review the adequacy of all risk and control related disclosure statements, including the Statement on Internal Control, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • review the adequacy of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements • review the adequacy of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service • consider the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework • consider the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources • ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organization • consider an annual review of the effectiveness of internal audit • consider the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit • discuss and agree with the External Auditor, before the audit commences, of the nature and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy • discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee • review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses • review and make recommendations to the Trust Board in respect of all proposed changes to Standing Orders, Standing Financial Instructions, Powers Reserved to the Board, Scheme of Delegation, and other financial procedures as appropriate • review schedules of losses and compensation. • review every reported breach of Standing Orders • consider the Director of Finance and Performance Management's Annual Opinion Statement on the adequacy of Internal Audit • ~~Advise the Board on internal and external audit services.~~ • ~~Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.~~ • ~~Ensure that there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.~~ • ~~Review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work.~~ • ~~Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.~~ • ~~Request and review reports and positive assurances from officer/associate members and managers on the overall arrangements for governance, risk management and internal control.~~ • ~~Review the Annual Report and Financial Statements before submission to the Board.~~ • ~~Review and make recommendations to the Trust Board in respect of all proposed changes to Standing Orders, Standing Financial Instructions, Powers Reserved to the Board, Scheme of~~

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		~~Delegation, and other financial procedures as appropriate.~~ • ~~Review schedules of losses and compensations.~~ • ~~Review every reported breach of Standing Orders.~~ • ~~Consider the Director of Finance's Annual Opinion Statement on the adequacy of Internal Audit.~~ • ~~Monitor progress against the data quality action plans.~~
SFI 20	REMUNERATION AND TERMS OF SERVICE COMMITTEE	The Committee will: • recommend the remuneration and terms of conditions of employment for the Chief Executive and the Executive Directors. • recommend the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service. • scrutinise and agree any termination payments made to the Chief Executive and Executive Directors. • ensure the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief executive and the Executive Directors. ~~1. Appoint, appraise, discipline and dismiss Executive Directors (excluding the Chair).~~ ~~2. Recommend the remuneration and terms of conditions of employment for the Chief Executive and Executive Directors.~~ ~~3. Recommend the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service.~~ ~~4. Scrutinise and agree any termination payments made to the Chief Executive and Executive Directors.~~ ~~5. Ensure the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief Executive and Executive Directors.~~ ~~6. Ratify the recommendations of the Clinical Excellence Awards Committee.~~
HSC 1998/70 HSC 1999/123	~~GOVERNANCE~~ QUALITY AND SAFETY ~~AND RISK MANAGEMENT~~ COMMITTEE	The Committee will: • Promote excellence in patient care in all aspects of quality and safety and monitoring and reviewing the implementation of the Trust's Quality and Safety Strategy. • Receive an agreed level of clinical data and trend analysis from divisions, directorates, Trust-wide governance committees and working groups to provide adequate clinical information to inform and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		analyse the quality and safety of clinical services provided. • Ensure that the Committee has adequate information on which to assure the Board of on-going compliance with the Care Quality Commission's Essential Standards of Quality and Safety. • Investigate and taking action on sub-standard quality performance. • Ensure the effective identification and management of risks to the quality and safety of care, with the supporting infrastructure of the Board Assurance Framework and Trust Risk Register. • Ensure that the Trust develops, maintains and reviews the effectiveness of systems and mechanisms that are able to achieve rapid and effective responses to risks and hazard alerts. • Ensure the learning from serious incidents, complaints and claims is identified, shared and delivered. • Ensure the Trust is proactive and creative in collecting and making use of service user and carer feedback from a variety of sources, and the involvement of service users and carers to drive quality improvement. • Ensure the Trust learns from staff feedback on quality of care through staff consultation, the operation of the Trust's whistle-blowing policy, staff surveys, focus groups etc • Ensure the Trust engages effectively with all key stakeholders on quality e.g. through communicating quality performance to Commissioners, considering feedback from PALS and LINks and working in partnership with other providers along care pathways to ensure quality. • Ensure the Trust has effective clinical governance systems and processes in place at all levels throughout the organisation, including the relevant policy, accountability, meetings, reports and communication structures. • Receive assurances regarding the workforce, including education, training and development, appraisal and performance. • Ensure there are robust systems for monitoring clinical quality performance indicators within divisions and directorates. • Ensure there is a comprehensive, well-functioning and effective clinical and internal audit programme in relation to quality governance; that recommendations from clinical and internal

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		audit reports are acted upon and required improvements delivered; and that national audits drive the clinical audit programme. • Ensure national reports, investigations, alerts, best practice guidance, NICE standards and other significant external reports are shared, reviewed for relevant findings and actions, and the necessary actions implemented locally. • Compare the Trust's quality performance against available national and local data. • Produce an annual report on progress against meeting its objectives and its annual reporting cycle. ~~1. Report regularly to the Board and giving advice on matters relating to the quality of clinical care, governance arrangements and risk management.~~ ~~2. Develop and monitor implementation of the Trust's Governance and Risk Management Strategies.~~ ~~3. Assess and monitor the standard of clinical care offered to patients.~~ ~~4. Ensure that all risk, including financial risk, within the Trust is known, properly assessed and managed.~~ ~~5. Develop the Trust's Corporate Risk Register and Assurance Framework.~~ ~~6. Ensure that the Trust develops, maintains and reviews the effectiveness of systems and mechanisms that are able to achieve rapid and effective responses to risks and hazard alerts.~~ ~~7. Develop a positive risk awareness culture and an open, self critical and thorough approach to investigating and learning from adverse events.~~ ~~8. Ensure that governance and risk management is embedded in training and education and human resources management.~~ ~~9. Ensure that effective mechanisms develop and operate across the Trust to involve service users, carers, the public and partner organisations in improving clinical governance and risk management.~~ ~~10. Ensure that the Trust has taken appropriate action in response to relevant independent reports, government guidance, statutory instruments and ad hoc reports from enquiries and independent reviews.~~ ~~11. Compare the Trust's clinical performance against available national and local data.~~ ~~12.~~1. ~~Produce an annual report on progress.~~
	CHARITABLE FUNDS COMMITTEE	The Committee will: • Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds. • Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds. • Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds. • Together with such brokers, recommend the investment strategy for such funds. • Receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds, prior to submission and to review the regular investment reports supplied by the Trust's brokers. • Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance. • Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds • Consider charitable fundraising for the new hospital • In accordance with the Scheme of Delegated Authority and authorisation limits, (see Standing Orders and Standing Financial Instructions) to consider all business cases involving the use of Charitable Funds prior to any required consideration by the Trust Board. ~~1. Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.~~ ~~2. Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.~~ ~~3. Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds.~~ ~~4. Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.~~ ~~5. Together with such Brokers, recommend the investment strategy for such funds.~~ ~~6. Receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds, prior to submission and to review the regular investment reports supplied by the Trust's~~

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		~~brokers.~~ ~~7. Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.~~ ~~8. Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds.~~ ~~9. Consider all business cases involving the use of Charitable Funds prior to consideration by the Trust Board.~~
	FINANCE AND PERFORMANCE MANAGEMENT COMMITTEE	The Committee will: • Consider regular financial reports and forecasts including prime statement of accounts and supporting analyses and forecasts, focusing particularly on: o Any changes in accounting and policies and practices o Major judgmental areas o The going concern assumption and underlying recurrent performance o Compliance with NHS accounting standards o Compliance with other legal requirements • Discuss financial issues arising from interim and final audits. • Commission and consider various financial reporting and analyses, as appropriate. • Consider explanations of significant variances/deviations from budget by Directorates and Departments on a regular basis and to consider proposals for remedial action. • Review the calculation adequacy and deployment of financial provisions for clinical negligence; doubtful debts; inflation etc. • Consider other topics or matters as directed by the Trust Board. • Consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue and Capital Budgets.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		• Review the Trust Business Plan and Annual Budgets before submission to the Trust Board. • Monitor performance compared with the Annual Business Plan and Budgets. • Retrospectively review business cases for benefits realisation. • Consider the likely impact of technical changes to accounting policy or practices. • Consider detailed cash flow and working capital forecasts. • Review proposals to enter into material contracts for the supply or services from financial and legal perspectives. • Review the financial outcome of material contracts. • Consider regular reports of the Trust and Directorate Performance in respect of service agreements agreed with Commissioners and to note findings. • Monitor the Local Delivery Plans (LDPs) with Commissioners. • Monitor the financial performance of individual Directorates and Departments. To consider regular management performance reports from individual Directorates and Departments. • Consider performance against external performance targets set from time to time by the Department of Health and Strategic Health Authority, e.g. waiting lists/times, management costs, etc. • Consider performance against a range of internally developed clinical, financial and operational indicators. • Consider business risk management processes in the Trust. • Review arrangements for risk pooling and insurance. • Consider the implications of pending litigation against the Trust. ~~1. Consider regular financial reports and forecasts including prime statement of accounts and supporting analyses and forecasts.~~ ~~2. Discuss financial issues arising from interim and final audits.~~

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		3. Commission and consider various financial reporting and analyses, as appropriate. 4. Consider explanations of significant variances/deviations from budget by Divisions and Departments on a regular basis and to consider proposals for remedial action. 5. Review the calculation adequacy and deployment of financial provisions for clinical negligence; doubtful debts; inflation etc. 6. Consider other topics or matters as directed by the Trust Board. 7. Consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue and Capital Budgets. 8. Review the Trust Business Plan and Annual Budgets before submission to the Trust Board. 9. To monitor performance compared with the Annual Business Plan and Budgets. 10. Consider the likely impact of technical changes to accounting policy or practices. 11. Consider detailed cash flow and working capital forecasts. 12. Review proposals to enter into material contracts for the supply or services from financial and legal perspectives. 13. Review the financial outcome of material contracts. 14. Consider regular reports of the Trust and Divisional Performance in respect of service agreements agreed with Commissioners and to note findings. 15. Monitor the Local Delivery Plans (LDPs) with Commissioners. 16. Monitor the financial performance of individual Divisions and Departments. To consider regular management performance reports from individual Divisions and Departments. 17. Consider performance against external performance targets set from time to time by the Department of Health and Strategic Health Authority, e.g. waiting lists/times, management costs, etc. 18. Consider performance against a range of internally developed clinical, financial and operational indicators. 19. Consider business risk management processes in the Trust. 20. Review arrangements for risk pooling and insurance. 21. Consider the implications of pending litigation against the Trust.
	PATIENT AND PUBLIC INVOLVEMENT	The Committee will: 1. Set the direction of the Trust in relation to patient and public involvement and to monitor the implementation of the Patient and Public Involvement strategy. 2. Create a framework which reflects processes and responsibilities associated with all aspects of the strategy ensuring it is implemented, monitored and maintained across the Trust. 3. Champion the Patient and Public Involvement agenda as part of corporate governance. 4. Create a Patient and Public Involvement accountability framework for Divisions as part of the Trust performance management process. 5. Receive national and local guidance and ensure that it is dealt with effectively by the Trust.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		~~6. Receive reports from the Patient and Public Involvement governance group.~~ ~~7. Direct the administration of the annual Patient Opinion survey and ensure the quality improvement plan is developed and monitored across the Trust.~~ ~~8. Develop partnerships with patient and public groups established within, and outside the organisation.~~ ~~9. Develop partnership working on Patient and Public Involvement in the Primary Care Trusts.~~ ~~10. Produce an annual Patient and Public Involvement report.~~

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND DIRECTOR OF FINANCE (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIR	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).
15	DOF	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that Director of Finance discharges this function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CE and DoF	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	If CE considers the Board or Chair is doing something that might infringe probity or regularity, he should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit

REF	DELEGATED TO	DUTIES DELEGATED
		Committee to inquire and if necessary the SHA and Department of Health.
21	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the Strategic Health Authority and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of gifts, hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/EXECUTIVE DIRECTORS	Chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 1. ~~4t~~to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 2. 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 3. 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
1.3.24	BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIR	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	NON EXECUTIVE DIRECTORS	Non Executive Directors are appointed by Appointments Commission to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND OFFICER AND NON EXECUTIVE DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Board meetings and associated responsibilities.
3.10	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIR	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to committees, sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
8.4	CHIEF EXECUTIVE/OFFICER OR ADVISING DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.4	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.4	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.7	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.8	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 &	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.2.1		
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an LDP which takes into account financial targets and forecast limits of available resources. The LDP will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the LDP.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
14.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
15.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.8	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.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	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.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.4	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other Executive Directors and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of officer and associate members and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
20.4.1 and 20.4.2	DIRECTOR OF FINANCE	Payroll: specifying timetables for submission of properly authorised time records and other notifications;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		final determination of pay and allowances; making payments on agreed dates; agreeing method of payment; issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS	Submit time records in line with timetable. Complete time records and other notifications in required form. Submitting termination forms in prescribed form and on time.
20.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	NOMINATED MANAGER	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	DIRECTOR OF FINANCE~~E~~	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE OFFICER ~~OR ASSOCIATE MEMBER~~	Make a written case to support the need for a prepayment.
21.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND ~~OFFICERS~~ALL STAFF	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
21.2.7	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Officer/advising director.
21.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	DIRECTOR OF FINANCE	The DoF will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)
22.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
23	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
25.2	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS	Security arrangements and custody of keys
25.2	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
25.2	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
25.2	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS ~~Supplies~~ Logistics stores.
26.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.
26.2.2	DIRECTOR OF FINANCE	Notify CFSMS and External Audit of all frauds.
26.2.3	DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	BOARD	Approve write off of losses (within limits delegated by DH).

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
26.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
26.2.7	DIRECTOR OF FINANCE	Maintain losses and special payments register.
27.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
27.1	DIRECTOR OF FINANCE	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 assurances of adequacy must be obtained from them prior to implementation.
27.1.3	~~DIRECTOR OF IM&T~~TRUST SECRETARY	Shall publish and maintain a Freedom of Information Scheme.
27.2.1	RELEVANT ~~OFFICERS~~STAFF	Send proposals for general computer systems to ~~DoF~~the Director with responsibility for IM & T
27.3	~~DIRECTOR OF IM&T~~DIRECTOR WITH RESPONSIBILITY FOR IM & T -AND DIRECTOR OF FINANCE	*Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.* Seek periodic assurances from the provider that adequate controls are in operation.
27.4	DIRECTOR WITH RESPONSIBILITY FOR IM & T ~~DIRECTOR OF IM&T~~	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and finance ~~and~~ staff have access to such data; Audits of computerised systems are carried out as considered necessary..~~Such computer audit reviews are being carried out as are considered necessary.~~
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	DIRECTOR OF GOVERNANCE~~DIRECTOR OF FINANCE~~	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance 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 Director of Finance 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.
33.4	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible limits.

Schedule of Delegated Authority and Authorisation Limits

1. General Conditions

In planned periods of absence of up to 21 days, ~~Officer and Advising~~ Directors may temporarily transfer their authorisation authority to a nominated deputy. This transfer should be recorded in writing or e-mail and a copy of the authorisation passed to the Director of Finance and the ~~Supplies Manager~~Head of Procurement.

In unplanned periods of absence or planned absence greater than 21 days, the Chief Executive may temporarily transfer the authorisation authority of ~~an Officer or Advising~~ a Director to a nominated deputy. This transfer should be recorded in writing or e-mail, specify the period of transfer and a copy of the authorisation be passed to the Director of Finance and the ~~Supplies Manager~~Head of Procurement.

2. Management of Budgets

SFI reference 13

Responsibility for maintaining expenditure within approved budget limits is specified below.

Budget Level	**Responsibility Delegated To**
Individual budgets (pay and non pay)	Budget Holder
Divisional Level	Divisional Director
All Other Areas	Director of Finance or Nominated Deputy

Virement of budgets within any limitations imposed in the Trust's Financial Plan and/or Annual Budget is specified below:

Budget Level	**Responsibility Delegated To**
Individual (cost centre level) budgets (pay and non pay)	Budget Holder (subject to any Personnel and Pay conditions specified in section 12)
Divisional Level	Divisional Director (subject to any Personnel and Pay conditions specified in section 12)
Between Operational Divisions (excluding reserves and other non operational budgets)	Chief Operating Officer or Chief Nurse with Director of Finance or authorised deputies
Use of Specifically Allocated Trust Reserves (as identified in Annual Budget)	Director of Finance or authorised deputy and reported to Finance & Performance Management Committee
Use of Other Trust Reserves and/or non operational budgets	Chief Executive and Director of Finance and reported to Finance &

	Performance Management Committee

3. Requisitions and Invoices

SFI reference 21

3.1. Conditions

Raising and authorisation of requisitions and orders and authorisation and payment of invoices are subject to financial procedures which have been agreed with the Director of Finance and Performance Management.

Raising and authorisation of requisitions and orders must comply with Standing Financial Instructions on the management of budgets.

Authorisation of expenditure must be within budgets specifically approved by the Trust Board as part of the Trust's revenue or capital financial plans.

3.2. Stock/Non Stock Requisitions and Invoices

Authorisation Level	**Authorise Stock/Non Stock Requisitions and Approve Invoices for Payment ***
First Line Budget Managers	<= £5,000
Officers Specifically Authorised by the Director of Finance as Trust Authorised Signatories	<= £10,000
Divisional General Managers and Nominated Deputies, Deputy Divisional Directors	<= £20,000
Divisional Directors	<= £30,000
~~Officer and advising directors and Other~~ Employees Specifically Authorised by the Chief Executive and Director of Finance	<=£50,000
Chief Executive	<= £100,000
Two ~~Officer or Advising Directors~~ Executive Directors (one of whom should be the Director of Finance)	<= £250,000
Chief Executive and Director of Finance	<= £500,000

- Invoices which relate to orders which have been placed through the Trust's procurement system and receipted in the same system will not require separate authorisation and will automatically be processed for payment by the Finance Department.

3.3. Pharmacy Orders

Authorisation Level	**Authorise Pharmacy Orders and Approve Invoices for Payment**

Authorisation Level	Authorise Pharmacy Orders and Approve Invoices for Payment
Pharmacy Authorised Signatory	<= £25,000
Pharmacy Authorised Signatory and Divisional General Manager	<= £50,000
Pharmacy Authorised Signatory and Divisional Director	<= £75,000
Pharmacy Authorised Signatory and ~~Officer/Advising Director~~one Executive Director	<= £250,000
Pharmacy Authorised Signatory and Director of Finance and Chief Executive	<= £500,000

3.4. Works Orders

Authorisation Level	Authorise Revenue Works Orders	Authorise Capital Works Orders
Staff specifically authorised by the Director of Finance as Trust Authorised Signatories	<= £25,000	<= £25,000
~~Officer and Advising Directors and Other~~ Staff specifically Authorised by the Chief Executive and Director of Finance	<= £50,000	<= £50,000
Chief Executive	<= £100,000	<= £100,000
Two ~~Officer or Advising Directors~~Executive Directors (one of whom should be the Director of Finance)	<= £250,000	<= £250,000
Chief Executive and Director of Finance	<= £500,000	<= £500,000

3.5. Granting and Termination of Leases

Leases which require the application of the Trust's seal will be considered individually by the Trust Board as the application of the seal must be authorised by the Board.

Authorisation Level	Value of Annual Rental
Director of Finance	<= £100,000
Non Executive Director and Chief Executive or Director of Finance	<= £500,000

4. Quotations, Tendering and Contracts

SFI Reference 17

4.1. Conditions

Quotation, tendering and contracting procedures must operate within the conditions specified in SFIs Section 17.

Quotations and tenders will be obtained by the ~~Supplies Manager~~Head of Procurement in respect of general goods and services, the Head of Pharmacy for pharmacy supplies and the Director of ~~Facilities~~Estates for works related goods and services within the limits specified under Section 3.2.

Quotations and tendering conditions may be waived by the Chief Executive within the terms of SFIs Section 17.5.

4.2. Financial Values of Quotations and Tenders

Authorisation Limits	Values
Obtain minimum of 2 verbal quotations	<= £4,999
Obtain a minimum of 2 written quotations	Between £5,000 and £19,999
Obtain a minimum of 3 written quotations	Between £20,000 and £49,999
Obtain a minimum of 3 written competitive tenders	Between £50,000 and £149,999
Obtain a minimum of 4 written competitive tenders	>= £150,000

4.3. Opening of Tenders

Tenders to be Opened By	Estimated Tender Value Over the Life of the Contract
Two officers of the Trust authorized by the Chief Executive and not from the originating department	<= £499,000
Two officers of the Trust as above, one of whom must be ~~a member~~an Executive Director of the Trust	>= £500,000

4.4. Evaluation of Quotations and Tenders

Where the result of a tender/quotation exercise or the receipt of a contractors variation notice results in the estimated tender/quotation sum being or the approved budget being exceeded then the following approval process for the additional expenditure will apply.

Amount of Excess Costs	Authority Delegated To
Up to 10% or £25,000 (whichever is the lower) more than the tender/quotation estimate	~~Officer or Advising Director~~Executive Director
Up to 10% or £100,000 (whichever is the lower) more than the tender/quotation estimate	Chief Executive
Over £100,000	Trust Board approval required

4.5. Authorisation of Quotations and Tenders

Subject to the evaluation limits specified in Section 4.4 above, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as specified in the following table.

Authorisation Level	Value of Contract
Designated Budget Holder	<= £10,000
Divisional Director or Divisional General Manager	<= £50,000
Executive Directors ~~and Advising Directors~~ of the Trust	<= £100,000
Chief Executive	<= £250,000
Chief Executive and Director of Finance	<= £500,000
Chair and Chief Executive	<= £1,000,000
Trust Board	> £`500,000

5. Setting of Fees and Charges

SFI reference 16.

Item	Authority Delegated To
Pricing of NHS Service Agreements (Where Not Covered By National Tariffs)	Director of Finance or Nominated Deputy
Private Patients, Overseas Visitors and Other Patient Services	Director of Finance or Nominated Deputy
Non Clinical Services	Director of Finance or Nominated Deputy in Conjunction with Responsible Officer/~~Advising Director~~Executive Director

6. Engagement of Staff Not Within Establishment

SFI reference 17 and 21.

Item	Authority Delegated To
Non Clinical Consultancy Staff with Commitment in any one Year <= £20,000	Chief Executive or Director of Finance
Non Clinical Consultancy Staff with Commitment in any one Year <= £50,000	Chief Executive and Director of Finance
Non Clinical Consultancy Staff with Commitment in any one Year > £50,000	Trust Board
Engagement of Trust's Solicitors	Chief Executive or ~~Officer/Advising Director~~Executive Director

7. Agreements and Licences

SFI reference 16.

Item	Authority Delegated To
Preparation and Signature of all Tenancy Agreements/Licences for Staff Accommodation	~~Officer/Advising~~Executive Director or Nominated Deputy
Extensions or Amendments to Above	~~Officer/Advising~~Ee~~e~~xecutive Director or Nominated Deputy
Letting of Premises to Outside Organisations	Director of ~~Facilities~~ Estates after Consultation with Chief Executive and Director of Finance
Approval of Rent Based on Professional Assessment	Director of Finance

8. Charitable Funds

SFI reference 29.

8.1. Conditions

Expenditure funded from charitable funds must be in accordance within the purposes of the fund being utilized and in accordance with any restrictions laid down by the Trust and/or the Charity Commission.

Expenditure must not exceed the balance of funds available.

8.2. Authorisation Limits

Type of Expenditure	Authorisation of Requests	Authorisation Limit per Request
Pay expenditure as part of a linked research programme.	Director of Finance and Fund Manager	Value of salary + on costs.
Non Pay	Fund Manager and Nominated Representative of DoF	<= £5,000
	Fund Manager and Director of Finance	£5,001 - £20,000
	Fund Manager and Director of Finance and the ~~Board~~ Executive Director responsible for the requesting department	£20,001 - £50,000
	Charitable Funds Committee	> £50,001

9. Condemnation, Disposal, Write Offs, Losses and Compensation

SFI reference 26.

9.1. Condemnation and Disposal

Items which are obsolete, redundant, irreparable or cannot be repaired cost effectively will be disposed of according to the following limits (subject to acting on appropriate professional advice regarding disposal).

~~Current/Estimated Replacement Price~~Estimated Current Value	Authority Delegated To
<= £1,000~~500~~	Budget Holder
<= £~~2,000~~10,000	Divisional Director or Divisional General Manager
<= £2,000	Director of Finance

9.2. Sale of Obsolete Equipment or Scrap

Item	Estimated Sale Value	Authority Delegated To
Mechanical and Engineering Plant	<= £~~5~~10,000	~~Director of~~Director with responsibility for Estates
Mechanical and Engineering Plant	Between £~~5~~10,001 and £2~~0~~5,000	Director with responsibility for ~~Director of~~ Estates after consultation with Director of Finance
IT Equipment	<= £5,000	~~Chief Operating Officer~~Executive Director with responsibility for IM & T
IT Equipment	Between £5,001 and £20,000	Executive Director with responsibility for IM & T~~Chief Operating Officer~~ after consultation with Director of Finance
Medical Equipment and Materials	< £5,000	Divisional Director or Divisional General Manager
Medical Equipment and Materials	Between £5,001 and £20,000	Divisional Director or Divisional General Manager after consultation with Director of Finance

9.3. Losses, Write Off and Compensation

Item	Value	Authority Delegated To
Losses Due to Theft, Fraud, Over Payment and Other	<= £50,000	Chief Executive or Director of Finance and Reported to Audit Committee
Fruitless Payments (Including Abandoned Capital Schemes)	<= £250,000	Chief Executive or Director of Finance and Reported to Audit Committee
Bad Debts, Write Off of Debtors and Claims Abandoned (Non NHS)	<= £50,000	Chief Executive or Director of Finance and Reported to Audit Committee
Bad Debts, Write Off of Debtors and Claims Abandoned (NHS)	<= £250,000	Chief Executive or Director of Finance and Reported to Audit Committee
Damage to or Loss of Property Due To Culpable Causes (e.g. Theft, Arson)	<= £50,000	Chief Executive or Director of Finance and Reported to Audit Committee
Compensation Payments Made Under Legal Obligation	Any	Chief Executive or Director of Finance and Reported to Audit Committee
Extra Contractual Payment to Contractors	<= £50,000	Chief Executive or Director of Finance and Reported to Audit Committee
Ex Gratia Payments to Staff and Patients for Loss of or Damage to Personal Effects	<= £1,000~~500~~	Divisional Director or Divisional General Manager and Reported to Audit Committee
	<= £50,000	Chief Executive or Director of Finance and Reported to Audit Committee

Item	Value	Authority Delegated To
Personal Injury Claims Involving Negligence Where Legal Advice Has Been Obtained and Guidance Applied (Including Plaintiff's Costs)	<= £250,000	Chief Executive or Director of Finance and Reported to Audit Committee
	~~> £250,000~~	~~Trust Board~~
Other (Excluding Cases of Maladministration)	<= £50,000	Chief Executive or Director of Finance and Reported to Audit Committee

10. Reporting of Incidents to the Police

Incident	Authority Delegated To
Criminal Offence of a Violent Nature	~~Chief Operating Officer or Deputy Chief Operating Officer~~Local Security Management Specialist/~~Advising~~ Executive Director On Call
Other Criminal Offence	Local Security Management Specialist ~~Chief Operating Officer or Deputy Chief Operating Officer~~ /~~Advising~~ Director On Call
Fraud	Nominated Local Counter Fraud Specialist

11. Petty Cash Disbursements

SFI reference 21.

Expenditure Up To	Authority Delegated To
Expenditure <= £25 Per Item	Budget Holder
Expenditure <= £50 Per Item	Divisional General Manager
Expenditure > £50 Per Item	Director of Finance or Nominated Deputy
Reimbursement of Patients Monies <= £100	Budget Holder
Reimbursement of Patients Monies > £100	Director of Finance or Nominated Deputy

12. Personnel and Pay

SFI reference 20.

12.1. Establishments

Item	Authority Delegated To
Authority to Fill Funded Post within Establishment with Permanent Staff	Staff specifically ~~Authorised to Sign~~Permitted to Authorise Permanent Payroll Documentation
Authority to Appoint Staff to Posts Not Within Formal Establishment but Within Total Available Budget	Chief Executive or Director of Finance and responsible ~~Officer/advising director~~Executive Director
Granting of Additional Increments to Staff Within Budget	~~Director of Human Resources~~Chief Nurse
Regrading of Staff	Staff secifically ~~Authorised to Sign~~Permitted to Authorise Permanent Payroll Documentation where Changes are in Accordance with Trust Procedures.
Increase Establishment with Specifically Allocated Finance	~~Director of Human Resources~~Chief Nurse
Increase Establishment without Specifically Allocated Finance	Chief Executive and Director of Finance

12.2. Pay

Item	Authority Delegated To
Completion of Standing Data ~~Forms~~ Changes Affecting Pay, Starters, Leavers and Amendments	Officers Specifically Permitted to Authorise Permanent Payroll Documentation~~Officers Specifically Authorised to Sign Temporary Payroll Documentation~~
Completion and Authorisation of ~~Positive Reporting Forms~~In Month Changes	Officers Specifically ~~Authorised to Sign~~Permitted to Authorise Temporary Payroll Changes~~Documentation~~
Authorisation of Overtime	Officers Specifically Permitted to Authorise Temporary Payroll Changes~~Officers Specifically Authorised to Sign Temporary Payroll Documentation~~
Authorisation of Travel and Subsistence Expenses	Officers Specifically Permitted to Authorise Temporary Payroll Changes~~Officers Specifically Authorised to Sign Temporary Payroll Documentation~~

12.3. Leave

Item	Authority Delegated To
Approval of Annual Leave	Line/Departmental Manager
Approval of Carry Forward of Annual Leave	Line/Departmental Manager within the Conditions laid down by the Trust.
Approval of Annual Leave Outside Conditions Laid Down by the Trust	~~Director of Human Resources~~Chief Nurse
First 3 Days Compassionate Leave	Line/Departmental Manager within Trust Policies on Compassionate Leave
Additional Compassionate Leave	Divisional General Manager within Trust Policies on Compassionate Leave
Maternity Leave (Paid and Unpaid)	Line/Departmental Manager, Divisional Director/General Manager (automatic

Item	Authority Delegated To
	approval within HR guidance)
Paternity Leave	Line/ Departmental Manager within Trust Policies
Carers and Other Special Leave	Line/Departmental Manager within Trust Policies
Leave Without Pay	Line/Departmental Manager in consultation with Human Resources Department
Medical Staff Leave of Absence	Divisional Director, Divisional General Manager or ~~Officer/Advising~~Executive Director
Time Off in Lieu	Line/Departmental Manager

12.4. Sick Leave

Item	Authority Delegated To
Extension of Sick Leave on Half Pay up to 3 Months	~~Officer/Advising Director~~Appropriate Executive Director in conjunction with ~~Director of Human Resources~~Chief Nurse
Return to work Part-Time on Full Pay to Assist Recovery	Divisional Director/~~Officer~~Appropriate Manager/~~Advising~~ Executive Director Director in Conjunction with ~~Director of Human Resources~~~~Chief Nurse~~ the Executive Director responsible for HR
Extension of Sick Leave on Full Pay	Chief Executive and ~~Director of Human Resources~~~~Chief Nurse~~Executive Director responsible for HR

12.5. Study Leave

Item	Authority Delegated To
Study Leave Outside the UK: Medical	Medical Director
Study Leave Outside the UK: Non Medical	Chief Executive
Study Leave Within the UK: Medical	Divisional Director
Study Leave Within the UK: Non Medical	As per Trust Policy

12.6. Other Employment Matters

Item	Authority Delegated To
Authorisation of Removal Expenses in Accordance with Trust Policies	~~Director of Human Resources~~~~Chief Nurse~~ Executive Director responsible for

Item	Authority Delegated To
	HR and Divisional General Manager
Grievances	In accordance with Grievance Procedure and with the advice of a Human Resources Officer when the grievance reaches the level of General Manager.
Authorisation of Regular Users as Car Users	~~Director of Human Resources~~ Executive Director responsible for HR ~~Chief Nurse~~ or Director of Finance
Authorisation of posts as portable data/communication devices	~~Hospital Director or Director of IM&T~~Chief Operating Officer/Deputy Chief Operating Officer
Renewal of Fixed term Contract	Chief Executive, ~~Officer/Advising Director~~Executive Director or Divisional Director
Authorisation of Extensions of Contracts Beyond Normal Retirement Age	~~Director of Human Resources~~ Executive Director responsible for HR~~Chief Nurse~~
Redundancy: Chief Executive, Officer and Advising Directors	Remuneration Committee (after consultation with Director of Finance in respect of financial implications)
Redundancy: All Other Staff	~~Director of Human Resources~~ Executive Director responsible for HR ~~Chief Nurse~~ (after consultation with Director of Finance in respect of financial implications)
Pursuit of Retirement on the Grounds of Ill Health	~~Director of Human Resources~~ Executive Director responsible for HR~~Chief Nurse~~
Dismissal: Chief Executive, Officer and Advising Directors	Remuneration Committee
Dismissal: All Other Staff	Divisional Directors or ~~Officer or Advising Directors~~Eexecutive Director

13. Patients and Relatives Complaints

Item	Authority Delegated To
Overall Responsibility for Ensuring Effective Management of Complaints	Chief Executive
Ensuring Thorough Investigation of Complaints Relating to a Division	Divisional Director, Divisional General Manager or ~~Officer/Advising~~ Executive Director
Management of Medico-Legal Complaints	Director of Governance ~~Development~~

14. Relationship with the Press

Item	Authority Delegated To
Non Emergency General Enquiries: Within Normal Working Hours	Head of Communications and Engagement

Item	Authority Delegated To
Outside Working Hours	Head of Communications and Engagement
Emergencies: Within Normal Working Hours	Head of Communications and Engagement
Outside Working Hours	Head of Communications and Engagement or On Call Manager/~~Advising Director~~Director

15. Patient Services

Item	Authority Delegated To
Variation of Operating and Clinic Sessions Within Existing Numbers: Out-Patients	Clinical Director/Divisional General Manager and Chief Operating Officer
Variation of Operating and Clinic Sessions Within Existing Numbers: Theatres	Clinical Director/Divisional General Manager and Chief Operating Officer
Variation of Operating and Clinic Sessions Within Existing Numbers: Other	Clinical Director/Divisional General Manager and Chief Operating Officer
Proposed Changes in Bed Allocation and Use: Temporary Changes	Divisional Director/Divisional General manager and reported to Chief Operating Officer
Proposed Changes in Bed Allocation and Use: Permanent Changes	Chief Operating Officer
Infectious Diseases and Notifiable Outbreaks	~~Director of Infection Prevention & Control~~Chief Nurse as DIPC
Extended Role Activities: Approval of Nurses to Undertake Duties/ Procedures Which Can Properly Be Described As Beyond The Normal Scope Of Nursing Practice	Chief Nurse

16. Compliance with Statutory and Other Regulatory Requirements

Item	Authority Delegated To
Review of Fire Precautions	~~Director of Facilities~~~~Estates~~Executive Director responsible for Estates
Review of all Statutory Compliance Legislation and Health and Safety Requirements Including Control of Substances Hazardous to Health Regulations	~~Director of Human Resources~~~~Chief Nurse/Director of Estates and Director of Facilities~~Executive/Advising Directors responsible for facilities and estates
Review of Medicines Inspectorate Regulations	Medical Director
Review of Compliance with Environmental Regulations (e.g. Clean Air and Waste Disposal)	Executive/Advising Directors responsible for facilities and estates~~Chief Nurse/Director of Estates~~~~Director of Facilities~~

Item	Authority Delegated To
Review of Compliance with the Data Protection Act	~~Director of Information Management and Technology~~Executive Director responsible for IM & T
Monitor Proposals for Contractual Arrangements Between the Trust and Outside Bodies	Director of Finance
Review of Compliance with the Access to Records Act	Executive Directors responsible for IM & T and HR~~Director of information Management and Technology and Director of Human Resources~~
Review of Compliance with the Disability Discrimination Act	Executive/Advising Directors responsible for Estates and HR ~~Director of Facilities and Director of Human Resources~~Chief Nurse/~~Director of Estates~~
Review of Compliance with the Code of Practice for Handling Confidential Information	Executive Director responsible for IM & T~~Director of Information Management and Technology~~
Compliance with Other Legislation and Regulations	Chief Executive (May Subsequently be Delegated by the Chief Executive to other ~~Officer or Advising Directors~~Executive Directors)

17. Other Requirements

Item	Authority Delegated To
Maintenance of a Declaration of Interests Register	Director of Governance ~~Development~~
Attestation of Sealings in Accordance with Standing Orders	Chair or Non Executive Directors and Chief Executive or ~~Officer or Advising Directors~~Executive Director
Maintenance of a Register of Sealings	Director of Governance ~~Development~~
Maintenance of Hospitality Register	Director of Governance ~~Development~~
Declaration of Gifts exceeding £10 and Hospitality exceeding £40	All Staff
Retention of Records	Executive Director responsible for IM & T~~Director of Information Management and Technology~~
Development and Maintenance of System for Ensuring Sound Clinical Governance	Director of Governance ~~Development~~/Medical Director/Divisional Directors
Implementation of External and Internal Audit Recommendations	Director of Finance and Appropriate ~~Officer or Advising~~Executive Director
Maintenance and Update of Trust Financial Procedures	Director of Finance

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

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

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

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

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of any significant and material breaches and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. Full details of any non-compliance will be periodically ~~be~~ reported to the Audit Committee. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

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

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

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Reservation and Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Decisions Reserved to the Board section of the Scheme of

Reservation and Delegation. All other powers have been delegated to such other committees as the Trust has established.

10.2.4 **The Chief Executive and Director of Finance**

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

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, 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.

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

10.2.6 **The Director of Finance**

The Director of Finance is responsible for:

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

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

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

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

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

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

10.2.7 **Board Members and Employees**

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

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

10.2.8 **Contractors and their employees**

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

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

11. AUDIT

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2005), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

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

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

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

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

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Director of Finance in the first instance.)

11.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Director of Finance

11.2.1 The Director of Finance is responsible for:

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

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

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

(e) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

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

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

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

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

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

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

(c) the suitability of financial and other related management data;

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

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

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

11.3.2 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 Director of Finance must be notified immediately.

11.3.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

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

11.4 External Audit

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

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

11.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in NHS Protect, the national counter fraud body incorporated within the NHS Business Services Authority also known as ~~the Counter Fraud and Security Management Services (~~CFSMS~~)~~ ~~(~~ ~~and the Regional~~ Counter Fraud and Security Management Services~~).~~ He or she shall work in ~~(CFSMS) in~~ accordance with the Department of Health Fraud and Corruption Manual.

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

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

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

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

12. RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Executive will compile and submit to the Board an Annual Plan ~~Local Delivery Plan~~ which takes into account financial targets and forecast limits of available resources. The Plan~~LDP~~ will contain:

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

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

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

(a) be in accordance with the aims and objectives set out in the ~~Local Delivery Plan~~Annual Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

13.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

13.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

13.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

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

13.3 Budgetary Delegation

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

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

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

13.3.3 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.

13.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

13.4 Budgetary Control and Reporting

13.4.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

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

13.5 Capital Expenditure

13.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

13.6 Monitoring Returns

13.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

14.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

14.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. BANK ~~AND OPG~~ ACCOUNTS and the GBS

15.1 General

15.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' the Trust shall use the GBS (Government Banking Service) which replaced the ~~Trusts should minimize the use of commercial bank accounts and consider using~~ Office of the Paymaster General. All transactions are to be processed through the banking facilities offered by the GBS which includes use of commercial bank accounts. ~~(OPG) accounts for all banking services.~~

15.1.2 The Board shall approve the banking arrangements.

15.2 Bank ~~and OPG~~ Accounts

15.2.1 The Director of Finance is responsible for:

(a) bank accounts including those secured through the GBS ~~and Office of the Paymaster General (OPG) accounts~~;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank ~~or OPG~~ accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Director of Finance will prepare detailed instructions on the operation of bank ~~and OPG~~ accounts which must include:

(a) the conditions under which each bank ~~and OPG~~ account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

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

15.4 Tendering and Review

15.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for ~~OPG~~ accounts directed under the GBS.

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

16.1 Income Systems

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

16.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

16.2 Fees and Charges

16.2.1 The Trust shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.

16.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall 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 Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

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

16.3 Debt Recovery

16.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

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

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

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

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

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

16.4.4 No member of staff is able to receipt a sum in cash form (in any currency) in excess of £1000 from an external source. The Director of Finance must be informed immediately if such an offer of payment in a cash form is made.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust 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.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

17.2 EU Directives Governing Public Procurement

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 Standing Orders and Standing Financial Instructions.

17.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

17.4 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

17.5 Formal Competitive Tendering

17.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

17.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000.

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

Formal tendering procedures **may be waived** in the following circumstances:

(d) 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 circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where PASA agreements are in place and have been approved by the Board;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) 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;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Approval of Single Tender Arrangements requires Board approval for any amount ~~(including VAT)~~ above the EU procurement limit for goods and services (£101,323~~119,054~~ as at 1 January 2010 net of VAT which for Board Approval purposes becomes **£121,587** inclusive of VAT as at 1 January 2011).

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and periodically reported to the Audit Committee.

17.5.4 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 17.1 and 17.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

17.5.5 **List of Approved Firms**

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 17.6.8 List of Approved Firms).

17.5.6 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance unless permitted under Department of Health Estates and Facilities guidance which may require specific Department of Health Approval. ~~(other than in accordance with Concode) without Department of Health approval.~~

17.5.7 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction 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.

17.6 Contracting/Tendering Procedure

17.6.1 **Invitation to tender**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works shall embody or be in the terms of a formal contract. The form of contract will be appropriate to the value and nature of the building or engineering works. This shall include, but is not limited to: Trust Terms and Conditions, NEC-ECC (New Engineering Contract-Engineering and Construction Contract) and the Joint Contracts Tribunal Standard Forms of Building Contract. Standard forms of contract will be completed to comply with DH guidance or relevant professional body recommendations where DH guidance is not available or not applicable. These documents if modified and/or amplified should accord with DH guidance. Modifications/amplifications should be in minor respects, to cover special features of individual projects.~~Every tender for building or engineering works (except for maintenance work, when Estmancode 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. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.~~

17.6.2 **Receipt and safe custody of tenders**

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

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

17.6.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £500,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Reservation and Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors / Members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SFI No. 17.6.5 below).

17.6.4 **Admissibility**

i) 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.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.6.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

17.6.6 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

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.

(iii) 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.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

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

17.6.7 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

17.6.8 **List of approved firms (see SFI No. 17.5.5)**

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the 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 because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equality Act 2010 ~~Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944~~ and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.6.9 **Exceptions to using approved contractors**

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

17.7 Quotations: Competitive and non-competitive

17.7.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed amounts as laid down in the Trust's Scheme of Reservation and Delegation.

17.7.2 **Competitive Quotations**

(i) Quotations should be obtained from firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust in accordance with the Trust's Scheme of Reservation and Delegation.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

*(*iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

17.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible/(sponsoring) Director, possible or desirable to obtain competitive quotations and the circumstances are detailed in an appropriate Trust record;

(ii) where the requirement is covered by an existing contract;

(iii) where a consortium arrangement is in place and a lead organisation has been appointed to carry out quotation activity on behalf of the consortium members;

(iv) where the timescale genuinely precludes competitive quotations and the supply of goods or manufactured articles are required quickly and <u>are not</u> obtainable under existing contracts; (failure to plan the work properly would not be regarded as a justification for a single quote)

(v) where specialist expertise is required and is available from only one source;

(vi) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(vii) 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 from competitive quotations;

(viii) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognized as having sufficient expertise in the area of work for which they are commissioned. The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(ix) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive quotation procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that obtaining competitive quotations is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and periodically reported to the Audit Committee.

Where the goods or services are for building and engineering maintenance, there is an expectation that when requesting a waiver, the responsible works manager will justify the request by reference to the first two conditions of this SFI (i.e.: (i) and (ii)).

17.7.4 **Quotations to be within Financial Limits**

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 Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and periodically reported to the Audit Committee.

17.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by staff to the value of the contract in accordance with the individual limits as laid down in the Trust's Scheme of Reservation and Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

17.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use central and local NHS supply organisations 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.

(b) If the Trust does not use central and local NHS supply organisations for procurement - where tenders or quotations are not required, because expenditure is below the level defined in the Scheme of Reservation and Delegation, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

17.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.12 Personnel and Agency or Temporary Staff Contracts

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

17.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC (public benefit corporation), is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

17.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.15 In-house Services

17.15.1 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.

17.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding the level specified in the Trust's Scheme of Reservation and Delegation, a non-executive director should be a member of the evaluation team.

17.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.15.4 The evaluation team shall make recommendations to the Board.

17.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions 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.

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the ~~Local Delivery Plan (LDP)~~Annual Plan 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 NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

18.2 Involving Partners and jointly managing risk

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

18.3 Locally Commissioned Services~~A 'Patient Led NHS and 'Practice Based Commissioning''~~

The Department of Health has published its document Health and Social Care Bill 2011 ~~'Creating a Patient-led NHS' and 'Practice Based Commissioning'~~ setting out the basis upon which the Government's major reform agenda should ~~will~~ be carried forward.

~~**A 'Patient-led NHS'**~~

Every aspect of the new system is designed to create a service which is patient-led, where:

- people have a far greater range of choices and of information and guidance to help make choices;
- there are stronger standards and safeguards for patients;
- NHS organisations, particularly GP led commissioning bodies are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

What services will look like

In order to be patient-led the NHS will develop new service models which build on current experience and innovation to:

- give patients more choice and control wherever possible;
- offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high quality care;
- make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

Securing services

The NHS will develop the way it secures services for its patients. It will:

- promote more choice in acute care by offering choice to the patient both in number and type of provider;
- encourage development of new community and primary services alongside new practices;
- strengthen existing networks for emergency, urgent and specialist services;
- build on current practices in shared commissioning to create a far simpler contract management and administration system that can be professionally managed.

Changing the way the NHS works

The NHS needs a change of culture as well as of systems to become truly patient-led, where:

- everything is measured by its impact on patients and type of provider;
- the NHS is as concerned with health promotion and prevention as with sickness and injury;
- frontline staff have more authority and autonomy to better support the patient;
- barriers which create rigidity and inflexibility are tackled and codes of conduct and shared values are instilled into the culture.

Making the changes

A Patient-led NHS needs effective organisations and incentives, with:

- a new development programme to help NHS Trusts become NHS Foundation Trusts;

- a similar structured programme to support GP commissioning bodies to take on their new responsibilities~~PCTs in their development of 'Practice Based Commissioning'~~;
- further development of Payment by Results to provide appropriate financial incentives for all services;
- greater integration of all the financial and quality incentives along with full utilization of new human resources and IT programmes

~~Commissioning a Patient-led NHS and Practice Based Commissioning are being rolled out by the Department of Health and full support and~~The latest guidance may be accessed at http://www.dh.gov.uk

18.4 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

19. COMMISSIONING

19.1 Role of the Trust in Commissioning Secondary Services

19.1.1 Where the Trust has responsibilities for commissioning secondary services on behalf of the resident population, this will require the Trust to work in partnership with GPs, NHS 'Clusters' (which supersede the role of PCTs), the Strategic Health Authority, other local NHS Trusts, ~~PCTs~~ and FTs, local authority, users, carers and the voluntary sector to develop an annual plan ~~LDP~~.

19.2 Role of the Chief Executive

19.2.1 The Chief Executive as the Accountable Officer has responsibility for ensuring secondary services are commissioned in accordance with the priorities agreed in the ~~LDP~~Annual Plan. This will involve ensuring SLAs are put in place with the relevant providers, based upon integrated care pathways.

19.2.2 SLAs will be the key means of delivering the objectives of the ~~LDP~~ Annual Plan and therefore they need to have a wider scope. The Chief Executive will need to ensure that all SLAs;

- Meet the standards of service quality expected;
- Fit the requirement of 'Standards for Better Health';
- Fit the relevant national service framework (if any);
- Enable the provision of reliable information on cost and volume of services;
- Fit the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based upon cost-effective services;
- that SLAs are based on integrated care pathways.

19.2.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast expenditure and activity for each SLA.

19.2.4 Where the Trust makes arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accountable Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the Trust should explore fully the scope to make maximum cost-effective use of NHS facilities.

19.3 Role of Director of Finance

19.3.1 A system of financial monitoring must be maintained by the Director of Finance to ensure the effective accounting of expenditure under the SLA. This should provide a suitable audit trail for all payments made under the agreements, but maintains patient confidentiality.

19.3.2 The Director of Finance must account for Out of Area Treatments/Non Contract Activity financial adjustments in accordance with national guidelines.

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of Executive Directors of the Board (and other senior employees) 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 for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual Executive Directors (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The Trust will pay allowances to the Chair and non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health.

20.2 Funded Establishment

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

20.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

20.3 Staff Appointments

20.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive;

(b) within the limit of their approved budget and funded establishment.

20.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, ~~social security~~national insurance and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

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

20.5 Contracts of Employment

20.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

21.1.2 The Chief Executive will set out:

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

(b) the maximum level of each requisition and the system for authorisation above that level.

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

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Director of Finance 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.

21.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Reservation and Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

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

(i) A list of members of the Board and employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

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

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

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

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Reservation and Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 7.4 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" as well as the Bribery Act 2010);

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

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchase cards;

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

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

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

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

21.2.7 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE, ~~and~~ ESTATECODE and NEC-ECC. The technical audit of these contracts shall be the responsibility of the relevant Director.

21.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

22. EXTERNAL BORROWING

22.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

22.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

22.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

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

22.1.6 All long-term borrowing must be consistent with the plans outlined in the current ~~LDP~~ Annual and/or Financial Plan and be approved by the Trust Board.

22.2 INVESTMENTS

22.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

22.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

22.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

23. OPERATING FRAMEWORK

23.3.1 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to Trust's. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

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

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

24.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

24.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "**Estatecode**".

24.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the **construction industry tax deduction scheme** in accordance with Inland Revenue guidance.

24.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

24.1.6 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:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a Scheme of Reservation and Delegation for capital investment management in accordance with **"Estatecode" guidance** and the Trust's Standing Orders.

24.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

24.2 Private Finance (see overlap with SFI No. 17.10)

24.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

24.3 Asset Registers

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

24.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health.

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

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

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

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

24.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Accounting Manual* issued by the Department of Health.

24.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Accounting Manual* issued by the Department of Health.

24.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified in the *Capital Accounting Manual* issued by the Department of Health.

24.4 Security of Assets

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

24.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated and government granted assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

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

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

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

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

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

24.4.5 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 employees in accordance with the procedure for reporting losses.

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

25. STORES AND RECEIPT OF GOODS

25.1 General position

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

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

25.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

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

25.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 26 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.

25.3 Goods supplied by NHS Logistics

25.3.1 For goods supplied via the NHS Logistics 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 Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

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

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

26.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

26.2.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

26.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

26.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

25.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

26.2.9 All losses and special payments must be reported periodically to the Audit Committee.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Director of Finance

27.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

27.1.3 The Director with responsibility for ~~of~~ Information Technology 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.

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

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance 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.

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

27.4 Risk Assessment

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

27.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

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

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

28. PATIENTS' PROPERTY

28.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

28.2 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; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

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.

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

28.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

28.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

28.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

28.7 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.

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI's which define the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 7.4 and SFI No. 21.2.6 (d))

The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 7.4).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trust's

32. RETENTION OF RECORDS

32.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

32.2 The records held in archives shall be capable of retrieval by authorised persons.

32.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHSLA

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

33.3 Insurance arrangements with commercial insurers

33.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the

Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

33.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance 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 Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Nursing Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

There has been significant progress made in achieving quality targets – most notably tissue damage, falls and nutrition.

Quality audits and ward reviews continue to show improvement.

The number of 'concern' wards has reduced and issues relating to flexible unfunded beds have decreased significantly. Staff:bed ratios (funded) remain fairly static and on the whole are acceptable. Attention now needs to be given to trained:untrained ratios.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2, 2.2, 2.3, 2.8, 2.11, 6.2 High quality care
Annual priorities	1.2, 2.2 Improve care to vulnerable adults Improve quality and safety
NHS LA standards	2.3.3 Safeguarding Adults 2.3.5 Slips, Trips and Falls
CQC Essential Standards Quality and Safety	Regulation 10, Outcome 16, Regulation 11, Outcome 7, Regulation 14, Outcome 5, Regulation 17, Outcome 1
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**x**	Requirement to agree staffing model for flexible beds
Business and market share		
Clinical	**x**	
Workforce	**x**	Requirement to agree flexible staffing model
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

The Nursing Update report is submitted to the Trust Board bi-annually.

Report Title	*Nursing Update*
Meeting	*Trust Board*
Author	*Rachel Overfield, Chief Nurse*
Date	*29th September 2011*

1) Introduction

The nursing quality agenda continues to be very high profile nationally and locally especially post mid staffs/Frances report and several highly publicised CQC reports.

Within the context of financial pressures and competing priorities, achievement of high quality nursing care is an on-going challenge.

This report is intended to brief the Trust Board on the main corporate nursing quality workstreams and progress since the last Board report in April 2011. It is also intended to brief the board on areas of concern around care and safety and what is being done to mitigate these.

The report references relevant standards/targets:

- High Impact Nursing Actions (DoH/CNO 2009) HIA
- Nurse sensitive indicators (DoH) NSi's
- CQUiN targets
- CQC standards
- Local/Trust standards/targets

The report includes the latest set of ward reviews for June 2011 and ward quality audits June 2011 (Appendix 1 and 2). Also included at appendix 3 and 4 are the latest updated action plans for CQC Outcomes 1 (Privacy and Dignity) and 5 (Nutrition) and nurse staffing ratios for August at Appendix 5.

There has been considerable work and progress over the past 6 months but some concerns remain around variability, these are detailed in the report together with remedial actions.

2) Nursing Quality Framework

Effectiveness

- Observations of care
- Nursing audit
- Optimal/Productive Ward
- Competent/skilled workforce
- Evidence based care plans and toolkits
- E rostering and acuity tools
- Workforce development and new role
- Measures Boards
- Absence management
- Bank/agency/flexible workforce
- Communication structures
- MDT Working systems
- Leadership/management

Patient Safety

- Falls Prevention
- Tissue damage
- Nutrition/hydration
- Safe staffing
- Communications/safe handover
- Resuscitation/rescue
- Catheter associated infections
- Skills and competence
- Infection prevention
- Safeguarding/vulnerable adults
- Professional Regulation
- Medicines Management
- Mental health/ DoL/Learning Disability
- Safe transfusion of blood

Patient Experience

- Surveys/diaries
- Patient Environment
- Privacy and dignity/respect
- Meal experience
- End of Life Care
- Hygiene/Mouthcare
- Equality and diversity
- Continence/bowel care
- Spiritual Care
- Compassion/kindness
- Communication

products and fluids
- Age consideration

A Nursing Strategy has been produced but delayed to enable Community Nursing and Health Visiting to be included. This will now be complete in October 2011. The remainder of this report highlights progress or otherwise around some of the key workstreams within the Nursing Framework.

3) Patient Safety

3.1 Falls Prevention

Falls in hospital create significant additional costs in terms of patient mortality and morbidity; nursing and medical care; length of stay and patient experience.

Targets/Metrics 2011/12

CQUiN target (Community Nursing only)

- All patients on a District Nursing caseload to be assessed for falls risk (Target = baseline + 30%)

Local/HIA

- Further 10% reduction in falls from Q4 2010/11 baseline (acute)
- 90% patients assessed for falls risk (acute)

Monitoring of falls age related (NSi)

CQC Outcomes – safeguarding/nutrition.

Table 1 - Trend of Falls across Acute In patient Divisions (1 year rolling data)

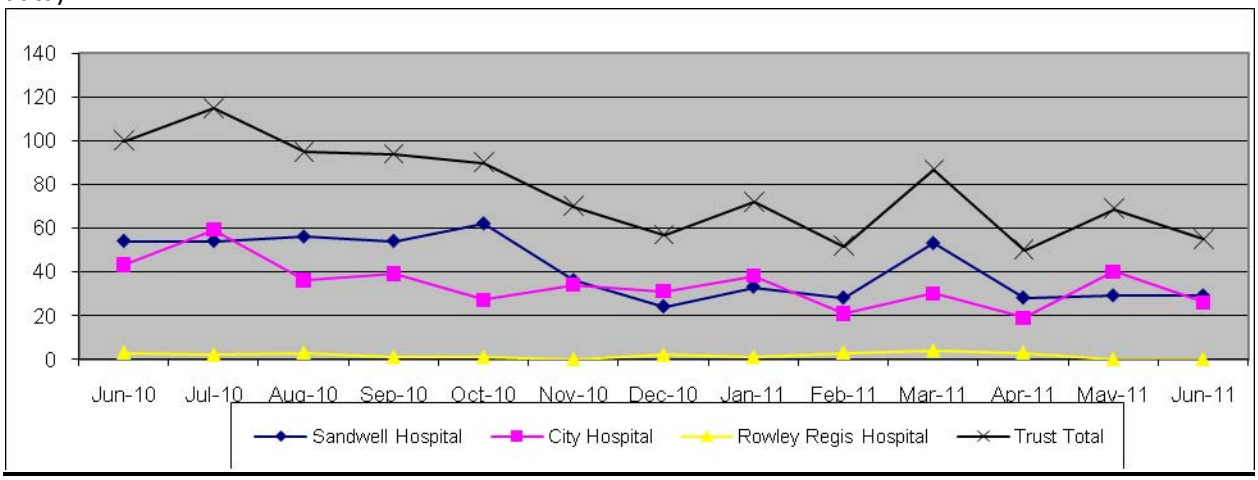


Table 2 - Acute In-Patient Divisions total numbers per month related to target

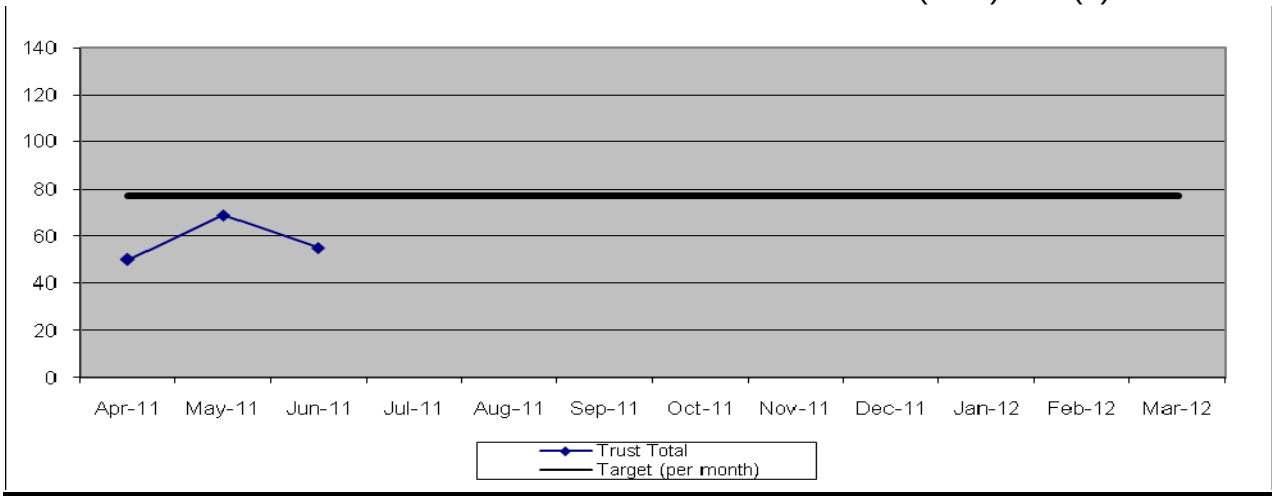


Table 3 – Age related monitoring (Incidence of Falls across the Acute In Patient Divisions using Nurse Sensitive Outcome Indicator)

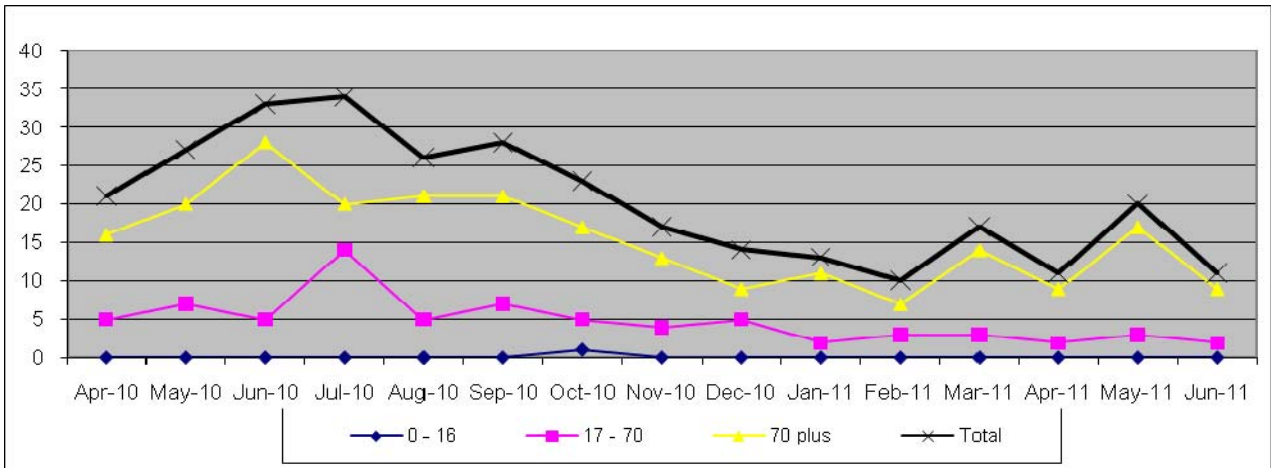
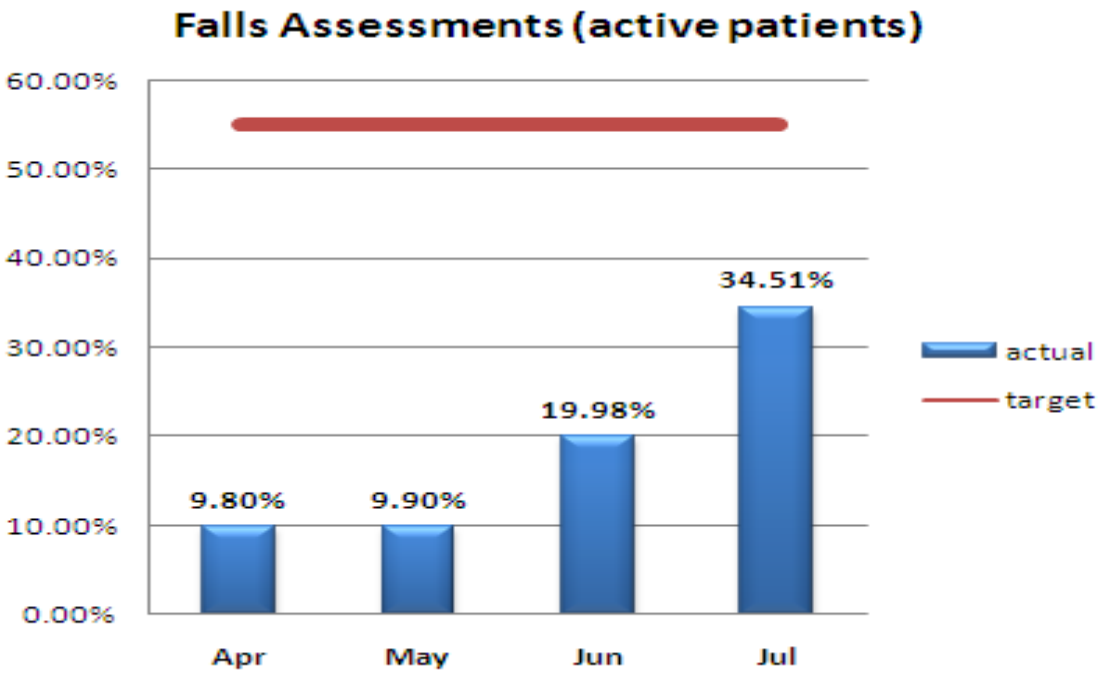


Chart 4 – Community Falls Assessments



<u>Summary against targets</u>

Reduction of falls YTD = 37.5% compared to Q4 outturn.

Compliance in falls risk assessment (acute) = 97.2% June.
Community falls assessment improving but not yet meeting the target.
Monitoring data for actual falls/age related is not yet available from the Community but is available for acute.

3.2 Tissue Damage (pressure sores/ulcers)

Pressure sores are incredibly painful, debilitating and resource intensive in terms of nursing care and the cost of consumables and additional length of stay. It is often difficult to establish the root cause of pressure sores as they evolve over time and do not usually relate to a specific incident. Increasingly, pressure sores are considered to be the result of 'neglect' and could therefore be subjected to safeguarding alerts and criminal investigation.

Targets/Metrics 2011/12

Local/HiA

- Further 10% reduction of grade 2 – 4 sores from Q4 outturn.
- 90% patients are risk assessed

NSI

- Age related monitoring

CQC Outcomes safeguarding/Nutrition

Table 5 - Number of hospital acquired pressure damage Grade 2, 3 & 4, April - July 2011 (Bold line indicates Quarter 4 2010/11 average set as target figure).

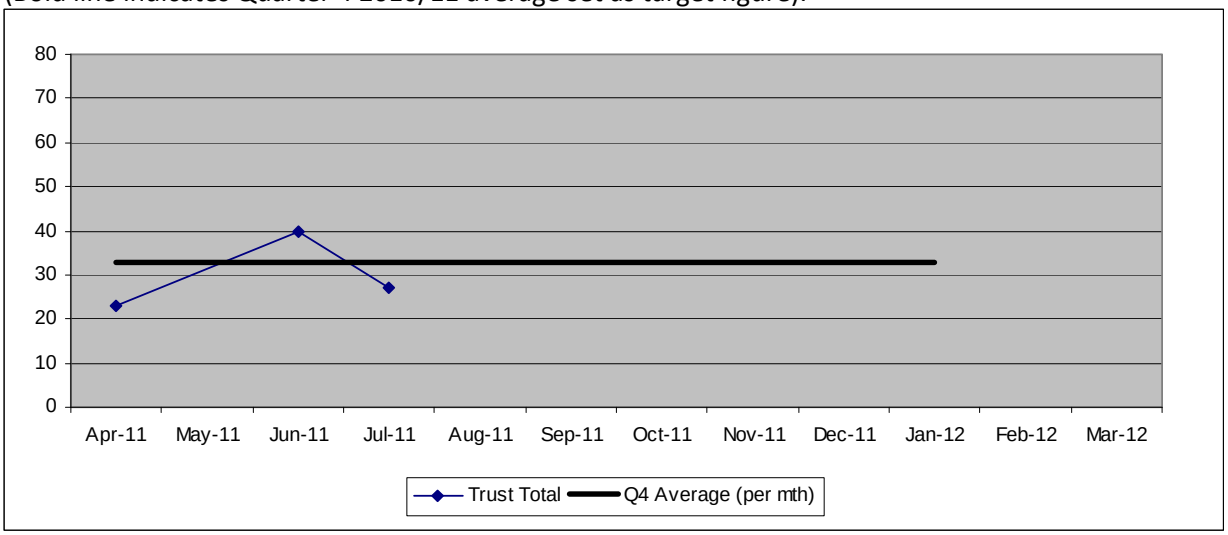


Table 6 - Incidence of hospital acquired pressure damage January - July 2011 (Hospital acquired data per 1000 bed days January - July 2011 Grade 1,2,3 + 4 pressure ulcers)

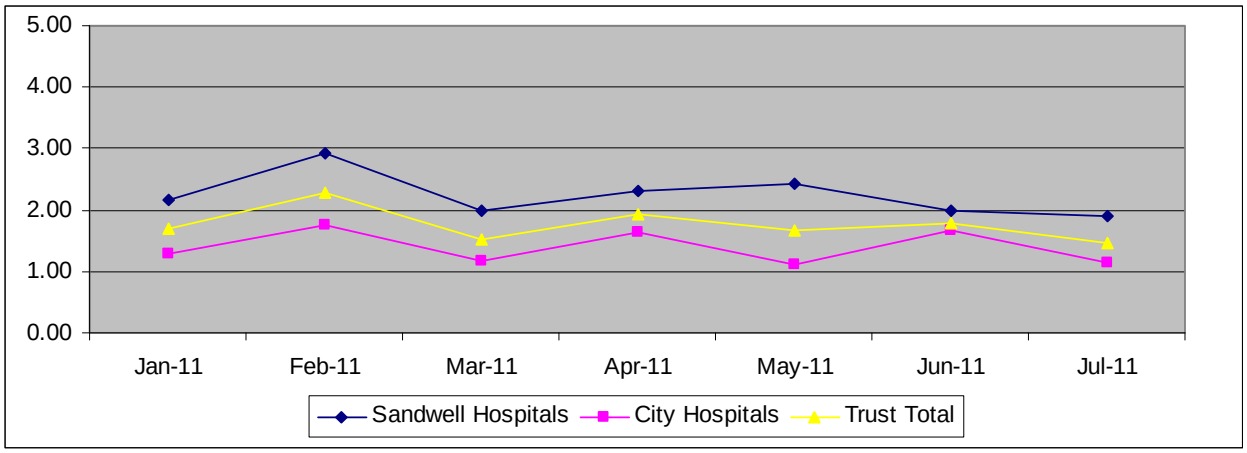


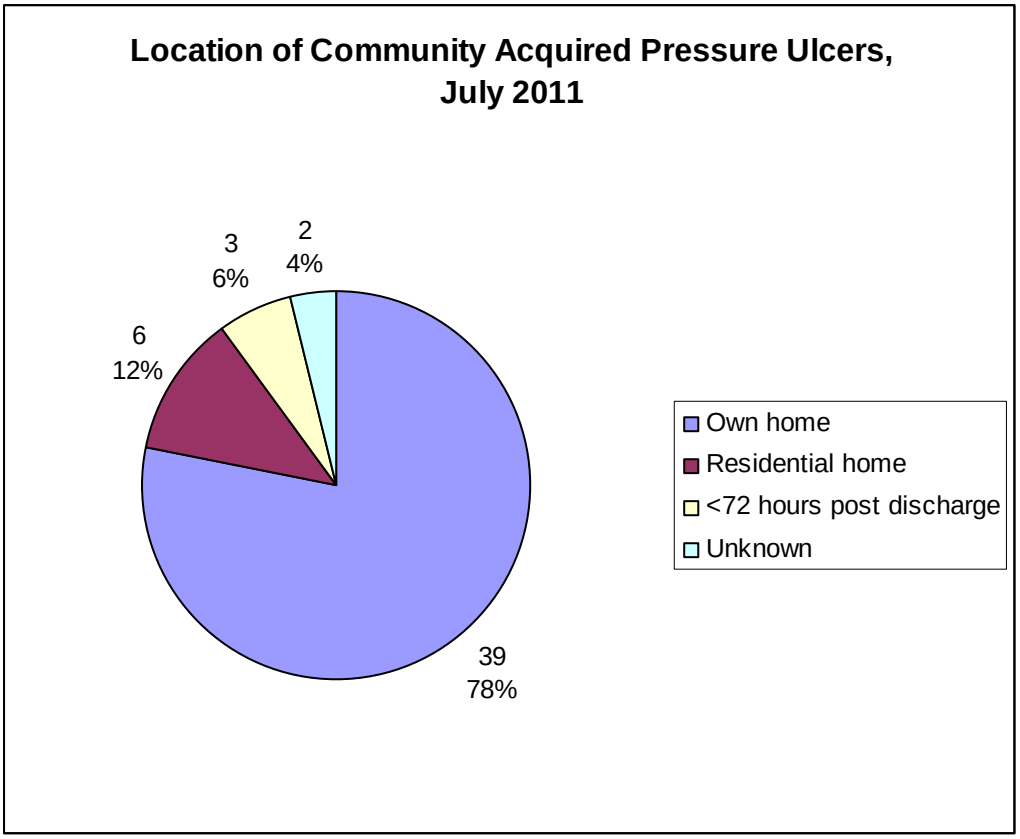
Table 7 - Age range of patients with reported pressure damage July 2011 – Hospital Acquired

Age	Grade 2	Grade 3	Grade 4
0-18	0	0	1
19-65	5	0	1
66-99	13	3	3
Total	18	3	5

Summary against targets

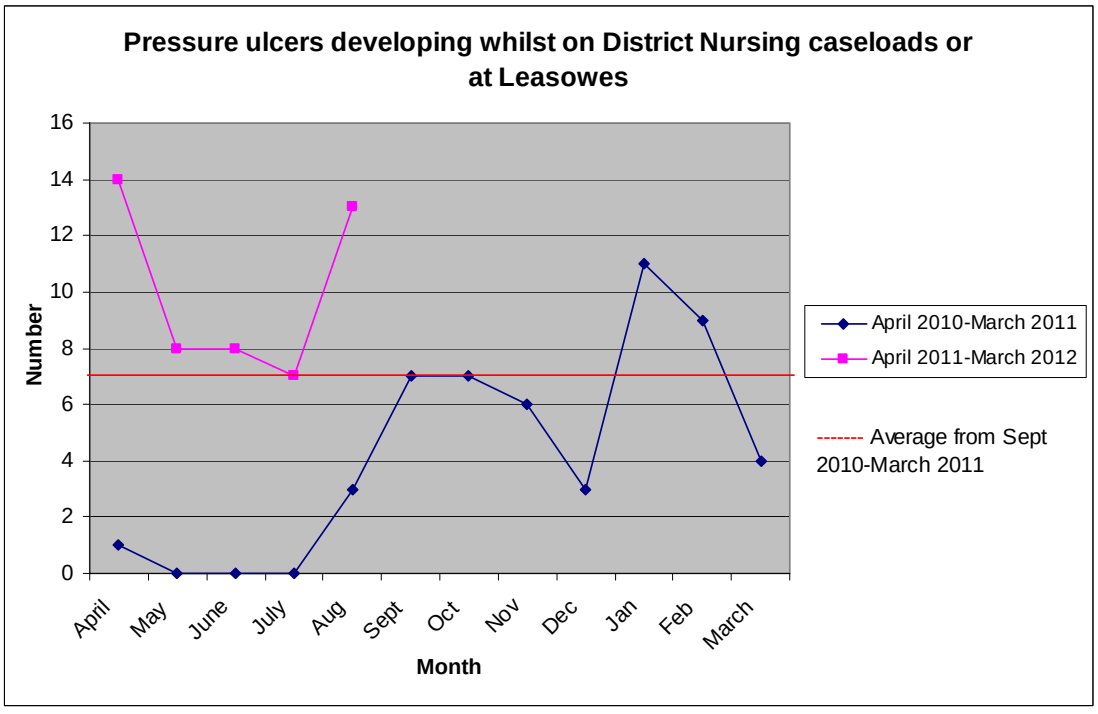
Reduction in pressure damage YTD (includes unavoidable sores) = 4.5% (acute)
Compliance for risk assessment = 98% in June (acute)

Chart 8



Nursing home data is not included as this is not available to the Trust via Datix. The majority of other sores in the Community develop in the patients own home prior to involvement with the District Nursing teams.

Table 9



3.2.1 Key Actions

- To align acute/community monitoring, reporting and training
- To separate avoidable sores from unavoidable to improve accuracy of reporting and enable targeted support/learning

- To agree Tissue Viability team support to Nursing Homes
- Continue to target support to 'hot spot' areas – Critical Care, D16, D47, P4

3.3 Nutrition/Fluid Challenge
(See also CQC action plan appendix 4)

Targets and Metrics
CQUiN

- 75% patients will be assessed using MUST tool within 12 hours admission (internal target of 90%)

Local standards

- 90% patients will be reassessed within 7 days
- All in patients will have a fluid intake chart unless written assessment indicates unnecessary
- All patients with a MUST score of 1 or more will be on a food chart.

CQC Outcome 5.

This continues to be an area of variable practice and therefore concern, although considerable progress has been made over the past 6 months.

The national average of patients in hospital with actual or potential risk of malnourishment/dehydration is 25 – 30%.

In August the figure at SWBH from risk assessments suggests 24.7% of patients are at risk.

MUST assessment compliance on admission		
October	**April**	**August**
2010	**2011**	**2011**
20%	73%	90.6% Range 60 – 100%

MUST reassessment compliance within 7 days		
June	**July**	**August**
2011	**2011**	**2011**
88%	91%	89.1%
For patients at risk has a food diary been commenced?		
June	**July**	**August**
2011	**2011**	**2011**
64.4%	62.5%	75%
For patients at risk has a fluid balance chart been commenced?		
June	**July**	**August**
2011	**2011**	**2011**
74.4%	82.1%	66.4%

Protected meal time compliance:
Trust overall – 92% (range 80 – 100%)

The attached action plan details the work being undertaken around nutrition/fluids. Key areas:

- Patient assessment for risk
- Monitoring of intake

- Mealtime experience
- Choice and access

3.3.1 Key Actions over the past 6 months:

- Monthly and spot check audits (including spot checks from the Trust Board – appendix 6)
- Meal time observations
- Task and Finish Group chaired by the Chief Nurse to drive the action plan
- Changes to drink, snack, hot food availability
- Introduction of meal co-ordinators
- Introduction of 'red=risk' concept – red tray, jug, beaker
- Zero tolerance approach to protected mealtimes (except where clinically indicated)
- Development of Nutrition and Hydration Policy

3.3.2 Key Actions Requiring Improvement

- Completion of bedside charts
- Completion of care plans
- Compliance of protected meal times in some key areas
- Making sure snacks etc are offered
- Launch Nutrition and Hydration Policy

3.4 Safer Handover/Communication

The vast majority of wards in the Trust now use 'safety briefings' at the start of every shift as a means of communicating key safety information quickly and effectively. We believe that this has contributed positively to improvement in falls, pressure damage, nutrition etc.

The SBAR (Situation, Background, Assessment and Recommendation) tool continues to be rolled out and encouraged as a means of communicating important and urgent information about a patient's condition from one health professional to another. Therapists and medical staff are included in training.

3.5 Resuscitation/Rescue

This continues to be a challenging area with an over reliance on response teams at ward level. However, turnover in the Trust Resuscitation Team, a new Head of Learning & Development and a successful funding bid means that we are now in a position to significantly change our approach to resuscitation training especially for registered nursing staff.

We have appointed a new lead Resuscitation Nurse who commenced in post in June and who is currently working on the following key areas:

- Training and competence
- Monitoring and reporting
- Equipment type and availability
- Response teams

A report is generated quarterly from the Trust Resuscitation Committee which provides details of Trust actions and progress.

3.6 Medicines Management

Targets and Metrics
CQUiN

- To achieve a 10% reduction in avoidable medicine omissions by Q4 compared to Q1 baseline.

Working with colleagues from Pharmacy, monthly audits are now in place to measure both drug omissions plus issues around drug storage and checking.

The baseline audit of medication omissions showed that of the 381 interventions audited, nearly 50% represented omitted doses. However, when the codes for omissions are considered, 41% of omissions were not avoidable, ie the patient could not be given the drug for valid clinical reasons. Avoidable drug omissions are made up of the following:

- Patient refused
- Drug not available
- No reason given

3.6.1 Key Actions

- Staff coding correctly on charts
- Ward Pharmacists and nursing staff to ensure drugs are available – various mechanisms have been introduced to assist with this.
- PRN (as necessary) medications to be prescribed in the correct section of the drug chart to reduce the number of 'patient refused' codes.
- Multi-dimensional awareness campaign launched to include Medicines Matter newsletter and a variety of educational sessions.

3.7 Age Consideration

We are now including age related monitoring into all of our key workstreams to ensure ageism is not a problem within nursing care across the Trust. This will extend to other equality strands as data collection becomes more sophisticated.

3.8 Safe Staffing Levels

The Trust now monitors staffing levels via monthly ratio reporting (Appendix 5).

In the absence of national agreed staffing levels the Trust aims to have as a minimum a ratio of 60:40 registered:non-registered staff and a ratio of no less than 1 WTE per bed establishment. There are exceptions to this around specific specialties where the acuity of the case mix of patients indicates a different staffing model.

The report takes into account the effect of any unfunded additional beds being open on staffing levels and the % bank/agency staff being used.

In April, there were 13 wards that did not reach the 60:40 trained:untrained ratio and 7 wards that fell below the 1 WTE per bed ratio (35 areas).

In August there were 14 wards that did not reach the 60:40 trained:untrained ratio and 7 wards that fell below the 1 WTE per bed ration (35 areas).

3.8.1 Current Actions to address this position

- Continued efforts to keep unfunded beds closed
- Approved additional staff trauma wards
- Approved additional staff D43
- Rebasing medical ward establishments
- Continued efforts to tackle sickness absence
- Continued efforts to keep vacancies to a minimum
- E-rostering and acuity tool implementation

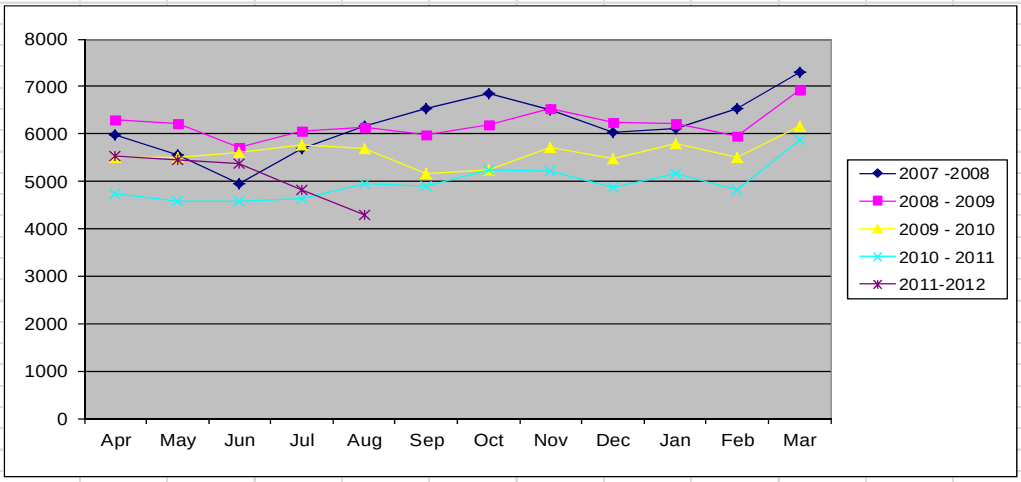
3.8.2 Bank and Agency Use

Bank and Agency use in nursing for August was at its lowest point for 4 years –

Table 10 – Total Trust Bank and Agency Use

Total Bank & Agency Use NURSING - August 2011

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007 -2008	5989	5550	4963	5691	6161	6547	6840	6510	6035	6120	6544	7309
2008 - 2009	6298	6214	5712	6056	6148	5977	6189	6537	6257	6214	5966	6926
2009 - 2010	5499	5502	5605	5767	5694	5167	5245	5729	5468	5797	5513	6168
2010 - 2011	4741	4583	4582	4624	4956	4905	5252	5204	4881	5164	4829	5881
2011-2012	5533	5445	5369	4814	4282							



We have improved the controls around bank/agency and introduced specific guidance for 'specialling' patients.

3.8.3 E-Rostering and Acuity Tools

E-rostering
Work is complete to select a provider and procurement has now commenced.

We have been undertaking preparation work with Ward Managers around effective e-rostering practices so that the transition is easier for them. It is anticipated that we will get the medical division onto the system this year with a roll out programme for the rest of the Trust in 2012/13. Management reports will be generated from the system at ward, directorate, division and Trust level.

Safer Nursing Care Tool (acuity measure)
This is now in place with training complete. We have run the first trustwide report which showed a considerable amount of work still to do regarding the grading system. We intend to run the report again in October. Once satisfied with the accuracy of the scoring we will be able to run reports by ward, directorate, division and Trust.

The above two tools will enable a much more informed and sophisticated approach to managing staffing arrangements.

4) Effectiveness

4.1 Observations of Care and Nursing Quality Audits

These are conducted across all adult wards every quarter and results are used as part of the ward review process.

Audits are undertaken on a peer review basis and include both notes audits and observations of actual care. The audits include:

- Essence of care standards (NHS Plan 2000)
- Same sex accommodation
- Observations of actual care
- Patient ID and Uniform audit (NHSLA and Hygiene Code)

The full results are included in appendix 2.

In summary, results from wards from the start of the audits in March 2010 to June of this year:

Category	March 2010	June 2011
Red (under 80% compliance)	31	1
Amber (80-90% compliance)	2	5
Green (90-100% compliance)	9	33

Best to worst compliance tables.

March 2010 Compliance		
1	Generic	91%
2	Patient ID	89%
3	Uniform	85%
4	Record Keeping	84%
5	Promoting Health & Well Being	70%
6	Environment	55%
7	Oral Hygiene	48%
8	Safety/Falls	43%
9.	Manual Handling	40%
10	Pressure Ulcers	39%
11	Pain	37%
12	Bladder & Bowel Care	30%
13	Mental Health	24%

November 2010 Compliance		
1	Generic	94%
2	Uniform	94%
3	Safety/Falls	93.6%
4	Pressure Ulcers	92.5%
5	Patient ID	92%
6	Bladder and bowel care	91.7%
7	Oral Hygiene	90.6%
8	Personal Hygiene/Self Care	90.4%
9.	Pain	88.9%
10	Manual Handling	88.7%
11	Record Keeping	86.5%
12	Environment	79%
13	Promoting health &	78%

14	Communication	22%

	wellbeing	
14	Mental Health	77%

Observations of Care Part A: Result Table

PATIENT CARE QUALITY AUDIT FOR ADULTS - TRUST-WIDE General and Observation of Care (Part A)						
Patients risk assessed (Base: 40 wards/units)	**June 2011**			**April 2011**		
	Yes	**No**	**Not Observed**	**Yes**	**No**	**Not Observed**
Generic	95.5%	3.7%	0.8%	93.2%	4.5%	2.3%
Observations of Care	85.4%	3.3%	11.3%	80.0%	6.0%	13.0%
Promoting health and well being	83.2%	15.2%	1.6%	81.6%	17.9%	0.5%
Bladder and Bowel care (HIA-8)	83.1%	2.5%	14.4%	81.6%	3.6%	14.2%
Environment and staff	81.5%	4.3%	14.2%	77.0%	8.8%	11.7%
Self care	81.2%	0.6%	18.2%	77.0%	1.3%	21.7%
Eating and drinking (HIA-3)	75.0%	3.7%	21.3%	82.9%	0.0%	17.1%
Safety (HIA-2)	68.5%	4.5%	27.0%	68.9%	6.3%	23.1%

Essence of Care Part B: Result Table – Risk assessments

PATIENT CARE QUALITY AUDIT FOR ADULTS - TRUST-WIDE Clinical Care - Part B						
Patients risk assessed (Base: 643 patients)	**June 2011**			**April 2011**		
	Yes	**No**	**No reply**	**Yes**	**No**	**No reply**
Pressure Ulcers	98.1%	1.7%	0.2%	96.1%	3.6%	0.3%
Safety(falls)	98.0%	1.6%	0.4%	92.0%	6.8%	1.2%
Bladder & Bowel Care	97.8%	1.7%	0.5%	91.4%	7.8%	0.8%
Communications	97.4%	2.2%	0.4%	94.8%	4.8%	0.4%
Personal Hygiene/Self care	97.0%	2.3%	0.7%	91.3%	8.3%	0.4%
Manual Handling	96.7%	3.0%	0.3%	90.6%	8.4%	1.0%
Pain	96.1%	2.6%	1.3%	93.0%	6.7%	0.3%
Oral Hygiene	94.6%	4.8%	0.6%	89.9%	9.6%	0.5%
Record Keeping (mean value)	91.6%	7.5%	0.9%	86.2%	12.7%	1.1%
Mental Health	91.4%	8.2%	0.4%	82.6%	17.1%	0.3%
Nutrition	81.5%	17.6%	0.9%	74.6%	25.1%	0.3%

4.2 Ward Performance Reviews

These are now undertaken quarterly by the Divisional Heads of Nursing and quality assured by the Chief Nurse.

We use a standard review template which reviews around 50 metrics within 8 domains:

- Environment
- Basic care
- Use of resources
- Patient Experience
- Privacy, Dignity and Respect
- Safeguarding
- Educational environment
- Safety

Results for the June reviews are included in Appendix 1 with a comparison to the March results. In summary, 40 wards were reviewed in June vs 37 in March:

	March 2011	**June 2011**
Red	12	10
Amber	160	60
Green	124	230

4.3 Optimal Wards

This programme focuses on delivering specific areas of improvement that wards have identified and also a general improvement toolkit for across all wards.

Generally, the programme commences with an LiA staff engagement process. All Trust wards are now signed up, but more attention needs to be given to the staff engagement part of the programme and to ward specific actions.

Corporately using LEAN and Productive Ward techniques, the programme is focused on:

- De-cluttering
- Measures boards – internal and external
- SBAR/handover and communications
- Bedside information
- Protected mealtimes
- Drug rounds/medicines management

4.4 Workforce Development

Competency

Competency Frameworks exist for all nursing bands. Newly qualified staff nurses cannot progress through the first gateway until basic competency achieved.

Numeracy and literacy testing has been re-introduced for newly qualified nurses and HCA recruitment. Preceptorship and clinical supervision frameworks exist for all nursing staff.

Graduate Profession

30% Trust nursing staff already have a relevant degree and Universities go to all graduate programmes from 2012. A fast track degree has been developed to progress existing staff to graduate level – 20 places per year.

Specialist Nursing qualifications have been reviewed and training needs agreed related to pay banding.

Assistant Practitioners
The first cohort have now graduated and are currently being 'precepted' into full practice. Three other cohorts are in progress and we anticipate these forming a valuable part of the nursing family in the future. Paid at Band 4, Assistant Practitioners offer a cost effective 'trained' solution to potential gaps created by the graduate profession in the future. The Trust continues to be the most advanced with this role across the region.

MOT (Clinical Skills Update)
An essential one day update has been developed for all registered ward based staff to attend over the next year.

Aimed at updating staff in one day on essential care standards the programme has been very well received.

Ward Manager Framework
The second cohort of Ward Managers are currently progressing through the framework intended to equip them with essential skills for their role.

5) Patient Experience

5.1 Privacy, Dignity and Respect

See attached CQC action plan, Appendix 3.
Key focus areas over the past 6 months:

- Equality and diversity training at ward level
- Ward clothing/nightwear/laundry
- Communication/choice
- Information provision
- Individualised care plans/documentation
- Patient feedback/user involvement
- Occupational activities

Current key actions:

- Trust laundry, pyjamas, dressing gowns available as soon as a supplier is found
- Toiletry packs provision
- Own clothes provision in rehabilitation areas
- Protected meal times
- Reduced pad usage and unnecessary glove use
- Access to day rooms, TV and activities
- Bathroom access
- Improved relationships with LINKS and Community groups
- Responding to patient survey results and other forms of feedback

Progress against these actions can be seen in Appendix 3.

5.2 End of Life Care

Targets and Metrics
CQUiN

- 10% improvement in patients achieving a choice of place to die (acute and community) against Q4 baseline.

HIA

- Avoidance of inappropriate admissions to hospital for end of life care.
- 10% reduction in emergency admissions and an increase of 10% patients achieving choice of place to die.

NSI's

- Identification of patients considered end of life
- Proportion on an end of life pathway
- Proportion who have preferred place of death documented
- Proportion who die in preferred place of death

CQC Outcome 4.

Acute

- For the Acute areas within the Trust in July 57% of patients achieved their preferred place of death against a target of 67% by year end
- This represents a small improvement from the June position
- 73 patients in July were referred to the acute palliative care team
- 85% of these were emergency admissions
- 42% were known to the Community Palliative Care team
- 31% were repeat admissions
- Average length of stay was 11 days

Community

- For Community palliative care services 71 patients known to the hospice at home service died in July
- 38% of patients achieved choice of place to die in July against a baseline of 28% therefore 10% improvement target achieved

There is still room for considerable improvement in end of life care, even if the 10% improvement target in CQUiN is achieved.

Key areas for continued work:

- Education of wider clinical teams around symptom management
- Medical support in the Community
- Increased autonomy in palliative care teams
- More patients on end of life pathways with clear discussions and decisions

6) External Assessments

PCT
The PCT have undertaken 2 visits to wards since the April report – both at Sandwell. We have yet to receive reports from these visits.

CQC

The CQC undertook an unannounced visit to City site in May. This was around outcome 1 and 5. Judgement:
Outcome 1 – minor concerns
Outcome 5 – minor concerns

West Midlands Quality Review Service (WMQRS)

The WMQRS visited 7 wards in July as part of a review of adult safeguarding. We have received their draft report but have yet to receive the final report.

CQC

The CQC revisited Sandwell on August 3rd to review compliance with Outcome 1 and 5. We have received their draft report but not their final report.

7) Wards escalated via Early Warning Systems

We have an approach to gathering both hard and soft data about individual wards, much of which has been described in this report, that prompt an early response to wards beginning to struggle with key standards.
Early warning signs include:

- Poor review results
- Slipping patient satisfaction
- Clusters of incidents and/or complaints
- Sliding standards – falls, pressure damage etc
- Increase staff sickness/turnover
- High levels bank/agency
- Intelligence from third parties

One or more can trigger a 'worry ward' flag which is discussed by the Trust senior nursing team. A 'condition report' may be commissioned in order to get a full up to date 360° view of the ward and depending on the result the ward may be put into 'special measures' by the Chief Nurse.

In the period since the last Trust Board report in April, one condition report has been requested and is pending discussion at the next Advisory Group, and one ward has been assigned 'special measures' status.

Wards established as 'of concern'

Ward	Action
N4	Assisgned 'special measures' status in April. Action plan progressing. Significant increase in WTE and flexible beds option removed. Ward to be closed end of September and re-established as two separate units for acute stroke and stroke rehabilitation.
L3+N3	Identified as concern areas as the staffing arrangements were failing to meet increasing patient acuity. Agreed at August Trust Board to increase staffing levels by additional funding. Standards being maintained via bank use and close monitoring. New Matron in post impacting positively.
D43	Impact of flexible beds adversely effecting on standards over the winter months. Standards are now improving. Beds are being permanently established.

D16	Was a ward of concern 3 years ago but standards were improved significantly and feedback from patients has been good. In recent months sickness has risen considerably and standards are sliding especially around documented assessments. A condition report has been requested and will be discussed at the next Advisory Group.

In the April report one of the issues raised as a considerable concern and having a negative impact on nursing standards was the number of 'flexible, unfunded' beds open across the Trust. This position has improved considerably and plans for this winter are not dependent on this type of bed capacity plan.

Plans are in place to staff two winter wards from October – March.

8) Conclusion

Work of nursing across the Trust continues to be varied and challenging.

Highlights since April

- Continued improvement in quality audits
- Continued reduction in falls and tissue damage
- Improvement in nutrition audits and protected meal times
- Improvements in care around vulnerable adults, privacy and dignity and safeguarding
- Reduction in bank/agency use
- First Assistant Practitioners in practice

Concern Areas

- Concern wards, especially issues around Newton 4
- Slow improvements in some nutrition and privacy and dignity standards
- Controls around staffing in Medicine
- Resuscitation training/confidence to act
- Limited training capacity dementia/safeguarding/mental health

Next Steps

- Deliver and embed CQC action plans
- Close and re-establish Newton 4
- Improve D16 standards
- Complete various nursing actions Medicine
- Implement changes to Resuscitation training
- Continue to deliver dementia/mental health/safeguarding training
- Deliver CQUiNs and essential targets
- Incorporate Community actions/targets into places more
- Complete Nursing Strategy
- Complete reviews of Specialist Nursing
- Embed surveys and reviews in non-ward areas
- Nursing conference December

Recommendations

The Trust Board are asked to note the contents of this report.

Table shows comparison of the results which indicate movement in terms of increase or decrease against key

jective Rag Rating- status change in target met

Medicine & Emergency Care	Qtr 1 March 2011				Qtr 2 June 2011			▲ or ▼
D5/PCCU	0	8	0	D5/PCCU	0	3	5	▲
D7 [D20]	0	4	4	D7 [D20]	0	0	8	▲
D11	0	6	2	D11	0	3	5	▲
D12	0	5	3	D12	0	0	8	▲
D15	0	5	3	D15	0	5	3	—
D16	0	6	2	D16/D18	0	3	5	▲
D17 [D24]	0	4	4	D17 [D24]	0	1	7	▲
D18	0	3	5	D16/D18	0	3	5	—
D28		closed		D28		closed		
D24 [D29]		closed		D24 [D29]		closed		
D41	0	0	8	D41	0	1	7	▼
D43	0	4	4	D43	1	2	5	▲
D47	0	2	6	D47	0	0	8	▲
Skin [D48]	0	2	6	Skin [D48]	0	0	8	▲
MAU	0	4	4	MAU	0	1	7	▲
Endoscopy	0	0	8	Endoscopy	0	0	8	—
Priory 3	0	5	3	Priory 3	0	1	7	▲
Lyndon 4	0	2	6	Lyndon 4	0	0	8	▲
Newton 4	0	5	3	Newton 4	not applicable			
Priory 4	0	5	3	Priory 4	0	2	6	▲
Lyndon 5	0	5	3	Lyndon 5	0	1	7	▲
Newton 5	0	1	7	Newton 5	0	0	8	▲
Priory 5	0	4	4	Priory 5	0	6	2	▼
McCarthy	2	5	1	McCarthy		closed		
EAU	1	5	2	EAU	0	2	6	▲
CCU- SGH	0	2	6	CCU-SGH	0	0	8	▲
A&E- CHT	Tool	needs	Adapting	A&E-CHT	0	2	6	
A&E- SGH	Tool	needs	Adapting	A&E-SGH	0	2	6	

Surgery	Qtr 1 March 2011				Qtr 2 June 2011			▲ or ▼
D6	0	3	5	D6	0	0	8	▲
D21	0	5	3	D21/D24	0	1	7	▲
D25	0	4	4	D25	0	2	6	▲
D26	1	6	1	D26	2	5	1	▼
D30	Postponed			D30	1	2	5	
D42 [SAU]	0	4	4	D42 [SAU]	0	0	8	▲
ASU [BTC]	3	4	1	ASU [BTC]	0	3	5	▲
Eye Ward	0	4	4	Eye Ward	0	3	5	▲
Lyndon 2	2	4	2	Lyndon 2	2	1	5	▲
Newton 2	0	7	1	Newton 2	0	2	6	▲
Priory 2	0	8	0	Priory 2	0	2	6	▲
Lyndon 3	2	6	0	Lyndon 3	0	2	6	▲
Newton 3	1	7	0	Newton 3	4	3	1	▲
SDU	0	3	5	SDU	0	1	7	▲

Women and Childrens	Qtr 1 March 2011				Qtr 2 June 2011			Unable to score
D27	no	review	done	D27	0	0	8	—
D19	unable	to	score	D19	0	0	5	3
Priory Ground	unable	to	score	Priory Ground	0	0	5	3
Lyndon Ground	unable	to	score	Lyndon Ground	0	0	5	3
Lyndon One	unable	to	score	Lyndon One	0	0	5	3

Qtr1 Total wards/depts per division

Medicine	24
Surgery	13
W&CH	0

Total wards/ Dept reviewed previous quarter March 2011: 37

Qtr2 Total wards/depts per division

Medicine	24
Surgery	14
W&CH	2

Total Wards/Dept reviewed this quarter June 2011: 40

Rag Rating Analysis

Medicine	Reds	Ambers	Greens	All
Mar 2011- Qtr 1	3	94	95	192
June 2011 - Qtr 2	1	33	154	420

Analysis

Surgery	Reds	Ambers	Greens	All
Mar 2011- Qtr 1	9	66	29	104
June 2011 - Qtr 2	9	27	76	112

Rag Rating Analysis

W&CH	Reds	Ambers	Greens	All
Mar 2011- Qtr 1	ne/ tool does not fit need.			
June 2011 - Qtr 2	0	0	16	16

Low Risk' performance indicators - colour coded green- the target is either being met or exceeded.

Medium Risk' performance indicators color coded amber- the target is not being met but performance is within 60% of target.

High Risk' color coded red- the target is not met and is less than 30%.

Observations of Care Part A: Result Table

PATIENT CARE QUALITY AUDIT FOR ADULTS - TRUST-WIDE General and Observation of Care (Part A)						
Patients risk assessed (Base: 40 wards/units)	**June 2011**			**April 2011**		
	Yes	**No**	**Not Observed**	**Yes**	**No**	**Not Observed**
Generic	95.5%	3.7%	0.8%	93.2%	4.5%	2.3%
Observations of Care	85.4%	3.3%	11.3%	80.0%	6.0%	13.0%
Promoting health and well being	83.2%	15.2%	1.6%	81.6%	17.9%	0.5%
Bladder and Bowel care (HIA-8)	83.1%	2.5%	14.4%	81.6%	3.6%	14.2%
Environment and staff	81.5%	4.3%	14.2%	77.0%	8.8%	11.7%
Self care	81.2%	0.6%	18.2%	77.0%	1.3%	21.7%
Eating and drinking (HIA-3)	75.0%	3.7%	21.3%	82.9%	0.0%	17.1%
Safety (HIA-2)	68.5%	4.5%	27.0%	68.9%	6.3%	23.1%

The observations findings remained very similar to previous results – however our thresholds have increased to include a RAG rating of red for results below 80%. Positively, observations of patient care during meal times has improved reflecting the corporate campaign to improve nutrition**.**

Essence of Care Part B: Result Table – Risk assessments

PATIENT CARE QUALITY AUDIT FOR ADULTS - TRUST-WIDE Clinical Care - Part B						
Patients risk assessed (Base: 643 patients)	**June 2011**			**April 2011**		
	Yes	**No**	**No reply**	**Yes**	**No**	**No reply**
Pressure Ulcers	98.1%	1.7%	0.2%	96.1%	3.6%	0.3%
Safety(falls)	98.0%	1.6%	0.4%	92.0%	6.8%	1.2%
Bladder & Bowel Care	97.8%	1.7%	0.5%	91.4%	7.8%	0.8%
Communications	97.4%	2.2%	0.4%	94.8%	4.8%	0.4%
Personal Hygiene/Self care	97.0%	2.3%	0.7%	91.3%	8.3%	0.4%
Manual Handling	96.7%	3.0%	0.3%	90.6%	8.4%	1.0%
Pain	96.1%	2.6%	1.3%	93.0%	6.7%	0.3%
Oral Hygiene	94.6%	4.8%	0.6%	89.9%	9.6%	0.5%
Record Keeping (mean value)	91.6%	7.5%	0.9%	86.2%	12.7%	1.1%
Mental Health	91.4%	8.2%	0.4%	82.6%	17.1%	0.3%
Nutrition	81.5%	17.6%	0.9%	74.6%	25.1%	0.3%

There is an overall trend of improvement – however wards are aware when they are to be audited and there may be an element of planned preparation. However the organisation has also committed time and resources into increasing awareness and monitoring of essential elements of care. Nutrition and Mental Health continue to be the most challenging of subjects resulting in investment of time, equipment and training to increase staff knowledge, skills and change attitude. External expertise is required to further support the development of the MH agenda particularly on the Sandwell site.

Sandwell & West Birmingham Hospitals NHS Trust
CQC Essential Standards for Quality and Safety
Outcome Measure 1 – Respecting and Involving People Who Use Services
Improvement Plan v8 (updated post meeting 14/9/11)

Compiled post CQC unannounced visits to Sandwell – 28th March 2011 and City – 4th May 2011.
The Action Plan incorporates part or all of the existing Trust Action Plans for Privacy, Dignity and Respect and Nutrition.

Key

Rachel Overfield	**RO**	**Donal O'Donoghue**	**DO'D**
Steve Clarke	**SC**	**Linda Pascall**	**LP**
Anita Cupper	**AC**	**James Pollitt**	**JP**
Kam Dhami	**KD**	**Helen Shoker**	**HS**
Matthew Dodd	**MD**	**Debbie Talbot**	**DT**
Helen Jenkinson	**HJ**	**Ward Managers**	**WMs**
Jessamy Kinghorn	**JKi**		

Executive Lead	RO
Implementation Leads	Outcome 1 – DT
Divisional Leads	HS and HJ

Status Key:

	Complete.
	On track.
	Slight delay/expect to complete on time.
	Significant delay/unlikely to be completed as planned.
	Not yet commenced.

Board Approved:
Governance Board – 08.07.11
Trust Board – to be approved 28.07.11

Ref	Action	By Who	When	Evidence	Progress	Status
1	***1A - People understand the care, treatment and support choices available to them.***					
1.2	Ensure information is available to patients in all settings regarding treatment choices.	JKi	Sept 2011	Visits Space utilisation Patient surveys	Task and Finish Group to oversee. The group agreed that information was freely available on all wards regarding aspects of choice, care and healthy living. Further information is available on intranet sites.	
1.3	Ensure information is accessible to patients, ie language format etc.	JKi	Sept 2011	Visits Space utilisation Patient surveys	Information is presented following a standard Trust format (supported by policy) and a reader panel comment on language ect	
1.4	Ensure appropriate areas exist to enable private conversations with patients.	MD	Sept 2011	Visits Space utilisation Patient surveys	Designated quiet areas located at all sites.	
1.13	All wards/departments record in the patients/nursing notes any information given to patients regarding their planned care/treatment.	WMs/ Matrons	September 2011	Notes audit. Ward reviews.	Matrons round introduced and outcome audit - communication section added to Daily Care Record currently in draft	
1.14	All wards/departments understand how to access services to promote communication for service users that are: - Deaf - Visually impaired - Cannot speak English as first language - Require Easy Read/translated information	LP	~~August 2011~~ Oct 2011	Ward info leaflet. Pre-admission info. Disabled Go website. Communication Aides Folders	18.07.11. Hearing Loop leaflets have been distributed to all areas promoting use of facilities. Staff training provided for effective use of hearing loops. Disabled Go due to go live in August. Communication folders missing on some wards – more folders to be made up by DT team.	
1.16	All wards to have information re complaints process and advocacy services.	KD		See complaints action plan.		
1.17	All wards have patient information to support DSSA and privacy and dignity.	DT/LP	Sept 2011	Evidence in bedside directory.	Information re SSA displayed.	
1.18	All wards to document patient choice re: - Choice to get dressed	Matrons/ WMs/JK	Sept 2011	In house unannounced visits. Notes audits.	First draft of Patient Folder viewed and received well – funding agreed	

	- Choice of meals - Choice to self-medicate - Choices re discharge			Ward Reviews. Nutrition audits.	– prior to making up and disseminating JK will forward list of contents to group members to comment on .	
1.21	Continue to develop Trust privacy and dignity website.	DT/ET/EB	Sept 2011	Website. Patient views.	Requires refresh. DOH links included for: dignity , EOC, SSA, NSF Older People, NMC and RCN – need to add more info re work in progress at SWBH , contacts, dignity champions etc.	
2	***1B*** ***People who use services have their care, treatment and support needs met.***					
2.1	The process for assessing and planning care is clearly described.	DT/RO	~~Sept 2011~~ Dec 2011	Notes audits. Ward reviews	Patient Assessment Record (PAR) under review .	
2.2	All patients have plans of care relevant to their assessment needs.	DT	Sept 2011	Notes audits. Ward reviews	Generic care plans to be added to Daily Care Record and care plan library to be up-dated.	
2.3	All patients have completed documentation.	Matrons/ WMs	Sept 2011	Notes audits. Ward reviews	Progress commenced via Privacy, Dignity and Nutrition Task and Finish Group.	
2.4	Records are concise, legible and signed/dated.	Matrons/ WMs	Sept 2011	Notes audits. Ward reviews	Progress commenced via Privacy, Dignity and Nutrition Task and Finish Group.	
2.5	Patient views are sought regarding their care.	Matrons/ WMs	Sept 2011	Notes audits. Ward reviews Satisfaction Surveys	PSS undertaken – with aim of all wards achieving feedback from a minimum of 40% of their discharged patients/cares. 1,300 returns last month.	
2.7	Tools such as the SAP are used to ensure specific care needs are passed on and understood.	DT	In place. Dec 2011	Patient Assessment Record (PAR/SAP) Safety Briefing	Evidence based document in place – due for review this year. Review commenced. Meetings planned late Aug/sept.	
3	***1C - People who use services receive care, treatment and support where clear procedures are followed in practice, monitored and reviewed.***					
3.1	All Clinicians adhere to the Consent Policy.	DO'D	Via consent NHSLA Action Plan.			
3.6	All wards/departments involve patients in decision making about care/treatment.	DT	Sept 2011	Audit data – not yet available. Patient Satisfaction Surveys	Need to add to Quality audits data collection. -JK	
3.7	Discharge arrangements ensure involvement of	HJ	October	Discharge records.	Work progressing.	

	patients in planning and choices.		2011	Readmissions. LINK audit. Patient surveys.	Evidence of good practice but requires further work. Project Plan to PEPAG in Oct.	
4	***1E*** ***People who use services are supported to make informed choice about their care, treatment and support.***					
4.1	All wards/departments have relevant up to date condition specific information.	JKi	Sept 2011	Patient surveys. Observation of Care Team.	Info available in most areas, however, process for distributing to patients erratic.	
4.2	All clinical teams ensure patients have the opportunity to discuss care and treatment.	Matrons/ WMs		Patient Satisfaction Surveys		
4.3	All wards/departments have access to quiet areas for private conversations.	MD	See action 1.4	See action 1.4	See action 1.4	
5	***1F*** ***People who use services receive care, treatment and support that is provided in a way that ensures independence.***					
5.1	Wards/departments ensure patients are involved in care planning and treatment choices.	Matrons/ WMs	Part of action 2.1			
5.2	Self-care is encouraged wherever possible.	DT/ET	Sept 2011	PAR Quality Audits	To be added to Daily Care Record.	
5.3	All nursing staff encourage the following as the norm: - Use of bathrooms/toilets - Use of dayrooms - Occupational activities - Protected mealtimes - Self-administration of drugs	Matrons/ WMs/ET	Sept 2011	Dayroom use. Protected meal times audits. Medicines management audits. Patient surveys. Volunteer strategy.	Clocks with day /date ordered. Pet visits in rehab ruled out by ICT. Planned activities implemented in day room in Sheldon. 2 potential volunteers were identified by group members to undertake voluntary beauty and Tai Chi interventions. – names to be forwarded to Glynis Fenner. DT has emailed local colleges to offer 'placements' to students on health and beauty courses.	
5.4	Environments are managed to promote 'normality', eg: - Reduced noise at night - Access to TV/radio - Relaxed visiting where possible - Protected mealtimes - Own clothes	Matrons/ WMs	Sept 2011	Dayroom use. Protected meal times audits. Medicines management audits. Patient surveys. Volunteer strategy.		

	- Choice of food - Access to food/snacks/drinks 'round the clock'.					
7	***1H*** ***People who use services are provided with information.***					
7.1	All wards/departments/services will have information on the service.	JKi	See previous action notes.	See previous action notes.	See previous action notes.	
7.2	All wards/departments will have a meet and greet pack that describes the service, care, treatment and staff.	HoN	Sept 2011	Patient surveys. Ward reviews.	In place in many areas. Requires audit and rigorous implementation.	
7.4	All other departments will 'publish' key quality/performance measures.	RO/MD	Oct 2011	Audits.	Actions to be defined.	
7.5	All wards/departments will have information about how to raise a concern/complaints.	KD	See complaints action plan.			
7.6	All wards/departments will have information about advocacy services.	DT			As above.	
8	***1I*** ***People who use services are given encouragement, support and opportunity to describe their needs and raise concerns.***					
8.1	All wards/departments have clear assessment/admission processes in place.		See action 2.1			
8.2	All wards/departments have information about Complaints/PALS in place.		See above re complaints action plan.			
9	***1J*** ***People who use services can influence how the service is run.***					
9.3	Establish a user group/forums.	DT	Oct 2011	User group minutes.	User forum to initiated in partnership with E&D lead. Help the Aged just joining the Trust forums.	
9.4	Develop productive relationships with LINKS and other local networks.	JKi/DT	Sept 2011		Not commenced. Met with Head of LINKS B'ham and due to meet with Sandwell w/c/ 29/8. Contact made with Patients Association member.	
9.5	E&D roadshows to local community groups.	LP	In place.	Reports to E&D Steering Group.	18.07.11. Results of engagement are shared with Trust Management Board and divisions to action some joint working with Patient Experience team and matrons to respond to issues raised by	

					attending community forums.	
9.7	All wards to have a 'dignity' champion – clearly identifiable to patients/visitors and responsible for local dignity initiatives.	RO/ET/SH/JK	August 2011 Revised date due to audit – SH- Sept 2011	Displayed on ward.	Email circulated to determine dignity champions and follow up audit to check information is displayed. ET to explore option of badges for champions. Names of champions to be inserted into external measures boards- JK	
10	***All staff treating patients, carers and families do so with respect.***					
10.1	All staff do not use inappropriate 'terms of endearment'. Staff will ensure tone and volume of voice is respectful.	Matrons/ WMs/JK	~~August 2011~~ Oct 2011	Observations of care quarterly	Some wards have new boards above beds which includes 'preferred name'- JK to cost provision for all wards.	
10.2	All wards to document preferred name the person would like to be called.	Matrons/ WMs	~~July 2011~~ Oct 2011	PAR/SAP- need to audit as part of quality audits or matron checklist	. Preferred name to be displayed on bed board over bed.	
10.4	All wards/departments to have appropriate patient nightwear available including footwear and provision for bariatric patients.	Matrons/ WMs	Oct 2011	Matron rounds. Patient surveys.	Laundry rebuilt. PJ's bespoke ordered.	
10.5	All ward staff to provide timely assistance to meet comfort needs, eg toileting, pain relief.	Matrons/ WMs/DT	~~August 2011~~ Dec 2011	Patient surveys. Matron rounds.	Part of observations of care. Philosophy of 'intentional rounding' to be adopted (part of documentation review)	
10.6	Permission should be sought and documented before every intervention by staff.	Matrons/ WMs/JK	August 2011 Completed	Patient surveys. Observations of care.	Change survey question. Educate staff required. Need to add to obs of care – JK. completed	
10.11	Laundry development to be completed.	SC	Oct 2011		Progressing on target structural work underway and equipment purchased.	
10.12	Purchase of new Trust nightwear.	SC/ward managers/JK/ RO	Oct 2011		Some problems with providers encountered . Local firm to provide sample by next week with potential order delivery in 6/52. Dressing gowns have been orderd (£15k-£20k). JK to draft a letter (with duplicate)to relatives/carers to bring in toiletries/clothes/nighwear	

					and take dirty home for laundering. Included in Patient information folder. RO to source funding for small toiletry packs.	

COMPLETED ACTIONS

Ref	Action	By Who	When	Evidence	Progress	Status
1	***1A*** ***People understand the care, treatment and support choices available to them.***					
1.1	Ensure Consent Policy is up to date and robustly in place.	DO'D	In place.	NHSLA evidence.	Achieved NHSLA level 2 this year.	
1.5	Ensure training/awareness raising re privacy, dignity and respect available and delivered.	DT	August 2011 ?completed	Training programme and lesson plan.	Part of clinical MOT starting in July. Integrated in other training plan to use patient story approach. Ward to Board patient experience stories commenced and include P&D. Campaign planned for Autumn.	
1.6	Ensure Trust is compliant with Equality Act.	LP	In place.	Action Plan. Minutes of E&D Steering Group.	Action in place to deliver through the Divisions 18.07.11. E&D Delivery framework in place compliance is monitored via function of E&D Steering group. Trust equalities publication requirements are carried out as part of its specific duties obligations. Staff receives training on Equality Impact Assessments to ensure that all policies and services are EqIA and registered on the central database. Equality & Diversity awareness training is available for staff to ensure that the Trust carries out it general duty obligations.	
1.7	Ensure SES up to date and captures actions required to ensure patients human rights are respected.	LP	In place.	SES. Action Plan.	Action in place through audit to E&D Steering Group.	
1.8	Provide MT training on E&D.	JP	June 2011	MT records.	In place.	

1.9	Ensure patients confidentiality is protected.	DO'D/ Matrons/ WMs	Oct 2011	Policy. Audits. Data Protection.	Confidentiality re PCs and phone calls observed in quality audits .- complete	
1.11	Observe care to ensure privacy, dignity and respect are maintained.	DT	In place.	Observation of care results. Patient surveys. Unannounced visits.	Robust audit continues.	
1.12	Ensure staff aware of and use independent advocacy services	DT	July 2011	Poster. Referral to MCA.	Posters disseminated WC 04.07.11	
1.15	All wards to have copies of bedside directory.	JKi	In place.	Matrons round. Observation of Care Team	Requires check and updating.	
1.19	Trust to be fully compliant with SSA guidance.	MD	In place.	Fully compliant.	Fully compliant.	
1.20	Patient experience Ward → Board reports to continue monthly.	RO	In place.	Trust Board papers.	Monthly themed cycle.	
2	***1B*** ***People who use services have their care, treatment and support needs met.***					
2.6	Patients have access to a variety of support sources including: - Chaplaincy - Advocacy - Interpreter Services	RO/DT/LP	In place.	PALS posters. WMQRS assessment July 2011	Posters disseminated. 18.07.11. Patients have 24/7 access to Telephone Interpreting with Language Line and face to face Interpreting for all languages. BSL is also available. Recent raising awareness campaign for Language line and investigating using new company with improved phone adaptations for bed bound patients	
2.8	Staff demonstrate respect and kindness at all times.	Matrons/ WMs	Ongoing.	Patient survey visits.		
3	***1C*** ***People who use services receive care, treatment and support where clear procedures are followed in practice, monitored and reviewed.***					
3.2	The following Acts/requirements are understood by staff and discussions and plans of care/treatment documented - Deprivation of Liberty - Mental Capacity - Safeguarding - Decisions relating to religious beliefs	DT	In place.	Programme – Safeguarding training NHSLA assessment. Care plans WMQRS peer group- review 13th July	Training and tools and advice in place – difficult to assess knowledge and application.	

3.3	Access to advocacy services is in place and understood by staff.	DT	In place.	Programme – Safeguarding training NHSLA assessment. Care plans WMQRS peer group- review 13th July	As above.	
3.4	Access to Chaplaincy and spiritual care is available and understood by staff.	RO/LP	In place.	Patient Surveys.		
3.5	The Trust is DDA compliant.	LP	In place.	The Trust is fully compliant.	18.07.11. Significant improvement in all physical aspects of compliance, confirmed by compliance level established in 2010 audit. Works have been undertaken to external approaches, footpaths, roadways, building entrances, reception desks, corridors, signage, lifts and sanitary facilities to improve compliance.	
6	***1G*** ***People who use services receive care, treatment and support that is provided in a way that ensures human rights and diversity are respected.***					
6.1	The interpreting services will be accessible and clearly understood by staff.	LP	In place.	All actions in place via E&D Steering Group and Action Plan.	All actions in place via E&D Steering Group and Action Plan. 18.07.11. Interpreter Service accessible by phone, fax, web, e-mail with recently extended hours now 08:00-17:00 with increased call centre operators. Policy being re-written. Telephone Interpreting under review to improve service and handsets. Service Level Agreements coming to an end and new one in place Oct 2011 to ensure language availability to include British Sign Language	
6.2	Telephone and staff interpreting will be clearly defined and accessible.	LP	In place.	All actions in place via E&D Steering Group and Action Plan.	All actions in place via E&D Steering Group and Action Plan.	

					18.07.11. Interpreter Service accessible by phone, fax, web, e-mail with recently extended hours now 08:00-17:00 with increased call centre operators. Policy being re-written. Telephone Interpreting under review to improve service and handsets. Service Level Agreements coming to an end and new one in place Oct 2011 to ensure language availability to include British Sign Language	
6.3	Written information where appropriate will be available in other languages/formats.	JKi	In place.	All actions in place via E&D Steering Group and Action Plan.	All actions in place via E&D Steering Group and Action Plan.	
6.4	Devices to assist deaf/blind patients will be available.	LP	In place.	All actions in place via E&D Steering Group and Action Plan.	18.07.11. All actions in place via E&D Steering Group and Action Plan. For example Hearing loops installed to all reception desks, meeting rooms, outpatient receptions and catering facilities and Electronic reading devices available such as 'Browse Aloud'	
6.5	Chaplaincy/spiritual care will be sufficiently diverse to meet the needs of patients.	RO	In place.	All actions in place via E&D Steering Group and Action Plan.	All actions in place via E&D Steering Group and Action Plan.	
6.6	E&D training will be part of MT.	JP	In place.	All actions in place via E&D Steering Group and Action Plan.	All actions in place via E&D Steering Group and Action Plan.	
8	***1l*** ***People who use services are given encouragement, support and opportunity to describe their needs and raise concerns.***					
8.1	All wards/departments have clear assessment/admission processes in place.		See action 2.1			
8.2	All wards/departments have information about Complaints/PALS in place.		See above re complaints action plan.			
8.3	All in patients have the opportunity to complete a patient survey.	DT	In place.	Survey statistics.	Survey returns now 1000 per month – reported via PEPAG.	

9	***1J*** ***People who use services can influence how the service is run.***					
9.1	Regular FT member forums are in place.	JKi	In place.	Evidence of forums/timetables/ minutes.		
9.2	Patient views are sought via patient surveys.	DT	In place.	Surveys	Results shared with corporate leads and divisions to action.	
9.6	Engagement plan in place.	JKi	In place.	Reports to E&D Steering Group.		
10	***All staff treating patients, carers and families do so with respect.***					
10.3	Call bells should always be in easy reach and are answered responsively.	Matrons/ WMs	Ongoing.	Audit. Patient surveys. Matron rounds. Patient surveys.	Current audits suggests it is in place but requires audit.	
10.7	All wards to use Privacy signs.	Matrons/ WMs	In place.	Quality Audits		
10.8	All ward rounds/handovers to be carried out without breaching patient confidentiality.	Matrons/ WMs	In place.	Optimal Ward		
10.9	DSSA toilet signage to be in place.	Estates	In place.			
10.10	Patients confidentiality to be maintained when answering the phone/IT.	DT	In place but requires regular audits.	Quality Audits		

Sandwell & West Birmingham Hospitals NHS Trust
CQC Essential Standards for Quality and Safety
Outcome Measure 5 – Keeping Nourished and Hydrated
Improvement Plan v 8 (Updated post meeting 14. 9.11)

Compiled post CQC unannounced visits to Sandwell – 28th March 2011 and City – 4th May 2011.
The Action Plan incorporates part or all of the existing Trust Action Plans for Privacy, Dignity and Respect and Nutrition.

Key

Rachel Overfield	**RO**	**Linda Pascall**	**LP**
Luke Banfield	**LB**	**Helen Shoker**	**HS**
Steve Clarke	**SC**	**Fiona Shorney**	**FS**
Helen Jenkinson	**HJ**	**Ward Managers**	**WMs**

Executive Lead	RO
Implementation Leads	Outcome 5 – FS
Divisional Leads	HS and HJ

Status Key:

	Complete.
	On track.
	Slight delay/expect to complete on time.
	Significant delay/unlikely to be completed as planned.
	Not yet commenced.

Board Approved:
Governance Board – 08.07.11
Trust Board – 28.07.11

Ref	Action	By Who	When	Evidence	Progress	Status
1	5A and 5B Where the service provides food and drink, people who use services have their care, treatment and support needs met.					
1.1	All in patients will be assessed for nutritional risk using the MUST tool within 12 hours of admission to base ward.	Matrons/ Ward Managers	September 2011	In nursing records. Monthly nutrition audits. Red @ Risk patients included in handover report	August audit - 90.6% of wards exceeded compliance target. Non-compliant areas being specifically targeted by HoN, Matrons and Nutrition Team. Some wards continue to require coaxing to embed audit in to monthly activity	
1.2	All in patients will be reassessed for risk every 7 days as a minimum	Matrons/ Ward Managers	September 2011	In nursing records. Monthly nutrition audits.	91% compliance in August	
1.3	Bed plans will reflect those patients identified as being at nutritional risk ie. MUST score of 1 or 2	Matrons/Ward Managers	September 2011	Adherence to MUST guidance documented in nursing records. Monthly nutrition audits.	60.3% compliance in August audit. Plans inaccurate. Matrons/Nutrition Team to work with wards to raise awareness and embed process.	
1.4	Meal diaries will be kept for those patients identified as being at risk ie MUST score of 1 or 2	Matrons/Ward Managers	September 2011	Adherence to MUST guidance in nursing records. Monthly nutrition audits	75% compliance in August – improving slowly but process yet to embed	
1.5	All patients will have Fluid Balance Chart unless identified as an exception via risk assessment and documented accordingly	Matrons/Ward Managers	September 2011	In nursing documentation. Monthly nutrition audits	66.4% on audit and spot checks Compliance very variable	
1.6	Implement escalation process where compliance is not achieved and no sign of sustained improvement and where there is persistent failure to return audits in a timely way	LP FS Matrons	September 2011	Monthly nutrition audits. Nursing documentation	Sept PEPAG agreed pre-capability procedure will be invoked via HoN if required when monthly audit results published	
1.7	Weight will be monitored via the MUST process.	Matrons/ Ward Managers	September 2011	In nursing records. Monthly audits. Included in handover report	Increasing compliance to inclusion in handover but not yet embedded.	
1.8	Monthly audits of every ward for compliance.	FS	September 2011	PEPAG minutes. Audit results.	Update monthly. HoN to cascade to their Matrons.	
1.9	All wards will have access to SLT for swallow assessments via referrals.	FS	August 2011	Patient records.	Ward staff aware of process	
1.10	Matron/Ward Manager weekly checks	HoN	September	Records of checks	Shortfalls in some ward areas	

	introduced.		2011	undertaken.	not identified	
1.11	All patients assessed as being at risk will have an appropriate Nutritional care plan.	Matrons/ Ward Managers	September 2011	Patient records. Monthly audits.	Matron spot checks continue and address issues immediately	
1.12	Nutritional needs will be discussed with patients/relatives/carers	Matrons/ Ward Managers	September 2011	Patient records. Patient surveys.	Increasing numbers of family /carers involved at meal times	
1.13	All nursing staff in In patient areas will be trained in the use of MUST tool and nutrition/hydration.	FS	September 2011	Training records.	Urgent need to focus on what to do following MUST when at risk patients identified.	
1.14	Continue to monitor fluid balance on food diary charts and fluid balance chart on existing until launch of new documentation in the new year	FS	September 2011	Monthly audits	Compliance with food diaries and FBC still needs work. MUST improved but failing to carry out appropriate actions as per guidelines.	
1.15	All wards will have appropriate weighing/measuring equipment.	FS	September 2011	Audit required.	New conventional scales in place. Hoist scales on trial on D11, 18, 16	
1.16	Nutrition Policy to be produced and implemented to clearly identify what is expected.	FS	September 2011	Policy approved at September Governance Board.	Policy to be added to intranet	
1.17	Menus to be reviewed by Dieticians for Nutrition content when menu amended.	LB/SC	July 2011	Evidence of review.	Menus recoded by Dieticians.	
1.18	Cultural and a la carte menus to be combined	SC	October 2011	Audits. Patient surveys.	Due at next re-print	
1.19	Review diversity of additional cultural menus, eg Chinese and Thai.	SC	Jan 2012		Progressing as planned.	
1.20	Ensure patients can gain access to special diets	SC	August 2011	Audits. Patient surveys.	List of dietary supplements available on wards and included in Nutrition Resource folder.	
1.21	Ensure all ward staff know how to access hot/cold food out of hours.	SC Matrons/Ward Managers	July 2011	Audits. MOT study day Matrons rounds Spot checks to ensure staff knowledge.	Posters on all wards to ensure staff know how to access.	
1.22	Protected meal times will be enforced on all	Matrons/	September	PMT monthly audit, results	Medical staff in some areas	

	wards. Meal service co-ordinators must be identified at every meal.	Ward Managers	2011	to PEPAG. Patient surveys. Matrons spot checks.	unsupportive of process. Evidence of greater engagement on some wards. Chief Nurse urges all wards to adopt a common sense approach that works for individual ward areas Matrons urged to undertake audits and feedback to ward managers	
1.23	Appropriate cutlery and food aids will be provided to assist independence.	Matrons/ Ward Managers	September 2011	Observation. Patient views. Liaison with ward OT	Stock on order. All wards to receive buffer stock. Ordering information to be in resource folder. Specific equipment for individual patients acquired via ward OT	
1.24	Staff will be trained in how to feed patients and flexible workforce will be identified for wards with highly dependent patients.	LP	October 2011	Training records. MOT	Programme continues. Investigate further options for work experience opportunities.	
1.25	Relatives/carers will be encouraged to come in at mealtimes to assist with feeding where appropriate.	Matrons/ Ward Managers	July 2011	Patient surveys. Visual evidence/ observations. Measures boards. Visitors policy. Pt information.	Increased evidence of lunchtime feeders, including MDT. Pilot of volunteer feeders to be evaluated.	
1.26	Members of MDT working with patients during Protected Meal Times as part of their therapy will be identified by wearing tabards.	FS	Aug 2011	Observations.	Until tabards sourced silver aprons in use.	
1.27	Pre meal time routines will be established in all wards to ensure patients are/have: - Positioned - Clean Hands - Toilet needs met - Cleared table	Matrons/ Ward Managers	September 2011	Monthly PMT audits to PEPAG. Patient surveys. Weekly Ward Manager rounds. Spot checks.	Progress made but Sept PMT audit reports comprehensive meal preparation yet to be embedded at every meal time.	
1.28	Red trays and mugs will be used to identify patients those at risk and those who need assistance.	Matrons/ Ward Managers	July 2011	Monthly audits. Observation of care.	Mugs and glasses delivered to all wards. Additional supplies acquired via Catering Dept. Laminated symbol posters at	

					bed head identify at risk patients	
1.29	At every meal time a meal co-ordinator to be identified. Meal times will be supervised by an identified member of nursing staff.	Matrons/ Ward Managers	September 2011	Monthly PMT audits. Observation of care.	Some wards need encouragement to identify co-ordinator, Matrons to raise awareness.	
1.30	Provision of bottled water to all wards.	SC	August 2011	Supplies orders.	In place at Sandwell, for roll out at City as able. Positive feedback from patients. Hydration posters issued to wards and in Nutrition folder	
1.31	Re-launch the Nutrition champions and develop a Nutrition resource folder for each area	LB	September 2011	Staff aware of their ward champion. Monthly PMT audits Nutrition folder on each ward.	Up to date list of Nutrition Champions acquired	
2	***5C*** ***Where the service provides food and drink people who use services can make decisions about their food and drink.***					
2.1	Menu cards are available equitably for all patients	SC	August 2011	Patient Survey	All menus available.	
2.2	Menus include cultural meals, special diets and soft/pureed options	SC	In place.	Patient Survey. Mealtime audits. Patient groups.	SLT continue to monitor options for dysphagia patients	
2.3	Range of snacks (cake, yoghurts, cheese & biscuits etc) will be available at all times to most vulnerable patients, biscuits to all patients	SC	In place.	Patient Survey. Mealtime audits. Patient groups. Matrons rounds	Biscuits available on all drinks rounds. Successful pilot of snacks and light bites on D43, D47, D11, D16, D18, N4, N3, L3 and P4. All wards will have access to full range of snacks	
2.4	Information regarding diet/nutrition will be provided to patients routinely.	Matrons/ Ward Managers	Sept 2011	Patient Survey. Mealtime audits. Patient groups.	Copies to wards and in resource folder.	
3	***5D*** ***People who use services benefit from clear procedures that are followed in practice, monitored and reviewed.***					
3.1	Develop a Trust Fasting Policy that reflects Enhanced Recovery recommendations.	HS	Oct 2011	Policy in place.		
3.2	Audit Fasting arrangements as a baseline and	HS	Aug 2011	Audit reports.		

	then quarterly thereafter.					
4	***5E*** ***People who use services have access to facilities for infant feeding including facilities to support breastfeeding.***					
4.1	Predominantly for outpatients or visitors in an unplanned situation.	SC/FS	Sept 2011	Identified areas.	Baby changing with seating in BTC. Phil Foley yet to source similar in Sandwell OP. Matthew Dodd also aware for acquiring suitable space.	

Ratios. Nursing Staff (WTE) to Bed Numbers. Surgery
August 2011

	BUDGETED POSTS & FUNDED BEDS				BUDGETED POSTS& ACTUAL BEDS OPEN		ACTUAL IN POST & ACTUAL BEDS OPEN				
Ward	TOTAL WTE	% of Trained Staff	No of funded beds	No of staff per Bed	ActualNo of beds open	No of staff per Bed	TOTAL WTE	% Trained Staff	% Bank & Agency Staff	No of staff per Bed	Sickness Rate (%) (July)
Surgery											
Eye Ward/ Day Surgery Unit	28.54	84.34%	10	2.85	/		25.41	83.55%	2.28%		
D6 (Pre Assessment Unit)	7.95	74.84%		#DIV/0!	/		7.72	77.07%	0.00%		7.56
ENT/Vascular (D21/24)	40.38	67.01%	25	1.62	25	1.62	35.73	66.02%	5.40%	1.43	0.91
D25	19.61	66.29%	18	1.09	15	1.31	19.82	61.55%	5.10%	1.32	4.02
Orthopaedics/Ortho Rehab (D26/28)	45.09	59.53%	36	1.25	25	1.80	46.28	56.33%	9.64%	1.85	3.26
D30	19.15	64.49%	19	1.01	19	1.01	20.39	56.45%	16.09%	1.07	1.06
D42 (SAU)	24.34	75.35%	17	1.43	19	1.28	25.00	71.64%	4.36%	1.32	7.91
ASU	26.20	74.05%		#DIV/0!	20	1.31	22.75	67.69%	2.42%	1.14	5.19
Newton 2 ***(5 day ward, there shown beds as 24*5/7)***	19.24	62.16%	18	1.07	24	**0.80**	22.37	64.19%	3.76%	**0.93**	6.57
Lyndon 2	28.73	54.30%	32	**0.90**	34	**0.85**	27.30	45.31%	18.83%	**0.80**	2.34
Lyndon 3	30.40	51.02%	28	1.09	28	1.09	31.78	44.34%	14.00%	1.13	3.43
Priory 2	22.99	55.76%	20	1.15	20	1.15	25.51	50.96%	13.06%	1.28	4.51
Newton 3	30.98	52.58%	33	**0.94**	33	**0.94**	34.45	41.36%	24.12%	1.04	5.06
Total/Average	**343.60**	**64.75%**	**256**	**1.31**	**262**	**1.20**	**344.51**	**60.50%**	**9.16%**	**1.21**	**4.32**

Feedback from the Exec/Non-Exec Walkabouts

The Non-Executive and Executive Teams carried out Protective Meal Time Observation Audits of 11 wards over two dates - 18th and 25th August 2011, visiting City and Sandwell sites respectively.

18th August

D18, D47, D11, D43

Description	Compliant	Partially Compliant	Non Compliant	Comments
Meal Preparation				
Is the protective meal time sign outside the ward?	2		2	Both of the signs broken and being fixed.
All unnecessary work on ward being stopped.	3			Box not completed on one audit.
Identified meal time co-ordinator.	4			
Appropriate number of staff available to serve meals on red trays.	3	1		
Patients sat up and ready to eat.	2	2		
Patients offered opportunity to use toilet.		1	2	1 ward been offered but not witnessed.
Patients offered opportunity to wash hands.		2	1	1 ward been offered but not witnessed.
Over-bed table cleared.	1	3		
Bed plan accurate.	2	1		Box not completed on one audit.
Meal Distribution				
Red tray provided, if required.	4			
Red mug and glass provided, if required.	2	1	1	
Drinks are available for all patients.	2	2		
Staff allocated to feed patients with red trays.	3	1		
Ward staff wearing appropriate apron.	4			
Protected mealtime rules are known to staff and enforced.	4			

25th August

P5, N4, P3, L4, P4, P2, L2

Description	Compliant	Partially Compliant	Non Compliant	Comments
Meal Preparation				
Is the protective meal time sign outside the ward?	7			
All unnecessary work on ward being stopped.	4	1		One box not completed and one commented that patients returning from surgery so not possible.
Identified meal time co-oridinator.	7			
Appropriate number of staff available to serve meals on red trays.	6			One ward not relevant as no red trays required.
Patients sat up and ready to eat.	7			
Patients offered opportunity to use toilet.	5		1	One ward not observed for this.
Patients offered opportunity to wash hands.	7			
Over-bed table cleared.	6	1		
Bed plan accurate.	6	1		
Meal Distribution				
Red tray provided, if required.	5			One ward not required and another ward slightly vague about the numbers.
Red mug and glass provided, if required.	4			One ward not observed for this. One ward not required and another ward slightly vague about the numbers.
Drinks are available for all patients.	7			
Staff allocated to feed patients with red trays.	6			One ward not required.
Ward staff wearing appropriate apron.	7			
Protected mealtime rules are known to staff and enforced.	6	1		One Consultant queried 'how long will this last and when can I come back?'.

Combined results over the two dates

Description	Compliant	Partially Compliant	Non Compliant	Comments
Meal Preparation				
Is the protective meal time sign outside the ward?	9		2	
All unnecessary work on ward being stopped.	7	1		
Identified meal time co-oridinator.	11			
Appropriate number of staff available to serve meals on red trays.	9	1		
Patients sat up and ready to eat.	9	2		
Patients offered opportunity to use toilet.	5	1	3	
Patients offered opportunity to wash hands.	7	2	1	
Over-bed table cleared.	7	4		
Bed plan accurate.	8	2		
Meal Distribution				
Red tray provided, if required.	9			
Red mug and glass provided, if required.	6	1	1	
Drinks are available for all patients.	7	2		
Staff allocated to feed patients with red trays.	9	1		
Ward staff wearing appropriate apron.	11			
Protected mealtime rules are known to staff and enforced.	10	1		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Patient Experience
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Rachel Overfield, Chief Nurse
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The purpose of the report is to highlight to the Trust Board 3 months-worth (May – July 2011) of results. Surveys are given to patients (or carers) during their stay to be completed before discharge. The Board is asked to note:

- the increasing number of responses received
- upwards trend around the 5 CQUiN indicators
- the numbers of responses received from patients with learning disabilities/mental health needs
- the improvement in cleaning standards after a decline noted in June
- the on-going issue regarding access to information on how to complain
- an improvement in the overall ratings

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	1.2 Continue to improve patient experience.
Annual priorities	1.2 Continue to improve patient experience.
NHS LA standards	
CQC Essential Standards Quality and Safety	Regulation 9, Outcome 4 – Care and welfare of people who use services. Regulation 10, Outcome 16 – Assessing and monitoring the quality of service provision. Regulation 17, Outcome 1 – Respecting and involving people who use services.
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial		
Business and market share		
Clinical	**x**	
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Routine monthly agenda item for Trust Board.

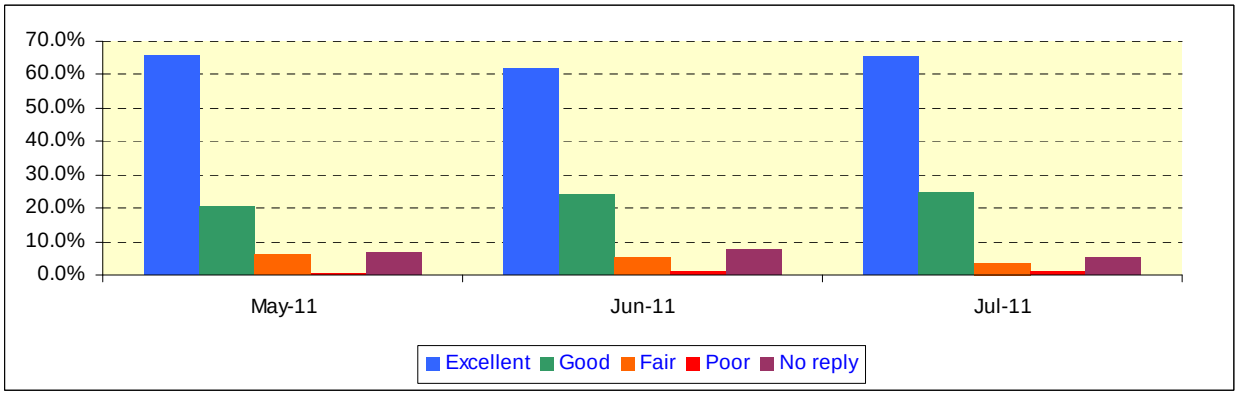
PATIENT SATISFACTION SURVEY- ADULT INPATIENTS

TRUST-WIDE RESULTS

MAY- JULY 2011

- Results of surveys received back from the wards for the months of May – July 2011.
- 'No replies' are not displayed in the results figures below.

Care as rated by patients:



THE 5 CQUIN INDICATORS			
Was your privacy respected when discussing your condition and treatment?			
	May	**Jun**	**Jul**
Total number of surveys received:	**535**	**915**	**1216**
Yes……..	92.3%	89.8%	92.4%
Sometimes……..	4.9%	3.4%	4.1%
No……	0.7%	3.3%	1.7%
2.6% increase in 'Yes' from Jun 2011which brings it to the May 2011 level			

Did the staff listen to your worries and fears?			
Yes.....	69.3%	71.8%	71.1%
No	3.2%	2.1%	2.9%
Not needed	21.7%	18.6%	20.6%
Slight dip in 'Yes' from Jun 2011 but maintained overall level from previous months.			

Were you involved as much as you wanted to be in decisions about your care and treatment?			
Yes.....	84.3%	84.3%	85.1%
No	7.1%	6.6%	6.7%
Registered 0.8% increase in the' Yes' from previous two months.			

Did the staff tell you about medication side effects to watch out for when you went home?			
Yes.....	41.1%	38.0%	43.0%
No	9.5%	12.6%	9.8%
Not required.....	32.7%	32.8%	31.0%
'Yes' increased by 5% and is at the highest level in last 6 months.			

Were you told whom to contact if you were worried about your condition or treatment after you left the hospital?			
Yes.....	64.5%	66.0%	68.7%
No	14.0%	13.9%	11.4%
An increase of 2.7% in 'Yes' from Jun 2011 and is highest in last 6 months.			

THE FULL SURVEY

PATIENT PROFILE			
Are you	**May**	**Jun**	**Jul**
Total number of surveys received:	**535**	**915**	**1216**
Male…….	36.8%	44.8%	43.3%
Female…….	55.5%	47.2%	48.8%
What is your age?			
Under 18…...	1.1%	0.8%	1.7%
18 to 24…….	8.0%	7.3%	8.2%
25 to 44…….	24.9%	23.5%	26.0%
45 to 60…….	22.1%	20.8%	24.9%
Over 60…….	39.6%	43.4%	35.0%
Do you have any of the following:			
Learning disabilities	4.1%	8.0%	4.9%
Mental health needs	5.8%	7.7%	6.7%

Which of the following best describes your ethnic background?			
White - British ……	66.4%	59.1%	60.3%
White - Irish ……..	3.4%	2.3%	2.2%
White – European……..	1.7%	1.0%	1.2%
White – any other white b/g……..	0.4%	0.2%	0.3%
Mixed-White & Black Caribbean…….	2.4%	2.7%	2.6%
Mixed-White & Black African……	0.2%	0.5%	1.0%
Mixed-White & Asian……	0.7%	2.1%	1.0%
Mixed- any other mixed b/g…….	0.2%	0.1%	0.4%
Asian/Asian Brit – Indian……..	7.5%	9.9%	9.5%
Asian/Asian Brit – Pakistani……..	5.0%	5.1%	6.8%
Asian/Asian Brit – Bangladeshi……..	1.3%	1.1%	1.8%
Asian/Asian Brit-any oth Asian b/g…..	1.1%	0.8%	0.6%
Black/Blk Brit-Caribbean……	6.2%	8.6%	6.6%
Black/Blk Brit-African……	0.6%	1.3%	1.3%
Black/Blk Brit – Any other Blk b/g	0.2%	0.3%	0.7%
Other Ethnic Group - Chinese	0.2%	0.7%	0.2%
Other Ethnic group	0.7%	0.7%	1.0%
Do not want to stated	0.6%	0.9%	1.2%
Were you provided with a language interpreter if you needed one?			
Yes……	3.2%	5.4%	5.6%
No……	9.2%	12.5%	11.6%
Not Applicable……	78.9%	72.5%	74.7%

PRIVACY & DIGNITY			
Were you treated with respect and dignity while you were on this ward?			
Yes, always……..	93.3%	89.3%	90.7%
Yes, sometimes……	4.9%	6.0%	5.6%
No……	0.2%	1.5%	1.0%

During your stay on this ward, did you ever share a sleeping area (room or bay) with patients of the opposite sex?			
Yes……	3.9%	7.7%	6.2%
No……	92.9%	88.7%	90.0%
On this ward, did you ever have to use the same bathroom or shower area with patients			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Equality & Diversity Update
SPONSORING DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Linda Pascall, ADN/Pauline Richards, Head of Equality and Diversity
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The report identifies progress achieved against the Equality delivery framework within the organisation. It also describes the recent changes in legislation resulting in the introduction of the Equality Delivery Service [EDS] and identifies progress towards meeting the implications of this change.

Key topics covered in the report include:-

- Equality Act 2010
- Equality Delivery System
- Equality Impact Assessments
- Education and Training
- Community Engagement

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to note the contents of the attached report.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	High quality, safe care Workforce fit for future
Annual priorities	Equality Delivery System should contribute to the achievement of annual priorities, enhancing user engagement and public involvement activities.
NHS LA standards	Supports and enables compliance with NHSLA Risk Management Standards.
CQC Essential Standards Quality and Safety	Care standard/Outcome 1.
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial		
Business and market share		
Clinical	**x**	
Workforce	**x**	
Environmental	**x**	
Legal & Policy	**x**	
Equality and Diversity	**x**	
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Received by ED Steering group.

Report Title	***Equality & Diversity Update***
Meeting	***Trust Board***
Author	***Linda Pascall, Assistant Director of Nursing/Pauline Richards, Head of Equality and Diversity***
Exec Lead	***Rachel Overfield, Chief Nurse***
Date	***29th September 2011***

Introduction

This report summarises the Trusts progress in delivering the framework for Equality and Diversity (E&D) and continues with a summary of the implications of the recent changes in Legislation relating to Equality.

Currently, delivery of the Framework is monitored by the E&D steering group chaired by the Chief Nurse. There are three subgroups reporting into the E&D steering group; Workforce, Policies and Assessment and Independent Living each chaired by a senior manager. This structure provides leadership, monitoring and reporting functions to give assurances to Trust Board. This report will summarise the work undertaken by these groups

Since April 2011 and the partnership with Sandwell Community Trust the Community ED lead has joined the Acute Trust service and work is in progress to streamline processes to deliver a corporate service.

The final part of the report identifies recent changes in Legislation. The Equality Act 2010 came into force on 1st October 2010 which draws together existing legislation relating to Equality. A gap analysis has been completed to determine how the Trust complies with the new arrangements

The change in legislation has resulted in the introduction of the Equality Delivery System [EDS] This supersedes the Single Equality Scheme and the report concludes with a summary of the Trusts responsibilities in relation to this.

Progress from Original Framework

Equality Impact Assessments [EqIA]

The Trust has a duty to ensure that its service and policies meet the requirements of the Equality act and this responsibility is delegated to managers of a service to ensure they are compliant. A Toolkit has been developed and implemented to support managers in completing assessments in line with the general duty.

A monitoring system is in place which ensures that all policies have a completed EqIA prior to ratification. Existing policies are EqIA at their review.

A central EqIA register has been developed and holds information on all services and policies that have successfully gone through the EqIA progress, to date there are 249 entries. Whilst most policies have an EqIA, there remain a number of services still to have an EqIA.

All EqIA that have highlighted any issue/adverse impact have a full assessment undertaken and an action plan agreed to resolve or minimise the impact of the issue. This action is the responsibility of the Divisional teams to ensure that their services meet the requirements within the Act with the support of the ED team.

Education and Training

Components of E&D are delivered through the trust mandatory training programmes such as Trust Induction, conflict resolution, harassment & bullying. EqIA education is delivered on a rolling basis for all relevant managers.

In addition to this the E&D team deliver E&D awareness training sessions throughout the organisation and over 1500 staff have attended in the last 8 months.

Since April 2011 and the partnership arrangements with the Sandwell Community, the training program has been revised to ensure it is relevant to all staff groups wherever they deliver service.

With the appointment of a new Head of Learning and Development, discussions have commenced to review the content and method(s) of delivery of E&D education to determine the most appropriate approach for the future.

Staff Support

The E&D team provides an advice and information service for all staff to support an understanding of the principles of E&D and how it impacts on their day-to-day work and behaviours. The team also provide a listening ear and individual support for staff members who are seeking help in relation to Equality & Diversity issues. The introduction of the Harassment Advisors has provided staff with additional support and signposting to discuss or explores individual areas of concern

Equality and Diversity Conference

On 10th May 2011 the Trust held its first Equality & Diversity Staff conference. The aim of the conference was to raise awareness of the principles of equality and diversity and this was borne out in the variety of speakers and interactions on the day. Immediate feedback was extremely positive and encouraging, demonstrating that the conference was well received and successful.

The conference was well supported by staff with over 124 delegates attending, excluding those presenting the exhibitions. It was clear from the level of engagement and involvement throughout the day that staff were enthused and inspired to the extent that some staff felt able to share emotional experiences that impacted on their lives. Telling the story and understanding the story was very much a successful key message during the day which is reflected in the written evaluation.

The evaluation also highlighted the need for further information on a number of issues, in particular 'Transsexual' and 'Religious Beliefs and faiths within our local communities'. The issues have been fed back and incorporated into the appropriate action plans to ensure that the issues are dealt with successfully.

Community Engagement

This activity is one of the most effective ways to capture genuine and meaningful information which is important to each community. It provides powerful feedback that can truly influence the way the Trust provides its services, interact with individuals and create environments where people feel valued, respected and at ease.

Listening to local communities will help us improve our service users' experiences, whether as an inpatient, an outpatient or a visitor. It also helps to build staff confidence and competence when caring for their patients.

The ED team 'outreach' to a wide variety of community groups with weekly sessions held with various community groups. People attending are asked to give their views on the care they have received with a

particular emphasis on them as individuals and their diverse needs. There is an acceptance by respondents that it would be an impossible task for the hospital to meet all of their individual diverse needs and this is taken into consideration in their balanced responses.

A summary of the outcomes of the engagement sessions to date is reported through the Steering group and to the individual managers concerned with a request for action to address where possible. Questions asked are categorised into four areas; Hospital meals/food, Privacy and care, Environment/Cleanliness and Communication/language.

Examples of feedback include:

- ***Hospital meals/Food***

"The hospital has good intentions, but the reality is different". Comments referred to a lack of cultural intelligence on our part, often demonstrated in poor understanding of needs and preferences.

- ***Privacy and care***

Not being encouraged to use bathrooms was cited by a number of respondents even when they were capable of using such facilities. Having a wash by the bed seemed to be the preference of nursing staff and not necessarily the patient.

- ***Environment/Cleanliness***

At one engagement event the feedback was quite positive; the general consensus was that cleanliness was excellent. Other events generated more discussions and difference in experience and expectations.

- ***Communication/Language***

This topic generates a great deal of discussion at every event so far! Comments like "staff don't want to understand you" and "doctors use terminology which is not understood" – require simple language. It was felt that mistakes are made because of lack of understanding and suggestion that patients' letters could ask the patient what support they need for language.

Changes in Legislation

Summary

The Equality Act 2010 came into force on 1st October 2010; it has harmonised existing discrimination law and strengthened the law to support progress on equality. The Act established a new public sector Single Equality Duty which has replaced and simplified the three separate duties that organisation need to take into account as employers, when making policy decisions and in delivering services. Theses duties are gender, race and disability equality. The duty also extends protection to cover age, religion & belief, sexual orientation and gender reassignment.

As a public body organisation the Trust has a general duty to deliver a service with due regard to the need to:

- eliminate unlawful discrimination, harassment or victimisation;
- advance equality of opportunity; and
- foster good relations

The general duty is underpinned by a number of specific duties requiring the publication of equality monitoring data.

Following the implementation of the Equality Act 2010, a gap analysis was undertaken (Appendix 1) within the Trust to determine the current position against the requirement of the Act. In summary it reveals that

the Trust is able to demonstrate good progress in meeting the requirements of the act however there are some areas that required further work to achieve full compliance. An action plan has been compiled to ensure that issues are addressed; each action has been integrated into existing action plans such as patient experience, safeguarding, workforce and progress will be monitored through the steering group. Progress against the action plan will be included in future reports.

Equality Delivery System [EDS]

In line with the implementation of Equality Act 2010, the Department of Health Equality Delivery Council has introduced the Equality Delivery System (EDS), a new framework intended to assist NHS organisations achieve compliance of duties under the Equality Act. This will replace our current Single Equality Scheme (SES).

The Equality Delivery System (EDS) aims to "drive up equality performance and embed equality into the mainstream of NHS business".

The EDS is a set of nationally agreed objectives and outcomes comprising of 18 outcomes grouped under the following 4 objectives:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

All NHS organisations will be required to develop 4-year Equality objectives and priorities based on the grading of their equality performance against the EDS goals and outcomes. The organisations Equality objectives would be developed through analysis of their performance in conjunction with local interest groups and staff.

The grades are RAG rated according to the following categories:

- Excelling - Purple
- Achieving - Green
- Developing - Amber
- Undeveloped - Red

The ED steering group is undertaking a review of the action required to achieve compliance – there is a deadline of April 2012, by which time the Trust equality objectives should be agreed and in place. These will require further discussion with the Trust Board and agreement before 'sign off'.

Summary

A great deal of activity is taking place across the organisation with some progress made as part of embedding the principles of equality and diversity within the culture of the organisation.

Work has commenced with the migration of our SES to the EDS framework; success is dependent on ownership at all levels of the organisation and purposeful engagement with our service users and local interest groups.

Appendix 1

EQUALITY Act 2010

1. Introduction

The Equality 2010 gained royal assent on 8th April of this year. It has harmonised existing provisions to give a single approach where appropriate. Most of the existing legislation will be repealed. The Equality Act 2006 will remain in force (as amended by the Act) so far as it relates to the constitution and operation of the Equality and Human Rights Commission; and the Disability Discrimination Act 1995, so far as it relates to Northern Ireland.

The Act establishes a new public sector Single Equality Duty which will apply to all protected characteristics. Public authorities will have a **general duty** when carrying out their functions to have due regard to the need to:

- eliminate unlawful discrimination, harassment or victimisation;
- advance equality of opportunity; and
- foster good relations.

It also introduces a new public sector duty to consider reducing socio-economic inequalities when making decisions of a nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantaged.

A gap analysis has been undertaken to clarify the Trust current position in relation to the requirement of the Equality Act and understand where the gaps are and how to close them.

The preliminary results shows that the Trust is in a position to respond positively to the requirements however, there are some areas that will need further work to achieve full compliance. An action plan as has been compiled to address issues highlighted.

Below the gap analysis report is rag rated to demonstrate level of compliance

Code:

Dark Green		Light green		Amber		Red		White
[Complete]		[On track will be completed by target date]		[Unlikely to be completed by target date]		[Uncompleted beyond target date]		[not yet applicable]

2.0 GAP ANALYSIS

What is required by the Trust?	Where are we now / current activities?	Compliant (Full / Partial / Non)	Actions required to achieve compliance	Additional comments	Rag Rating
1. Reduce socio-economic inequalities [new public sector duty]. ***[Enforced April 2011] – Removed as a requirement following review of Act by Coalition Government.*** Analysis highlights some practical challenges when dealing with patients within the category and as such it is necessary that we take account of them and work to provide equitable services for all sections of society requiring our service.	• Homeless patients are referred to the local neighbourhood office during working hours for support; however staffs have mentioned lack of support from social services and difficulties discharging homeless patients' out-of-hours. • Trust Demography and Diversity Report describes current socio-economic climate and is available to staff as a resource. Equality Impact Assessment outcomes have led to current projects such as: • Pacesetter project – G&T women access maternity services. • FGM outreach work to promote early presentation for maternity services.	non	Staff need to made aware of alternative services available e.g. An out of hours Social Emergency Duty Team is available on 0121 6754806 (Council) that will provide support. Identify the socio-economic threshold and a method of capturing the service users who fall into this group Service, Policy Functions Assessment subgroup to implement mechanism to ensure that equality impact assessments outcomes are actioned and improvements published. Patient experience surveys to incorporate feedback from patients who fall within this group. Raise staff awareness of the health inequalities issues which can impact on the socio-economic disadvantaged.	This is quite a complex area as it potentially covers all ethnic groups and data is not currently captured as part of the Trust monitoring data.	
2. Protect people from discrimination on the basis of the **protected characteristics**. ***[Enforced October 2010]***	• Single Equality Scheme and delivery framework in place – E&D steering group and subgroups. • Equality Impact Assessment toolkit, procedures and central register are in place.	partial	• All services, policies and functions to be EIA. • EIA outcomes to be published • Central Register for EIAs developed, implemented		

	• Services, policies and functions are being EIA • EIA workshops are being provided. • E&D Awareness training integrated into Mandatory courses • Bespoke E&D Awareness training being delivered to all staff • E&D websites are in place • E&D Resource Pack in all areas and accessible via intranet		and monitored • EIA action plans are monitored to ensure that actions are implemented and impact evaluated. • Equality and Diversity training to be included as one of Trust Mandatory programmes • All staff exposed to E&D awareness training – continue with blitz training. • All relevant staff receive Equality Impact Assessment training and support to carry out assessments – continue with workshop programme.		
2.1 **Religion** - include Christians, Muslims, Jews, Hindus and members of other religions, as well as humanists and atheists.	• Chaplaincy service in place for most religious groups • Spiritual Care audit undertaken • Literature and essential information is available for staff on the different religious groups • Support groups in place e.g. Christian, Muslim • E&D Awareness Training	partial	• Establish Sikh Chaplaincy support • Implement outcome of Spiritual Care audit. • Consider the needs/resources/provision for humanists, atheists and provide guidance to staff. • Addressing the spiritual needs of patients in staff CPD/PDR. • Explore the need for FEMALE chaplaincy provision for the religions of Asian origin (due to cultural factors). • Develop and implement a Trust policy for Spiritual Care. • Equality Impact the Chaplaincy Service.		
2.1.1 Consider the needs of people with different religious and philosophical beliefs when designing and	• Muslim Liaison Group • Service redesign/configuration team • RCRH team • Community network	full	Hospital design team and service development team have undertaken equality impact assessments and consultations with the public and staff to ensure people needs are		

delivering services	groups		considered at this stage of the development.		
2.2 **Age** - Outlaw unjustifiable age discrimination against people aged 18 and over where goods and services are provided. ***[Enforced 2012]***	Initial review shows no evidence of age discrimination in the provision of goods and services within the Trust.	full			
2.2.1 Consider the needs of all people of all ages when designing and delivering services – children, teenagers, younger and older adults.	• Service redesign/configuration team • RCRH team • EIA consultation process • Trust involvement and engagement team and processes.	partial	• Ensure that service user engagement and consultation process is embedded as part of service design and delivery processes.		
2.3 **Gender** - Tackle the pay gap between women and men	• Gender pay audit completed within the Trust.	partial	• Recommendations to be implemented.		
2.3.1 Publish gender pay & employment equality data.	• Employment monitoring data available on internet.	partial	• Upload relevant and timely information on Trust Internet • Monitor websites to ensure information is published		
2.3.2 Protect pregnant women and new mothers from discrimination e.g. breastfeeding mothers.	• Trust Family Leave Policy is in line with the requirement of new legislation it states - "Suitable accommodation should be provided for new and expectant mothers to allow for appropriate rest periods, or to express milk" • There are number of breastfeeding provisions for new mothers within the maternity services in line with the national breastfeeding initiatives. • E&D Awareness training in place	partial	• Staff in all areas of the trust needs to be aware of the legal requirements and the relevant trust policies to support compliance. • Develop and implement risk assessment policy for breast feeding mothers [staff].	We have a duty to protect the health and safety of a breastfeeding employee and that of her baby. Preventing an employee from breastfeeding her baby may put the employee's and the baby's health at risk. We must provide suitable facilities for a breastfeeding employee to rest**. Preventing an employee from breastfeeding may also constitute sex discrimination.**	
2.4 **Disability** - Protection for disabled people from	Current application paperwork is in line with new legislation.		HR Services and Policies are being Equality Impact Assessed.	Except in very restricted circumstances or for very restricted purposes, it is not	

discrimination in the recruitment process	As of the 1st October 2010 the occupational Health questionnaire will only be sent to candidates who have received a confirmed or provisional job offer.			allowed to ask any job applicant about their health or any disability until the person has been: • offered a job either outright or on conditions, or • included in a pool of successful candidates to be offered a job when a position becomes available (for example, if an employer is opening a new workplace or expects to have multiple vacancies for the same role but doesn't want to recruit separately for each one). Therefore an applicant cannot be referred to an **occupational health practitioner** or ask an applicant to fill in a questionnaire provided by an occupational health practitioner before the offer of a job is made (or before inclusion in a pool of successful applicants) except in very limited circumstances	
2.4.1 Protect carers from discrimination e.g. someone caring for a disabled person or older relative			Established support group for SWBH Carers and Families, 'The Caring Connection'. Need carers strategy		
2.5 **Ethnicity** – Tackle the employment gap for people from ethnic minority communities, making the workplace more diverse in order to reflect the local community served.	• Employment data monitoring and analysis carried out by HR • Staff profile data survey carried out annually • Local demography profile conducted by E&D team • Ethnicity profile of local communities conducted as part of the Foundation status – [IBP Integrated Business Plan]		Review outcome of ethnic profile of local communities against current staff ethnicity to ensure it is proportionally representative or identified gaps/variations and agree remedial actions to be taken.		
2.6 **Sexual orientation** –	E&D Resource Pack in all areas and accessible via		• All services, policies and functions to be EIA.		

take account of the needs of lesbian, gay and bisexual people (LGB) when designing and delivering services.	intranet Equality Impact Assessment toolkit and assessments Covert LGBT Group exists within the organisation –email contact only. Equality & Diversity Awareness training sessions are rolled out across the organisation to all staff.		• Encourage disclose of information [EPR & EPR] to ensure appropriate data capture and monitoring. • Response to patients' concerns or complains • Support staff to take time out for attending meetings without having to disclose if 'not out'. • Staff who feel vulnerable in their work area and are not 'out' should receive reassurance and support to overcome any issues. • Ensure procedure/policy in place to deal with discrimination from patients to other patients and/or staff and from staff to staff staff are appropriately used? • To establish a 'non-covert' LGBT group that provides E&D guidance.		
2.6.1 Advance equality of opportunity for transsexual people.	Initially there is no evidence to suggest that there is an issue of advance equality of opportunity with this group of people within the organisation?		Not aware we now have any in organisation as this type of information is often not disclosed – need to encourage disclosure and offer appropriate support? • Transsexual information to be made available on website.		
2.7 **Gender reassignment** – protect a trans person from discrimination and harassment even if the person is not under medical supervision.	E&D Resource Pack in all areas and accessible via intranet Equality Impact Assessment toolkit and assessments Equality & Diversity Awareness training sessions are rolled out across the organisation to all staff.		• Need a policy/Guideline/ resource for managers and staff re persons undergoing gender reassignment • Provide specific guidance on ensuring single sex accommodation and gender-reassigned patients.		
2.7.1 Protecting people associated with	There is lack of clarity within organisation around		Provide clarity on caring for the transsexual individual and	Doh guidelines	

transsexual people e.g. as their partner.	transsexual people and ensuring single sex accommodation		patient choice and those associated with them e.g. policy/guideline.		
3. Use procurement process to improve equality. ***[Enforced October 2010]***	Procurement Strategy 2009 – 2014 includes a section on equality impact assessments requiring all tenders to submit their EIA as part of that process.		Procurement EIA to be completed.		
4. Employment Tribunals have extended powers to make recommendations in discrimination cases the benefit the wider workforce as the individual claimant. ***[Enforced October 2010]***	E&D Awareness Training.		• Identify HR lead to ensure that trust is made aware of any such rulings. • Have mechanism in place to capture any such ruling and disseminate across the organisation - HR.		
5. Protect people from dual discrimination e.g. A black woman or a Muslim man. ***[Enforced April 2011]***	No initial evidence to suggest this is happening across the organisation		• Ensure our recruitment process is reflective of our duties under the equality legislation. • Provide all relevant staff with update on requirements and practices. • To add this information to EIA workshop session (a case study).	The new proposal would mean, for example, that a black female member of staff who is discriminated against because her manager who has a particular stereotyped attitude towards black women - could bring a single claim for combined race and sex discrimination.	
6. Protect people from discrimination because they are thought to have a protected characteristic e.g. a male job applicant is rejected because the employer wrongly thinks he is a woman, because his name is commonly used as a woman's name***[Enforced October 2010]***.	No initial evidence to suggest this is happening across the organisation. We do have in place • E&D Awareness Training. • EIA Workshop training. • Information on E&D website		• Improve staff awareness • Support staff with understanding of this type of discrimination		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – August 2011
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The report provides an update on the financial performance of the Trust for August 2011.

For August, the Trust generated a "bottom line" surplus of £35,000 which is £16,000 lower than the planned position (as measured against the DoH performance target).

For the year to date, the Trust has a surplus of £112,000 which is £101,000 worse than the planned position

Capital expenditure for the year to date is £1,722,000 and the cash balance at 31st August was £10.8m above the plan.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

NOTE the contents of the report and endorse any corrective actions required to ensure that the Trust achieves its financial targets.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Compliance with financial management and governance standards.

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial		Potential impact on trust financial performance targets.
Business and market share		
Clinical		
Workforce		
Environmental		
Legal & Policy		
Equality and Diversity		
Patient Experience		
Communications & Media		
Risks		Potential impact of higher than planned expenditure on trust financial performance.

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 20 September 2011; Finance and Performance Management Committee on 22 September 2011

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2011

EXECUTIVE SUMMARY

• For the month of August 2011, the Trust delivered a "bottom line" surplus of £35,000 compared to a planned surplus of £51,000 (as measured against the DoH performance target).

• For the year to date, the Trust has a surplus of £112,000 compared with a planned surplus of £213,000 so generating an adverse variance from plan of (£101,000).

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were approximately 136 below plan. After taking into account the impact of agency staff, actual wte numbers are 39 below planned levels. This compares with a position last month of 85 below plan. Total pay expenditure for the month, inclusive of agency costs, was £39,000 below plan.

• The month-end cash balance remains approximately £10.8m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(16)	(101)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(21)	(133)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	39	(269)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	105	(199)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	39	12	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	10,827	10,827	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	213	112
Capital Resource Limit	18,524	1,722
External Financing Limit	---	10,827
Return on Assets Employed	3.50%	3.50%

2010/2011 Summary Income & Expenditure Performance at August 2011	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	374,016	31,261	31,202	(59)	155,752	155,724	(28)	374,016
Other Income	39,681	3,249	3,143	(106)	16,142	16,505	363	40,531
Operating Expenses	(390,131)	(32,645)	(32,501)	144	(162,614)	(163,082)	(468)	(391,056)
EBITDA	23,566	1,865	1,844	(21)	9,280	9,147	(133)	23,491
Interest Receivable	25	2	7	5	10	42	32	100
Depreciation & Amortisation	(13,269)	(1,106)	(1,106)	0	(5,529)	(5,529)	0	(13,269)
PDC Dividend	(5,803)	(484)	(484)	0	(2,418)	(2,418)	0	(5,803)
Interest Payable	(2,156)	(180)	(180)	0	(898)	(898)	0	(2,156)
Net Surplus/(Deficit)	**2,363**	**97**	**81**	**(16)**	**445**	**344**	**(101)**	**2,363**
IFRS/Impairment Related Adjustments	(557)	(46)	(46)	0	(232)	(232)	0	(557)
SURPLUS/(DEFICIT) FOR DOH TARGET	**1,806**	**51**	**35**	**(16)**	**213**	**112**	**(101)**	**1,806**

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

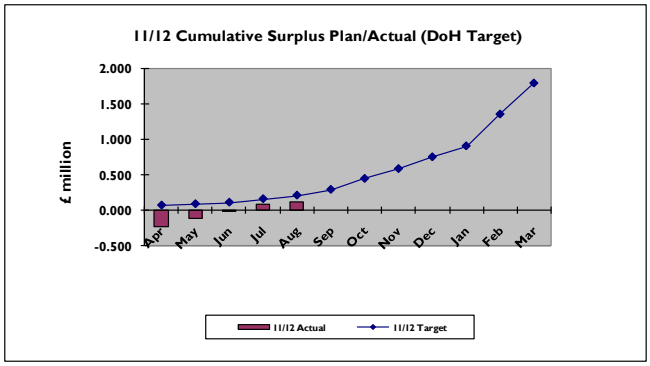
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2011

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Overall bottom-line performance delivered an actual surplus of £35,000 in August against a plan of £51,000. The resultant £16,000 adverse variance reduces the Trust's surplus for the first 5 months, although this currently remains positive at £112,000. The year to date surplus position is £101,000 below targeted levels.



Divisional Performance

• For August, divisional performance has generally been significantly better than that generated for the first four months of the financial year although within this position, the profile of emergency admissions within Medicine was planned to increase in July based on previous experience and this did not materialise, thus creating short-term income pressures. For Medicine and Surgery A, Anaesthetics and Critical Care, the monthly performance reflects changes made to budgets and CIP targets linked with the implementation of special measures in those divisions.

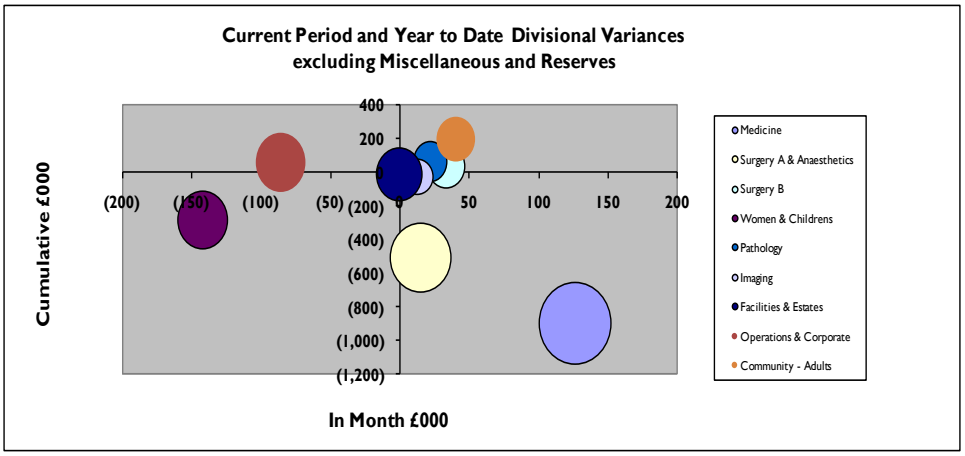
• The only significant adverse in month performances were recorded by Womens & Childrens (which is primarily driven by lower than planned activity levels particularly for births) and corporate services (owing to higher levels of expenditure in Strategy & Operations linked with external data storage requirements, the profile and timing of external consultancy costs and high levels of postage and stationery expenditure, the last of these creating an adverse impact on the performance of the Facilities Division). To a limited degree, over spending in some corporate areas has been offset by ongoing under spending in other areas, primarily Finance and central administration costs.

• There are some ongoing signs of improvement in August, particularly the further reduction in agency expenditure (although there has been a slight increase in bank costs in month). However, significant pressures remain within the Trust, particularly on capacity and the ability to deliver against performance targets whilst maintaining levels of quality. This is all set in the context of tight controls on expenditure. Concerted and intense management of performance will need to be maintained for the remainder of the year and the development and implementation of a longer term sustainable cost reduction programme is being rapidly progressed as part of the Trust's work on its strategic efficiency programme.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

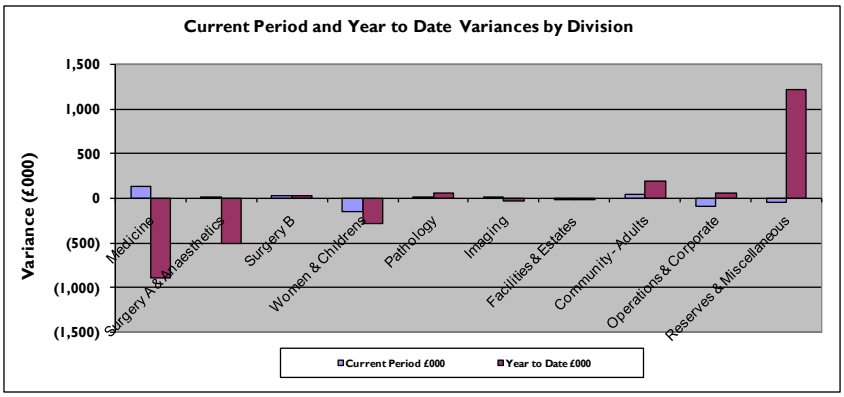
Financial Performance Report – August 2011



The tables adjacent and below show ongoing sizeable year to date adverse performance for Medicine, Surgery A and Womens & Childrens but generally with more positive in month variances (with the significant exceptions of Womens & Childrens and corporate services).

Divisional Variances from Plan

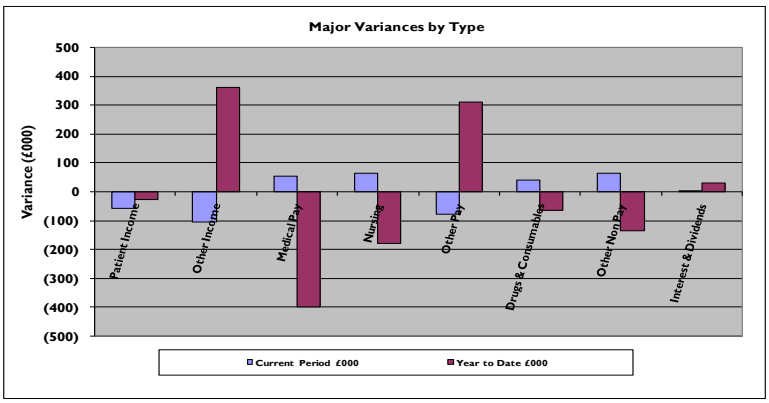
	Current Period £000	Year to Date £000
Medicine	126	(895)
Surgery A & Anaesthetics	15	(502)
Surgery B	33	34
Women & Childrens	(142)	(281)
Pathology	22	64
Imaging	13	(22)
Facilities & Estates	(0)	(9)
Community - Adults	40	199
Operations & Corporate	(86)	63
Reserves & Miscellaneous	(41)	1,217



For August, the table and graph below show more variable performance than has been experienced in earlier months with positive variances for medical and nursing pay and other non pay and adverse variances on other income and other pay.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	(59)	(28)
Other Income	(106)	363
Medical Pay	54	(399)
Nursing	64	(180)
Other Pay	(79)	310
Drugs & Consumables	41	(63)
Other Non Pay	64	(136)
Interest & Dividends	5	32



Sandwell and West Birmingham Hospitals NHS

NHS Trust

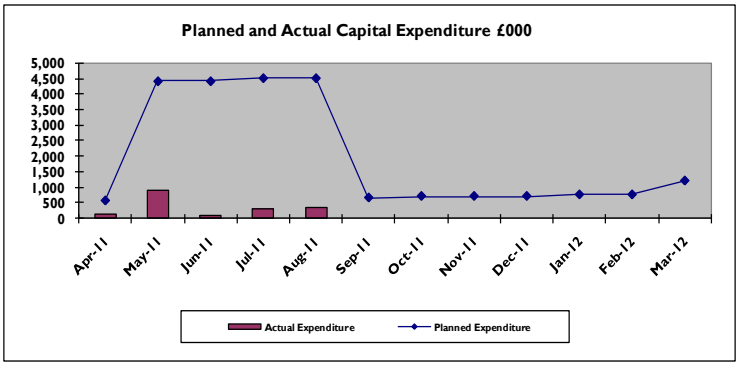
Financial Performance Report – August 2011

Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph.

• The profile (particularly the high level of planned expenditure between May and August) reflects the original expected pattern of Grove Lane land transactions. No expenditure has yet been incurred for the year to date although progress is being made on acquisitions and expenditure will then flow through to the capital programme.

• August expenditure was, similar to previous periods, at very low levels, even after taking into account the delay in land purchases.

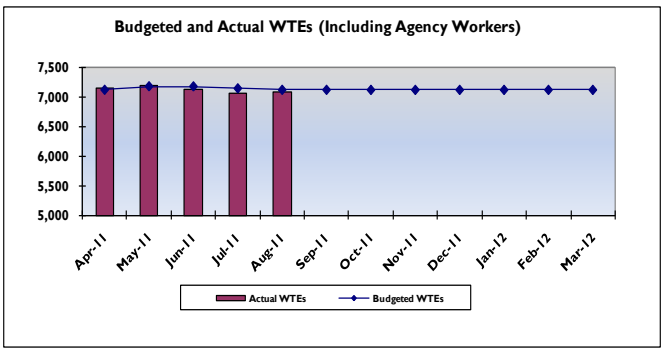


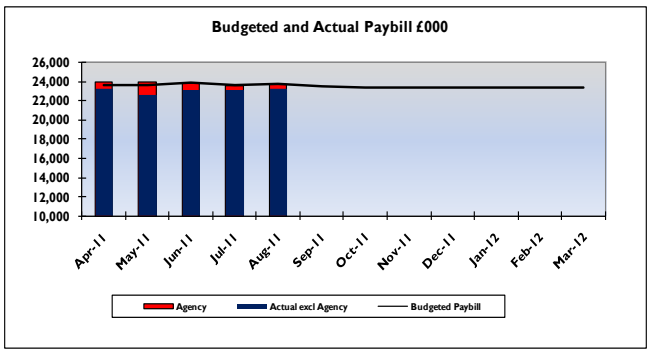
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 39 below plan for August compared with 85 below plan in July. Excluding the impact of agency staff, wte numbers are around 136 below plan. Actual wtes have risen by 23 compared with July but are 54 lower than the average for the first four months of the year.

• Total pay costs (including agency workers) are £39,000 below budgeted levels for the month with higher than planned levels of spend being incurred for administration and estates and other pay offset by lower than planned spend in other pay groups.

• Expenditure for agency staff in August was £490,000 compared with £590,000 in July, an average of £660,000 for the year to date and an August 2010 spend of £626,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – August 2011

Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category with actual expenditure analysed for substantive, bank and agency costs.

Analysis of Total Pay Costs by Staff Group

	Year to Date to August					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	31,671	30,314		1,756	32,070	(399)
Management	6,513	6,205		0	6,205	308
Administration & Estates	13,443	12,459	478	454	13,391	52
Healthcare Assistants & Support Staff	12,481	11,755	959	138	12,852	(371)
Nursing and Midwifery	36,370	34,535	1,369	647	36,550	(180)
Scientific, Therapeutic & Technical	18,347	17,704		307	18,011	336
Other Pay	(27)	(12)			(12)	(15)
Total Pay Costs	118,798	112,960	2,806	3,302	119,067	(269)

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2011.

• Cash balances at 31st August are approximately £29.6m which is around £3.1m higher than at 31st July.

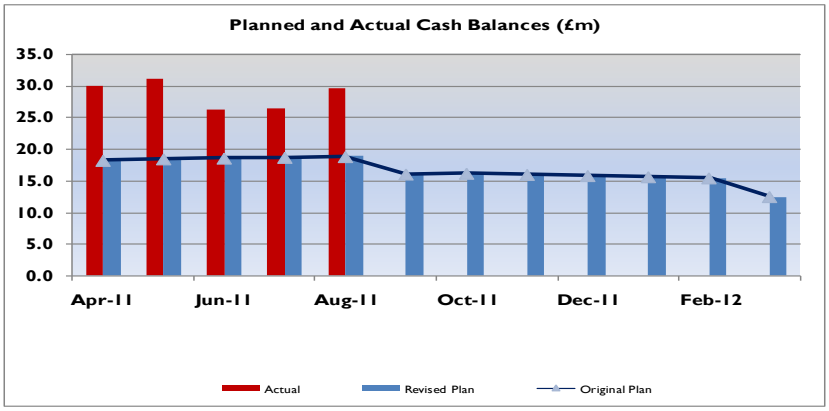
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION

		Opening Balance as at 1st April 2011 £000	Balance at 31st August 2011 £000
Non Current Assets	Intangible Assets	1,077	1,027
	Tangible Assets	216,199	212,392
	Investments	0	0
	Receivables	649	650
Current Assets	Inventories	3,531	3,685
	Receivables and Accrued Income	12,652	16,434
	Investments	0	0
	Cash	20,666	29,640
Current Liabilities	Payables and Accrued Expenditure	(33,513)	(43,339)
	Loans	0	0
	Borrowings	(1,262)	(1,250)
	Provisions	(4,943)	(4,129)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	0	0
	Borrowings	(31,271)	(30,855)
	Provisions	(2,237)	(2,237)
		181,548	182,018
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	36,573	36,573
	Donated Asset Reserve	2,099	2,099
	Government Grant Reserve	1,662	1,662
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(28,075)	(27,605)
		181,548	182,018

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2011



Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT August 2011

ACTUAL/FORECAST	Aug-11 £000s	Sep-11 £000s	Oct-11 £000s	Nov-11 £000s	Dec-11 £000s	Jan-12 £000s	Feb-12 £000s	Mar-12 £000s	Apr-12 £000s	May-12 £000s	Jun-12 £000s	Jul-12 £000s	Aug-12 £000s
Receipts													
SLAs: Sandwell PCT	**18,079**	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,434	14,434	14,434	14,434	14,434
HoB PCT	**7,347**	7,314	7,314	7,314	7,314	7,314	7,314	7,314	7,168	7,168	7,168	7,168	7,168
Associated PCTs	**5,362**	5,425	5,425	5,425	5,425	5,425	5,425	5,425	5,317	5,317	5,317	5,317	5,317
Pan Birmingham LSCG	**1,377**	1,376	1,376	1,376	1,376	1,376	1,376	1,376	1,348	1,348	1,348	1,348	1,348
Other SLAs	**462**	462	462	462	462	462	462	462	453	453	453	453	453
Over Performance Payments	**0**	0	0	0	0	0	0	0	0	0	0	0	0
Education & Training	**1,290**	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255
Loans		8,000											
Other Receipts	**3,187**	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Total Receipts	**37,104**	41,061	33,061	33,061	33,061	33,061	33,061	33,061	32,475	32,475	32,475	32,475	32,475
Payments													
Payroll	**13,998**	13,700	13,500	13,500	13,500	13,250	13,250	13,250	12,985	12,985	12,985	12,985	12,985
Tax, NI and Pensions	**9,369**	9,340	9,310	9,310	9,310	9,250	9,250	9,250	9,065	9,065	9,065	9,065	9,065
Non Pay - NHS	**2,494**	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,715	1,715	1,715	1,715	1,715
Non Pay - Trade	**6,926**	6,550	7,050	7,050	5,550	7,050	6,550	8,392	8,224	7,224	7,224	7,474	7,474
Non Pay - Capital	**341**	4,750	4,750	500	500	750	750	3,750	500	500	500	500	500
PDC Dividend		2,928						2,928					
Repayment of Loans								1,000					
Interest								70					
BTC Unitary Charge	**396**	400	400	400	400	400	400	800	415	415	415	415	415
Other Payments	**330**	200	200	200	200	200	200	200	200	200	200	200	200
Total Payments	**33,854**	39,618	36,960	32,710	31,210	32,650	32,150	41,390	33,104	32,104	32,104	32,354	32,354
Cash Brought Forward	**26,390**	29,640	31,083	27,184	27,535	29,386	29,797	30,708	22,379	21,750	22,120	22,491	22,612
Net Receipts/(Payments)	**3,250**	1,443	(3,899)	351	1,851	411	911	(8,329)	(629)	371	371	121	121
Cash Carried Forward	**29,640**	31,083	27,184	27,535	29,386	29,797	30,708	22,379	21,750	22,120	22,491	22,612	22,733

Actual numbers are in bold text, forecasts in light text.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2011

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	5.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	98.6%	4
Return on Assets	Surplus before dividends over average assets employed	1.6%	2
I&E Surplus Margin	I&E Surplus as % of total income	0.2%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	25.8	4
Overall Rating			**2.8**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at August.

• An adjustment has now been made to the liquidity ratio to reflect an uncommitted overdraft facility (which would be in place as an FT) as this more accurately reflects performance against the Monitor risk rating regime. The changes the Liquid Ratio score from 2 to 4.

• Return on Assets and I&E Surplus Margin are lower than would normally be expected due to marginal levels of surplus being delivered.

External Focus

• Strong indicators of a difficult financial position and potential (and, in some cases, actual) problems for NHS organisations in delivering financial balance in 2011/12 and beyond continue to be published.

• The report by the Audit Commission *NHS Financial Year 2010/11* published on 12th August, whilst focussing primarily on 2010/11, raised some significant concerns about the future of NHS funding and the financial resilience of NHS organisations going into 2011/12 and future years.

• The report identified 9 NHS organisations which had failed to meet financial targets in 2010/11 and 27 trusts and 18 PCTs which received qualified Value for Money conclusions on the basis of weaknesses in financial management and planning, a requirement for financial support or the existence of significant levels of unidentified savings in 11/12 plans.

• The report clearly states that 2011/12 will be a more financially challenging year than 2010/11. It identifies the difficulties in delivering high quality savings while operating in a tougher financial environment without the funding growth of previous years and concluded that some NHS bodies struggled to achieve planned efficiency savings in 2010/11. Consequently, a determined effort to make larger savings in 2011/12 I is required.

• The Trust's main commissioners (Sandwell Primary Care Trust and Heart of Birmingham teaching Primary Care Trust) continue to forecast achievement of their start of year plans and consequently are not reporting significant in year financial pressure.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2011

Conclusions

• The Trust generated an actual surplus of £35,000 during August bringing its financial performance for the first five months of the year to an overall surplus of £112,000 which includes a matched utilisation of brought forward Right Care, Right Here balances.

•The Trust's year to date performance against both its Department of Health control total (i.e. the bottom line budget position it must meet) and the statutory accounts target shows a deficit of (£101,000) against the planned position.

• The £35,000 surplus in August is £16,000 lower than planned for the month.

• Year to date capital expenditure was £1,722,000 which is significantly lower than plan, the bulk of which relates to the later than originally expected acquisition of land in Grove Lane although expenditure on other capital items remains relatively slow.

•At 31st August, cash balances are approximately £10.8m higher than the cash plan which is around £3.1m greater than the position at 31st July.

• Performance across most divisions is generally better than has been seen for the first four months of the year. This level of performance reflects the adjustments made to budgets linked with the implementation of special measures in Medicine and Surgery A, Anaesthetics & Critical Care. The only significant in month deficits in August has been recorded by Womens & Childrens (mainly a result of lower than planned income levels particularly for births) and corporate services as offset by underspending with the financial services and central administration.

• Monitoring and review of the recovery measures implemented in Medicine and Surgery A, Anaesthetics & Critical Care continues on a regular basis and, where necessary, this is being extended into other key areas. The current situation will be kept under review and further action taken when and if this is deemed necessary.

Recommendations

The Trust Board is asked to:

i. NOTE the contents of the report; and

ii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Performance Monitoring Report
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – August 2011.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to NOTE the report and its associated commentary.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Internal Control and Value for Money

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	x	
Business and market share	x	
Clinical	x	
Workforce	x	
Environmental	x	
Legal & Policy	x	
Equality and Diversity		
Patient Experience	x	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Financial Management Board and Trust Management Board on 20 September 2011 and Finance and Performance Management Committee on 22 September 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS CORPORATE QUALITY & PERFORMANCE MONITORING REPORT - AUGUST 2011

EXECUTIVE SUMMARY

Note	Comments
	A colour coded Key identifies which Indicators which comprise the NHS Performance Framework, Monitor's FT Compliance Framework and the SHA Performance Framework.
a	The overall percentage of **Cancelled Operations** increased to 0.7% during August, influenced by increased numbers on the Sandwell site.
b	**Delayed Transfers of Care** increased at Sandwell to 8.6% and reduced at City to 7.0% during the month. The overall rate fell to 7.8%, from 8.3%, but the year to date rate increased further to 6.2%. Census data at the end of August indicated that of 41 delays, the proportions attributable to the NHS and Social Care were similar, and in terms of local authority, 27 related to Sandwell and 14 to Birmingham. During September performance improved , particularly at the Sandwell end which has fallen to 4%.
C	**Stroke Care** - provisional data for the month of August indicates that the percentage of patients who spent at least 90% of their hospital stay on a Stroke Unit remained above 80% (actual 88.6%). **TIA** outpatient performance (the percentage of High Risk patients who were treated within 24 hours from initial presentation to the medical profession) was 50.0%.
d	**Accident & Emergency Clinical Quality Indicators** - performance against the 5 Headline Clinical Quality Indicators is indicated. For the purpose of performance monitoring, which is effective for Quarter 2 onwards, the indicators are grouped into two groups, timeliness and patient impact. Organisations will be regarded as achieving the required minimum level of performance where robust data shows they have achieved the thresholds for at least one indicator in each of the two groups, which for the month has been achieved, although thresholds for 2 of the indicators, 'Total Time in Department' and 'Time to Initial Assessment' were not met. The 95% threshold for 4-hour waits was also not met with performance for the month reported as 94.4%.
e	There were 7 cases of **C Diff** reported across the Trust during the month of August, within the trajectory for the month and the year to date. There remain no cases of **MRSA Bacteraemia** reported for the year to date. Data for MSSA Bacteraemia and E Coli Bacteraemia is also included in the report.
f	There were 22 Breaches of **Same Sex Accommodation** reported during the month of August, all related to the Medical Assessment Unit at City Hospital. Despite this being caused by one patient, the method of assessing breaches includes all patients affected within the clinical area.
g	In excess of 2500 staff have received a PDR for the 5-month period to date, this is equivalent to a rate of 75.7%. **Mandatory Training** compliance at the end of August decreased to 81.8%.
h	**CQUIN -** The range of schemes agreed with commissioners and their financial values are included within the report.
	VTE (Venous Thromboembolism) Risk Assessment - this CQUIN continues from 2010 / 2011. Performance of at least 90% each month is required to trigger payment. During the month of August 91.2% of eligible patients were assessed.
	Patient Experience Acute Services (Personal Needs) - this CQUIN also continues from 2010 / 2011. Composite of response to 5 inpatient survey questions. Goal to improve responsiveness to personal needs of patients. Survey to be conducted between October and January, for patients who had an inpatient episode between July and August. Target is an improvement (increase) of 2 percentage points on 2010 / 11 baseline.
	Smoking Cessation (training) Acute Services - the target is to train 90% of frontline staff in key specialties (Oral Surgery, Gastroenterology, MAU, Respiratory Medicine, A/E, Cardiology and pre-op assessment to identify smoking and provide brief advice. A training action plan will be circulated by the end of August, with trained scheduled to commence mid September. Approximately 500 frontline staff have been identified to require training.
	Smoking Cessation (delivery) Acute Services - a target of 2000 referrals to the smoking cessation service within the year. A total of 804 referrals have been recorded year to date, marginally short of the 833 trajectory for the period.
	End Of Life Care (Acute Services) - The Acute and Community schemes are harmonised to deliver an Increase (by 10% on baseline (56%)) in people on a supportive care pathway dying in the place of their choice by Quarter 4. Performance for the most recent month (July) for which data is available is 100%.
	Medicines Management (Missed Doses) - Decrease (by 10% on Q1 baseline) in avoidable medicines omissions. Baseline (Quarter 1) established at 59% with reduction to 53.1% required by March 2012. Performance during July was 67.9%.
	Nutritional Assessment - target is for 75% adults reported as having had a nutritional assessment within 12 hours of admission (not in assessment units) using a validated tool (e.g. MUST). Data for Q1 indicates 81% patients assessed.
	Enhanced Recovery - the implementation of an enhanced recovery model for 4 specified procedures in 4 surgical specialties. Specific details of this scheme are currently being finalised.
	Stroke Discharge - 90% of patients discharged meet 5 set criteria such as discharge information, clinical contact within 48 hours and community contact details. A process to capture and report data is being set up. a project plan is in place with a trajectory to deliver this target by January 2012.
	Mortality Review - target to review 60% of all qualifying (adult) deaths within hospital during March 2012. During the month of July 43.6% of deaths were reviewed compared with a target for the month of 30%, with a straight line trajectory to the final target of 60%.
	Alcohol Screening - 80% (throughout Q4) of patients (aged 16+) within agreed groups (Emergency Department, EAU, MAU and Gastroenterology OP to have an alcohol assessment and be offered advice. Nursing staff and junior doctors are currently receiving training in alcohol awareness and screening. It is anticipated that systems will be in place for Quarter 3, in advance of the Quarter 4 period of assessment.

	Comments
h	**Patient Experience Community Services (Personal Needs)** - comprises composite of response to 6 national patient survey questions of patients receiving care at home by the district nursing service. Composite score of 69 required.
	End Of Life Care (Community Services) - The Acute and Community schemes are harmonised to deliver an Increase (by 10% on Q1 baseline) in people on a supportive care pathway dying in the place of their choice by Quarter 4. Baseline identified as 26.73%, target is 36.73%. Performance for the month of July was 27.4%.
	Health Visiting - Children on the Health Visitor Case List who have had a full developmental review at 2 years and 6 months. Target 70% during Q4. Performance during July reduced to 44.7%.
	Falls Assessment - Increase (by 30% on baseline of 25% (determined by manual audit)) in the percentage of patients on the district nursing caseload who have a falls assessment. Performance during the month of July further improved 34.5% (trajectory 30%).
	Smoking Cessation (training) Community Services - the target is to train 80% of frontline staff (by end Quarter 2) in District Nursing, Diabetes, Community Heart Failure and Chiropody services. 91.7% of staff are reported to have received training to date.
	Smoking Cessation (delivery) Community Services - a target of 90% smokers seen by agreed services (Musculo-Skeletal, Diabetes, Heart Failure and COS) will have received an offer of brief intervention and onward referral to cessation services. 88.9% of patients were referred during the month of July.
	Access to Chemotherapy Out of Hospital is aimed at increasing the volume of chemotherapy / anti-cancer drug deliveries made either at the patient's home or in a community setting closer to the patient's home. The targets are to increase the number of patients in receipt of Herceptin at Home by 15 during 2011 / 2012, and to provide a total of 500 (non-Herceptin) deliveries (drugs, not patients) by year end. to date (April - August) 10 additional patients have received Herceptin at Home (trajectory 5), but only 23 non-Herceptin home deliveries have been made, compared with a trajectory for the period of 95.
	Improving Access to Organs for Transplant comprises 5 separate measures (each with a specific target) which relate to improving the availability of organs for transplant based upon the recommendations of the Organs for Donation Task Force. The Trust will collect and collate data in conjunction with the NHS Blood and Transplant special health authority. Data has been captured internally for the 5 months year to date. The Trust met each of the measures for each month.
	Screening for Retinopathy of Prematurity. A target of 90% has been set for babies born during the 5 month period September 2011 - January 2012 inclusive. Performance for the first 3 months of the year has met / exceeded this threshold.
	Auditing Neonatal Pathways requires the Trust to complete a audit template designed to identify where, why and how often transfers occur which fall outside the agreed newborn network pathways. The audit has been completed for each of the 5 months year to date.
i	**Quality and Efficiency Programme** - performance relative to a number of QuEP schemes is included in the report. The majority of indicators which comprise the various schemes have identified performance targets, trajectories and thresholds identified. Some of the indicators feature elsewhere in the report, but are also included in this section for completeness.
j	Detailed analysis of **Financial Performance** is contained within a separate paper to this meeting.
k	**Activity** (trust-wide) to date is compared with the contracted activity plan for **2011 / 2012** - Month and Year to Date.

	Month				Year to Date			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%
IP Elective	849	917	-68	-7.4	4535	4818	-283	-5.9
Day case	4385	3618	767	21.2	22087	19018	3069	16.1
IPE plus DC	5234	4535	699	15.4	26622	23836	2786	11.7
IP Non-Elective	4279	4579	-300	-6.6	22423	24738	-2315	-9.4
OP New	12787	11375	1412	12.4	65840	59792	6048	10.1
OP Review	34337	29642	4695	15.8	173840	155810	18030	11.6
OP Review:New	2.69	2.61	0.08	3.1	2.64	2.61	0.03	1.1
AE Type I	13914	14378	-464	-3.2	74835	77676	-2841	-3.7
AE Type II	2925	2855	70	2.5	16096	15423	673	4.4

Activity to date is compared with **2010 / 11** for the corresponding period

	2010 / 11	2011 / 12	Variance	%
IP Elective	4969	4535	-434	-8.7
Day case	22376	22087	-289	-1.3
IPE plus DC	27345	26622	-723	-2.6
IP Non-Elective	25626	22423	-3203	-12.5
OP New	67649	65840	-1809	-2.7
OP Review	184632	173840	-10792	-5.8
OP Review:New	2.73	2.64	-0.09	-3.3
AE Type I	78911	74835	-4076	-5.2
AE Type II	15612	16096	484	3.1

Overall Elective activity for the month and year to date continues to be in excess of the plans for the respective periods, by 15.4% and 11.7% respectively. Non elective activity is 6.6% less than plan for the month and 9.4% less than plan for the first 5 months of the year. Outpatient New and Review activity continues to exceed the plan for the year to date by 10.1% and 11.6% respectively. The Follow Up to New Outpatient Ratio increased during the month to 2.69. Activity across all categories reported is less than that delivered during the corresponding period last year (as indicated) with the exception of Type II (BMEC) A&E attendances.

l	**Ambulance Turnaround -** the proportion of ambulances waiting greater than 30 minutes increased during the month to 31.5% compared with a West Midlands average of 30.2%**.**
m	**Bank and Agency - the** overall use of Nurse Bank & Nurse Agency staff reduced during the month, the Nurse Bank Fill Rate remained high. Medical Agency and Medical Locum Costs remain fairly stable. The Overall spend on Agency Staff expressed as a percentage of Total Pay Spend has decreased for each of the last 3 months.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary performance assessed against the NHS FT Governance Risk Rating (FT Compliance Report)
SPONSORING DIRECTOR:	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of planning & Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the NHS Performance Framework.

Service Performance (August):- There are 2 areas of underperformance during the month of August; A&E 4-hour waits and Delayed Transfers of Care. For the month this attracts a score of 2.73 with the Trust classified as Performing.

Performance against the A&E Clinical Indicator 'Time to Initial Assessment 95th Percentile' of 25 minutes did not meet the indicator threshold of equal to or less than 15 minutes, but the other indicator, 'Time to Treatment in Department Median', within the Timeliness Grouping, did meet the indicator threshold, thus satisfying the requirement for at least 1 indicator in each of the 2 groups to be met in order to attract the maximum score of 3.
(Formal assessment of A&E Clinical Indicator performance for Quarter 2 will be based upon the performance during July, with Quarter 3 performance based upon the aggregate of August, September and October)

Financial Performance (August) - The weighted overall score is 2.90 and is classified as Performing. Underperformance is indicated August in 3 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume) and Creditor Days.

Foundation Trust Compliance Summary report:
There was 1 area of underperformance reported within the framework during the month of August which relates to the A&E 4-hour wait performance which was 94.40%. The overall score for the month is 1.0, with an AMBER / GREEN Governance Rating.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to NOTE the report and its associated commentary.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Accessible and Responsive Care, High Quality Care and Good Use of Resources
Annual priorities	National targets and Infection Control
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	Internal Control and Value for Money

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**x**	
Business and market share		
Clinical	**x**	
Workforce		
Environmental		
Legal & Policy	**x**	
Equality and Diversity		
Patient Experience	**x**	
Communications & Media		
Risks		

PREVIOUS CONSIDERATION:

Finance and Performance Management Committee on 22 September 2011.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2011/12

Operational Standards and Targets

Indicator		Weight	Thresholds		July 2011	Score	Weight x Score	August 2011	Score	Weight x Score
			Performing	Underperforming						
A/E Waits less than 4-hours		1.00	95.00%	94.00%	96.80%	3	3.00	94.40%	2	2.00
A/E Unplanned re-attendance rate	{Patient Impact Group}	2.00	=<5.00%	>5.00%	1.70%	3	6.00	2.14%	3	6.00
A/E Left Department without being seen rate			=<5.00%	>5.00%	4.58%			4.52%		
A/E Time to Initial Assessment - 95th centile	{Timeliness Group}		=<15mins	>15mins	23.00			25.00		
A/E Time to treatment in department (median)			=<60mins	>60mins	60.00			55.00		
Cancelled Operations - 28 day breaches		1.00	5.0%	15.0%	0%	3	3.00	0%	3	3.00
MRSA Bacteraemia		1.00	0	>1.0SD	0	3	3.00	0	3	3.00
Clostridium Difficile		1.00	0	>1.0SD	4	3	3.00	7	3	3.00
18-weeks RTT Admitted 95 Percentile(weeks)		0.50	<=23.0	>27.7	18	3	1.50	<=23.0*	3	1.50
18-weeks RTT Non Admitted 95 Percentile(weeks)		0.50	<=18.3	>18.3	13	3	1.50	<=18.3*	3	1.50
18-weeks RTT Incomplete Pathway 95 percentile (weeks)		0.50	<=28.0	>36.0	16	3	1.50	<=28.0*	3	1.50
18-weeks RTT 90% Admitted		0.75	=>90.0%	85.0%	95.1%	3	2.25	=>90.0%*	3	2.25
18-weeks RTT 95% Non -Admitted		0.75	=>95.0%	90.0%	98.9%	3	2.50	=>95.0%*	3	2.50
Cancer - 2 week GP Referral to 1st OP Appointment		0.50	93.0%	88.0%	93.2%	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms		0.50	93.0%	88.0%	96.9%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers		0.25	96.0%	91.0%	98.8%	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)		0.25	94.0%	89.0%	98.0%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)		0.25	98.0%	93.0%	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)		0.25	94.0%	89.0%	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers		0.50	85.0%	80.0%	86.5%	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening		0.50	90.0%	85.0%	100.0%	3	1.50	>90.0%*	3	1.50
Stroke (Stay on Stroke Unit)		1.00	80.0%	60.0%	82.93%	3	3.00	88.60%	3	3.00
Delayed Transfers of Care		1.00	3.5%	5.0%	8.30%	0	0.00	7.80%	0	0.00
Sum		**14.00**								
Average Score							**2.80**	* projected		**2.73**

Scoring:	
Underperforming	**0**
Performance Under Review	**2**
Performing	**3**

Assessment Thresholds	
Underperforming if less than	**2.1**
Performance Under Review if between	**2.1 and 2.4**
Performing if greater than	**2.4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Clinical Services Reconfiguration Programme - Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the Clinical Services Reconfiguration Programme as at the end of September 2011.

It covers:

- An update of progress with each area of clinical service reconfiguration that the Trust is involved in, including a range of wider SHA/health economy plans for clinical service consolidation.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE that the Halcyon Birth Centre is due to become operational on 31st October with an official opening on 11th October.

2. NOTE the implementation phase for the reconfiguration of Colorectal Inpatients and Emergency Gynaecology have started and both are due to have completed by the end of October.

3. NOTE progress with the Stroke Services review and the plan to present the short listed options and the case for consultation to its meeting in January or February 2012.

4. NOTE the current position and proposed timescales with regard to potential clinical service reconfiguration in Vascular Surgery.

5. NOTE the Trust has submitted an expression of interest and supporting evidence to be designated a Trauma Unit and the next steps and timescales associated with this.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Corporate Objective 2: High Quality Care
Annual priorities	Delivery of Maternity Reconfiguration Review of Stroke Services
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	Each area of clinical service reconfiguration will require a Business Case as part of the approval process.
Business and market share	**x**	The Business Case for each area of clinical service reconfiguration will require an assessment of the impact on market share.
Clinical	**X**	The prime driver for clinical service reconfiguration should be clinical and so each business case will include a clinical case for change and the benefits realisation will include benefits to clinical care.
Workforce	**X**	The Business Case for each area of clinical service reconfiguration will require an assessment of the impact on workforce and a related workforce plan.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The Business Case for each area of clinical service reconfiguration will require an equality impact assessment.
Patient Experience		
Communications & Media	**X**	Within the Right Care Right Here Programme there is a Communications and Engagement workstream.
Risks		

PREVIOUS CONSIDERATION:

Previous progress report relating to Clinical Service Reconfiguration in June 2011.

Sandwell & West Birmingham Hospitals NHS Trust

CLINICAL SERVICES RECONFIGURATION PROGRAMME
September 2011

1. Introduction

In order to ensure future clinical sustainability, we have undertaken a number of clinical service reconfigurations over the last 3 years and identified a number of other clinical services with the potential need for reconfiguration ahead of the opening of the Midland Metropolitan Hospital (the single site new Acute Hospital) in 2016/17. In addition NHS West Midlands is looking at whether there are any clinical services which due to their specialist nature may require an element of consolidation within the SHA to ensure the critical mass necessary to develop and retain specialist skills and deliver the best clinical outcomes.

This purpose of this paper is to provide the Trust Board with an update of progress with each area of clinical service reconfiguration following the meeting of the Clinical Service Reconfiguration Programme Board on 8th September 2011.

2. Service Reconfigurations in the Implementation Phase

2.1 Maternity Reconfiguration

Phase 1 involving the consolidation of deliveries, inpatient services and consultant led services was implemented in January 2011. An initial 6 month post implementation evaluation of this phase will be undertaken in the autumn.

Progress has continued and is on track against the project plan for the implementation of phase 2 which involves the establishment of a stand alone midwifery led unit, the Halcyon Birth Centre, in Sandwell. The new facility will be handed over to Sandwell PCT on 3rd October. This will be followed by a 4 week period of operational commissioning, staff induction and public tours. There will be a formal opening on 11th October and the Halcyon Birth Centre will become operational on 31st October 2011.

2.2 Colorectal Inpatient Surgery Reconfiguration

The final phase of the interim reconfiguration changes relating to General Surgery is the consolidation of Colorectal and Upper Gastrointestinal Inpatient Surgery at Sandwell Hospital. Implementation of this phase commenced in September 2011. Following some ongoing work around job planning and logistics it is anticipated that the implementation will be complete by the end of October 2011.

2.3 Emergency Gynaecology Services

Reconfiguration of the Emergency Gynaecology Service will involve fewer emergency admissions through the use of alternative outpatient based pathways and consolidation of the inpatient service at City Hospital. The service will continue to provide the ability to assess women presenting to Sandwell A&E with emergency Gynaecology conditions and to provide immediate treatment where this is required with subsequent transfer to the service at City Hospital if further assessment or treatment is needed. An Early Pregnancy Assessment Unit (EPAU) will remain at Sandwell Hospital.

The Joint Health Scrutiny Committee at its meeting in July 2011 confirmed that this service reconfiguration did not require a formal consultation exercise. The Trust's Strategic Investment Review Group (SIRG) approved the Business Case for Change in July 2011 and so the implementation phase has commenced. It is anticipated that consolidation of the inpatient service will take place in October 2011.

3. Potential Service Reconfigurations in the Planning Phase

3.1 Stroke Services

Following the Clinical Service Reconfiguration Programme Board's agreement to the Clinical Case for Change in relation to Stroke Services (in June 2011) further staff engagement events have been held to identify a long list of options and the evaluation criteria which will be used to produce a short list of options. We have been working with our PCTs to establish a formal reconfiguration project and this has now been set up with Sandwell PCT confirmed as the lead organisation for the planning phase of the project. A Project Board has been established along with a Steering Group which has clinical staff representatives and is chaired by one of our Deputy Medical Directors.

The Stroke Service review process was discussed with the Joint Health Scrutiny Committee at its meeting in July 2011 and it was confirmed that if the short listed options involve consolidation of services on one hospital site a formal consultation would be required. The Committee requested an update at its September meeting and so we will be presenting a report outlining the long list of options, proposed evaluation criteria and process for short listing the options to the meeting.

The next steps in the project and anticipated milestone dates are:

- Patient survey/interviews – October 2011
- Short list the options – November 2011
- Develop a formal consultation plan and document – December 2011
- Gateway Review and National Clinical Advisory Team review (if deemed necessary by NHS West Midlands) – December 2011/January 2012
- Present the short listed options and case for consultation to the Joint Health Scrutiny Committee, Black Country and Birmingham and Solihull Cluster Boards and SWBH Trust Board – January/February 2012
- Formal public consultation – start February/March 2012.

The Trust Board is requested to note the plan to present the short listed options and the case for consultation to its meeting in January or February 2012. The exact date will depend on confirmation from the SHA as to whether an Office of Government Commerce (OCG) Gateway Review and National Clinical Advisory Team (NCAT) review are required and if so the date these need to take place.

3.2 Vascular Surgery Services

As reported previously, in response to national and NHS West Midlands standards we have been working jointly with University Hospitals of Birmingham NHS Foundation Trust (UHBT) to look at options to develop a single clinical team for Vascular Surgery and as part of this to consolidate major inpatient surgery on one site. These proposals are likely to result in our inpatient Vascular Surgery service being transferred to the new Queen Elizabeth Hospital either in total or just complex cases with day case and outpatient services continuing to be provided at City and Sandwell Hospitals.

The next steps in this project and anticipated milestone dates are:

- To formalise the planning work for the proposed Vascular Surgery Service changes as a reconfiguration project and confirm the lead organisation for the planning phase – end of September 2011.
- Establish our internal project team to undertake the detailed analysis required around the impact on our services – end of October 2011.

The Vascular Surgery Service review process was discussed with the Joint Health Scrutiny Committee at its meeting in July 2011. The Committee requested an update on the review process to be presented to a future meeting.

3.3 Major Trauma Centres

As previously reported NHS West Midlands has developed proposals to consolidate major trauma services in fewer Trauma Centres including one at UHBT. Each Trauma Centre would form part of a Trauma Network which would include a number of Trauma Units (next level of trauma care). NHS West Midlands by establishing Major Trauma Centres (MTCs) and Trauma Units within a trauma system, are aiming to reduce mortality from major trauma. Whilst there is still an ongoing discussion about the number and location of Trauma Units, Trusts have been asked to submit an expression of

interest in being designated a Trauma Unit with a self assessment against the Trauma Unit standards (specified by NHS West Midlands) and supporting portfolio of evidence to the Black Country PCT Cluster for onward submission to the NHS West Midlands Trauma Designation Panel.

We submitted an expression of interest to be designated a Trauma Unit covering both City and Sandwell Hospitals along with our self assessment and portfolio of evidence at the end of August 2011. Our self assessment identified a number of standards that we currently meet partially and so actions to ensure full compliance were identified along with timescales with the latest being June 2012.

The Black Country PCT Cluster and NHS West Midlands Trauma Designation Panel have considered our submission and will be making a recommendation to the West Midlands Trauma Project Board for the Trust to be granted potential designation as a Trauma Unit from June 2012, provided the remaining outstanding standards are met. The Project Board meets on 16th September and if agreed at that meeting, the recommendation will be included in the Trauma System Business Case, due to be completed by the end of September.

We will then be asked to develop an action plan and business case to achieve the outstanding standards and to submit these by the end of January 2012. NHS West Midlands will undertake a check on progress against the action plan in March 2012. Trusts will be designated and 'go live' will only be at the date that full compliance has been met, for us this currently anticipated as June 2012 but there will be an opportunity as part of the review in March 2010 to indicate compliance at an earlier date and amend the agreed designation date.

There will be a formal peer review of all services designated, by site visit, undertaken by West Midlands Quality Review Service (WMQRS) in 2013.

It is expected that the SHA will coordinate any necessary formal public consultation on the proposals for Trauma Centres and related Trauma networks between November 2011 and February 2012.

4. Conclusion

We are undertaking or involved in a number of clinical service reviews which may generate options involving consolidation of services onto one hospital site and away from others. This report has provided the Board with an update of progress with these clinical service reviews.

The Trust Board is recommended to:

1. NOTE that the Halcyon Birth Centre is due to become operational on 31st October with an official opening on 11th October.

2. NOTE the implementation phases for the reconfiguration of Colorectal Inpatients and Emergency Gynaecology have started and both are due to have completed by the end of October.

3. NOTE progress with the Stroke Services review and the plan to present the short listed options and the case for consultation to its meeting in January or February 2012.

4. NOTE the current position and proposed timescales with regard to potential clinical service reconfiguration in Vascular Surgery.

5. NOTE the Trust has submitted an expression of interest and supporting evidence to be designated a Trauma Unit and the next steps and timescales associated with this.

Jayne Dunn
Redesign Director Right Care Right Here
20 th September 2011

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Right Care Right Here Progress Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	29 September, 2011

SUMMARY OF KEY POINTS:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at the end of August 2011.

It covers:

- Progress of the RCRH Programme.
- Progress with the transfer of a range of services, activity and related income from secondary care to community and primary care during 2011/12 as agreed in the LDP.
- Changes within the RCRH Programme Team.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress made with the Right Care Right Here Programme and the new format for reporting performance.

2. NOTE progress with identifying schemes to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme and LDP agreement with schemes having been agreed to the value of £13.8million against a target of £16.2million. Work is underway to implement these schemes and identify additional schemes.

3. NOTE changes to the RCRH Programme Team with Andy Williams being the new Senior Responsible Officer for the RCRH Programme and Chris Gibbs the RCRH Programme Director. In addition the communications and engagement service to the Programme will be provided by the Birmingham and Solihull Cluster Communications and Engagement Team under a Service Level Agreement.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Care Closer to Home: • Deliver the agreed changes in activity required as part of the Right Care Right Here programme. • Make fuller use of the facilities at Rowley Regis Community Hospital to provide care closer to home.
Annual priorities	
NHS LA standards	
CQC Essential Standards of Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	The Right Care Right Here Programme sets out the future activity model for the local health economy including the transfer of activity into the community and to new PBC provider services.
Business and market share		
Clinical	**X**	The Right Care Right Here Programme sets the context for future clinical service models.
Workforce	**X**	The service redesign within the Right Care Right Here Programme will require development of the workforce to deliver redesigned services in a new way and in alternative locations. This will be overseen by the Workforce workstream within the Right Care Right Here programme.
Environmental		
Legal & Policy		
Equality and Diversity	**X**	The service redesign elements of the Right Care Right Here Programme will require equality impact assessments.
Patient Experience		
Communications & Media	**X**	Within the Right Care Right Here Programme there is a Communications and Engagement workstream.
Risks		

PREVIOUS CONSIDERATION:

Monthly progress report to Trust Board

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT

SEPTEMBER 2011

INTRODUCTION

The Right Care Right Here Programme is the partnership of SWBH, HoB tPCT, Sandwell PCT and Birmingham and Sandwell local authorities leading the development of health services within Sandwell and Western Birmingham. This brief paper provides a progress report for the Trust Board on the work of the Programme as at the end of July 2011. It summarises the Right Care Right Here Programme Director's report and the RCRH Service Redesign Report that were presented to the Right Care Right Here Partnership Board at the end of August.

The work of the Right Care Right Here Programme and involvement of the Trust in this is also discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings.

PROJECT PERFORMANCE

The RCRH Programme has developed a new format for reporting activity performance related to service redesign. These reports are included in Appendix 1 for information. They attempt to summarise overall progress with the Programme in key areas by providing data for the first quarter of 2011/12 and comparing it with actual performance in 2010/11, the trajectory in the RCRH Activity and Capacity (A&C) for 2011/12 and the targets in the A&C model for 2016/17.

In summary activity trends for April-June 2011 show:

- Inpatient Activity: SWBH Acute Occupied Bed Days (OBDs; in Summary A, figure 1) whilst just below 2010/11 levels appear to be rising and currently exceed the 2011/12 trajectory. It is envisaged that this will be addressed by plans for intermediate care beds at Rowley Regis Hospital due to be implemented in the Autumn. Community OBDs both month on month (in Summary B, figure 3) and year to date (in Summary B, figure 4) are above 2010/11 levels but just below the 2011/12 trajectory. SWBH Acute elective inpatient activity (in Summary A, figure 2) is just on or below 2010/11 levels and the 2011/12 trajectory.

- Emergency Department Attendances: SWBH Emergency Department attendances (in Summary A, figure 3) are just below 2010/11 levels, but above the 2011/12 trajectory. The Urgent Care Centre attendances (in Summary B, figure 2) are above both 2010/11 levels and the 2011/12 trajectory.

- Outpatient Attendances: SWBH Outpatient Activity (in Summary A, figure 4) had been below the 2011/12 trajectory but in the last month has risen above it. Community Outpatient Activity (in Summary B, figure 1) is on or around the 2010/11 levels and above the 2011/12 trajectory although still some way from the 2016/17 trajectory.

At this stage it is suggested that none of the above trends give great cause for concern, given current plans which should begin to impact in the second and third quarters of the year.

In terms of performance against previous projects established through specific exemplars and individual re-design initiatives, the activity for Cardiology, Musculoskeletal, Rehabilitation, Respiratory and Urgent Care Centres generally continues to exceed target levels, although some are now showing a slow-down. However, there continue to be a few services, such as ENT, Rehab. at Rowley and Dermatology where performance is well below planned levels and which will need to be kept under review.

CARE PATHWAY AND SPECIALITY REVIEWS

As part of the Orthopaedic Review the three proposed pathways, for Elective Knee, Elective Hip and Shoulder Pain, were presented at an event for muskuloskeletal services as the end of July and were

well received. The emphasis of all three pathways is diagnostics within Primary Care and Community based follow up. The pathways have now been submitted to the RCRH Clinical Group for formal approval.

Proposed pathways for Endometriosis and Carpal Tunnel Syndrome are also awaiting approval via the Clinical Group. Whilst proposed pathways for Falls, Rheumatoid Arthritis, Sickle Cell and Irritable Bowel Syndrome are expected to be presented at September's Clinical Group meeting for approval.

There have been some technical issues with publishing some pathways across the three Map of Medicine views available locally (Sandwell, HoB and ICOF), which may result in some pathways not being published to all 3 views at the same time. Map of Medicine are aware of the issues and are working on trying to rectify them. Areas requiring further service re-design have been identified on all of the pathways to be published, to ensure clinicians are not searching for services that are not yet available.

The Rheumatology Review continues and so far has included a stock-take of local services and initiatives, the identification of a programme budget, the development of a local model of care and an assessment of the potential workforce implications of the review. The deadline for completion of the Review has been extended to September to allow inclusion of a more detailed proposal for an integrated model of care for Rheumatology, which takes account of the RCRH A&C model and trajectories, identifies a cost envelope for the speciality and can be extended across the whole of the RCRH health economy.

TRANSFER OF ACTIVITY

There have been ongoing discussions across the local health economy regarding implementation of the LDP agreement to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme. The Trust and GP commissioners have identified a number of specific schemes which have now been agreed and for which implementation plans are now being developed. Examples include undertaking review appointments following planned hip and knee surgery in community locations, physiotherapists undertaking planned joint injections that do not require specialist x-ray equipment in community locations etc. The LDP agreement set a target of transferring activity worth £16.2million and to date the trust and PCTs have identified schemes that will result in the transfer of activity worth £13.8million over a full year. Since April 2011 there has been a transfer of activity worth £1.4 million with a number of the schemes due to commence in the early Autumn. Work is ongoing within the Trust and PCTs to identify additional schemes.

PROGRAMME MANAGEMENT STRUCTURE

The role of designated Senior Responsible Officer (SRO) for the RCRH Programme has in recent years been fulfilled by Rob Bacon, in his previous role as Chief Executive of Sandwell PCT. Given that Rob Bacon has now become the Chief Executive of the Black Country Cluster, a new SRO is required and it has been agreed that Andy Williams should become SRO, in his role as Managing Director of Sandwell PCT.

Les Williams the RCRH Programme Director has been seconded to the role of Strategy and System Planning Lead for the Black Country Cluster until March 2013. As a result Chris Gibbs has been seconded to the role of RCRH Programme Director until March 2013. Chris Gibbs was previously seconded into the role of RCRH Programme Manager to cover maternity leave.

1. The RCRH Programme recently undertook a limited tendering exercise within partner organisations for the provision of a full communications and engagement service to the Programme. As a result the tender has been awarded to the Birmingham and Solihull Cluster Communications and Engagement Team, headed by Lynda Scott. The current RCRH Programme Engagement and Communications Facilitator, Abi Clinton, will transfer to the Cluster Team for the duration of the Service Level Agreement.

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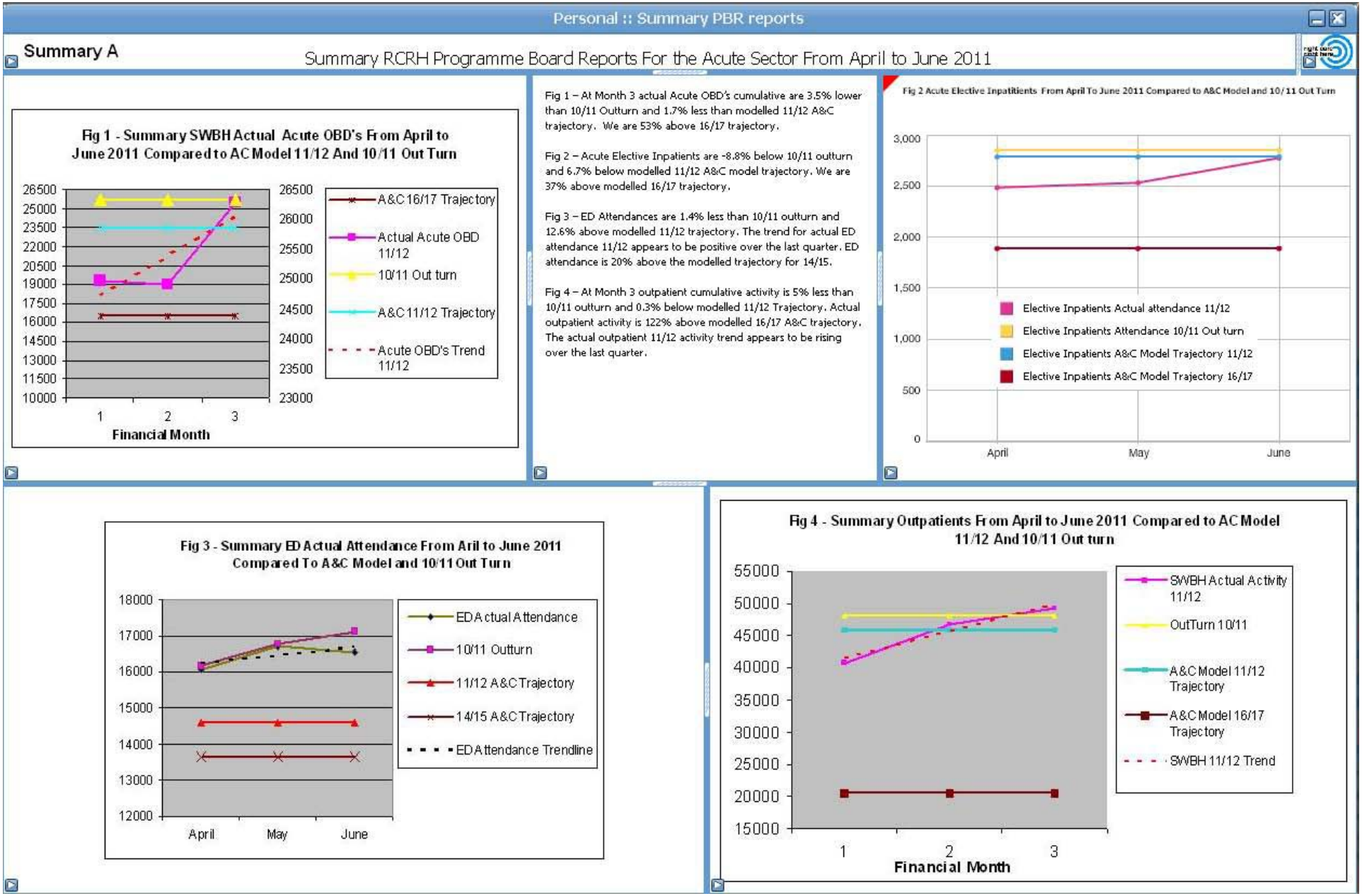
RECOMMENDATIONS

The Trust Board is recommended to:

2. NOTE the progress made with the Right Care Right Here Programme and the new format for reporting performance.
3. NOTE progress with identifying schemes to transfer a range of services, activity and related income from secondary care to community and primary care during 2011/12 in line with the RCRH Programme and LDP agreement with schemes having been agreed to the value of £13.8million against a target of £16.2million. Work is underway to implement these schemes and identify additional schemes.
4. NOTE changes to the RCRH Programme Team with Andy Williams being the new Senior Responsible Officer for the RCRH Programme and Chris Gibbs the RCRH Programme Director. In addition the communications and engagement service to the Programme will be provided by the Birmingham and Solihull Cluster Communications and Engagement Team under a Service Level Agreement.

Jayne Dunn
Redesign Director – Right Care Right Here
20th September 2011

APPENDIX 1 - RCRH Activity Summaries



Personal :: Summary PBR Community reports

Summary B

Summary RCRH Programme Board Reports For Community Sector From April to June 2011

Fig 1 Summary Community Outpatients From April To June 2011 Compared to A&C Model and 10/11 Out Turn

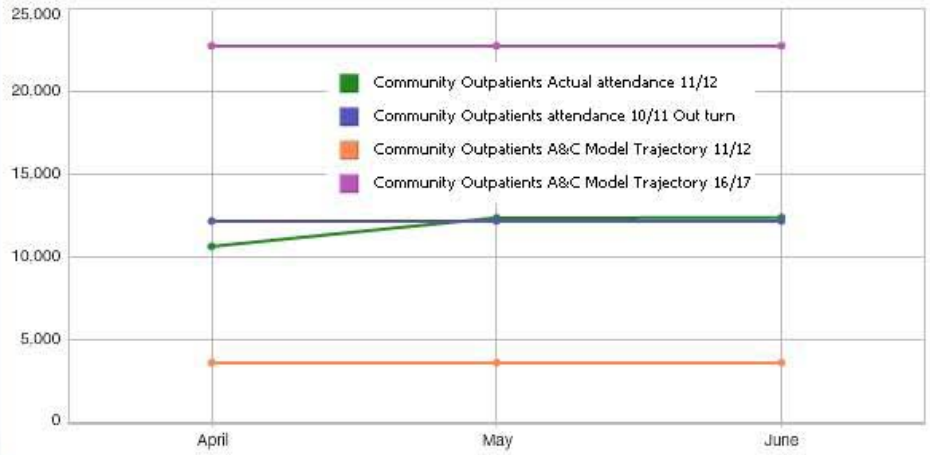


Fig 1 – At Month 3 community outpatient attendance is 3% less than 10/11 outturn. In comparison to the A&C model it is 226% above 2011/12 Trajectory and 48% less than 2016/17 trajectory.

Fig 2 – Urgent Care Centre attendance is 12% above 10/11 outturn. Even though the trend appears to be declining over the last three months we are still over performing in comparison to last years outturn. We are 30% above 16/17 Trajectory and 87% above 11/12.

Fig 3 - Community OBD's monthly appear to be trending upwards. Previous years out turn is currently being maintained.

Fig 4 –Cumulative community OBD's are 6% above 10/11 outturn and 14% below modelled trajectory for 11/12. To meet 11/12 trajectory we need to introduce 16,154 new OBD's . The introduction of these new beds commences September 2011 and thus the trajectory will need to be phased in from that point onwards. Note Community OBDS includes:

Leasowes IC Centre
Barthalomew Lodge Nursing Home
Waterside Nursing Home
Greenhaven Care Home
Moseley Hall
Riverside Lodge
RCRH Exemplar projects

Fig 2 Summary UCC Attendance From April To June 2011 Compared to A&C Model and 10/11 Out Turn

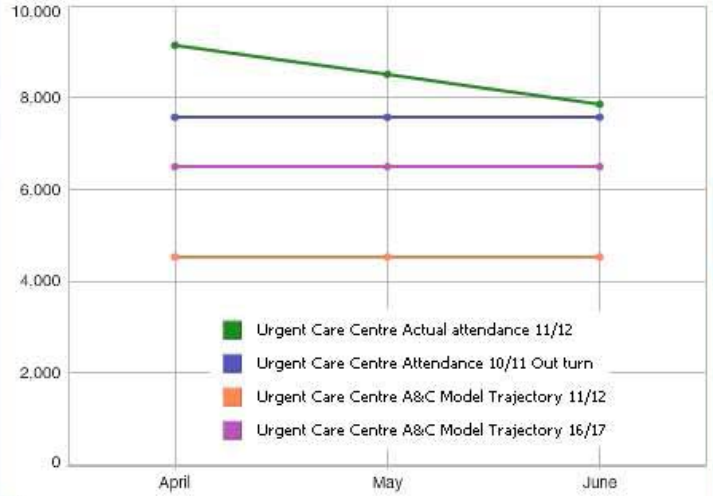


Fig 3 Summary Community OBD's From April To June 2011 Compared to A&C Model and 10/11 Out T...

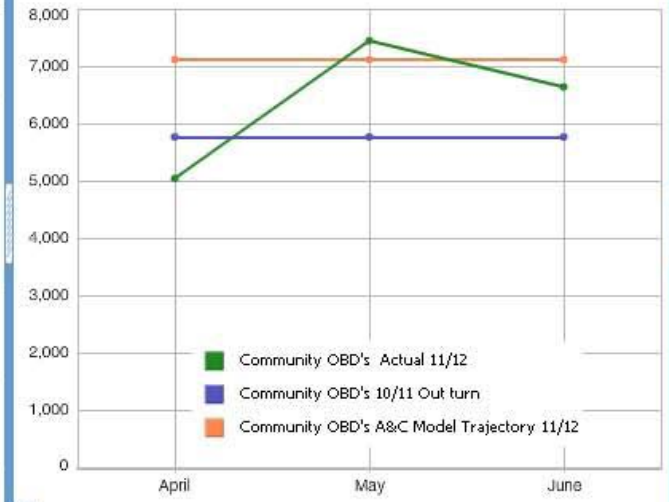
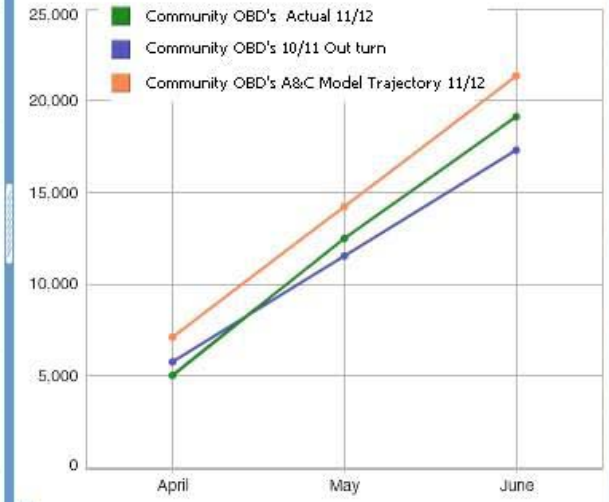


Fig 4 Cumulative Community OBD's From April To June 2011 Compared to A&C Model and 1...



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Foundation Trust Programme: Project Director's Report
SPONSORING DIRECTOR:	Mike Sharon, Director of Strategy & Organisational Development
AUTHOR:	Mike Sharon, Director of Strategy & Organisational Development
DATE OF MEETING:	29 September 2011

SUMMARY OF KEY POINTS:

The Project Director's report gives an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	X	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to **receive** and **note** the update.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	An Effective Organisation
Annual priorities	Make Significant progress towards becoming a Foundation Trust
NHS LA standards	
CQC Essential Standards Quality and Safety	
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

Financial	**X**	
Business and market share	**X**	
Clinical	**X**	
Workforce	**X**	
Environmental	**X**	
Legal & Policy	**X**	
Equality and Diversity	**X**	
Patient Experience	**X**	
Communications & Media	**X**	
Risks		

PREVIOUS CONSIDERATION:

FT Programme Board on 29 September 2011

FT Programme Director Report June 2011 – Overall status - Amber

Activities this period

- First version of IBP submitted to SHA/Deloitte
- SHA IBP feedback received
- Deloitte IBP feedback received
- Deloitte Board development activities completed (board effectiveness and staff survey's, staff focus groups, external stakeholder survey and board committee observations)
- "Soft" mock Board to Board with SHA for September postponed
- HDD1 Start date postponed
- More detail on milestones for the remainder of the programme developed

Activities next period

- Mckinsey feedback on PFI review due
- Quality Governance Self Assessment to commence
- Risk assessment of Strategic Objectives
- TFA to be agreed
- Board presentation on LTFM

Issues for resolution and risks in next period

- DH has not signed the TFA
- Outputs from McKinsey review of our PFI position expected