

**PUBLIC TRUST BOARD
HELD AT 10.00AM ON THURSDAY 30 MAY 2019
CLINICAL SCIENCES BUILDING**

AGENDA

Ap: APPROVAL R: RATIFICATION As: ASSURANCE D: DISCUSSION I: FOR INFORMATION

Item	General Business	Lead	Format	Action	Time
1.	World Class Colleague Award	A Hardy			10:00
2.	Apologies for Absence	A Meehan	Verbal	As	10:05
3.	Confirmation of Quoracy	A Meehan	Verbal	As	
4.	Declarations of Interest	A Meehan	Verbal	As	
Patient Experience					
5.	Patient Story	R de Boer	Enc	As	10:10
6.	Minutes of previous meeting held on 28 th March 2019	A Meehan	Enc	Ap	10:20
7.	Matters arising	A Meehan	Verbal	As	
8.	Public Trust Board Action Matrix	A Meehan	Enc	As	
9.	Chairman's Report	A Meehan	Enc	As	10:25
10.	Chief Executive Officer and Chief Officers' Report	A Meehan	Enc	As	10:30
Performance					
11.	Integrated Quality, Performance and Finance Monthly Report <ul style="list-style-type: none"> Performance Quality Finance Workforce 	K Martin L Kelly R de Boer/N Morgan S Rollason K Martin	Enc	As	10:45
Patient Quality and Safety					
12.	Mortality Update	R de Boer	Enc	As	11:25
13.	Controlled Drug Accountable Officer Report (April 2018 – March 2019)	R de Boer	Enc	As	11:30
14.	Safe Staffing Report: Acuity and Dependency Q4 2018-19	N Morgan	Enc	As	11:40
15.	Patient Experience Quarterly Report	R de Boer	Enc	As	11:45
16.	2017-2019 CQUIN Scheme (Healthy Eating)	L Kelly	Enc	As	11:50
Strategy					
17.	UHCW Improvement System (UHCWi)	K Martin	Enc	As	11:55
Research and Innovation					
18.	Research & Development Annual Report 2018-19	R de Boer	Enc	As	12:00
Regulatory, Compliance and Corporate Governance					
19.	Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions	G Stokes	Enc	Ap	12:10

20.	Employee Relations Report	K Martin	Enc	As	12:15
21.	Register of Interests 2019/20 and Gifts/Hospitality 2018/19	G Stokes	Enc	Ap	12:20
22.	Trust Seal Register 2017/18	G Stokes	Enc	As	12:25
23.	Declaration of Compliance against the NHS Provider Licence	G Stokes	Enc	As	12:30
24.	Raising Concerns policy – extension request	G Stokes	Enc	Ap	12:35

Feedback from Key Meetings

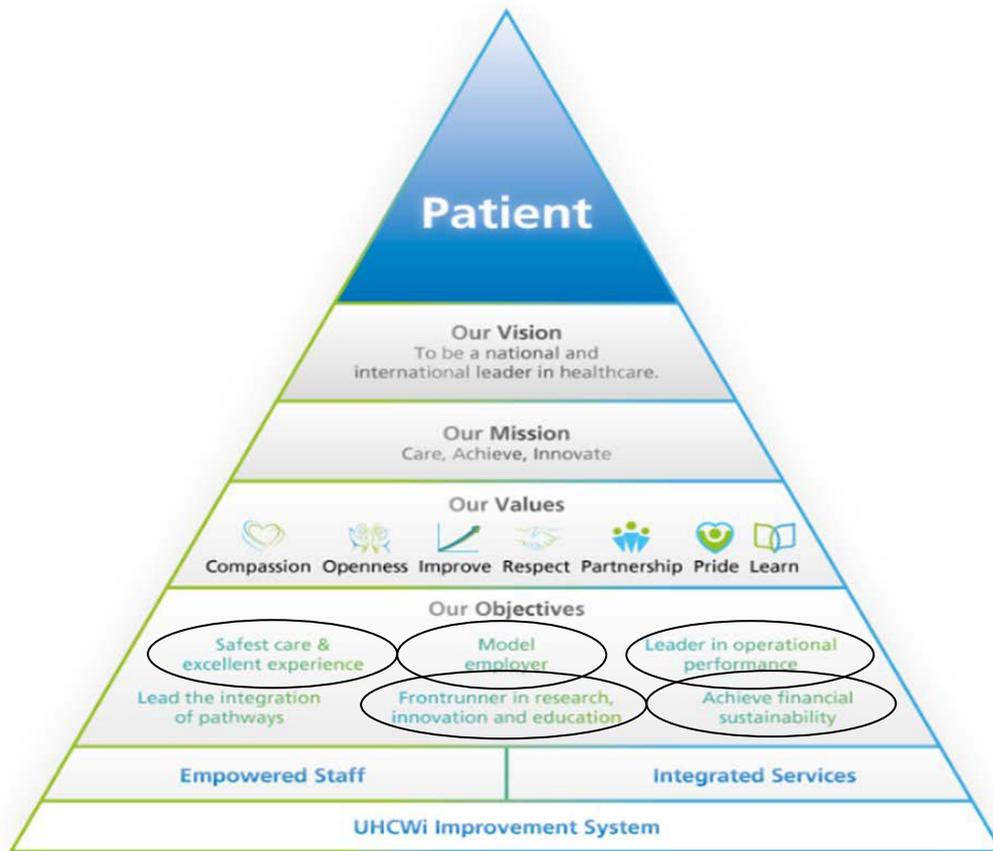
25.	Audit Committee Meeting report from 11 th April 2019	J Gould	Enc	As	12:40
26.	Quality Governance Committee Meeting Report for 15 th April and 23 rd May 2019	E Macalister-Smith	Enc	As	
27.	Finance and Performance Committee Meeting Report for 30 th April and 23 rd May 2019	I Buckley	Enc	As	
28.	Any Other Business	A Meehan	Verbal		12:45
29.	Questions from Members of the Public which relate to matters on the Agenda: Please submit questions to our Director of Corporate Affairs by no later than close of business Tuesday 28 th May 2019 (Geoff.Stokes@uhcw.nhs.uk)				

Next Meeting:

Thursday 25th July 2019 at 10.00 am, in the Clinical Sciences Building, University Hospital, Coventry, CV2 2DX

Resolution of Items to be Heard in Private (Chairman)

In accordance with the provisions of Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997, it is resolved that the representatives of the press and other members of the public are excluded from the second part of the Trust Board meeting on the grounds that it is prejudicial to the public interest due to the confidential nature of the business about to be transacted. This section of the meeting will be held in private session.



**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	RIPPLE – Respiratory Innovation: Promoting a Positive Life Experience
Executive Sponsor	Richard de Boer, Chief Medical Officer
Author	Julia Flay, Patient Involvement Manager
Attachment	Patient Story: ‘The Ripple (Respiratory Innovation: Promoting a Positive Life Experience) Group’
Recommendation	The Board is invited to NOTE the Patient Story and to RAISE any questions

EXECUTIVE SUMMARY

Ms Jeffries wanted to formally feedback to the Trust Board about the personal benefits she had experienced by attending RIPPLE and in particular the emotional support her membership affords her. In addition you will hear how Ms Jeffries enjoys the social aspect of the Group as well as the practical exercises and tips to help members deal with the condition.

PREVIOUS DISCUSSIONS HELD

This story forms part of the Patient Story Programme 2019/20 which was agreed by the Patient Experience and Engagement Committee for this financial year.

KEY IMPLICATIONS

Financial	
Patients Safety or Quality	The patient story links to our strategic objective to deliver excellent patient care and experience.
Human Resources	
Operational	

We are Listening: Patient Story

‘The Ripple Group’

Specialties/ Departments / Staff groups concerned	RIPPLE (Respiratory Innovation: Promoting a Positive Life Experience)
Why was this Story chosen	To demonstrate the emotional and practical value that a Support Group can be to patients.
Storyteller	Annie Jefferies, RIPPLE Patient

Please describe your experience of being a patient at UHCW (Ripple)?

I was diagnosed with COPD about ten years ago. As my condition progressed I was sent to the Community COPD Team who suggested that I should go to RIPPLE. I didn't like the idea because of travelling to get there. Having said this, they told me a taxi would pick me up and take me home again. When they told me this I thought then that I would give it a try. When I arrived at RIPPLE, I was given a very warm welcome by the staff and Janelle. I was told to find a seat at one of the four tables. When I did sit, I was again given a very warm welcome and was made to feel at home. It was an eye-opener to see so many people with the same condition as myself. It was nice to know I was not on my own and had people to talk to who would understand. We even knitted baby hats, poppies, teddies and comfort blankets for the hospital as our charitable contribution.

Please detail what you thought was good about your care and treatment at UHCW?

That day at RIPPLE was an experience that made me want to go again. At that time the doctor used to pop in most weeks. There was also a nurse and volunteers who brought us help and also a cup of tea. There was a lady who would give you a massage if you were feeling tense too. Another woman would come and put us through our paces with some light exercise, and for those of us who could join in, it would help with our breathing. On a few occasions, a young man came in sometimes and brought his guitar and we'd have a sing song. We do a quiz which is a good way of getting everyone talking to each other. We would have a fifteen minute relaxation where we closed our eyes and a lady talked to us through a walk in the woods, or on the beach; wherever we wanted to go. We also play bingo and have lunch together. It is idea for us who are on our own.

Where could we have improved?

I don't think anything could be improved on so far. We had people come in and talk about various things regarding our condition. [The talk on long term] oxygen [therapy] was one which I found very useful as I am now in that position. Medicine and breathing techniques were also discussed. During the time I've been going to Ripple, I've met some lovely people. I became close friends with some of the people I sat with but unfortunately three of them died. It is the nature of the beast with COPD but all the more reason why we need groups like Ripple where we can get together and forget about the future if only for one day a week.

What actions would you like to see the Trust Take?

I find this is a difficult question to answer as I know most things are down to funding. But speaking to most people they miss having a doctor or nurse coming into the group. These are the two things that are missing. It would please people to see them reinstated.

Most of the things I talked about are still going on. Having more people to come in to talk to us, especially the new patients [is important] but needs to be sustainable. I know that funding is the mainstay of these projects. Hopefully I'll still be coming to Ripple for a long time to come.

Points for the Board to consider:

- How does the story relate to the information contained in our quality or performance report?
- What does this story tell us about progress towards our quality improvement goals?
- What does this story reveal about our staff?
- What does it suggest about morale and organisational culture?
- What does it reveal about the context in which clinicians work?
- What does it reveal about staff attitudes to harm?
- What actions need to be taken as a result of what we have heard?
- What needs to be done immediately to make things right for the patient and prevent a recurrence for other patients?
- What implications does it have for board decisions?

**MINUTES OF A PUBLIC MEETING OF THE TRUST BOARD
OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
HELD ON 28 MARCH 2019 AT 10.00 A.M. IN ROOM 10009/11 OF THE CLINICAL
SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY**

AGENDA ITEM	DISCUSSION	ACTION
HTB 19/029	PRESENT	

Andrew Meehan, Chairman (AM)
 Andrew Hardy, Chief Executive Officer (AH)
 Ian Buckley, Vice Chair (IB)
 Richard De Boer, Chief Medical Officer (RdB)
 Lisa Kelly, Chief Operating Officer (LK)
 Sudhesh Kumar, Non-Executive Director (SK)
 Ed Macalister-Smith, Non-Executive Director (EMS)
 Karen Martin, Chief Workforce and Information Officer (KM)
 Jenny Mawby-Groom, Associate Non-Executive Director (JMG)
 Nina Morgan, Chief Nursing Officer (NM)
 David Poynton, Non-Executive Director (DP)
 Justin Richards, Chief Strategy Officer (JR)
 Su Rollason, Chief Finance Officer (SR)
 Brenda Sheils, Non-Executive Director (BS)

IN ATTENDANCE

Lincoln Dawkin, Director of Estates and Facilities (LD) for item HTB 19/048
 Andrew Wilkins, Head of Patient Relations (AW) for item HTB 19/034
 Ross Palmer, Modern Matron (RP) for item HTB 19/034
 Dr Sailesh Sankar, Consultant (SS) for item HTB 19/044
 Dr Andreas Ruhnke, Consultant (AR) for item HTB 19/045
 Rajni Martin, Organisational Development Manager (RM) for item HTB 19/047
 Lynda Scott, Director of Marketing and Communications (LS)
 Geoff Stokes, Director of Corporate Affairs and Acting Director of Quality (GS)
 Rebecca Hough, Head of Corporate Affairs (RH) (minute taker)

HTB 19/030	APOLOGIES FOR ABSENCE
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Barbara Beal, Non-Executive Director (BB)
 Jerry Gould, Associate Non-Executive Director (JG)

HTB 19/031	WORLD CLASS COLLEAGUE AWARD
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AH was pleased to present a World Class Colleague Award to Sonia Wootton, Sister for being nominated by her colleagues against the Trust's Compassion value.

Her colleagues nominated her for going above and beyond her role

AGENDA ITEM	DISCUSSION	ACTION
HTB 19/032	<p>especially for mental health patients and treating people with dignity and respect at all times.</p> <p>CONFIRMATION OF QUORACY</p> <p>The Chairman declared the meeting to be quorate.</p>	
HTB 19/033	<p>DECLARATIONS OF INTEREST</p> <p>There were no conflicts of interest declared.</p>	
HTB 19/034	<p>PATIENT STORY</p> <p>RdB introduced the patient story given by two daughters about their experience of their mother's cancer diagnosis in 2017. Their mother received surgery, chemotherapy and radiotherapy but unfortunately not long following this treatment, further growths were found and during a routine appointment at the Arden Centre she was admitted and rapidly deteriorated. A family wedding was planned and the family describe these weeks as a turbulent time for them but gave recognition to the Doctors who provided support to the family during this time.</p> <p>RP advised that the clinical team work well together as a multidisciplinary team and meet regularly to discuss their patients. The team work together to put their patients first and will use open and honest communication with their patients. He also informed Trust Board that the team have undertaken a lot of training on head and neck cancers.</p> <p>AW said that the story presents the best possible experience for a patient and would be using this as a demonstration of what 'good' looks like for future training.</p> <p>EMS reported he had undertaken a Board Walk Round on ward 35 and had witnessed the compassion of staff to their patients.</p> <p>The Trust Board RECEIVED the patient story.</p>	
HTB 19/035	<p>MINUTES OF PUBLIC TRUST BOARD MEETING HELD ON 31 JANUARY 2019</p> <p>Trust Board APPROVED the minutes of the meeting as a true and accurate record.</p>	
HTB 19/036	<p>MATTERS ARISING</p> <p>There were no additional matters arising.</p>	
HTB	<p>PUBLIC TRUST BOARD ACTION MATRIX</p>	

AGENDA	DISCUSSION	ACTION
ITEM 19/037	There were no outstanding actions.	
HTB 19/038	CHAIRMAN'S REPORT	
	There were no questions raised.	
	The Trust Board RECEIVED ASSURANCE from the Chairman's report.	
HTB 19/039	CHIEF EXECUTIVE OFFICER AND CHIEF OFFICERS' REPORT	
	AH introduced his report and highlighted the main points:	
	<ul style="list-style-type: none">• Tommy Whitelaw, Lead Campaigner for Dementia was welcomed to the Trust to talk about dementia and the wider aspect of care to patients• He undertook a visit to the dietetics team who demonstrated their work using UHCWi methodology. The production board showed the changes they have made eradicating waste from the service• The first TDG Away Day was held with the newly appointed Group Clinical Directors. The day looked at individual insight reports to understand the team's strength; and• He attended a celebratory lunch for Sue Crewe-Smith, MBE which was attended by many of her colleagues.	
	AH was pleased to confirm the following appointments:	
	<ul style="list-style-type: none">• Dr Domenico Mesiano has been appointed to the position of Consultant Cellular Pathologist• Dr Massimiliano Codispoti has been appointed to the position of Consultant Cardiac Surgeon• Dr Abigail Louise Bishopp has been appointed to the position of Consultant in Respiratory and General Medicine with interest in Sleep Studies and NIV• Dr Jayanth Bhat has been appointed to the position of Consultant in Respiratory and General Medicine with interest in COPD• Dr Shofiqul Islam has been appointed to the position of Consultant Oral & Maxillofacial Surgeon with special interest in Head and Neck Thyroid Surgery• Dr Duncan Murray has been appointed to the position of Consultant Haematologist	
	KM informed Trust Board that the revised UHCW Brief has been released which is receiving positive feedback. Non-executive directors recognised that this is a difficult achievement due to the number of staff it requires to be cascaded to.	

AGENDA DISCUSSION
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She highlighted the workforce growth and reminded Trust Board that there is now more staff demonstrating a degree of success and growth for the organisation. A number of recruitment campaigns for medics and nurses have been successful and open days continue to be held.

IB queried if there are any financial and quality measurements which could be considered to evaluate the increasing number of staff. AH recognised that whilst the financial element could be easy to measure, quality would be more difficult. However it was recognised that the minors department has seen an increase in workforce numbers but that the service is still not achieving the Trust's 98% stretch target. RdB acknowledged that the pace of change has been slow but reminded Trust Board about the inability to recruit and that Trust is training its workforce. Therefore this effect will take longer than anticipated. It was also confirmed that all approved business cases now include KPI's to allow the outcomes to be monitored.

An electronic solution for expenses is being brought into the Trust as part of the Trust's approach to digitalise systems. This will save time, cost and have a positive impact for both staff and the organisation.

The flu vaccination has been successful for 2018/19 with the Trust reaching 77.96% of the workforce, the highest the Trust has ever achieved. Preparation for the vaccination programme for 2019/20 has begun. KM confirmed, in response to EMS's query, that the workforce team were establishing the reasons for absence over the same period to understand if there is any correlation. AH further advised Trust Board that this was a success story because the NHS in general had not achieved this target.

KM further advised Trust Board that the second pay gender gap report will be published on 31 March.

RdB advised that the recruitment to two posts as part of the £15m PathLAKE /Innovate UK project has begun.

A Duty of Candour Event kaizen was held which identified several changes, including renaming it to 'Saying Sorry'.

He was pleased to inform Trust Board that the General Medical Council (GMC) has given notification that the Trust is no longer under review for Acute Medical concerns.

He participated in the trip to Virginia Mason Institute, Seattle and reported that this had been a positive experience which would not have been gained from not visiting. A lot of learning has been brought back by the participants and will be shared.

NM advised that she was delighted to report that the Trust has two nurses who have places on the NIHR 70 programme. This is a prestigious

AGENDA DISCUSSION
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programme and a privilege to have two members of staff selected.

The Trust's Chaplaincy Team will be hosting an innovation day for Chaplains across the country who are interested in developing new ways of working.

She was further pleased to advise that Amy Billington, Trainee Nursing Associate has been shortlisted for trainee of the year at Student Nursing Times.

LK reported that Mathew Wyse, Major Trauma Lead will be stepping down from the role. She reminded Trust Board that he has played a pivotal part in shaping the current service and confirmed a replacement has been made who will continue to develop the service.

There have been 79 kidney transplantations undertaken by UHCW this year. This service will continue to be provided with the competitive timeframe and outcomes. This is a good example of how a networking approach works demonstrated by the partnership work with Oxford University Hospitals NHS Foundation Trust as part of Oxnet and under challenge from the commissioners.

The Trust is engaging in the Hope Exchange Programme and will be receiving European colleagues during May who are aiming to understand more about the NHS.

Finally, she reported that she is submitting daily and weekly situation reports regarding the EU exit. The Trust's largest risk is managing the supply of drugs from suppliers who are co-ordinated nationally. The Trust's Business Continuity Plan has been developed over the last year and this will be tested but it is currently demonstrating its strength.

SR informed Trust Board that Health Service Executive Ireland has contacted the Trust to retain the current transplant agreement and has requested a new contract should there be a no deal outcome in the UK's EU exit.

The Finance Team has been working to finalise the 2018/19 contract and the financial position to work upon next year's Annual Plan and contracts.

She has undertaken a visit to the Play Specialists during the 'Day in Life' programme and reported that she is extremely proud of the service they provide as advocates for the children, their therapists and play makers.

She was pleased to see a number of Trust staff at the Coventry Half Marathon who were involved in running in the race and gave the Trust presence on the day.

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IB enquired about support from the STP concerning mental health which requires more funding and financial challenges in other emerging areas. SR advised that this relates to the construction of future services and the contracts to manage the integrated pathways to provide a seamless service for patients from Coventry and Warwickshire providers. The pathway will be reviewed as part of the contractual discussions and the finances structured around this. JR noted services will need to demonstrate impacts for community and whilst funding is required earlier in the pathway, the Trust has a part in resolving these issues and will be looking at how best to respond.

JR informed Trust Board that she has been working closely with the Finance Team to look at the system wide STP to allow the Trust to work in a more integrated way across Coventry and Warwickshire for cancer and to improve and support the local priorities through the STP.

The primary care networks for GPs are now in place and Clinical Leads will be encouraged to hold structured dialogues to support the GPs and assist with proposed changes.

The frailty service has gathered pace and commitment has been made by the partners to develop this. The STP understands that the frailty service includes the Trust's front door and this will be developed as part of the model.

Finally, she reported that there is a financial gap in the community providers for Stroke services. This is being discussed with the CCG for a mobilisation and an implementation plan to be developed.

The non-executive directors were supportive of the work being undertaken for the frailty service but noted that this needs to move at pace. JR acknowledged this challenge which relates to a cultural shift and capacity of staff to work differently and resources to support this work may be required but the Trust was committed to making this change.

Trust Board **RECEIVED** the Chief Executive and the Chief Officer updates and **RATIFIED** the consultant appointments. It was **AGREED** that Strategic Board would be used to conduct an 'audit review' over the agreed business cases and their outcomes achieved.

HTB
19/040

INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT

KM introduced the report which detailed the Trust's key performance indicators for the period ending February 2019.

LK reported that the A&E four-hour target in February delivered at 79.1% which demonstrates significant deterioration in performance, reflective of the pressures currently in A&E. She recognised that the service is

AGENDA DISCUSSION
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currently not to the standard that the Trust would like offer its patients. Whilst it is hoped the Trust can achieve the target at 95% and above next year there are pockets that make this difficult. For example ED minors is underperforming against that target at 93.8%. There is a challenge on patient flow within the hospital and Trust Board was reminded that extra capacity has been opened and there are also nearly 200 stranded patients currently in the Trust.

The number of Delayed Transfers of Care (DTOC) has increased due to the Community Neuro Rehab Team (CRNT) beds which currently have a 40 day wait. Early discharges are required and support is needed to increase the number of DTOC's. A pilot assessment model was undertaken during November and December and whilst this had been stopped it has been reviewed and reinstated.

There are currently 80 patient medical outliers within the Trust which is good in comparison to previous years. EMS advised that these patients have been discussed at Quality Governance Committee (QGC) but he was concerned that this number of patients represents 7- 8 wards. He further queried the quality of care provided to these patients but recognised the stranded patients should not be in a hospital environment and suggested that this should be raised as a concern to the STP.

LK advised that there had been a rise in ambulance attendances equating to approximately 200 ambulances per day. There has been a rise of 50% in ambulances from East Midlands Ambulance Services (EMAS) and further work is required to understand what is going on locally and nationally to understand these pressures.

She was pleased to report that there were no 52 week waits and the teams were working to maintain this.

RTT performance during January was at 84.6% against the national target of 92%. Whilst this target had not been achieved, in comparison to last year it has improved.

The 62-day cancer target was not achieved at 81.4% for January and it is hoped the team can deliver the national target again before April. The underperformance has been driven by pockets of underperformance by the urology and gynaecology teams. LK confirmed the new starter for gynae/oncology has begun and is bringing new ideas and suggestions to the team. She assured Trust Board that the urology team have been engaging well and have held a Perfect Week on the robot which went well.

LK was pleased to report that the two-week wait cancer and six-week diagnostics performances were being delivered.

In answer to IB's query regarding urology, it was explained that the Trust

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continues to work with Worcestershire Acute Hospital for specialist referrals. Alongside AH and JR, LK has met with the urology team and they are supporting working in partnership with this trust.

RdB advised that the published HSMR score is 96.1 which is below the 100 index standard. The SHMI score was higher than expected at 112.03 and it is thought this has been affected by the sepsis pathway and better coding with accurate data.

He finally informed Trust Board that the complaints performance had deteriorated further due to a number of challenges with increased complexity and pressures of the team due to sickness levels. EMS assured Trust Board that a lengthy discussion had been held at QGC and that this was being monitored.

GS gave assurance that as part of the process to improve the quality of responses the team were liaising with complainants to understand their particular concerns and outcomes they are seeking to be addressed. DP was assured that the Trust received very few car park related complaints and this issue did not present a large amount of complaints received.

NM was pleased to inform Trust Board that the harm free indicators had performed well over 2018/19 and this remains above the national target at 96.2%. This demonstrates that catheterised UTI remains to be managed and grade 3 pressure ulcers have reduced.

SR informed Trust Board that there was a £31.7m deficit at month 11, 15.9 adverse to plan. The forecast position for the year end remains at £33.6m deficit and NHSI are holding the Trust to this.

The agency run rate is holding at £21.6m actual spend year to date against a profile of £19m. It is expected that this will be slightly over the target by the end of the year but it was reminded that extra capacity had been opened earlier in the year.

One key risk to the Trust is the current arbitration process with NHS Coventry and Rugby CCG (CRCCG) which a degree of risk has been factored into the 2019/20 contract. A decision will not be made on this until May. The non-executive directors were disappointed that the decision would not be made until May considering the Trust has delivered responses to the requests for information from NHSI and NHSE without delay. It was recognised that this delay may have an impact on approving the annual accounts.

SR also advised Trust Board that it was not yet known if the Provider Sustainability Fund (PSF) currently withheld from those organisations missing the performance targets would be distributed at year end as a bonus to trusts achieving their control total. However, this is only likely for

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trusts who can demonstrate financial control and high level efficiency.

SK enquired how much CRCCG spends on private providers and was advised that this is very little at approximately £8m. LK reminded Trust Board that there are nationally a low proportion of mental health beds held and CCGs are trying to resolve this. NM further reminded that tier 4 beds were highly specialised and none were available nationally with a number being closed down.

KM informed Trust Board that she has a concern regarding the sickness rate which has increased to a little over 5%. She assured them that work is being undertaken to identify areas within both staff and Clinical Groups and aims to reduce this figure by 1%.

Mandatory training has been previously discussed by Trust Board and its sub-committees and it was again recognised that the Trust has set itself an ambitious target. KM informed members that non-compliance by bank staff remains a challenge but this is no longer acceptable and that by May if this training has not been completed, individuals will be removed from the bank. However she noted that this is a capacity risk for the Trust. Whilst mandatory training is now required to be completed by staff to retrieve their step change (increment) under the revised Agenda for Change terms and conditions, it is not known if this will impact the completion rates. KM further advised that direct line managers will not receive their step change if staff have not received an appraisal or are up to date on their mandatory training, further driving mandatory training to be completed.

Trust Board was also reminded that one of the CQC requirements relating to mandatory training was for the workforce team to understand the staff compliance rates achieved and gave assurance that the team had completed this. It was further noted by Trust Board that other trusts rated as outstanding had lower mandatory training completion targets which seems to be an inconsistent approach.

The Trust **RECEIVED** the report.

HTB
19/041

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

GS introduced the report that presented the Trust's Board Assurance Framework and the high scoring risks on the Corporate Risk Register.

There are six key BAF risks which have been reviewed by the Risk Committee in March. The Committee recommends to Trust Board that the likelihood score for BAF 6: Integrated Care decreases from 12 to 8 on the basis that the Provider Alliance had been established and the ICS for Coventry and Rugby 'place' had also been established.

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JR provided assurance that the score for BAF 6 should be reduced because Professor Chris Hamm has been appointed who is focusing on moving the patient and community together and undertaking broader engagement within the community by better engagement via the ICS.

GS further confirmed that following the Internal Auditor's recommendation to capture the assurance controls, this is being recorded and the process has been reviewed by the Audit Committee in February.

The Corporate Risk Register provided details of the five high scoring corporate risks and GS gave assurance to the Trust Board that these are being managed by the Risk Committee.

Trust Board debated whether the score for BAF 6, integrated care, should decrease to reflect the current assurance and that the score could be increased at a later stage if work on the priorities across Coventry and Rugby is not delivered.

The Trust Board **RECEIVED ASSURANCE** from the report and **AGREED** to decrease the score for BAF 6: integrated Care from 12 to 8.

HTB
19/042

INFECTION PREVENTION AND CONTROL – QUARTER 3 REPORT

NM presented the quarter 3 report providing assurance that the Trust continues to perform well against the nationally reported criteria for infection control.

She was disappointed to report that there had been one MRSA case reported during December following 19 months since the last instance was reported. She explained that the case relates to a delay in taking blood culture thus being determined as hospital acquired. However, despite this one case the Trust remains eighth nationally out of the 43 large acute trusts.

There have been 27 cases of clostridium difficile reported and it is envisaged the Trust will hold its position under the NHSI ceiling of 41 cases. The Trust is the third best performing large acute teaching trust.

RdB has been leading improvements in sepsis management and screening within the Emergency Department. He reported that there have been challenges to embed the changes within the clinical teams but things are now moving forward.

The non-executive directors were keen to understand if there was a real increase in sepsis cases or if this is more awareness driven by media coverage. RdB advised that there had been a national drive on sepsis management following a number of high-profile cases which have highlighted the need for more rapid treatment with antibiotics provided

AGENDA ITEM	DISCUSSION	ACTION
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within the first hour.

RdB provided assurance that all of the teams are aware of the requirements for providing antibiotics in the first hour. They are also fully supported by the Sepsis Team and trolley.

Trust Board **RECEIVED ASSURANCE** from the report.

HTB 19/043	SERIOUS INCIDENT AND NEVER EVENT REPORT	
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RdB introduced the report which included a summary of the Serious Incidents that were reported in the previous four months.

There has been an increase in the number of incidents in the category Treatment Delay for Ophthalmology regarding a backlog of appointments. These patients are reviewed to identify if there has been harm equating to deterioration in their sight. This backlog was identified in 2018/19 and a review of the patients has been completed. He further confirmed that these patients have been reported as a Serious Incident (SI) and Root Cause Analyses (RCA's) have been completed and duty of candour conversations have been held with the patients. Any additional cases will be added to the revised plan.

RdB further informed that there are five RCAs outstanding within Ophthalmology taking their overall total to 21.

There continues to be no never events being reported by the Trust in this financial year.

Outstanding actions relating to SIs have reduced over the last two years but there has been a setback in the last four months which may relate to the implementation of the new group structure. Assurance was given to Trust Board that these are still being picked up at both Accountability and Quarterly Performance Meetings.

Trust Board **RECEIVED ASSURANCE** from the report.

HTB 19/044	MEDICAL EDUCATION REPORT	
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RdB welcomed SS to the meeting to present the recent progress that has been made. He firstly thanked Trust Board and the teams for their support and progress that has made over the last three years.

He confirmed that the final report from Warwick Medical School following their inspection has been received. Some of the positive points to take forward include:

- Clear engagement with Trust Board

AGENDA ITEM	DISCUSSION	ACTION
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- The feedback ratings
- Restructure of Clinical Fellowships, and
- Working closely with Warwick Medical School

Some of the concerns raised include:

- The level of engagement from the key leaders and wider consultant body, and
- The booking of rooms and Wi-Fi issues

Health Education England West Midlands (HEEWM) will no longer fund the Anatomy teaching provided to the first year students at WMS. Funding for first year medical education is paid to the medical school and a fairer way of funding is needed for the medical school.

Following the restructure in the Trust, SS has lost the Undergraduate Lead however a replacement is to be appointed.

He further confirmed that the letter from the GMC confirmed to the Trust they will no longer be monitoring the training provision with Acute Medicines following actions taken by the Trust to improve the service.

In response to BS' query, he advised her that the Medical Education Strategy will take into account the University plans and shift in funding. The strategy will be presented at the next Trust Board meeting. SK requested that this strategy should provide more ambition and opportunity to work on a centre of excellence.

SS further informed Trust Board that with the current workforce issues there is more of an emphasis upon coaching and strategic partnerships. He confirmed the Trust has signed a memorandum of understanding (MOU) with both Manipal Academy of Higher Education and Amrita Institute of Medical Science. LK was pleased and highlighted that this also provides an opportunity for the Trust workforce.

SS advised that there is a Doctor to Supervisor challenge with the number of Doctors becoming more challenging and asked if this job planning should be conducted as a team rather than individuals. KM confirmed that this could be explored alongside staffing and workforce issues during a session with TDG.

Trust Board **RECEIVED ASSURANCE** from the report and **REQUESTED** that staff workforce be explored in a TDG meeting.

**HTB
19/045**

GUARDIAN OF SAFE WORKING HOURS ANNUAL REPORT OCTOBER 2017 TO DECEMBER 2018 AND TRIMESTER REPORT OCTOBER 2018 TO JANUARY 2019

AGENDA DISCUSSION
ITEM

ACTION

RdB welcomed AR to the meeting to present the report to provide assurance that Junior Doctors in Training are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

In comparison to similar local trusts for example Nottingham University NHS Trust, the Trust compares well. During October 2018 and January 2019 there were 32 Exception Reports (ER) raised. Over the year, October 2017-2018, there were 230 ERs raised in total of which 21 remain unresolved.

AR advised Trust Board that there are now fewer ERs. Of those reported, they were as a result of long working hours due to increased workload, unable to handover and unfamiliarity of the ward.

There are 40 cases logged as 'pending' of which some have been reviewed but not updated correctly on Allocate. AR enquired about the next steps for the ERs that still require a review, despite the email reminders. It was requested that he discussed this further with RdB and KM.

There have been no work schedules reviewed during the period covered by the Trimester Report. The previous report detailed a high number submitted by F1 Doctors in Surgery which reported that they were unable to finish work on time. As a result of this, SS confirmed that they are now handing over outstanding tasks to the HPB ANS team.

HEE filled their GP trainee placements in August 2018 which may have improved staffing levels. The Rota Team are now identifying unfilled slots earlier so that they can be covered by locums more reliably.

AR also informed Trust Board that the WTR opt-out forms require completing in the absence of an electronic rostering software. The forms need to be completed by the Juniors to state they opt-out of WTR.

Trust Board **RECEIVED ASSURANCE** from the report.

HTB
19/046

CALDICOTT GUARDIAN ANNUAL REPORT

GS presented the annual report for 2018/19 which described the work that has been undertaken by the Caldicott Guardians during the year.

GS advised that the report includes the self-assessment against the Caldicott Guardian checklist of improvements to undertake. The actions included:

- Placing telephone calls to switchboard to ensure the call is redirected appropriately and to the correct person
- A separate Caldicott Guardian email address

AGENDA ITEM	DISCUSSION	ACTION
HTB 19/047	<p>Further developments are planned for 2019/20.</p> <p>Trust Board RECEIVED ASSURANCE from the report.</p> <p>NHS STAFF ATTITUDE AND OPINION SURVEY RESULTS</p> <p>KM introduced RM to present the detail of the results of the staff survey which was undertaken during 2018/19. The report also included the benchmarking data.</p> <p>Nationally, there were 29,120 members of staff participating in the staff survey. The survey was conducted online and to mitigate this challenge a number of one stop clinics were held for people to attend. Across the ten themes, significant improvements have been made in the Quality of Care, Safety Culture and Staff Engagement themes.</p> <p>Within the benchmark data, the best scoring areas were Safe Environment, Safety and Staff Engagement. The areas showing a dip in the results are Equality and Diversity regarding career progression and promotion, Bullying and Harassment and Health and Wellbeing. An action plan has been developed to start improving in these three areas.</p> <p>The results are to be shared with the Clinical Groups, however it was to note that the teams have realigned to the new structure and the survey cannot be amended to reflect this. Trust Board were assured that the Group actions would not be lost and Groups are being requested to resubmit their action plans and present these to Chief Officers' Forum in July. Trust Board was further assured that the Clinical Groups were taking this seriously.</p> <p>NM stated that she was pleased that there was no reporting of violence within the survey. This was a concern raised 18 months ago and it is reassuring that the environment created for staff to work in is safe.</p> <p>DP gave consideration to the Freedom to Speak Up Guardian and the Confidential Contact roles having a link to improving the results.</p> <p>JWG enquired about the quality of staff appraisals. She was advised that a revised process is in place that links to the Trust's talent rating.</p> <p>The Trust Board RECEIVED ASSURANCE from the presentation.</p>	
HTB 19/048	<p>ESTATES STRATEGY MARCH 2018 – 2021</p> <p>LK introduced the Estates Strategy 2018-2021 which requires Trust Board approval.</p> <p>The Strategy supports the Trust's plans for its future development of services and links together current projects with planned investment</p>	

AGENDA ITEM	DISCUSSION	ACTION
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priorities and work streams. LD confirmed it takes into account current and past requirements whilst ensuring the Trust's estate is fit for purpose and has the ability to support services with the changing demand for healthcare.

LD advised Trust Board that the strategy was written with flexibility to allow future consideration on how to utilise the Trusts' estate from an STP perspective, the outliers of Model Hospital and Carter Metris.

LD reminded Trust Board that the combined heat power business case was recently approved which will have a significant impact for the Trust as well as an £780k investment to replace all lighting to LED at St Cross Hospital.

DP enquired about the improvements to the Trust's buildings immediately and in future years. LD advised that the STP focus is influencing this and that there will be no more new builds but a review will be held on the existing estate to utilise these more.

LD advised of a key risk relating to the backlog of the estates maintenance not being completed which could see the Trust's estate deteriorate further with a lack of capital to maintain this. NM advised this was discussed regularly at the Infection Prevention and Control meetings concerning the risk around infection.

Trust Board **APPROVED** the Estates Strategy 2018-2001 and for a copy to be sent to NHSI.

HTB 19/049	MATERNITY SAFETY REPORT	
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NM introduced AT and SK to present the report which requires Trust Board approval. The report documents an overview and update on maternity safety within the Trust against the Clinical Negligence Scheme for the Trust's Maternity Incentive Schemes.

NM further informed Trust Board that a deep dive is scheduled to be received by Quality Governance Committee in April.

AT advised that the report included the Patient Safety Action Plan and evidence of its achievement against these ten points.

She advised that a range of actions have been implemented for safety including the bi-weekly production board meetings which are attended by both NM and RdB. She assured Trust Board that concerns were regularly raised at this meeting which demonstrates staff have been empowered to speak up about safety.

Both AT and SK gave assurance that whilst only 77% of the action plan is completed the remainder will be achievable by July. EMS advised Trust

AGENDA ITEM	DISCUSSION	ACTION
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Board that the Quality Governance Committee has received assurance for its completion.

AH reminded Trust Board that the CQC will be returning to inspect the Trust, anticipated by August. This was one of the areas which did not achieve 'good' for the CQC safe domain and all actions identified are to ensure that a rating of 'good' can be achieved. AT assured him that the Must Do actions will be achieved. There has been a large recruitment campaign and the Trust is working with NHSI on the retention scheme.

AH referred to the staff survey results and was assured that this data is being triangulated with patient experience feedback.

Trust Board was further assured that staff were more informed with the discussion and circulation of daily brief, staffing graphs are visible on the huddle board and the number of new staff starting is more transparent. Therefore AT was confident staff knew what was going on. SK supported this and advised Trust Board that people are requesting to work at the Trust in particular because of the research and development into miscarriage.

Trust Board **SUPPORTED** a deep dive by Quality Governance Committee in April and **RECEIVED ASSURANCE** from the report presented.

HTB 19/050	FIT AND PROPER PERSONS
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GS presented the report which gave assurance that members of the Trust Board are compliant with the requirements of the Fit and Proper Persons Test.

Whilst the Trust undertakes a range of pre-employment checks as part of the recruitment process, as part of regulation 5 of the Care Quality Commissioner's fundamental standards, Trust Board members are required to submit their compliance. GS confirmed that a signed declaration form has been received from all Trust Board members.

Trust Board **RECEIVED ASSURANCE** from the report.

HTB 19/051	DATA SECURITY AND PROTECTION TOOLKIT
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LK introduced the report which provided a copy of the Data Security and Protection Toolkit which is to be submitted by 31 March 2019. The DSP is an online assessment tool which replaces the former IG Toolkit. The report measures the Trust's compliance against law and central guidance and assesses information is handled correctly and protected from unauthorised access.

GS explained that whilst the Trust had met 9 of the 10 mandatory

AGENDA ITEM	DISCUSSION	ACTION
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assertions in the DSP Toolkit compliance to training was still outstanding at the time of the audit. GS provided assurance that the training has subsequently been achieved by the Trust at 95.1%. He acknowledged a lot of hard work has been conducted by the IG team to achieve this.

Trust Board **APPROVED** the submission of the DSP Toolkit once the outstanding evidence relating to training has been updated.

HTB 19/052	UHCW CHARITY NOMINATION
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AM provided a verbal update to Trust Board that in anticipation that he will be leaving the Trust within the next 6 months, a Trust Board member will be required to sit on the Trust's Charity.

BS had previously agreed to be nominated and she confirmed she remained committed to undertake this role.

Trust Board **SUPPORTED** BS to replace AM on the UHCW Charity Board following his departure within the next 6 months.

HTB 19/053	TRUST BOARD WORK PROGRAMME 2019-20
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GS presented the proposed work plan which detailed the plan for business to be taken during 2019/20.

The Trust Board **AGREED** to the 2019/20 work plan.

HTB 19/054	ITEMS DELEGATED TO COMMITTEES
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There were no items delegated.

HTB 19/055	AUDIT COMMITTEE MEETING REPORT FROM 21 FEBRUARY 2019
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The Trust Board **RECEIVED ASSURANCE** from the report.

HTB 19/056	QUALITY GOVERNANCE COMMITTEE MEETING REPORTS FROM 18 FEBRUARY 2019 AND 20 MARCH 2019
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NM advised that there was a paragraph regarding MRSA which was factually incorrect. This should have read:

The MRSA case recognised was attributed to the Trust through lack of screening whereby the sample was tested 72 hours after the patient had been admitted. It was confirmed this has been identified as a community acquired infection'.

The Trust Board **RECEIVED** the reports and the **REVISION** to February's report.

AGENDA ITEM	DISCUSSION	ACTION
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HTB 19/057	FINANCE AND PERFORMANCE COMMITTEE MEETING REPORTS FROM 20 FEBRUARY 2019 AND 20 MARCH 2019	
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The Trust Board **RECEIVED ASSURANCE** from February’s meeting. The meeting scheduled for March was cancelled owing to lack of quoracy.

HTB 19/058	ANY OTHER BUSINESS	
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AM advised that this was DP’s last meeting and thanked him for his support and contributions made to Trust Board and committees.

AH notified Trust Board that he would be attending an event to celebrate the life of Professor Lord Kumar Bhattacharyya.

HTB 19/059	QUESTIONS FROM MEMBERS OF THE PUBLIC	
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There were no questions raised.

HTB 19/060	DATE OF THE NEXT MEETING	
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The next Public Trust Board will be held on Thursday 30 May 2019 at 10.00am in the Clinical Sciences Building, University Hospital, Coventry, CV2 2DX.

SIGNED
	CHAIRMAN
DATE

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
30 MAY 2019

The Trust Board is asked to **NOTE** the progress with regards to the actions below and to **APPROVE** the removal of those that are marked completed.

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
There are no outstanding actions					

REPORT TO PUBLIC TRUST BOARD

HELD ON 30 MAY 2019

Subject Title	Chairman's Report
Executive Sponsor	Andrew Meehan, Chairman
Author	Andrew Meehan, Chairman
Attachments	None
Recommendation(s)	Trust Board is asked to RECEIVE ASSURANCE from the report.

EXECUTIVE SUMMARY

To update the Trust Board of the key details of meetings and events attended by the Chairman.

The key meetings and areas of interest since the previous Board meeting were as follows:

- Met with Kiran Patel (the Trust's new Chief Medical Officer)
- Attended the presentation and 'thank you' celebrations in regard to the Half Marathon
- Attended the UHCW Charity Board of Trustees meeting
- Attended the Extraordinary Audit and Trust Board to sign off the Annual Report

PREVIOUS DISCUSSIONS HELD

None

KEY IMPLICATIONS

Financial	None
Patients Safety or Quality	None
Human Resources	None
Operational	None

REPORT TO PUBLIC TRUST BOARD

HELD ON 30 MAY 2019

Subject Title:	Chief Executive and Chief Officer Updates
Executive Sponsor:	Chief Officer's
Author:	Andrew Hardy, Chief Executive Officer
Attachments:	None
Recommendations:	Trust Board is asked to RECEIVE ASSURANCE from the report.

EXECUTIVE SUMMARY:

This paper provides an update to the Board in relation to the work undertaken by each of the Chief Officers each month and gives the opportunity to bring key issues in relation to areas within their respective portfolios and external issues to the attention of the Board.

Each of the Chief Officers has provided brief details of their key areas of focus during April and May 2019.

Mr Andrew Hardy – Chief Executive Officer

Meetings attended:

- Attended the Celebration of the life of Professor Lord Kumar Bhattacharyya
- Attended the Quarter 4 Performance Reviews for all Groups
- Attended the UHCW / CWPT Board to Board meeting
- Attended the Health and Well-Being Board meeting at Coventry City Council
- Attended the CIPFA Board and dinner in London
- Attended the West Midlands Provider CEO Meetings
- Attended the Blooming with Pride 2019 event at University Hospital
- Participated in “A day in the life of Chaplains”
- Attended the Progress Review Meeting with NHSI
- Attended the West Midlands Academic Health Science Network (AHSN) Board Meeting in Birmingham
- Attended the Transformation Guiding Board Meeting in London
- Attended the Leading Together, Service Leader Cohort 16 (Residential 2) Q&A session
- Attended the Health Partnership Board
- Attended the CIPFA Board meeting in London
- Attended the Public Finance Awards Dinner and presented an award
- Attended the NHS Elect - Reflections on delivering integrated care in the NHS event and NHS Elect Advisory Board in London
- Attended the launch of the Nursing and Midwifery Strategic Plan
- Attended the Dr Robert Livingston events in London
- Attended the Learning Set Future Vision Alumni event in London
- Facilitated a Thought Leadership Event: UHCWi - Our Partnership with VMI

Consultant Appointments:

Through the nominated Chief Executive Representative and other Committee Members, the Trust Board is advised to note and ratify the following appointments:

Appointed Candidate	Consultant Position
Dr Vincent Leung	Consultant Clinical Radiologist with an interest in both Gastrointestinal Imaging and Nuclear Medicine
Dr Nikhil Rao	Consultant Clinical Radiologist with an interest in both Gastrointestinal Imaging and Nuclear Medicine
Mr Nick Maycock	Consultant Ophthalmologist with Special interest in Cornea
Mr Mrinal Rana	Consultant Ophthalmologist with Special interest in Cornea
Dr Hannah Tween	Consultant Clinical Oncologist
Mr Altan Omer	Consultant Urologist
Dr Amrit-deep Samra	Consultant Neurologist with a special interest in Movement Disorders

Karen Martin – Chief Workforce and Information Officer/ Deputy CEO

I have attended all the usual Chief Officer meetings including COG, QGC, F&P and TDG. I have also chaired Strategic Workforce Committee, Partnership Engagement Forum, VSST for Simple Discharge and Transforming Workforce Supply Committee. Other commitments included:

- C&W LWAB meeting in Nuneaton
- Consultant Clinical Oncologist Interview Panel
- Blooming with Pride Event at UHCW & Rugby St Cross
- Joint Nurse & WF Forum
- RPIW Exec Sponsor week
- Leadership Transformation Board, Birmingham
- Interview panel for Group Head of Workforce
- HRBP quarterly meeting
- Thought Leadership Event
- Better Health Better Care Better Value (STP) Board meeting
- Leading Together, Orientation & Residential events
- Workforce 2019: supporting our future NHS
- Tour of Coventry University New Health Building with Sarah Baxter
- Clinical Leadership Meeting with Warwick Business School
- Nursing and Midwifery Strategic Plan Launch
- Buckingham Palace Event
- Understanding & Addressing Racial Inequality with Prof Livingston
- HRD network chairs conference call
- Coaching/Mentoring sessions
- West Midlands HRD meeting, Birmingham
- West Midlands HRD Teleconference
- Lead for HEE Improving Patient Care and Quality of Healthcare Education

Communications

- In May the communications team launched our annual **Outstanding Service Contribution Awards** which recognise the excellent work delivered by staff. Deadline for nominations is 16th June with an awards ceremony Friday 20th September 2019.
- We continue to improve internal communications across UHCW and our recently relaunched weekly e-bulletin *This Week@UHCW* now includes **news updates led by each Clinical Group area** so we can improve 'operational' communications.
- Our fourth monthly Team Brief, **UHCW Brief**, is gaining momentum with excellent feedback for both the actual process but helpful messages and questions coming back to the UHCW leadership teams used to inform and improve our communications.
- Externally the Trust is investing in some streamlining and making **improvements on its**

popular website to enable patients to find essential information.

Equalities and Diversity

- **Disability Confident** (previously Two Ticks): As a Trust we currently at Stage One (Committed.) Work has commenced to achieve Stage Two (Employer) with a view to achieving Stage Three (Leader) within the next 12 months.
- **Race at Work and Gender at Work Summits**– Head of Diversity attended 2 summits looking at identifying and addressing issues relating to Race and Gender at work. Presentations and workshops from predominantly private sector provided an insight into how they have tackled inequality within their organisations.
- **Independent Advisory Group (IAG)** – Meeting took place 13th May. Presentation by Overseas and Private Patients Manager. Membership now includes Macmillan Information and Support Manager and Health and Wellbeing Manager

Performance and Informatics

- The **Performance Team** have supported monthly accountabilities through effective agenda setting and focused information packs to support delivery. The new performance dashboards aligned to groups have now gone live.
- The **Analytical Team** have been focussed on productivity schemes through effective performance reports and KPI development. Seasonal RTT analysis continues to be a key focus and has been demonstrated at national forums.
- **Elective Care Validation Team** continues to support the RTT validation across the Trust on a daily basis. A key area of work is the follow up position for the trust with key processes and management being developed by the team.
- The **Information Systems Development Team** has completed the development work on **InSite** and across all data to ensure all items are represented aligning to **new groups**.
- The **Information team** continue to ensure national submissions are completed in a timely manner. Further work continues on **data quality processes** and SOPs.
- The **Clinical Coding Team** has managed the deadline effectively throughout April. The team have also **planned effectively** to ensure robust training courses and development throughout the year to manage the deadline throughout FY19/20. **Clinical Engagement** and development of new ways to ensure accurate data capture continue.

Workforce

- The Payroll team have completed the 3 year cyclic **pension auto re-enrolment** process for 445 eligible staff.
- The Trust is going live on 1st June with an **e-Expenses solution** called EASY. It is a web-based system, accessible on any device and staff enter details of mileage and expenses, which directly interfaces with Electronic Staff Record (ESR). A range of training dates, guides and video tutorials are being arranged to support the implementation.
- Temporary Staffing Solutions (TSS) continues to successfully negotiate transfer of **agency workers** to our internal bank, with 7 individuals joining us this year so far.
- To support our recruitment drive, we are currently working with M3 which is an organisation which allows us to advertise and **promote our Medical & Dental vacancies via Doctors.net.uk website**. They currently have 3,989 'active' users within a 30 mile radius of the Trust across all specialties, with this increasing to 7,133 users within a 50 mile radius. We are currently developing our web pages and sending out surveys to their users with the aim to commencing advertising via the platform in late July 2019.
- We continue to implement the new **AFC pay arrangements** and only those staff that are 100% compliant with their statutory/mandatory training and have had an appraisal in the past 12 months are receiving their pay-step (previously known as increment).
- On 8th May 2019 we held a successful **Staff Health and Wellbeing event** at the University Hospital. The event, which forms part of our wider health and wellbeing programme, was

attended by hundreds of staff and provided staff with awareness of the physical, emotional and financial well-being interventions across the Trust and on the day access to personal health checks delivered through our Occupational Health Service.

- In May 2019, we were successful in gaining **SEQOHS (Safe Effective Quality Occupational Health Service) re-accreditation**, a formal occupational health quality standard.

Transformation:

ICT

- The roll-out of the **Managed Print Service** has concluded at Rugby with 59 devices being installed and a lessons learnt review will be undertaken before the roll-out on the Coventry site commences.
- **Digital letters improvement:** Technical development work to enable the Docman Connect subscribe service to be implemented has resulted in an additional 10,000 letters per month being sent digitally to our out of area GP's in addition to the 80,000 letters that already go via this method to Coventry and Warwickshire GPs.
- The **Vitalpac Alcohol assessment** is now live in Emergency Department and work is well underway to introduce the Smoking Cessation assessment which will contribute to the delivery of the associated CQUIN.
- **Information Sharing agreements with prisons** have been put in place to allow staff at Onley and Rye Hill prisons access to CRRS.
- Technical assistance and support was provided to enable completion of end-to-end testing for the Implementation of the **Faecal Immunochemical Test (FIT) in the NHS Bowel Cancer Screening Programme**

Enablement

- Work continues to implement Trust's project management system, UHCW Greenhouse with plans in progress to replace our Cost Improvement Programmes database with supportive training sessions.
- The team are supporting implementation for Trust-wide Waste Reduction programmes
- Recruitment to the team has been successful with four appointments arriving in June/July.

Innovation Team

- Joseph Hardwicke, a plastics consultant was appointed as UHCW's **Clinical Innovation Lead** and started 7th May 2019.
- Following success at UHCW Innovation Den, we have been **supporting Peter Ward with his e-rostering swap doc innovation** by enabling his participation in an Academic Clinical Fellowship between Acute Medicine and Innovation. He will complete a Master's degree in Digital Health and complete his project work with the Innovation Team.
- **Secured grant sponsorship** from Pfizer for an Oncology Chatbot, led by Dr Penny.

UHCWi

- Our improvement work continues with a Rapid Process Improvement Week (RPIW) held in **Simple Discharge** in April looking to test improvements for our acute medicine inpatients who need an ultrasound scan. The initial testing led to a patient being safely discharged reducing time for an ultrasound. Satellite ultrasound room located near the Acute Medicine inpatient areas being tested.
- Next cohort of **Lean for Leaders** will be invited to introduction sessions in May.

Organisational Development

- **2018 Staff Survey:** Results and action plans have been published internally and presented at Trust Board, Chief Officer's Forum, JNCC, Strategic Workforce Committee, Trust Delivery Group and Trust Guiding Team. All Clinical Groups are developing action plans which will be published on the intranet and their progress for implementation presented at Chief Officer's

Forum in July.

- **Blooming with Pride:** On the 12th April 2019 we held two annual Blooming with Pride Events at University Hospital (12th April) and Hospital of St Cross (14th May). These events provided all staff with the opportunity to showcase the work that they are proud of.

EPR

- The initial stage of the EPR procurement completed on 2nd April. EPR Programme Board approved moving to the final stage with both suppliers (Cerner and Meditech). Clarifying any commercial and contractual issues.
- The Outline Business Case (OBC) was approved by:
 - 12th April – EPR Programme Board
 - 16th April – Chief Officer Group (COG)
 - 26th April – Trust Board
- Following which the OBC was submitted to NHSI on 30th April for approval along with the Trust responses to some initial informal feedback from NHSD.

Healthcare Worker Flu Vaccination 2018/2019 Overview

Total Uptake and Opt-Out Rates

In line with national definitions, 7074 staff at UHCW NHS Trust were classified as frontline Healthcare Workers for the purposes of the 2018/2019 campaign.

	Total numbers	Proportion
Number of frontline Healthcare Workers	7074	
Uptake of vaccine by frontline Healthcare Workers	5515	77.96%
Completed opt-out of vaccine by frontline Healthcare Workers	239	15%

High Risk Areas

These areas have been identified based on national guidelines. Throughout the campaign local management teams have been provided with up-dates on compliance levels and action required.

Area name	Total number of frontline staff	Number who have had vaccine	Vaccination Uptake Level (5)	Number who have opted-out	Staff redeployment required
Haematology	98	66	67.34%	32	N
Oncology	111	76	68.4%	35	N
Neonatal intensive Care	84	48	57%	36	N

Opt-out Reasons

During the 2018/2019 campaign, individuals actively choosing to opt-out of the flu vaccination were requested to complete an opt-out form. During the campaign 15% of eligible staff completed an opt-out, with the rationale for opting out listed against the nationally determined categories. This information will be utilised both locally and nationally to develop communication campaigns for the 2019/2010 campaign.

Reason	Number
I don't like needles	54
I don't think I'll get flu	28
I don't believe the evidence that being vaccinated is beneficial	16
I'm concerned about possible side effects	109
I don't know how or where to get vaccinated	0
It was too inconvenient to get to a place where I could get the vaccine	0
The times when the vaccination is available are not convenient	0
Other reason	32

Actions Overview

The Trust made a commitment to achieve 100% compliance for all eligible frontline Healthcare Workers to receive the vaccination during the campaign. As outlined in November 2019 Trust Board Report, the Trust undertook several actions to support this ambition:

- (a) Executive Sponsorship and engagement of senior leadership teams
- (b) Dedicated Multi-Disciplinary Flu Working Group
- (c) Fortnightly Regular Reporting provided to Clinical Group Management teams
- (d) A dedicated communications campaign launched in August 2019 and running until February 2019
- (e) Increased accessibility through 122 peer vaccinators mobile/roving clinics, dedicated sessions at pre-existing events, drop-in clinics available within Occupational Health and utilisation of One Stop Clinics.
- (f) Use of incentives, including monthly prize draws sponsored by ISS.

Richard de Boer – Chief Medical Officer

Meetings to highlight (since 28 March 2019)

1:1 meetings with colleagues and consultants
7 Day Services Steering Group
Cardiac Services Meeting
Chairing Clinical Advisory Group
Chief Officer Forum
Chief Officers Group & COG Residential
Clinical Design Authority Executive Group
Consultant Interviews for Paediatrician and Neurosurgeon
Day in the Life – Outpatients
Health Partnership Board
Integrated Care Record Launch
Junior Doctor's Mess
Maternity Safety Champion meeting
Medical Efficiency WRP
Mortality Review Committee
Patient Meeting after complaint
Patient Safety and Clinical Excellence Committee
Patient Safety Review
Quality Governance Committee
Registrar Leadership Training
Risk Committee
Serious Incident Group
Strategic Trust Board
Telephone call with GMC ELA regarding a case
Thought Leadership Event
Trust Delivery Group
UHCWi Standup
VMI Sensei
VMI Trust Guiding Team
VMI Visit Debrief
Waste Reduction Board

This report summarises the activities and achievements in my portfolio since the previous Trust Board Meeting.

Research and Development

Following significant work to ensure appropriate governance processes were in place, the Trust's first phase I (healthy volunteer study) commenced. Following the first overnight stay of 2 participants, an external audit was commissioned: no serious breaches or critical findings were determined, recommendations for improvement have been reviewed and implemented.

Nic Aldridge (R&D Lead Nurse) and Liz Bailey (Midwife Research fellow) both secured places on the National Institute for Health Research '70@70' programme, which aims to increase capacity and capability of research midwifery and nursing. To get 2 of the 70 places available nationally is a big coup and will raise UHCW's profile at a national level.

A consortium led by UHCW cardiologists and an exercise physiologist has secured external funding with Coventry and Warwick Universities to evaluate the use of an exercise regime for patients with Postural orthostatic tachycardia syndrome (POTS).

We had to reapply to retain our National Institute for Health Research (NIHR) Clinical Research Facility (CRF) status. This was reviewed by an expert panel and we have received confirmation that the NIHR continue our designation for the next 3 years (and will provide an additional £515K).

Patient Safety and Risk

The end of year (2018/19) data for progress against the Quality Strategy is now published and the patient safety elements have seen statistically significant reductions of both hospital acquired pressure ulcers and falls with harm, further improvement work continues to sustain this improvement.

The team have presented at the Thought Leadership Forum to share the journey and learning from the Patient Safety Value Stream. The team have a number of external visits from other NHS Acute Trusts lined up in 2019 for those who wish to come and see the work of the Patient Safety Team and safety culture of the organisation at UHCW.

The pilot of Learning from Excellence continues, with a plan to implement trust-wide in 2019/2020. This is an initiative to report positive incidents, where good outcomes are achieved or staff provide a high standard of care in challenging circumstances. This can then be used to replicate the good care more often, or spread good practice.

Approval has been obtained from the Chief Officers Group to introduce Schwartz Rounds into the Trust. These are facilitated multidisciplinary meetings that encourage staff of all grades and professional groups to share stories around a common theme. Research has shown that they can lead to improvements in staff – patient interactions, multidisciplinary team working and a reduction in staff burnout. Funding has been obtained from the UHCW charity and facilitators are being recruited for training, with a staff awareness campaign to follow before the launch. This was shared at the Nursing and Midwifery Strategy Launch to engage staff in some of the ways we are working to support them.

Clinical Effectiveness

The Clinical Audit Team have helped ensure the Trust achieved 100% participation in the National Rheumatoid Arthritis Audit. As a result of the excellent participation the Trust also exceeded the threshold for receiving the best practice tariff, so patients are receiving the best possible care. The team has also been asked by the national body of the National Asthma Audit to share our good practice around the delivery of this audit, as we have achieved one of the highest participation rates amongst other trusts. The team are looking at ways to improve the delivery of the clinical audit programme within the Trust for the next year.

The Trust's mortality indicators HSMR and SHMI are now both reporting as within expected range for the latest data.

The Assurance Manager has been working with the Getting it Right First Time implementation team to support clinical teams in making improvements to patient care with progress being made in a number of implementation plans.

The Assurance manager for CQC has been working closely with clinical groups to progress the CQC action plan and support clinical groups in making improvements in their services. The Trust has also been welcoming Jacqui our CQC relationship manager to the Trust to visit and spend time with different services such as Urgent Care, Neurosurgery, Maternity, Outpatients, and the safeguarding team. Regular meetings with Jacqui are planned with more opportunities to showcase the care and services provided to patients at UHCW.

- The Trust achieved 100% participation in the mandated National Clinical Audit Programme during 2018/19.
- A total number of 372 actions have been fully implemented relating to clinical audit activity undertaken during 2018/19, resulting in improvements to practice.
- The Trust was reported as the 5th highest performing nationally in regards to our participation in the National Chronic Obstructive Pulmonary Disease Audit.
- Positive changes have been made to the way in which clinical audit performance is reported to clinical specialties. Reports are now automatically generated using data derived from the online Clinical Audit Database.

Patient Experience

Patient Experience of Care Week (22 – 26 April) was launched in the Involvement Hub on the 22nd April, a range of activities took place across the week which included a video sharing a powerful Patient Story which promoted the importance that effective communication has on patient experience. The fourth Trust We Care event took place in April at the University Hospital site. The event showcased improvements which have been made based on patient feedback.

The First Voluntary Sector Advisory Group Meeting took place 28 March, The meeting identified the range of voluntary sector organisations within the region, and highlighted the range of services that they can offer to patients and particularly after discharge, work is now taking place to look at how we begin to link the opportunities to UHCW patients.

The First Patient Partner Forum meeting took place 25 April, where members agreed the Terms of Reference and commenced the voting process for their first Chair and Vice Chair.

Two Patient Partners delivered a powerful presentation at the Thought Leadership Event this quarter which is further embedding patient voice at the heart of the Trusts Quality Improvement initiatives.

Medical Education

A number of key new appointments have been made. Dr Jacqueline Woodman has taken on the role of Trust Lead for Undergraduate Medical Education (TLUME) leading the Trust management of the Warwick medical school student clinical placements and education. Mr Kai Leong and Mr Devraj Srinivasmurthy have taken on the two Surgery College Tutor posts (SCT). Our thanks to Dr Pijush Ray (former TLUME) and Mrs Abigail Tomlins (former SCT) for the support they have given medical education during the challenges of the last 3 years, they have left the Directorate in a much stronger position than when they took on the roles. We wish them every success with their new roles as the Clinical Directors for Medicine and Surgery.

The full results of the Trainee and the Trainer GMC surveys are due to arrive within the Trust imminently, the survey closed on the 1st May. We will report the findings to the next Board meeting. The National students survey results are also due soon and again these will be reported as

soon as they are available.

The Affiliation agreement with the American University of Antigua has been signed and the University are now seeking approval from the American Education authorities for the placement of 24 students for an 8 week clinical elective starting this September. Our team is working on the pack of information that will be provided to students that will be sent off imminently and ensuring the time table does not impact our students and use the clinical facilities and resources more effectively.

The Trust is continuing to work with WMS and HEEWM to resolve the SIFT funding gap created by changes in apportioning of funds to different parts of the student programme. Part of the resolution is the need for the Trust to identify all elements of the training it offers and to have these captured in the WMS return to HEEWM.

Legal Department

The Legal Department during March and April 2019 received 19 new inquests cases. During this period there were no Prevention of Future Deaths Reports issued by Her Majesty's Coroner.

We reported 14 new clinical negligence claims to NHS Resolution.

Nina Morgan – Chief Nursing Officer

In addition to regular meetings, I have undertaken the following activities since the last Trust Board meeting held 28 March 2019

- Q4 Performance Reviews
- Corporate Nursing UHCW Brief Meeting
- West Midlands Provider and CCG Director of Nursing Meeting
- C&W LMS Board Meeting
- UHCW & CWPT Board to Board Meeting
- Mandatory Training
- STP Mental Health & Emotional Wellbeing Programme Board
- C&W LWAB Meeting
- CQC Check & Challenge Meetings
- Blooming with Pride 2019 Event
- Executive Genba Roundings
- Delivered Opening Address at Trainee Nursing Associates Group –Newly Qualified Event
- Delivered Opening Address at Children & Young People Engagement Day
- Joint strategy Meeting between UHCW/Coventry University
- Participated in Children in Crisis Escalation Teleconference
- Master of Ceremonies for International Nurses Day and International Day of the Midwife Celebrations at Coventry Cathedral
- Launched the Nursing & Midwifery Strategic Plan with support from CEO and CWIO.

Recruitment and Retention

- In 2018/2019 we recruited 320 nurses and midwives (against 2018/19 target of 310)
- HCSW recruitment was successful in February and we are expecting all to be commenced in post by June 2019.
- Our overseas recruitment campaign continues to be successful. There are presently 19 nurses working across the trust who are working towards their OSCE to become registered in the UK.
- A celebration event was held to congratulate UHCWs first cohort of Trainee Nursing Associates completing their foundation degree. Preparations are underway to prepare them for registered status.
- Open days for recruitment have been held at St Cross and UHCW sites.

Education & Research

- As a training placement provider for the Trainee Nursing Associate apprenticeship programme, Clay Lane Haemodialysis unit was visited by OFSTED inspectors to review clinical placements. Vicky Williams (Education Lead) and Practice Facilitators were interviewed as part of the inspection. The review was positive and the preliminary results are good.
- In order to prepare for the new role of Nursing Associate, a scope of practice document is in development detailing roles and responsibilities in line with the NMC standards of proficiency and HEE role recommendations. A bespoke preceptorship programme has also been developed in order to support the transition of our trainees into registered practitioners.
- Strategic partnership with Coventry University continues, and a new education governance document for all NMC approved programmes is in development.
- Vicky Williams presented a keynote speech regarding the possibilities of advanced level practice for nursing and midwifery at the Florence Network Annual Meeting conference, a European wide HEI conference which this year was hosted by Coventry University. Vicky has since been invited to Switzerland to speak at a conference on advanced practice.
- A multi-professional education sub group has been set up with representation from nursing, midwifery, therapies, dietetics, speech therapy, radiography and clinical scientists. This meeting is chaired by Vicky Williams and vice-chair is Clare Pheasant as AHP lead. The group discusses set items regarding: pre-registration governance, preceptorship, continuing professional development and advanced level practice. The group has reviewed new best practice guidance on preceptorship and has adapted current policy to be reflective of the new standards.
- The launch of the N&M strategy saw great interest in the first draft prospectus of training opportunities available at UHCW, and an updated improved version is already in development

Technology

- Implementation of NEWS2 trust wide including ED meeting national guidelines and timeframes
- Alcohol assessment on vitalpac has gone live in ED- alerts alcohol liaison team
- Vitalpac ED module has been implemented and gone live in ED urgent care- April 2019
- A project to deploy **Windows 10** to all Trust PCs and Laptops has commenced. A dedicated team are building the environment, supporting the testing of our applications and will start the rollout from Jan 19 for approximately a year. There are just over 5000 devices to update in this time. The new version of Windows will ensure that we are able to receive continued patches and support from Microsoft beyond Jan 2020 when Windows 7 will be end of life.

Lisa Kelly – Chief Operating Officer

In addition to the regular meetings such as, COG, Trust Delivery Group, COF, F & P, Quality Governance Committee, and Risk Committee, I have undertaken the following since the last Board meeting held on 29th March 2019

- Hosted Outpatient Waste Programme
- Hosted Theatres Waste Programme
- Attended Quarterly Performance Reviews
- Attended a meeting regarding GMTS expansion
- Met with Justine Richards regarding RSS
- Attended NHS Tackling & Undermining Bullying Event
- Met with Simon Holmes, Theatre Lead
- Continued monthly meetings with Jo Crinigan, Dementia Lead
- Attended UHCW/CWPT Board to Board
- Hosted WiC Contract Meeting
- Participated in AEC First Birthday Celebrations
- Hosted meeting regarding McKesson

- Participated in Consultant Interview Panel
- Hosted initial Recruitment Value Stream Sponsor Team Meeting
- Participated in Interview Panel for Director of Strategy & Integration
- Attended UHCW PRM
- Attended COG Residential
- Chaired Cancer Board
- Met with Chairman and Trustee of WSBB
- Attended Strategic Board
- Continued activity with global health by travelling to Somaliland
- Attended as panel member at IST panel
- Participated in Leading Together Q & A
- Hosted two participants from HOPE Exchange Programme
- Chaired Coventry & Rugby Local A & E Delivery Group meetings
- Oversight of Elective Care Board
- Oversight of Emergency Care Improvement Board
- Attended TGT meeting
- Attended Coventry & Warwickshire A & E Delivery Board
- Continued oversight of the organisational restructure
- Continued oversight of Brexit
- Hosted weekly huddles with Group Clinical Directors

Su Rollason – Chief Finance Officer

In addition to regular meetings, I have undertaken the following activities since the last Trust Board meeting held on 28 March 2019:

- Attended the Task & Finish Group meetings, chaired by David Moon, to review contracting for and funding NHS services
- Meeting with the C&R CCG around RSS
- External requirement meeting with KPMG
- Attended Finance Advisory Board meetings
- Attended the SW Midlands Provider Alliance Steering Group meeting
- Chaired the HFMA Healthcare Costing for Value Institute - Costing Conference on 10 April 2019
- Attended the Blooming with Pride event in the Innovation Hub
- Numerous stroke meetings / conference calls, including joint DOF stroke discussions
- Attended Session 3 & 4 of the Lean for Leaders Programme
- Financial Management Development Day – lead session to discuss financial priorities for 2019/20
- HTE Framework Review
- Attendance at Coventry Place Delivery Board meetings
- Internal meeting to discuss SLR packs
- Meeting with South Warwickshire CCG to discuss the Maternity and Paediatrics Programme Finance
- Chaired first Demand Management meeting
- Attended first meeting to manage the process / produce STP 5 year strategy
- Chief Officer Day in the Life - Interventional Radiology
- Understanding and Addressing Racial Inequality Event
- Blooming with Pride Event at St Cross
- Closure meeting with KPMG
- Chair - Healthcare Costing for Value Institute Council meeting
- Chaired meeting to Align Theatres VSST and Waste Reduction Schemes
- Photo call for Dementia awareness week
- Attended first meeting of the Waste Reduction Board (Vice Chair)

Contracting

- Extended WIC contract for further year. Sent performance notices to WIC
- Met with CCG for preliminary contract discussion around upgrade to UTC
- Agreed Specialised Commissioning Contract as well as Secondary Dental and Screening Contracts for Bowel, FIT programme, AAA.
- Quality Surveillance Information System responsibility transferred to Contracting.
- Joint CCG Trust working group set up to improve the LPP and Evidence based Procedures set up. Process mapping in progress
- Attended meeting with Group managers to explain new CCG contract and roll out of CQUINs
- CQUIN governance improvements. Leads and Clinical Directors formally signed up. Joint paper with Andy Smith to QSC 16/5/19

Financial Management

- Submission of the agreed Annual Plan April 2019.
- The implementation of the budgets for the new Group structure from April 2019
- Assisting in the completion of the working papers for the annual accounts
- Reviewing the Ward Establishment Rotas with Chief Nursing Officer in preparation of 2019/20 Budgets.
- Development of the reduction in reporting timetable from May 2019.

Financial Services

- Participated in meetings related to the implementation of an STP-wide finance and procurement system and internal meetings to progress testing of the upgraded finance and procurement system which is scheduled to go live at the beginning of June.
- Team members supported the quarterly Charity Trustee Board meeting.
- Team members supported meetings/teleconferences connected with the EPR procurement.
- Continued to support the Pathology Analyser Managed Service procurement and finalised witness statements for court proceedings to allow procurement to progress following a supplier challenge.
- Facilitated and attended monthly Capital Planning and Review Group meetings.
- Completed re-submission of the Annual Plan in early April.
- Submitted draft annual accounts on 24 April 2019 and met with external auditors upon commencement of the audit of the accounts.
- Participated in meeting regarding renal RO plant replacement.
- Participated in Director of Procurement interviews.

Procurement

- Provided targeted resource to support the Theatres Productivity Waste Reduction Programme
- Established the corporate support teams for waste reduction schemes for each clinical group (PDO, Finance, Transformation, Informatics)
- Pilot for device strategy commenced with community nurses
- Supported a successful Orthopaedics standardised theatre loan kit pilot, including loan kit database with a plan for wider rollout
- Attended Regional NHSI CIP Network Meeting.
- Directed across the organisation for the adoption of the UHCW Greenhouse (I-Nexus) system for the 2019/20 Waste Reduction Programme
- Supported Chief Officers in the design and planning of the trust-wide waste reduction programmes
- Review revised funding model summary from NHS Supply Chain
- Supported recruitment with the appointment of the Director of Procurement
- Oversight of the STP Finance and Procurement work streams and in particular the upgrade of the finance and procurement for all STP Trusts

Project Delivery Office

- Provided targeted resource to support the Theatres Productivity Waste Reduction Programme
- Established the corporate support teams for waste reduction schemes for each clinical group (PDO, Finance, Transformation, Informatics)
- Pilot for device strategy commenced with community nurses
- Supported a successful Orthopaedics standardised theatre loan kit pilot, including loan kit database with a plan for wider rollout
- Attended Regional NHSI CIP Network Meeting.
- supported the organisation for the adoption of the UHCW Greenhouse (I-Nexus) system for the 2019/20 Waste Reduction Programme
- Supported Chief Officers in the design and planning of the trust-wide waste reduction programmes

Justine Richards – Chief Strategy Officer

In addition to regular meetings, I have undertaken the following activities since the last Trust Board meeting held 28 March 2019:

- Participated in the Quarterly Performance Reviews (Q4)
- Chaired the Strategic Partnership Board meeting
- Participated on the interview panel for Consultant Ophthalmologist
- Met with partnership colleagues for discussion on Clinical Diagnostics Centre
- Attended the first Governance group meeting chaired by Sir Chris Ham
- Attended UHCW / CWPT Board to Board meeting
- Attended South West Midlands Provider Alliance Steering Group meeting
- Introductory meeting with Stephen Hildrew, Regional Director Partnerships, Siemens Healthcare Limited
- Attended Clinical Design Authority to prevent on Urology Network
- Hosted the Waste Reduction Programme: Agency Usage workshop
- Attended Coventry Out of Hospital Design Board
- Attended STP Planned Care Steering Group meeting with local health economy partners
- Attended the Blooming with Pride event
- Chaired the interview panel for the Director of Strategy and Integration
- Joined Chief Officer colleagues for Progress Review Meeting
- Joined Chief Officer colleagues for COG Residential
- Attended Sessions 3 and 4 (Cohort 15) of the Lean for Leaders programme
- Hosted the Children's ED Value Stream session with clinicians
- Chaired the Theatres Programme Board meeting
- Participated in the Coventry Health & Wellbeing Strategy Prioritisation Workshop hosted by Coventry City Council
- Attended Trauma & Orthopaedics departmental meeting
- Joined local health economy partners for meeting on Joint Transformation Programmes
- Attended Coventry Place Delivery Board meetings
- Met with local health economy colleagues for discussions on Maternity & Paediatric Services
- Attended 5 Year Planning meeting with local health economy colleagues
- Hosted the Children's ED Sponsor Development Session
- Attended Place workshops with key stakeholders from the local health economy as part of Coventry & Warwickshire STP's Estates Programme
- Attended a Population Health Management Summit facilitated by The Advisory Board
- Attended a Proactive & Preventative Enabling Delivery Group meeting
- Participated on the interview panel for Consultant Neurosurgeon
- Attended a Strategy Directors Network event facilitated by NHS Providers
- Attended meeting with local health economy partners to discuss the Coventry Frailty Plan

Acute Frailty Network

The Trust is continuing to work through the Acute Frailty Network (AFN) on developing its front door model for frailty. Training for ED staff commenced in May; to capture the baseline measure for frailty during June. This project is one stream of the Frailty programme being taken forward across the STP, specifically through our place partnership in Coventry and part of our joint programme with CWPT. A workshop is planned to take place with front line staff from across Coventry on 26 June, to bring together the key elements of the pathway work across acute, community and primary care.

Theatres Programme

Hybrid

The Hybrid Theatres project is progressing at pace. The following have been signed off:

- Clinical and strategic case for change
- Project objectives
- Options appraisal evaluation criteria Long list of Hybrid Theatre Options
- Short list of Hybrid Theatre Options

Two options have been short-listed; (a) Hybrid Theatre and a Standard Theatre; (b) two Hybrid Theatres.

Stakeholder and design team; has been working on the high level plan for the two options located within the theatre complex. An evaluation process to agree the preferred option is planned for 21 June 2019. An OBC is planned for presentation to the December 2019 Trust Board.

Rugby Interim Business Case – Update

The theatres at Rugby are now beyond their planned lifespan. An interim Rugby Theatres Contingency Business Case is being developed for submission to Trust Delivery Group (TDG) proposing a short-term solution for the lease of either one or two Modular theatres to be sited at Rugby. The purpose of which will be to act as a contingency to the risk of failure of the current theatres as well as the recent removal of the Vanguard theatre from the site. The case is due to be presented to TDG on 28 May.

Rugby Theatres Outline Case Development – Project Update

The Rugby Theatres project is moving forward with two site options being considered as possible locations for the new theatre development.

A design team has been commissioned to scope the feasibility of the potential sites for development of the new theatre block. A review and update of the schedule of accommodation to ensure fit with the current requirements of the development will be completed by end May. The Design team will then progress the development of the options in order to produce the OBC by February 2020 Trust Board.

There is now a piece of work in train across the STP to understand current theatre capacity requirements of the STP footprint; this outcome of which will underpin the business case for the Rugby Theatre development.

Faecal Immunochemical Test (FIT) Screening

The Trust has been working with NHS England to implement faecal immunochemical testing (FIT) to support bowel cancer screening. FIT replaced the guaiac faecal occult blood test (gFOBT) with effect

from April 2019. Essentially this is a more sensitive test that is easier for candidates to use. The objective is to improve bowel cancer screening uptake with new technology. The outcome will be an increase in the number of patients that require nurse assessment and subsequent colonoscopy with biopsy results for assessment and reporting.

The Trust has worked with NHS England to develop a business case to expand capacity to manage this increased demand. Additional resources include more nurse assessors; additional consultant sessions and an expanded histo-pathology workforce, has been funded in full by NHSE and a project team is in place managing implementation.

Lung Screening Pilot

The West Midlands Cancer Alliance has identified lung cancer as a priority within the West Midlands and C&W Cancer Group has proposed to the STP that a pilot proposal for lung cancer screening should be worked up. There are a number of pilots across NHS England including Stoke, Nottingham and Leeds.

At the request of C&W STP the Trust has prepared a pilot proposal; the purpose of the pilot is to identify patients with a confirmed lung cancer earlier in the patient's disease process, so that treatment can be initiated earlier and potential life expectancy post diagnosis increased.

The pilot will last 12 months from the start date this summer. Post pilot evaluation will include improvement in the proportion of patients with a lung cancer diagnosed at stage one or stage two as a percentage of all diagnosed lung cancers (in the target area); improvement in the proportion of patients diagnosed with a cancer via elective rather than emergency or non-elective pathways for the pilot area; acceptability and patient satisfaction of pilot screening for Coventry population; and finally the replicability and scalability of the pilot project.

Partnership

- **Better Health, Better Care, Better Value Board (BHBCBV)**

As previously reported, there are four "places" in our STP footprint, these being Coventry, Rugby, South Warwickshire and North Warwickshire. The STP will own the plan and vision, and 'Places' will take forward transformation work to suit their 'Place' population needs. The BHBCBV Board agreed that arrangements at Place level should not be prescribed by the STP but should reflect local requirements; this will form the basis of the 5 year system transformation plan being developed over the summer.

- **Coventry and Warwickshire Place Partnerships**

In Coventry, the Trust is working closely with the CCG, CWPT, Coventry City Council and Primary Care to develop a place based transformation programme built around the STP clinical priorities of Frailty, MSK and Mental Health. This will be the delivery mechanism for the work described above.

The current phase of work includes developing the governance structures, the programme plan and identifying the resources required to deliver the programme.

Similar groups are being developed in Warwickshire but are not as advanced at this stage.

- **Board to Board with CWPT**

A Board to Board meeting was held on 8 April to agree on joint working priorities. It was a positive meeting from which a set of actions were agreed and a follow up meeting will be convened in October to review progress against these. It was also agreed that the two executive teams would meet before this to identify a number issues to work towards, including outcome measures, Carter opportunities,

improvement methodologies, and joint board development activities etc.

Both Trusts agreed to work together on the three STP priority areas of Mental Health, MSK and Frailty, a follow up report will be presented at the Strategic Board in June.

Primary Care Engagement

The emergence of the national Primary Care Network (PCN) programme gives an opportunity for UHCW to strengthen its clinical links between primary and secondary care. The Trust is hosting an evening network event on 11 June to bring together the PCN Leads for Coventry and Rugby and the Group Clinical Directors to discuss the approach to more integrated care.

KEY IMPLICATIONS:

Financial:	None
Patients Safety or Quality:	None
Human Resources:	None
Operational:	None

REPORT TO PUBLIC TRUST BOARD
HELD ON Thursday 30 May 2019

Subject Title:	Integrated Quality, Performance & Finance Report – Month 1 – 2019/20
Executive Sponsor:	Karen Martin, Chief Workforce and Information Officer
Author:	Laura Crowne, Director of Performance and Informatics
Attachments:	Integrated Quality, Performance & Finance Report – Reporting period : April 2019
Recommendations:	For Noting
Trust Board is asked to review and note the contents of the report.	



EXECUTIVE SUMMARY:

The attached Integrated Quality, Performance & Finance Report covers the reported performance for the period ending 30th April 2019

The Trust has achieved 15 of the 35 ragged indicators reported within the Trust's performance scorecard. The Trust scorecard aligns Trust level indicators with the objectives outlined in the Trusts 2018-2021 Organisational Strategy.

Key indicators in breach are the Trusts performance against:

- Complaints Turnaround <= 25 Days
- Cancer 62 Day Urgent Referral to Treatment
- Emergency Care 4 Hour Wait
- Complaints Turnaround <= 25 Days

Key indicators achieving the target include:

- Personal Development Review Non- Medical
- Personal Development Review Medical
- Last Minute Cancelled Operations

Emergency 4 hour wait was 82.9% for April.

The RTT incomplete position remains below the 92% national target and stands at 85.1% in March.

The Cancer 62 day referral to 1st treatment standard was not meet with the Trust achieving 76.3% for March and 82.2% for 2018/19 overall. 62 day screening also failed target in March at 84.6% against a target of 90% (1 patient breach). All other national cancer standards were achieved for March, Q4 and 2018/19.

A Medication error causing serious harm has been reported – further detail is included in the quality and safety section is report.

Cdiff is now known as Clostridiodes difficile. In addition, the measure has been changed to report all Cdiff detected in hospital on or after the third day of admission or inpatient in the 28 days prior to detection.

The Trust is reporting a £4.4m deficit at Month 1, £0.2m adverse to plan.

PREVIOUS DISCUSSIONS HELD:

Standard monthly report to Trust Board

KEY IMPLICATIONS:

Financial:	Deliver value for money and compliance with NHSI
Patients Safety or Quality:	NHSI and other regulatory compliance
Human Resources:	To be an employer of choice
Operational:	Operational performance and regulatory compliance

Integrated Quality, Performance and Finance Reporting Framework

Reporting period: April 2019

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15 KPIs achieved the target in April

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Safest care and excellent experience	5	5	0	10
Leader in operational performance	3	8	0	11
Model employer	2	1	2	5
Achieve financial sustainability	1	1	0	2
Frontrunner in research innovation and education	4	3	0	7
All domains	15	18	2	35

KPI Hotspot

What's Good?

Personal Development Review –
Medical and Non Medical
Last Minute Cancelled Operations

What's Not So Good?

Complaints Turnaround <= 25 days
Cancer 62 Day Urgent Referral to
Treatment
Emergency care 4 Hour Wait

The Trust has achieved 15 of the 35 rag rated indicators reported within the Trust's performance scorecard. The Trust scorecard aligns Trust level indicators with the objectives outlined in the Trusts 2018-2021 Organisational Strategy.

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The Trust is reporting a £4.4m deficit at Month 1, £0.2m adverse to plan.

Trust Scorecard

Reporting Month April 2019

DoT	
↑	Improving
→	No change
↓	Falling

White	No Target or RAG rating
Green	Achieving or exceeding target
Yellow	Slightly behind target
Orange	Not achieving target
Red	Date not currently available
Black	Annual target breached

Target Type	
Light Green	National Target
Light Orange	Regional Target
Light Yellow	Local Target

Trust Board Scorecard								
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Trend
Safest care and excellent experience								
Infection Control								
	Healthcare associated incidents of Clostridioides difficile - Cumulative		9		5	60	CNO	
	MRSA Bacteremia - Trust Acquired - Cumulative	1	0	↑	0	0	CNO	
Safe Care								
	Never Events - Cumulative	0.0	0.0	→	0	0	CMO	
	Harm Free Care	96.1%	95.8%	↓	95%	95%	CNO	
	Serious Incidents - Number	13	3	↑	15	15	CMO	
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	90.29	112.70	↓	RR	RR	CMO	
	SHMI - Quarterly (6 months in arrears)	113.33	112.03	↑	RR	RR	CMO	
	Average Number of Daily Stranded Patients (21 Days)	206	208	↓	175	175	CNO	
Patient Experience								
	Friends & Family Test - Recommender Targets Achieved	0	1	↑	7	7	CMO	
	Complaints Turnaround <= 25 Days (1 month in arrears)	46%	44%	↓	90%	90%	CMO	
Leader in operational performance								
Patient Flow								
	Emergency Care 4 Hour Wait	80.9%	82.9%	↑	95%	95%	COO	
	Bed Occupancy Rate - KH03 (3 months in arrears)	98.9%	99.3%	↓	93%	93%	COO	
	Delayed Transfers as a Percentage of Admissions	5.3%	4.9%	↑	3.5%	3.5%	COO	
	Breaches of the 28 Day Readmission Guarantee	12	15	↓	0	0	COO	
	Diagnostic Waiters - 6 Weeks and Over	0.15%	0.21%	↓	1%	1%	COO	
RTT								
	18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	84.3%	85.1%	↑	92%	92%	COO	
	RTT 52 Week Waits Incomplete (1 month in arrears)	0	0	→	0	0	COO	
	Last Minute Non-clinical Cancelled Operations - Elective	0.9%	0.7%	↑	0.8%	0.8%	COO	
Cancer								
	Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	75.68%	76.27%	↑	85%	85%	COO	
	Cancer 104+ Day Waits (1 month in arrears)	10.0	10.5	↓	0	0	COO	
	National Cancer Standards Achieved (1 month in arrears)	7	6	↓	8	8	COO	

RR = Relative Risk : The target for this indicator uses the relative risk as calculated by Dr Foster. The performance is classed as achieving target if the UHCW value is either below or within the expected range.

Trust Scorecard

Reporting Month April 2019

DoT	
↑	Improving
→	No change
↓	Falling

	No Target or RAG rating
	Achieving or exceeding target
	Slightly behind target
	Not achieving target
	Data not currently available
	Annual target breached

Target Type	
	National Target
	Regional Target
	Local Target

Trust Board Scorecard								
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Executive Lead	Trend
Model employer								
	Mandatory Training Compliance	91.84%	92.68%	↑	95%	95%	CWIO	
	Personal Development Review - Non-Medical	92.27%	94.72%	↑	90%	90%	CWIO	
	Personal Development Review - Medical	87.89%	91.51%	↑	90%	90%	CWIO	
	Sickness Rate	4.57%	4.55%	↑	3.99%	3.99%	CWIO	
	Staff Survey - Recommending as a Place of Work (Quarterly)	N/A	64.06%		70%	70%	CWIO	
Achieve financial sustainability								
	Income & Expenditure Margin Rating	4					CFO	
	Forecast Income & Expenditure - £'000	-28330	0	↑	0	0	CFO	
	WRP Delivery - £'000	30193	0	↓	1021	36000	CFO	
Frontrunner in research innovation and education								
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	4273	4640	↑	3743	4083	CMO	
	Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	750	783	↑	1200	1200	CMO	
	NIHR Research Capability Funding (£000s)	488	650	↑	1000	1000	CMO	
	Trial Recruitment Income (£000s)	2410	3213	↑	3150	3150	CMO	
	All Grant Income (£000s)	2621	3869	↑	2200	2200	CMO	
	Educational Supervisors with a Completed Educational Appraisal – Quarterly	100%	100%	→	100%	100%	CMO	
	Medical Trainees per Educational Supervisor – Quarterly (1 month in arrears)				2	2	CMO	
	Medical Student Placements Achieving Feedback Targets – Quarterly	9	9	→	12	12	CMO	

Trust Heatmap

Measure	Reporting Period:							April 2019	
	Emergency Medicine	Medicine	Trauma and Neuro Services	Surgical Services	Women and Children's Services	Clinical Diagnostics Services	Clinical Support Services	Trust	Trust Target
Group Level Indicators									
Safest care and excellent experience									
Healthcare associated incidents of Clostridioides - Cumulative	1	3	N/A	2	0		N/A	9	5
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	0	0	0		0	0	0
Never Events - Cumulative	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0
Harm Free Care	97.7%	93.0%	97.4%	98.1%	100.0%		91.4%	95.8%	95%
Serious Incidents - Number	0	2	1	0	0	0	0	3	15
HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	101.40	101.38	122.98	82.77	388.76			112.70	100
Average Number of Daily Stranded Patients (21 Days)	0	104	75	18	2	0	9	208	175
Friends & Family Test - Recommender Targets Achieved	0	0	0	0	2	0	1	1	7
Complaints Turnaround <= 25 Days (1 month in arrears)	50%	50%	25%	50%	75%	0%	50%	44%	90%
Leader in operational performance									
Emergency Care 4 Hour Wait	81.2%			99.7%	99.0%			82.9%	95%
Breaches of the 28 Day Readmission Guarantee			10	5	0		0	15	0
Diagnostic Waiters - 6 Weeks and Over		0.00%	0.48%	0.00%		0.21%		0.21%	1%
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	N/A	92.2%	81.9%	82.9%	88.1%	85.1%	77.4%	85.1%	92%
RTT 52 Week Waits Incomplete (1 month in arrears)	N/A	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Last Minute Non-clinical Cancelled Operations - Elective		0.0%	2.1%	2.2%	0.3%		0.4%	0.7%	0.8%
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	N/A	88.06%	N/A	76.76%	44.44%			76.27%	85%
Cancer 104+ Day Waits (1 month in arrears)		0.0	0.0	9.0	1.5			10.5	0
National Cancer Standards Achieved (1 month in arrears)		6	5	6	5			6	8
Model employer									
Mandatory Training Compliance	92.25%	95.85%	93.29%	93.43%	94.78%	95.93%	97.41%	92.68%	95%
Personal Development Review - Non-Medical	94.94%	94.25%	94.68%	95.58%	95.60%	96.28%	95.86%	94.72%	90%
Personal Development Review - Medical	89.29%	91.78%	93.28%	90.00%	90.91%	94.64%	96.25%	91.51%	90%
Sickness Rate	4.96%	4.07%	3.94%	4.56%	4.97%	4.79%	5.28%	4.55%	3.99%
Staff Survey - Recommending as a Place of Work (Quarterly)								64.06%	70%
Achieve financial sustainability									
WRP Delivery - £000	0	3	51	59	21	0	39	0	
Frontrunner in research innovation and education									
Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	278	803	561	832	1612	0	554	4640	3743
Educational Supervisors with a Completed Educational Appraisal -	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medical Trainees per Educational Supervisor - Quarterly (1 month in									2
Medical Student Placements Achieving Feedback Targets - Quarterly	N/A		N/A	N/A	3			9	12

Performance Trends

Improving

(3 months consecutive improvement)

Measure	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Sickness rate	3.99%	4.08%	4.06%	4.39%	3.99%	4.37%	4.38%	4.62%	4.92%	5.15%	5.12%	4.57%	4.55%

- Following a seasonal decline in sickness performance this KPI has now shown a steady improvement for the last three months.

Deteriorating

(green/amber indicators worsening)

(3 months consecutive deterioration)

- None of the indicators that are achieving their targets this month have deteriorated for three consecutive months

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Average Number of Daily Stranded Patients (21 Days)	175	182	169	164	205	194	188	183	182	193	197	206	208
Complaints Turnaround <= 25 Days (1 month in arrears)	90%	83%	78%	71%	68%	66%	74%	87%	95%	79%	46%	44%	
Cancer 104+ Day Waits (1 month in arrears)	0	3.5	3	3	8.5	13.5	5.5	10.5	8	9.5	10	10.5	

- Super Stranded patient numbers have increased for a fourth consecutive month and reflects pressures in the Trust. These figures include patients who are part of the Trusts 'Hospital at Home' service. The target for this indicator will be updated for 2019/20 once confirmed.
- Cancer 104+ day numbers have increased for three consecutive months.
- Complaints Turnaround <= 25 days performance continues to deteriorate. High priority cases are being focussed on first.

Failed Year End Target

- No indicators have failed their end of year target.

INFECTION CONTROL

This month 0 MRSA and 9 Cdiff cases were reported.

Infection Rates
Cumulative
9 Cdiff
5 YTD target
Annual Target 60

0 MRSA
0 YTD target
Annual Target 0

- **MRSA** decolonisation: **71.4%**
- **MRSA** High Risk Elective Inpatient Screening: **96.3%**
- **MRSA** High Risk Emergency Screening: **88.5%**

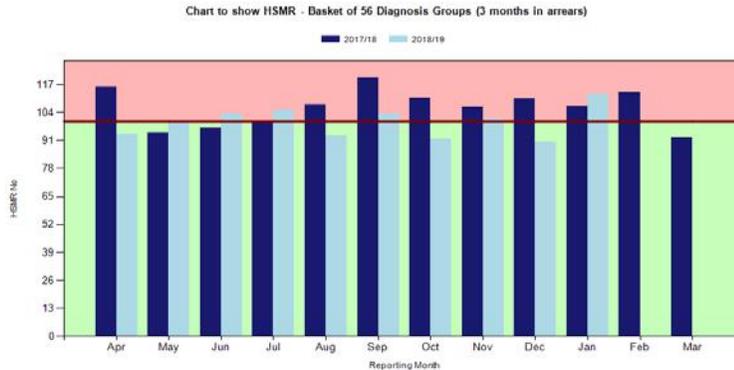
MEDICATION ERRORS CAUSING SERIOUS HARM



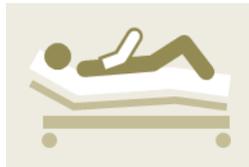
One medication error causing serious harm has been reported.

HSMR

The latest HSMR score reported from Dr Foster is 112.7



No 12 hour trolley waits



No urgent operations have been cancelled for the second time

RIDDOR



4

Incidents reported for April

4hr Achievement Overview - as at 20/5/2019

Stream	Last Month	Current Month	Last Year	This Year
Type 1 Minors	92.90%	96.40%	93.83%	94.20%
Type 1 Majors	54.73%	62.38%	64.82%	57.72%
Type 1 Resus	49.47%	52.53%	59.63%	50.52%
Type 1 Paediatrics	86.99%	95.15%	93.27%	90.03%
Local Health Economy	82.93%	86.42%	86.92%	84.24%

44%
Complaints turnaround in ≤ 25 days

Last month 47%
Target 90%

Never Events

0

YTD performance against target of 0



0

(March)

Previous month 0
Target 0

Incomplete RTT pathways

Trust Scorecard – Quality and Governance Committee

Reporting Month April 2019

Quality and Safety Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
Patient Outcomes									
	MRSA Bacteremia - Trust Acquired - Cumulative	1	0	↑	0	0	0	CNO	
	Healthcare associated incidents of Clostridioides difficile - Cumulative	5	9	↓	5	60	60	CNO	
	E. Coli - Trust Acquired - Cumulative	76	2	↑	5	62	62	CNO	
	MRSA Decolonisation Score	100.0%	71.4%	↓	100%	100%	100%	CNO	
	MRSA High Risk Elective Inpatient Screening	96.3%	96.3%	↔	95%	95%	95%	CNO	
	MRSA High Risk Emergency Screening	86.5%	88.5%	↑	90%	90%	90%	CNO	
	Serious Incidents - Number	13	3	↑	15	15	15	CMO	
	Serious Incidents - Overdue	7	7	↔	0	0	0	CMO	
	Medication Errors Causing Severe Harm/Death	0	1	↓	0	0	0	CMO	
	Reported Harmful Patient Safety Incidents (1 month in arrears)	23.1%	24.9%	↓	24.94%	24.94%	24.94%	CMO	
	CAS Alerts - Overdue	2	2	↔	0	0	0	CMO	
	NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	4	4	↔	8	10	10	CMO	
	Never Events - Cumulative	0.0	0.0	↔	0	0	0	CMO	
	Mixed Sex Accommodation Breaches	0	0	↔	0	0	0	CNO	
	HSMR - Basket of 56 Diagnosis Groups (3 months in arrears)	90.29	112.70	↓	RR	RR	RR	CMO	
	SHMI - Quarterly (6 months in arrears)	113.33	112.03	↑	RR	RR	RR	CMO	
	Harm Free Care	96.1%	95.8%	↓	95%	95%	95%	CNO	
	Pressure Ulcers Category 3 - Avoidable Trust Associated (1 month in arrears)	1	2	↓	1	12		CNO	
	Pressure Ulcers Category 4 - Avoidable Trust Associated (1 month in arrears)	0	0	↔	0	0		CNO	
	Falls with Moderate Harm or Above per 1000 Occupied Bed Days	0.03	0.03	↔	0.13	0.08	0.08	CNO	
	Eligible Patients Having VTE Risk Assessment (1 month in arrears)	96.8%	97.0%	↑	95%	95%	95%	CNO	
	C-UTI	99.9%	99.9%	↔	99%	99%	99%	CNO	
	Average Number of Daily Stranded Patients (21 Days)	206	208	↓	175	175	175	CNO	
	Transfer of Patients at Night (UH to Rugby)	7	1	↑	0	0	0	COO	
Patient Experience									
	Friends & Family Test Inpatient Recommenders (Inc. Day Cases)	91.9%	91.3%	↓	95%	95%	95%	CMO	
	Friends & Family Test Inpatient Coverage (Inc. Day Cases)	23.6%	22.4%	↓	26%	26%	26%	CMO	
	Friends & Family Test A&E Recommenders	79.5%	79.5%	↔	87%	87%	87%	CMO	
	Friends & Family Test A&E Coverage	12.6%	12.7%	↑	15%	15%	15%	CMO	
	Friends & Family Test Outpatient Recommenders	89.15%	90.12%	↑	95%	95%	95%	CMO	
	Friends & Family Test Outpatient Coverage	3.75%	4.13%	↑	8%	8%	8%	CMO	
	Maternity FFT Recommenders - 36 weeks	90.14%	89.47%	↓	97%	97%	97%	CMO	
	Maternity FFT Recommenders - Labour / Birth	84.71%	87.69%	↑	97%	97%	97%	CMO	
	Maternity FFT Recommenders - Postnatal Hospital	94.12%	89.19%	↓	97%	97%	97%	CMO	
	Maternity FFT Recommenders - Postnatal Community	95.59%	98.57%	↑	97%	97%	97%	CMO	
	Maternity FFT No of Touchpoints Achieving a 15% Response Rate	3	2	↓	4	4	4	CMO	
	Number of Registered Complaints (1 month in arrears)	67	62	↑	33	33	33	CMO	
	Complaints per 1000 Occupied Bed Days (1 month in arrears)	2.18	1.82	↑	0.99	0.99	0.99	CMO	
	Complaints Turnaround <= 25 Days (1 month in arrears)	46%	44%	↓	90%	90%	90%	CMO	

Target Type
National Target
Regional Target
Local Target

No Target or RAG rating
Achieving or exceeding target
Slightly behind target
Not achieving target
Data not currently available
Annual target breached

DoT
Improving
No change
Falling

Trust Scorecard – Quality and Governance Committee

Reporting Month April 2019

Quality and Safety Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
Theatres									
	Surgical Safety Checklist - WHO	100.00%	100.00%	→	100%	100%	100%	CMO	
National Quality Requirements									
	Valid NHS Number - Inpatients - Cumulative (2 months in arrears)	99.5%	99.5%	→	99%	99%	99%	COO	
	Valid NHS Number - A&E - Cumulative (2 months in arrears)	96.9%	96.8%	↓	95%	95%	95%	COO	
Operational Quality Measures									
	12 Hour Trolley Waits in Emergency Care	0	0	→	0	0	0	COO	
	Ambulance Handover within 30 Minutes	89.5%	92.2%	↑	100%	100%	100%	COO	
	Ambulance Handover within 60 Minutes	99.1%	99.4%	↑	100%	100%	100%	COO	
	Urgent Operations Cancelled for the Second Time	0	0	→	0	0	0	COO	
	RTT 52 Week Waits Incomplete (1 month in arrears)	0	0	→	0	0	0	COO	
Leading research based health care organisation									
	Patients Recruited into NIHR Portfolio-Cumulative (2 months in arrears)	4273	4640	↑	3743	4083	4083	CMO	
	Performance in Initiating Trials - Quarterly	62.5%	75.0%	↑	80%	80%	80%	CMO	
	Performance in Delivery of Trials - Quarterly	50.0%	52.9%	↑	80%	80%	80%	CMO	
	Research Critical Findings and Serious Incidents - Quarterly	0	0	→	0	0	0	CMO	
	Peer Reviewed Publications - Calendar Year Cumulative (2 months in arrears)	12	16	↑	16	0	0	CMO	
Leading training and education centre									
	Educational Supervisors with a Completed Educational Appraisal – Quarterly	100%	100%	→	100%	100%	100%	CMO	
	Medical Trainees per Educational Supervisor – Quarterly (1 month in arrears)				2	2	2	CMO	
	Medical Student Placements Achieving Feedback Targets – Quarterly	9	9	→	12	12	12	CMO	

RR = Relative Risk : The target for this indicator uses the relative risk as calculated by Dr Foster. The performance is classed as achieving target if the UHCW value is either below or within the expected range.

Target Type
National Target
Regional Target
Local Target

	No Target or RAG rating
	Achieving or exceeding target
	Slightly behind target
	Not achieving target
	Data not currently available
	Annual target breached

DoT	
	Improving
	No change
	Falling

Improving

(3 months consecutive improvement)

- No indicators have improved for three consecutive months.

Deteriorating

(green indicators worsening)

(3 months consecutive deterioration)

Measure	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Reported harmful patient safety incidents (1 month in arrears)	24.94%	18.70%	19.50%	20.40%	21.90%	21.10%	19.60%	23.20%	20.50%	23.10%	23.10%	24.90%	

- The number and proportion of reported harmful patient safety incidents reported have increased for a third month.

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

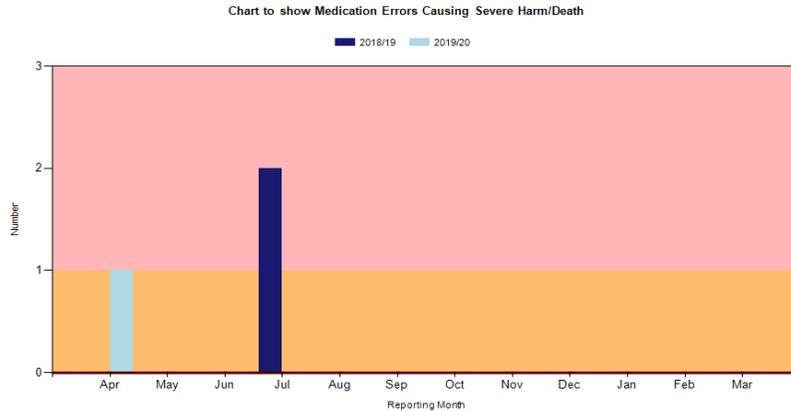
Measure	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Average Number of Daily Stranded Patients (21 Days)	175	182	169	164	205	194	188	183	182	193	197	206	208
Maternity FFT Recommenders - 36 weeks	97%	91.92%	96.63%	88.00%	92.86%	78.05%	92.73%	93.10%	92.00%	92.73%	90.70%	90.14%	89.47%
Complaints Turnaround <= 25 Days (1 month in arrears)	90%	83%	78%	71%	68%	66%	74%	87%	95%	79%	46%	44%	

- Super Stranded patient numbers have increased for a fourth consecutive month and reflects pressures in the Trust. These figures include patients who are part of the Trusts 'Hospital at Home' service. The target for this indicator will be updated for 2019/20 once confirmed.
- Maternity FFT Recommenders – 36 weeks has reduced for the fourth month.
- Complaints Turnaround <= 25 days performance continues to deteriorate. High priority cases are being focussed on first.

Failed Year End Target

- No indicators have failed their end of year target.

A medication error causing serious harm has been reported in April.



The incident relates to 89 year old patient who was discharged on regular medication of Digoxin 125 micrograms plus amiodarone as prescribed by General Practitioner.

Both medications are contraindicated, as they are known to be toxic when prescribed and administered together.

During the inpatient stay in November 2018, the patient was reviewed by multiple teams, however nobody identified the patient was on a toxic dose.

The patient was readmitted March 2019 with severe digitoxicity due to the incorrect co-prescription of digoxin with amiodarone.

The patient passed away on 22nd March 2019, the cause of death was recorded as Cause of death: 1a Bronchopneumonia, there has been no clinical indication the toxic dose resulting in this death.

Immediate Learning

- A Mortality Review was completed, this reviewed the standard of care delivered by the Trust. The review was graded as NCEPOD B, this identifies Room for Improvement Aspects of clinical care that could have been better.
- The Incident was discussed at Cardiology Quality Improvement and Patient Safety and learning was disseminated regarding the medication error.
- An immediate review was carried out by Pharmacy and the Acute Medical team.

Further review:

- A Learning Team will be held to review how this incident occurred. The Learning Team process consists of two facilitated group workshops. The first session maps out the process and identifies what could go wrong. This is followed by soak time – a period of reflection. The second workshop brings the team back to explore solutions and develop a plan for fixing the process
- A Serious Incident Investigation has been instigated and the final review by the lead investigator will determine the actual harm.

Ward	April 2019		March 2019
	Care Hours per Patient Day	Comments if RN fill rate > 105% or < 90% or significant variance in CHPPD	Care Hours per Patient Day
Ward 16	8.6	Managed internally , flexible workforce across wards 14,15,16, daily meeting to mitigate	7.2
Ward 23	10.6	Includes gynae assessment area, realigning . Erostering review in system , discuss as reallocating HCSW into gaps	9.5
Ward 24	5.1	Day prioritised , new plan three RN at night recruiting to, flexible workforce across group	4.9
Ward 52	10.1	Increased establishment in line with business case for approval . Actual CHPPD reviewed marginally over requirement	6.5
Labour Ward	22.5	Ongoing recruitment all expected to be in post by October 2019, unfilled shifts but flexing workforce across the group and safety huddle daily reallocating resources to mitigate any red flags	19.2
Ward 12 - Obs	11.6	CHPPD required not achieved although shifts filled due to increased observation requirements and increased patient acuity	10.8
Trust Total	8.4		8.1

National guidance from NHSi changed in September 2018 and safe staffing is now measured using Care Hours per Patient Day (CHPPD) rather than fill rate. This is calculated by dividing the amount of time available within a ward area by the numbers of patients on the ward and allows for a common approach for comparisons.

CHPPD has increased to 8.4 in April. This reflects an increase in extra capacity and the required nursing workforce.

We continue the following improvement work;

1. Safe staffing meetings are embedded to ensure that the right staff are in the right place at the right time day and night.
2. Women & Childrens areas both hold a daily safety huddle incorporating staffing escalations to allocate staff resources based on clinical needs.
3. Marginal variance in CHPPD and fill rates have been observed in adult inpatient areas for April.

A report for all wards is submitted to the Department of Health via Unify on a monthly basis as per National Quality Board guidance. This information is also published on the Trust's Internet Site.

Emergency 4 hour wait:
April 2019 - 82.9%

Latest benchmarked month:
UHCW – February 79.1%
England – February 84.2%

4hr Achievement Overview - as at 20/5/2019				
Stream	Last Month	Current Month	Last Year	This Year
Type 1 Minors	92.90%	96.40%	93.83%	94.20%
Type 1 Majors	54.73%	62.38%	64.82%	57.72%
Type 1 Resus	49.47%	52.53%	59.63%	50.52%
Type 1 Paediatrics	86.99%	95.15%	93.27%	90.03%
Local Health Economy	82.93%	86.42%	86.92%	84.24%

Diagnostic Waiters 6
Weeks and Over



0.21% : 26 breaches
22 imaging
3 neurophysiology
1 audiology

Summary

Emergency 4 hour wait was 82.9% for April. The Cancer 62 day referral to 1st treatment standard was not met with the Trust achieving 76.3% for March and 82.2% for 2018/19 overall. 62 day screening also failed target in March at 84.6% against a target of 90% (1 patient breach). All other national cancer standards were achieved for March, Q4 and 2018/19.

Incomplete RTT pathways

Submitted Position	Inc %	Backlog (Over 18 Weeks)
March 19	85.2%	4,759
March 18	82.3%	5,368
YTD UHCW Change	3.0%	-609

Latest Benchmarked Month	UHCW	NHS England
February 2019	84.3%	86.5%
February 2018	82.4%	87.5%
Benchmark Change	1.9%	-1.0%



52 Weeks

0 (March)

Previous month 0 Target 0

Ambulance Handover



Within 30 minutes :
92.2%
Within 60 minutes :
99.4%



No 12 hour trolley waits

Cancer standards - March



TWW: **93.9%**
31 day: **97.6%**
62 day: **76.3%**
62 day screening: **84.6%**

10.5 breaches (14 patients) treated over 104 days

Last minute Non-Clinical Operations –Elective

0.7% of elective admissions – 71patients
Last month – 53 patients



Trust Scorecard – Finance and Performance Committee

Reporting Month April 2019

Finance and Workforce Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
Emergency care									
	Emergency Care 4 Hour Wait	80.9%	82.9%	↑	95%	95%	95%	COO	
	12 Hour Trolley Waits in Emergency Care	0	0	→	0	0	0	COO	
	Ambulance Handover within 30 Minutes	89.5%	92.2%	↑	100%	100%	100%	COO	
	Ambulance Handover within 60 Minutes	99.1%	99.4%	↑	100%	100%	100%	COO	
	Delayed Transfers as a Percentage of Admissions	5.3%	4.9%	↑	3.5%	3.5%	3.5%	COO	
	30 Day Emergency Readmissions (1 month in arrears)	7.6%	8.3%	↓	8.04%	8.04%	8.04%	COO	
	Number of Medical Outliers - Average per Day	92.0	81.8	↑	50	50	50	COO	
	Length of Stay Acute - Average	7.0	7.1	↓	7.176	6.958	6.958	COO	
Non emergency care									
	Last Minute Non-clinical Cancelled Operations - Elective	0.9%	0.7%	↑	0.8%	0.8%	0.8%	COO	
	Breaches of the 28 Day Readmission Guarantee	12	15	↓	0	0	15	COO	
	Urgent Operations Cancelled for the Second Time	0	0	→	0	0	0	COO	
	18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	84.3%	85.1%	↑	92%	92%	92%	COO	
	RTT 52 Week Waits Incomplete (1 month in arrears)	0	0	→	0	0	0	COO	
	E-referral Appointment Slot Issues – National data (1 month in arrears)	2.2%	5.0%	↓	4%	4%	4%	COO	
	Diagnostic Waiters - 6 Weeks and Over	0.15%	0.21%	↓	1%	1%	1%	COO	
	Bed Occupancy Rate - KH03 (3 months in arrears)	98.9%	99.3%	↓	93%	93%	93%	COO	
Cancer									
	Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	97.34%	93.86%	↓	93%	93%	93%	COO	
	Cancer 2 Week Wait Breast Symptom (1 month in arrears)	98.00%	97.40%	↓	93%	93%	93%	COO	
	Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	97.97%	97.60%	↓	96%	96%	96%	COO	
	Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	97.06%	100.00%	↑	94%	94%	94%	COO	
	Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.00%	100.00%	→	98%	98%	98%	COO	
	Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	98.08%	96.79%	↓	94%	94%	94%	COO	
	Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	75.68%	76.27%	↑	85%	85%	85%	COO	
	Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	75.94%	75.83%	↓	85%	85%	85%	COO	
	Cancer 62 Day Screening Standard (1 month in arrears)	94.74%	84.62%	↓	90%	90%	90%	COO	
	Cancer 62 Day Consultant Upgrades (1 month in arrears)	85.0%	72.7%	↓	85%	85%	85%	CMO	
	Cancer 104+ Day Waits (1 month in arrears)	10.0	10.5	↓	0	0	0	COO	

Target Type
National Target
Regional Target
Local Target

No Target or RAG rating
Achieving or exceeding target
Slightly behind target
Not achieving target
Data not currently available
Annual target breached

DoT
↑ Improving
→ No change
↓ Falling

Trust Scorecard – Finance and Performance Committee

Reporting Month April 2019

Finance and Workforce Scorecard									
Type	Measure	Previous Position	Latest Position	DoT	Current Target	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience									
Theatre Productivity									
	Theatre Efficiency - Main	77.2%	77.2%	↔	85%	85%	85%	COO	██████████
	Theatre Efficiency - Rugby	80.2%	82.2%	↑	85%	85%	85%	COO	██████████
	Theatre Efficiency - Day Surgery	68.5%	68.5%	↔	70%	70%	70%	COO	██████████
	Theatre Utilisation - Main	80.3%	81.8%	↑	85%	85%	85%	COO	██████████
	Theatre Utilisation - Rugby	80.5%	81.4%	↑	85%	85%	85%	COO	██████████
	Theatre Utilisation - Day Surgery	70.3%	73.2%	↑	70%	70%	70%	COO	██████████
	Surgical Safety Checklist - WHO	100.00%	100.00%	↔	100%	100%	100%	CMO	██████████
	Theatre Lists Started within 30 mins of Start Time	70.3%	70.2%	↔	75%	75%	75%	COO	██████████
Deliver value for money									
	Capital Service Cover Rating	4					4	CFO	██████████
	Liquidity Rating	4					4	CFO	██████████
	Income & Expenditure Margin Rating	4					4	CFO	██████████
	Variance from Control Total Rating	4					4	CFO	██████████
	Forecast Income & Expenditure - £'000	-28330	0	↑			0	CFO	██████████
	Agency Rating	2					2	CFO	██████████
	Trust Financial Risk Rating	4					4	CFO	██████████
	WRP Delivery - £'000	30193	0	↓			7871	CFO	██████████
	YTD Income & Expenditure Trust - £'000	-28330	-4402	↑			0	CFO	██████████
	Agency Expenditure (£'000)	1580	1786	↓	1902.5	1902.5	1902.5	CWIO	██████████
Employer of choice									
	Personal Development Review - Non-Medical	92.27%	94.72%	↑	90%	90%	90%	CWIO	██████████
	Personal Development Review - Medical	87.89%	91.51%	↑	90%	90%	90%	CWIO	██████████
	Mandatory Training Compliance	91.84%	92.68%	↑	95%	95%	95%	CWIO	██████████
	Sickness Rate	4.57%	4.55%	↔	3.99%	3.99%	3.99%	CWIO	██████████
	Staff Turnover Rate	9.53%	9.60%	↓	12%	12%	12%	CWIO	██████████
	Vacancy Rate Compared to Funded Establishment	12.52%			10%	10%	10%	CWIO	██████████
	Staff Survey - Recommending as a Place of Work (Quarterly)	N/A	64.06%		70%	70%	70%	CWIO	██████████
Leading research based health care organisation									
	Submitted Research Grant Applications - Quarterly - Cumulative	105	137	↑	128	128	128	CMO	██████████
	Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	750	783	↑	1200	1200	1200	CMO	██████████
	NIHR Research Capability Funding (£000s)	488	650	↑	1000	1000	1000	CMO	██████████
	Trial Recruitment Income (£000s)	2410	3213	↑	3150	3150	3150	CMO	██████████
	All Grant Income (£000s)	2621	3869	↑	2200	2200	2200	CMO	██████████
Leading training and education centre									
	Educational Supervisors with a Completed Educational Appraisal – Quarterly	100%	100%	↔	100%	100%	100%	CMO	██████████
	Medical Trainees per Educational Supervisor – Quarterly (1 month in arrears)				2	2	2	CMO	██████████
	Medical Student Placements Achieving Feedback Targets – Quarterly	9	9	↔	12	12	12	CMO	██████████

Target Type
National Target
Regional Target
Local Target

No Target or RAG rating
Achieving or exceeding target
Slightly behind target
Not achieving target
Data not currently available
Annual target breached

DoT
Improving
No change
Falling

Statement of Comprehensive Income

1 month ended 30 April 2019	Plan		Full Year		Variance to plan		Year to date		Variance to plan	
	£'000	Budget (£'000)	Forecast (£'000)	£'000	%	Budget (£'000)	Actual (£'000)	£'000	%	
	Contract income from activities	593,355	593,355	593,355	0	0.0%	47,973	47,973	0	0.0%
Other income from activities	11,135	13,985	13,949	(36)	(0.3%)	1,159	1,194	35	3.0%	
Other Operating Income	96,698	97,640	96,650	(990)	(1.0%)	7,357	7,162	(195)	(2.7%)	
Total Income	701,188	704,980	703,954	(1,026)	(0.1%)	56,489	56,329	(160)	(0.3%)	
Pay costs	(385,842)	(379,497)	(405,825)	(26,328)	(6.9%)	(33,571)	(35,028)	(1,457)	(4.3%)	
Other operating expenses	(263,500)	(250,261)	(249,977)	284	0.1%	(20,875)	(19,373)	1,502	7.2%	
Additional savings required			27,073	27,073			0	0		
Reserves	0	(23,376)	(23,376)	0	0.0%	(1,983)	(2,124)	(141)	(7.1%)	
Total Operating Expenses	(649,342)	(653,134)	(652,105)	1,029	0.2%	(56,429)	(56,525)	(96)	(0.2%)	
EBITDA	51,846	51,846	51,849	3	0.0%	60	(196)	(256)	(426.7%)	
Depreciation	(23,629)	(23,629)	(23,629)	0		(1,969)	(1,969)	0		
Interest Receivable	100	100	100	0		8	21	13		
Interest Charges	(1,638)	(1,638)	(1,638)	0		(120)	(118)	2		
Financing Costs	(25,902)	(25,902)	(25,902)	0		(2,124)	(2,122)	2		
Unwinding Discount	(10)	(10)	(10)	0		(10)	(7)	3		
PDC Dividend	(374)	(374)	(374)	0		(31)	(31)	0		
Profit / loss on asset disposals	0	0	(3)	(3)		0	(3)	(3)		
Net Surplus/(Deficit)	393	393	393	0	0.0%	(4,186)	(4,425)	(239)	(5.7%)	
EBITDA %	7.4%	7.4%	7.4%			0.1%	(0.3%)			
Net Surplus %	0.1%	0.1%	0.1%			(7.4%)	(7.9%)			
Technical Adjustments:										
Donated/Government grant assets adjustment	(393)	(393)	(393)	0	0.0%	25	25	0	0.0%	
Trust Position Post Technical Adjustment (Control total)	0	0	0	0	0.0%	(4,161)	(4,400)	(239)	(5.7%)	

The Trust reports a break even forecast.

Year to Date - Surplus / (Deficit) position: The Trust is reporting a £4.4m deficit at Month 1, £0.2m adverse to plan.

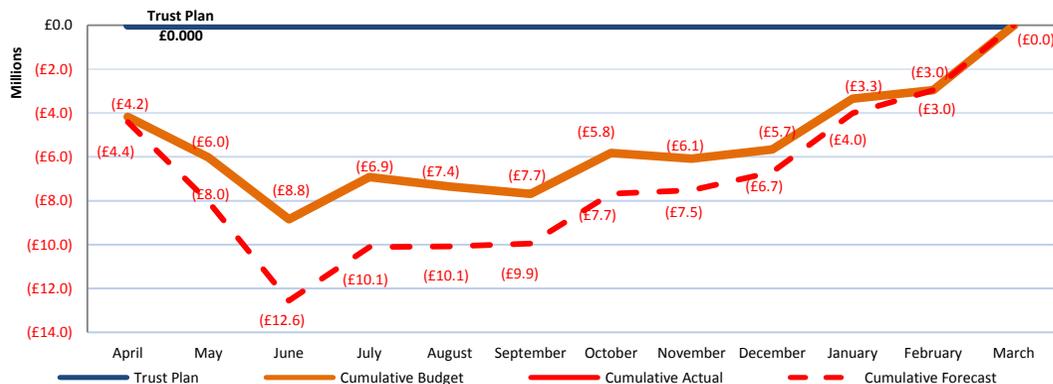
- Contract income is reported as per plan.
- Non-contract income is £0.2m adverse to budget.
- Total operating expenditure is £0.1m adverse to budget.

Outturn - Surplus / (Deficit) position: The forecast position at Month 1 is break even in line with the planned control total.

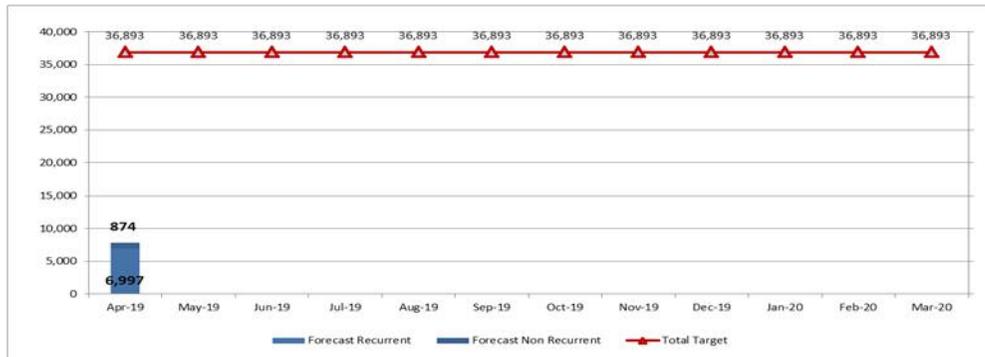
- Contract income is forecast at £593.4m, in line with budget.
- Non-contract income is forecast at £110.6m, which is £1.0m adverse to budget, primarily due to pathology network income and risks to education income.
- Total operating expenditure is forecast at £652.1m, which is £1.0m favourable to budget. This is driven by adverse performance on pay, including unidentified Waste Reduction targets.

Non-Operating Expenditure is forecast to break even.

Net Surplus / (Deficit) position



Waste Reduction Delivery



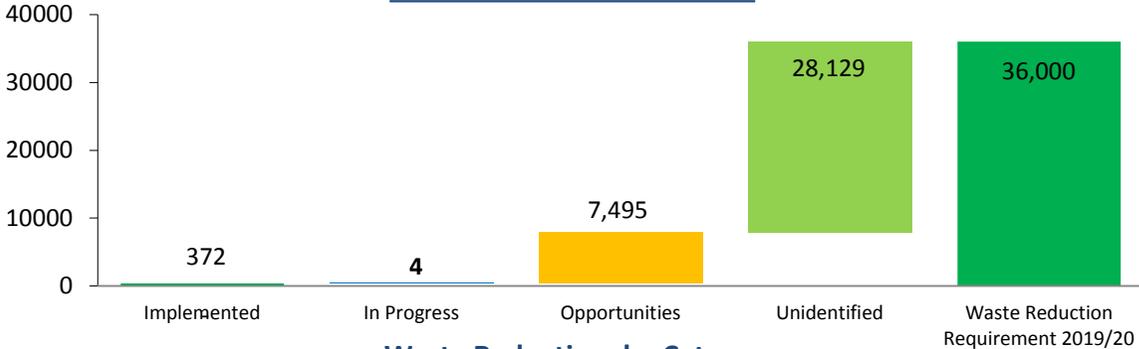
The gross waste reduction target for 2019/20 is £36.9m.

At Month 1 planned schemes total £14.2m with forecast delivery of £7.9m

Key Headlines – Waste Reduction

- The Trust has set a recurrent Waste reduction target of £26.9m in 2019/20.
- The 13 Trust wide schemes are a net total of £6.7m of the identified schemes
- As at Month 1 there was £6.4m forecast slippage against the identified schemes.

Waste Reduction Overview



Risks

- Detailed plans are not yet in place for the all of the Trust wide schemes
- Recurrent savings continue to represent a challenge

Waste Reduction by Category



Key Actions

- Groups to ensure assurance on each scheme are completed in-line with Trust's Waste Reduction policy.
- Local Waste Reduction Programme Steering Group to continue scrutiny of Group positions to ensure the focus is maintained as we go into the new financial year to minimise the risk of slippages that could result in under-delivery.
- PDO to support planning, governance and reporting with Transformation supporting project delivery
- The first Waste Reduction Board meeting is scheduled to take place on 20 May 2019.

This report provides a summary overview of workforce data. A detailed analysis of this data is provided within the monthly workforce report presented to the Finance and Performance Committee.



↑ Agency Spend
£1,786,428



↑ **HEADCOUNT**
9011 (7917.94 WTE)
(Inclusive of ISS/ROE)

MANDATORY

↑ **Training 94.40%**
(Substantive Employees)

95%
TARGET

VACANCIES

↑ **Vacancy Rate**
12.73%

10%
TARGET

Sickness 4.55%



4%
TARGET



↑ **Turnover**
9.60%
(Headcount %)

10%
TARGET



↑ **Medical**
91.51%
↑ **Non-Medical**
94.72%

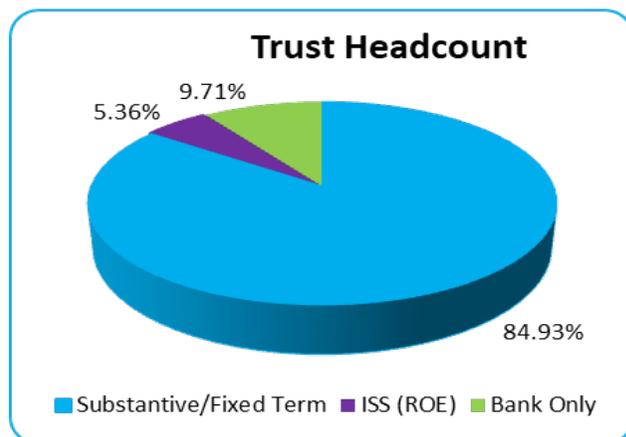
90%
TARGET



Headcount | WTE

Staff Headcount Breakdown	Feb-19	Mar-19	Apr-19
Substantive/Fixed Term	8496	8472	8476
ISS (ROE)	541	537	535
Trust Total	9037	9009	9011
Bank Only	1027	1029	969

Total Trust Headcount including ROE (ISS) staff is **9011**, an increase of **2** since March 2019. Bank headcount has decreased by **60**.



Staff in Post WTE	Feb-19	Mar-19	Apr-19
Staff in Post Actual (excluding ROE (ISS), Bank Workers)	7543.01	7511.61	7506.14

Overall, WTE has decreased by 5.47 WTE (which includes existing staff increasing or decreasing their hours).

Staff Group in Post | Monthly Variation

Staff in Post	Mar -19	Apr -19	Variance WTE	Variance %
Add Prof Scientific & Technic	270.01	265.59	-4.42	-1.66%
Add Clinical	1748.44	1748.38	-0.06	0.00%
Admin & Clerical	1260.44	1266.08	5.64	0.45%
AHP	437.57	438.21	0.64	0.15%
Estates & Ancillary	2.00	2.00	0.00	0.00%
Healthcare Scientists	356.21	357.40	1.19	0.33%
Medical & Dental	1023.33	1021.57	-1.76	-0.17%
Nursing & Midwifery	2393.70	2388.00	-5.70	-0.24%
Students	19.91	18.92	-1.00	-5.29%
Trust Total	7511.61	7506.14	-5.47	-0.07%
ISS	412.8	411.8	-1.00	-0.24%

Overall between March 2019 and April 2019 there has been a decrease of staff in post of **5.47 WTE**.

The staff groups with increases in post:

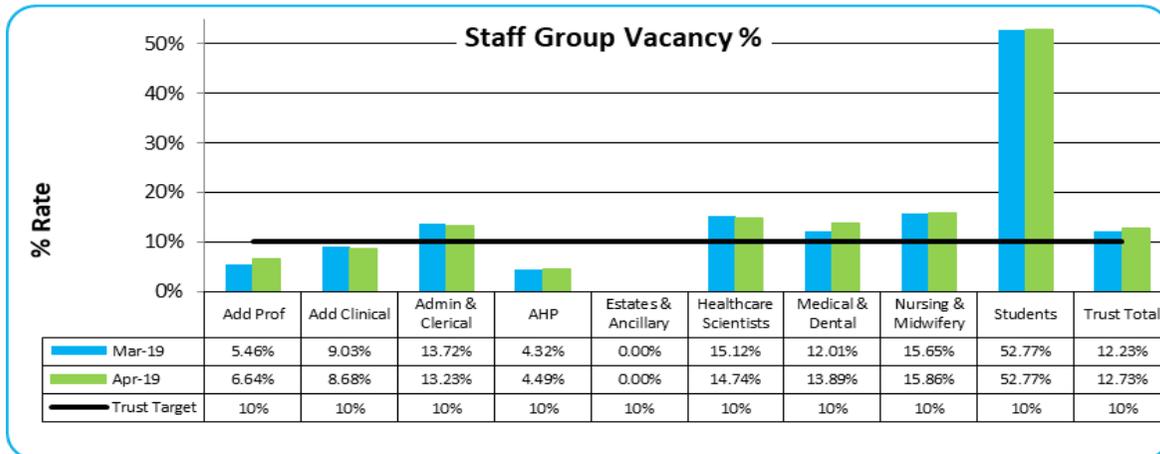
- Administration & Clerical (5.64 WTE)
- Healthcare Scientists (1.19 WTE)
- Allied Health Professionals (0.64 WTE)

The staff groups with decreases in post:

- Nursing & Midwifery (-5.70 WTE)
- Add Prof Scientific & Technic (-4.42 WTE)
- Medical and Dental (-1.76 WTE)
- Students (-1.00 WTE)
- Additional Clinical (-0.06 WTE)

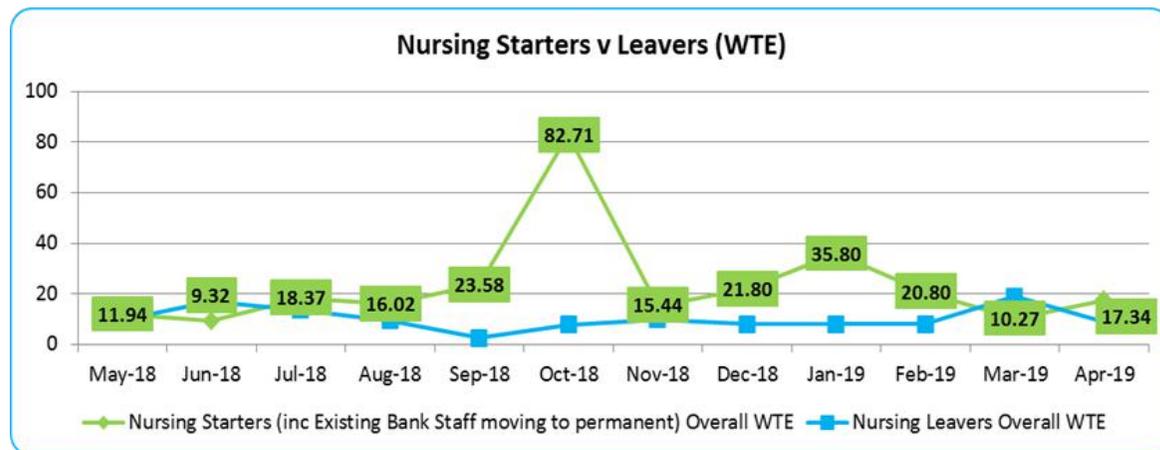
NB: Staff in Post data reflects new starters, monthly amendments to the increase and decrease hours and leavers. Therefore, whilst a number of staff may have been recruited in month the overall figure may go down due to the changes in hours and leavers.

Vacancy | by Staff Group



The overall vacancy rate is **12.73%** a **0.50%** increase on the previous month. The largest proportion of vacancies of staff groups from the previous month: **Nursing and Midwifery (15.86%, 449.99 WTE)**, **Healthcare Scientists (14.74%, 61.77 WTE)** and **Medical and Dental (13.89%, 164.82 WTE)**.

The forecast new starters in May for Nursing & Midwifery is **19 Nurses** and **2 Midwives**. (Source: Resourcing Department)

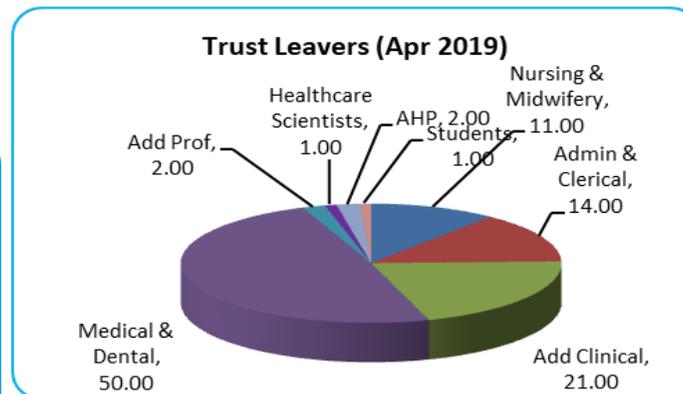


Turnover | by Staff Group (includes Bank)

The Trust overall turnover rate (12-months rolling) has increased to **9.60%** from **9.53%**.

The highest headcount of the **101** leavers in staff groups, **Medical & Dental (50 of which 45 rotational and 5 Trust Doctors)**, **Nursing and Midwifery (11)**, **Additional Clinical (21)**, and **Administrative & Clerical (14)** (The above does not include Bank staff)

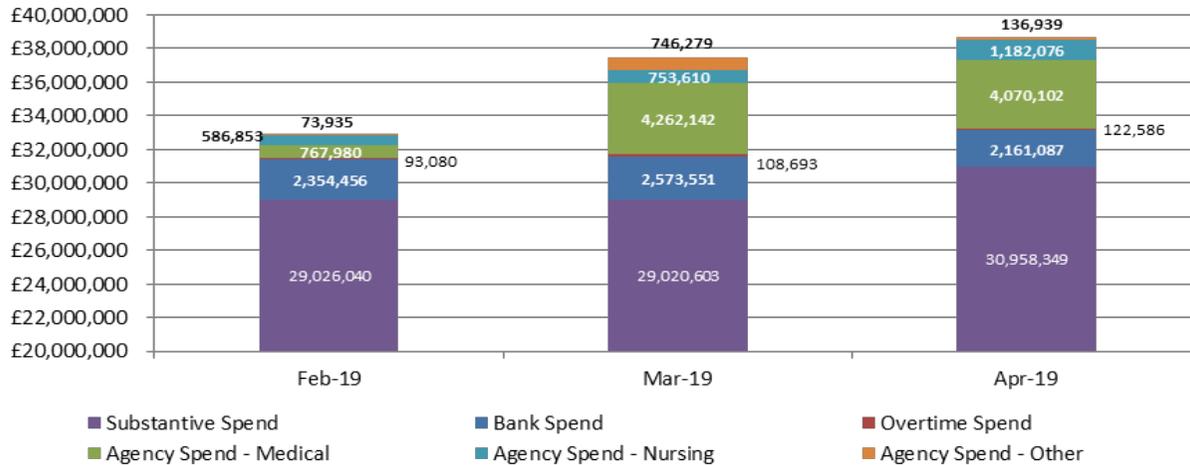
We have a dedicated Recruitment and Retention Group in place, led by the Lead Nurse - Workforce and Head of Employment Services. The group is taking forward a recruitment plan, which reports progress actions into Transforming Workforce Supply Committee on a monthly basis. One specific area of work is around Flexible Working Options, in order to boost retention rates.



*It is important to note that **Medical and Dental leavers will be significantly higher within peak doctor rotation months which include July, September, December, February, March and April.**

Pay Costs | Provided by Finance

Trust Total Staff Costs (Feb - Apr 2019)

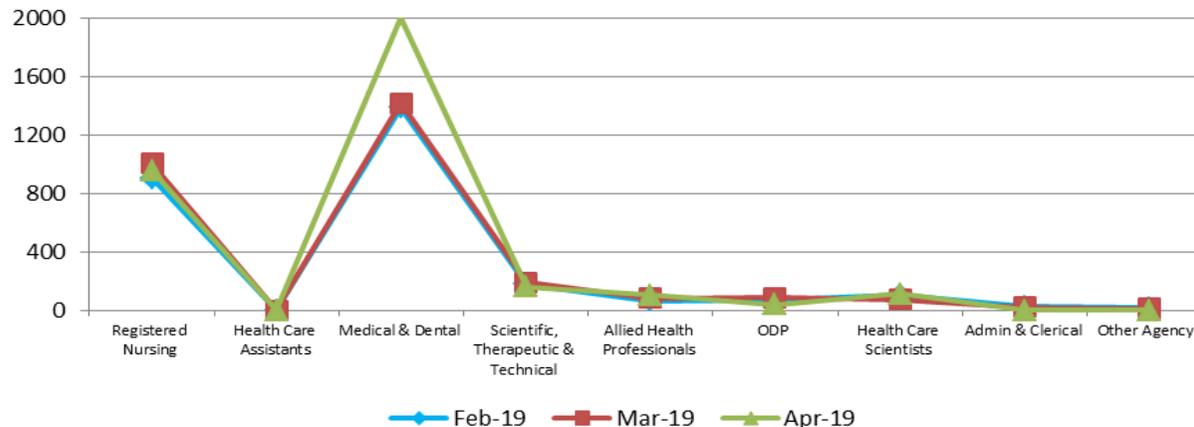


- The overall pay bill for April 2019 increased by **£1,586,375 (4.53%)** from March.
- Temporary costs equate to **11.62%** of the Trusts total pay bill (**£35,028,451**), this is a decrease of 1.12% on March 2019 which was 12.74%.
- Agency costs against total costs has increased **0.38%** from 4.72% to **5.10%**. There has been overall an increase in total agency spend of **£206,530 (11.56%)** to **£1,786,428** against March 2019.
- Overall Bank (**£2,161,087**) spend has decreased by **£412,464** down **19.09%** on the previous month.

NHSI Rate Caps | Percentage of Shifts Booked Over Cap



Quarterly Number of Agency Shifts by Staff Group - Shifts Booked Over Cap



- The percentage of medical shifts above agency cap rates has remained consistently 100% over the last 18 months.
- Discussions are taking place with Groups to understand the increase in booked agency.
- Nursing shifts over cap rates range between **54.55%** and **59.24%**.
- AHP over price cap has reduced in April to between **50.88%** and **63.64%**.
- Healthcare Scientists has remained similar to March, ranging from **37.28%** and **44.44%**.

Absence | by Group

The overall Trust sickness absence rate in April has decreased by **0.2%** to **4.55%**, which is above the current Trust **4.00%** target.

In relation to overall time lost due to absence, the highest reason for absence was Cold, Cough, Flu – Influenza with **219** episodes (**16.02%** of overall sickness).

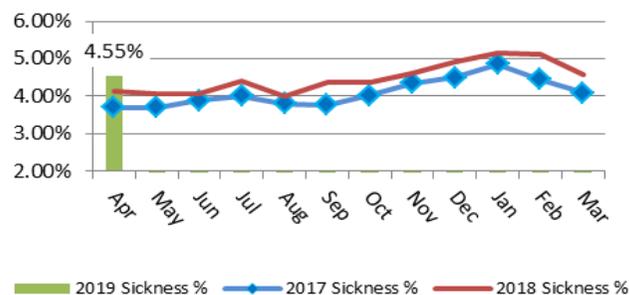
There are two specialty groups that meet the 4% target during April and seven of the Trusts new group structure that have not achieved the target. Managers are being reminded of the detail of the Policy and the number of managing attendance training sessions has been increased to capture more delegates.



Group Rolling Sickness Absence Rate %	Apr-19
218 Clinical Diagnostics	4.79%
218 Clinical Support Services	5.28%
218 Core Services	3.69%
218 Emergency Medicine	4.96%
218 Medicine	4.07%
218 Surgical Services	4.56%
218 Trauma and Neuro Services	3.94%
218 Women and Children	4.97%
Trust Total %	4.55%

Absence | by Month/Year

Monthly Sickness Absence % Comparison

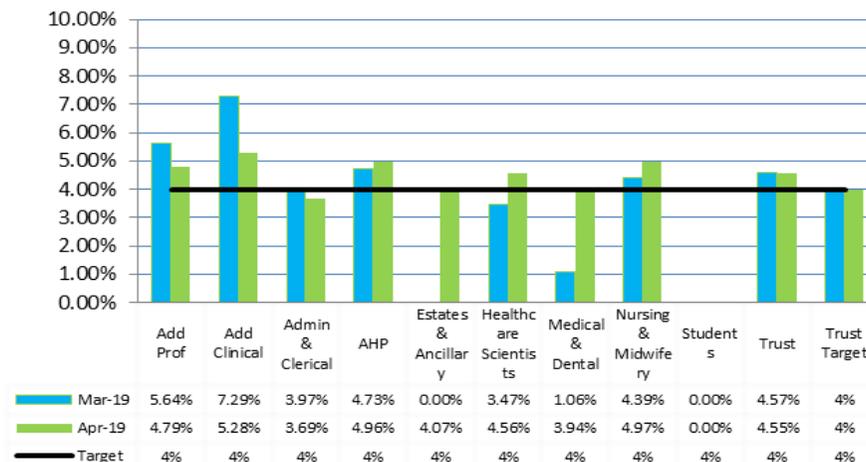


The sickness rate for April 2019 is higher in comparison to the same period in 2017 and 2018.

Absence | by Staff Group

Concentrated work has been completed in the Specialty Group areas experiencing a high number of long term sickness cases. This has helped to return to work 49 staff from long term sickness in April 2019.

Sickness by Staff Group



MANDATORY

Mandatory Training |by Group

Group Mandatory Training %		Apr-19
Clinical Diagnostics		95.93%
Clinical Support Services		97.41%
Core Services		97.10%
Emergency Medicine		92.25%
Medicine		95.85%
Trauma and Neuro Services		93.29%
Surgical Services		93.43%
Temporary Staffing Division		69.60%
Women & Children		97.78%
Trust Mandatory Training %	Mar-19	Apr-19
Trust Total	91.84%	92.68%
Substantive Staff Only	92.24%	94.40%
Bank Staff Only	67.24%	69.86%

- Mandatory Training compliance for all staff has increased by **0.84%** from **91.84%** in March to **92.68%** in April against a target of **95%**. The Group figures here are from the new group structural changes made in April and currently showing no comparisons.
- Bank only staff compliance has increased this month by **2.62%** to **69.86%**. Bank focused mandatory training days have been established to enable all training to be completed on one day.
- Continued support and challenge is provided to Groups through monthly accountability meetings to maintain focus on increasing/maintaining their compliance rates.
- As approved at Strategic Workforce Committee, bank only workers who do not meet the required compliance will be stopped from working from booking shifts from 31 May 2019.
- We continue to focus on making improvements to topics under 90% compliant with targeted actions monitored via our Training, Education & Learning Committee to ensure we are providing sufficient capacity and a range of opportunities for staff to undertake their mandatory training.

Appraisals |by Group



Non-medical appraisal compliance has increased from last month by **2.45%** and currently stands at **94.72%**, against a target of **90%**.

Medical appraisal is aligned to revalidation dates and is at **91.51%** an increase **3.62%** from last month. The Trust have an agreed process for validating the information each month between RMS and ESR. The CMO is contacting individuals who remain non-compliant.

Appraisal % by Group	Non-Medical Appraisals	Medical Appraisals
	Apr-19	Apr-19
Clinical Diagnostics	96.28%	94.64%
Clinical Support Services	95.86%	96.25%
Core Services	90.42%	92.31%
Emergency Medicine	94.94%	89.29%
Honorary Contracts & ESR Admin		87.50%
Trauma and Neuro Services	94.68%	87.50%
Medicine	94.25%	91.78%
Surgical Services	95.58%	90.00%
Women & Children		90.00%
Temporary Staffing	95.68%	87.10%
Trust Total	94.72%	91.51%

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Mortality Update
Executive Sponsor	Richard de Boer, Chief Medical Officer
Author	Sharron Oulds, Associate Director of Quality, Effectiveness and Assurance
Attachments	Quarterly Mortality Performance Report Q4– January 2019- March 2019 Quarterly Mortality Performance Report Q4 – May 2019
Recommendation	To NOTE the report.

EXECUTIVE SUMMARY

1. Purpose

The purpose of this paper is to provide a quarterly overview of Trust-level mortality data for the time period Q4 January 2019 to March 2019, and performance for the time period February 2018 to January 2019 (latest available Dr Foster Intelligence data), providing assurance that any highlighted concerns are investigated thoroughly and appropriate action is taken.

Investigating and reporting mortality data enables the Trust to identify ways to improve patient safety and patient outcomes.

2. Narrative

Mortality Review

- The completion rate for primary mortality reviews during Q4 January 2019 - March 2019 is 71%.
- During Q4 January 2019- March 2019 there have been 2 NCEPOD E graded deaths.

92% of completed primary reviews between Q4 January 2019- March 2019 received an NCEPOD grade A highlighting good standards of patient care.

All primary reviews graded B-E have a further secondary mortality review; these are discussed at specialty mortality and patient safety meetings to share the learning and improve patient care. There have been 36 identified opportunities graded B-E for learning from deaths between January 2019- March 2019.

During Q4 January 2019- March 2019 there have been 2 deaths of patients with Learning Disabilities and 7 Deaths of patients with identified Mental Illness during the primary review process.

Mortality indicators: HSMR

- The Trust HSMR value for the latest available 12 months of data (February 2018- January 2019) is 100.3. This is within the expected statistical ranges compared to acute non-specialist trusts in England.

The Hospital Standardised Mortality Ratio (HSMR) compares all inpatient deaths to expected deaths.

HSMR above 100 indicates more deaths than expected, and a HSMR below 100 indicates fewer deaths than expected. The Mortality Review Committee continues to proactively undertake investigations into diagnosis groups with a higher than expected number of deaths to identify potential improvements in care. Ongoing actions to reduce HSMR include the development and monitoring of care bundles and a review of diagnosis groups with higher observed deaths than expected.

Mortality Alerts – Dr Foster Intelligence

- Between February 2018- January 2019 the Trust received 52 mortality alerts, 29% of which were positive alerts.

Each month, diagnosis and procedure groups which have generated negative alerts through Dr Foster Intelligence (significantly more deaths than expected) are discussed at the Mortality Review Committee and appropriate action is agreed to address the alerts.

Mortality Indicators: SHMI

- The SHMI value (October 2017 – September 2018) is 1.12 indicating a 'within expected' position.

The Summary Hospital-Level Mortality Indicator (SHMI) differs from HSMR as it not only includes all inpatient deaths, but also deaths which occur 30 days after discharge. It uses a benchmark of 1 instead of 100. SHMI above 1 indicates more deaths than expected, and a SHMI below 1 indicates fewer deaths than expected.

An action plan to focus on the key diagnosis groups of Septicaemia and Intracranial Injury with a view to reduce SHMI has been completed alongside further work to progress collaborative working with the Clinical Commissioning Groups, Partnership Trust, GP's, other local Secondary Care Provides and Public Health to understand patient pathways including advanced care planning on discharge from hospital and explore ways of learning from deaths 30 days after discharge.

The group is initially focussing on reviewing the current SHMI position of local providers within the local area and working with community services to understand the factors that may be influencing patient care and experience including admission and discharge methods.

Learning from Deaths

Learning themes and areas of improvement identified from Secondary reviews of deaths in Q4 include timely diagnosis and treatment, the quality of healthcare records and appropriate ward transfer or hospital admissions

A continued focus on improving the recognition and management of sepsis has resulted in improvements in delivering antibiotics to patients within the hour in the Emergency Department. Sepsis trolleys are being used in both Emergency and selected inpatient areas to enable timely administration of antibiotics for patients with suspected sepsis. During Q4 there has been a consistent reduction in the number of deaths of patients admitted with sepsis.

During March 2019 the weekly safety message highlighted significant learning identified from a patient's death from fulminant meningococcal septicaemia highlighting the importance of active consideration of Sepsis and escalation of deteriorating patients using the NEWS score. The learning from this particular incident was also shared widely across the Trust in teaching and at the Trust Grand Round.

PREVIOUS DISCUSSIONS HELD

Mortality Review Committee:

January 14 & 28 2019

February 11 & 25 2019

March 13 & 25 2019

Patient Safety and Clinical Effectiveness Committee:

January 21 2019

February 21 2019

March 21 2019

KEY IMPLICATIONS

Financial	
Patient Safety or Quality	Completion of the mortality review process in a timely manner supports patient safety through investigation of problems in care and learning from deaths to improve services provided to patients
Human resources	Time needed to complete mortality reviews in a timely manner by consultants has implications for consultant availability.
Operational	

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Quarterly Mortality Performance Report Q4– January 2019- March 2019

1.0 Background to Report

UHCW is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes such as mortality is important to Trusts as it helps provide assurance and evidence that the quality of care is of a high standard, and to make sure any issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil 2 of the 5 domains set out in the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The Trust uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation.

In addition to this, the Trust has an in-depth mortality review process where each death of an inpatient aged 18 and above is subjected to an initial review of their care and graded according to the standard of care they received. Deaths in patients under 18 years old are reviewed using a separate mortality review process. This incorporates external processes for example, Child Death Overview Panel (CDOP). Further reviews are conducted by an appropriate consultant or team if potential problems in care have been identified. This is to encourage learning from patient outcomes.

The Trust mortality review process works to achieve the Trust objective to deliver excellent patient care and experience through:

- Sharing and identifying learning from mortality reviews and analysis of mortality indicators
- Actively participating in system wide working within Coventry and Warwickshire to ensure effective population health' through collaborative working with the Clinical Commissioning Groups and support of the LeDeR programme for Learning Disability deaths

All mortality processes are overseen by the Trust's Mortality Review Committee, chaired by a Deputy Chief Medical Officer and attended by the Chief Medical Officer. The Mortality Review Committee reports into the Trust's Patient Safety and Clinical Effectiveness Committee each month.

This report provides information to the Trust Board on the performance of UHCW NHS Trust during Q4 January 2019- March 2019, meeting national recommendations.

2.0 Trustwide Mortality Review: January 2019- March 2019 Performance

Each inpatient aged 18 or above is subjected to a structured primary mortality review by the specialty involved in their care at the time of their death. All patients subjected to a review have their care graded by a Consultant, using the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Classification of Care grading A-E.

2.1 During the time period 1 January to 31 March 2019 there have been 645 deaths (including ED and aged under 18) with 603 requested primary mortality reviews for inpatients (and those who died within the Emergency Department), 71% of which have been completed (426/603).

	Completed	Incomplete
2018/2019	86.56%	13.39%
Quarter 1	98.06%	1.94%
Quarter 2	96.62%	3.14%
Quarter 3	88.17%	11.83%
Quarter 4	67.59%	32.41%
Grand Total	86.56%	13.39%

Primary review completion of Inpatient deaths as at 14/05/2019 (excluding ED deaths)

To meet national recommendations, the Trust has moved to a peer review model for assessing primary and secondary reviews. Clinicians continue to be supported by the Clinical Effectiveness Team to promote the Trust Wide mortality review process with specialty focused training and frequent updates on the status of any outstanding Primary Mortality Reviews.

The figure below shows the NCEPOD grade of all completed primary reviews between 1 January 2019 – 31 March 2019. It highlights that 92% (334/540) of inpatient reviews were graded NCEPOD A for 'good care'.

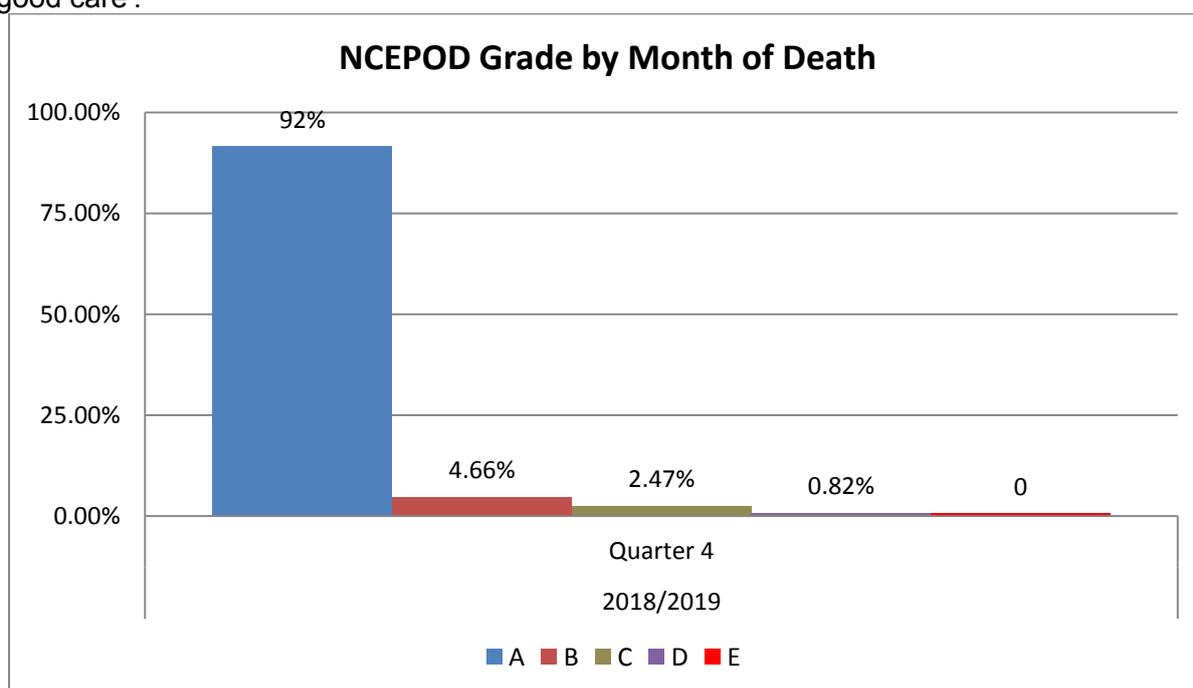


Figure 1: NCEPOD Classification Rate (All data extracted 14/5/2019)

2.2 All patients who are graded NCEPOD B-D during primary review, have a further secondary review completed as the grade highlights that there were aspects of care which could have been improved. The purpose of the secondary review is to identify areas for learning and actions to help improve patient care and avoid similar problems occurring. This is a multi-disciplinary approach and these cases are discussed in specialty meetings to ensure that learning is shared. Theme analyses are conducted from secondary reviews and shared throughout the Trust to promote improvements in patient care.

For all deaths between 1 January 2019 – 31 March 2019 which have had a completed primary mortality review, there were 36 requested secondary reviews (cases graded NCEPOD B-D),

suggesting an equal number of opportunities for learning. Currently 53% of these secondary reviews have been completed (19). Of the incomplete secondary mortality reviews (17), 100% are still within the 2 month allocation for completion (as at 14/5/2019). Of the completed secondary reviews, 31% (6 reviews) have been re-graded to NCEPOD A (good care) following discussions with their specialty's team members. The Trust is committed to identifying areas for improvement in an open and transparent manner.

- 2.3** Deaths which are graded NCEPOD E (less than satisfactory care) have an investigation into their death reviewing all aspects of care. This is completed by the Mortality Lead for the specialty involved and reported to the Mortality Review Committee. The Committee then discusses the case and agrees appropriate action including investigation via the serious incident group. Trend analyses for NCEPOD E deaths are also conducted in the Trust to enable identification for improvement areas and to disseminate learning.

For all deaths between 1 January 2019- 31 March 2019 there have been 2 cases graded NCEPOD E at primary or secondary review. All deaths graded E are investigated via the Serious Incident Framework.

The total number of deaths investigated via the Serious Incident Framework for Q4 January 2019- March 2019 is 8.

- 2.4** The deaths of patients with a learning disability are monitored within the Trust in line with national recommendations and reviewed as part of the Trust wide mortality review process. Patients with a learning disability are identified by the learning disability team using an alert on Clinical Results Reporting System (CRRS). Data on the number of patients with a learning disability who have died is received by the Mortality Review Facilitator from Performance and Informatics Office.

The number of inpatient deaths of patients with a learning disability between January 2019- March 2019 is 2. During the last financial year April 2018- March 2019 there were 7 deaths with reported learning disabilities. This information along with the learning identified from the mortality review process is reported through the Trust Mortality Review Committee.

The national Learning Disabilities Mortality Review Programme LeDeR has launched in the West Midlands. The Trust is committed to supporting the review programme as part of the current mortality review process. All patients with learning disabilities who have died at UHCW during Q4 have been referred to the LeDeR programme. The Trust is represented at the regional LeDeR steering group where learning from the LeDeR process is shared.

- 2.5** In hospital deaths of patients with severe mental illness are monitored as part of the Trust's current mortality process for all in hospital deaths over the age of 18. During 1 January – 31 March 2019 there were 7 in-patients that died with an identified mental illness on the Primary Mortality Review form.

3.0 Learning from Deaths

The mortality review process allows specialties to identify areas of learning and improve care for patients.

Learning themes identified from the Trust Wide mortality review process are transformed into local actions to improve patient care and fed back through the mortality review committee. Learning is also shared across the wider organisation with weekly safety messages, daily safety huddles, Grand Round presentations and the Mortality Newsletter.

Learning themes and areas for improvement identified from mortality review include timely diagnosis and treatment, the quality of healthcare records and appropriate ward transfer or hospital admissions. Admission to hospital of patients who are recognised as being at the end of life and a need for

appropriate advanced care planning are also learning themes identified from the learning from deaths process.

Improvements in care as a result of the Trust mortality review process continue to include additional training for junior doctors in the application of care bundles e.g. AMBER and 'Sepsis 6', and End of Life care.

3.1 A continued focus on improving the recognition and management of sepsis has resulted in improvements in delivering antibiotics to patients within the hour in the Emergency Department. Sepsis trolleys are being used in both Emergency and selected inpatient areas to enable timely administration of antibiotics for patients with suspected sepsis. During Q4 there has been a consistent reduction in the number of deaths of patients admitted with sepsis.

3.2 During January- March 2019 the weekly safety message highlighted significant learning identified from a patient's death from fulminant meningococcal septicaemia highlighting the importance of active consideration of Sepsis and escalation of deteriorating patients using the NEWS score. The learning from this particular incident was also shared widely across the Trust in teaching and at the Trust Grand Round.

4.0 Mortality Indicators: Hospital Standardised Mortality Ratio (HSMR)

4.1 The HSMR is a mortality indicator (provided monthly), which looks at inpatient deaths in comparison to 'expected' deaths. Expected deaths are calculated by assigning each patient a mortality risk, accounting for factors such as age, gender, co-morbidities, diagnosis group, palliative care coding, amongst others. The HSMR includes 56 diagnosis groups that contribute to 80% of inpatient hospital mortality (nationally). The HSMR is calculated using the below calculation:

$$\frac{\text{Actual deaths}}{\text{Expected deaths}} \times 100$$

Equation 1: HSMR and Relative Risk Calculation

The national benchmark for mortality performance is 100. If the HSMR value is above 100 it indicates that there has been more deaths than expected. If the HSMR value is below 100 it indicates that there have been fewer deaths than expected. If there is a statistically significant difference between the actual number of deaths and expected number of deaths, either a positive alert or a negative HSMR alert will occur.

4.2 HSMR data is received by the Trust 3 months in arrears. The most recent release of data includes mortality for all deaths for the year to January 2019. The HSMR for the most recent 12 months of data (Feb 2018- Jan 2019) is 100.3. This position is 'within expected' statistical ranges. The HSMR value for January 2019 is 112.7 which is also within the 'expected' ranges.

The chart below shows the HSMR trend for UHCW for each month from February 2018- January 2019. Changes in HSMR are discussed and investigated through the Mortality Review Committee including a review of elective admissions, clinical coding and diagnosis groups with more observed deaths than expected.

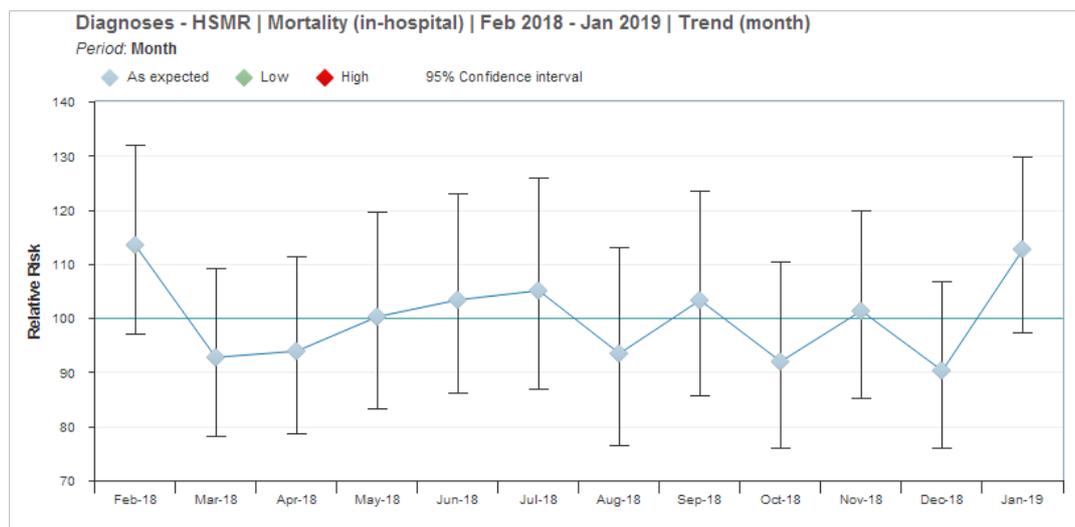


Figure 2: HSMR Trend by Month (February 2018- January 2019)

5.0 Mortality Alerts

- 5.1** Each month, diagnosis and procedure groups which have generated negative alerts through Dr Foster (significantly more deaths than expected) are discussed at the Mortality Review Committee. Appropriate action to address the alerts is agreed.
- 5.2** During the rolling 12 month period February 2018- January 2019 (latest available Dr Foster Intelligence data), the Trust identified 52 mortality alerts, 29% of which have been positive alerts (15). All negative mortality alerts have been reviewed by the Mortality Review Committee and appropriate actions assigned and monitored for completion. Ongoing actions to reduce HSMR include the development and monitoring of care bundles and the investigation of the diagnosis groups with the highest difference between observed and expected deaths.

6.0 Mortality Indicators: Summary Hospital-level Mortality Indicator

- 6.1** The SHMI is a national indicator published by NHS Digital quarterly and is 6 months in arrears. The national benchmark for the SHMI is 1. Similar to the HSMR, a value below the benchmark indicates fewer deaths than expected, while a value above this highlights more deaths than expected. UHCW reports SHMI data to the Mortality Review Committee on a quarterly basis.
- 6.2** The most recent publication for the SHMI is for October 2017 – September 2018 (published by NHS Digital, in January 2019). The majority of Acute Trusts in this publication were within the ‘expected’ mortality range (76%; 101 Trusts). In this publication, UHCW is within the expected position with a SHMI value of 1.12. During this time period there were 2,971 deaths recorded compared to 2,652.2 ‘expected’ deaths. The majority of deaths were inpatient deaths (67%), and 33% (964) of deaths were within 30 days of discharge. The Trust monitors SHMI through the mortality review committee and has identified areas of focus via a Mortality Oversight Group in response to the data.
- 6.3** An action plan to focus on the key diagnosis groups of Septicaemia and Intracranial Injury with a view to reduce SHMI has been completed alongside further work to progress collaborative working with the Clinical Commissioning Groups, Partnership Trust, GP’s, other local Secondary Care Provides and Public Health to understand patient pathways including advanced care planning on discharge from hospital and explore ways of learning from deaths 30 days after discharge.

The group is initially focussing on reviewing the current SHMI position of local providers within the local area and working with community services to understand the factors that may be influencing patient care and experience including admission and discharge methods.

7.0 Mortality Outlier Alerts

7.1 The Care Quality Commission (CQC) monitors mortality outlier alerts using statistical data. Outlier alerts are generated when there have been a significantly higher number of deaths than calculated. Other external or national bodies such as Royal Colleges will also contact the Trust regarding mortality outlier Alerts. 2 letters relating to mortality outlier alerts has been received between January 2019- March 2019 from CQC and Imperial College London relating to a Mortality Outlier Alerts for Acute Myocardial Infarction and Intracranial Injury.

Mortality Outlier Alert for Skin and Subcutaneous Tissue Infection and been closed by the CQC.

Responses to the alert notifications, outlining a review of the data and actions to improve patient care have been returned.

8.0 Additional Developments

8.1 Mortality Oversight Group

Collaborative working across the STP footprint between UHCW, surrounding providers, Clinical Commissioning Groups, GP's and Public Health has provided the opportunity to explore learning from deaths of patients in hospital and after discharge. The oversight group meets quarterly to review the key diagnosis groups identified in SHMI data and discuss the pathways of patients to identify improvement in primary and secondary care.

**Author: Sharron Oulds, Associate Director of Quality- Effectiveness and Assurance.
May 2019**

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Quarterly Mortality Performance Report Q4 – May 2019

1. Purpose

The purpose of this paper is to provide a quarterly overview of Trust-level mortality data for the time period Q4 January 2019- March 2019, and performance for the time period February 2018 to January 2019 (latest available Dr Foster Intelligence data), providing assurance that any highlighted concerns are investigated thoroughly and appropriate action is taken.

2. Background and Links to Previous Papers

Investigating and reporting mortality data enables the Trust to identify ways to improve patient safety and patient outcomes.

3. Narrative

Mortality Review

- The completion rate for primary mortality reviews during Q4 January 2019- March 2019 is 71%.
- During Q4 January 2019- March 2019 there have been 2 NCEPOD E graded deaths.

92% of completed primary reviews between Q4 January 2019- March 2019 received an NCEPOD grade A highlighting good standards of patient care.

All primary reviews graded B-E have a further secondary mortality review; these are discussed at specialty mortality and patient safety meetings to share the learning and improve patient care. There have been 36 identified opportunities graded B-E for learning from deaths between January 2019- March 2019.

During Q4 January 2019- March 2019 there has been 2 deaths of patients with Learning Disabilities and 7 Deaths of patients with identified Mental Illness during the primary review process.

Mortality indicators: HSMR

- The Trust HSMR value for the latest available 12 months of data (February 2018- January 2019) is 100.3. This is within the expected statistical ranges compared to acute non-specialist trusts in England.

The Hospital Standardised Mortality Ratio (HSMR) compares all inpatient deaths to expected deaths. HSMR above 100 indicates more deaths than expected, and a HSMR below 100 indicates fewer deaths than expected. The Mortality Review Committee continues to proactively undertake investigations into diagnosis groups with a higher than expected number of deaths to identify potential improvements in care. Ongoing actions to reduce HSMR include the development and monitoring of care bundles and a review of diagnosis groups with higher observed deaths than expected.

Mortality Alerts – Dr Foster Intelligence

- Between February 2018- January 2019 the Trust received 52 mortality alerts, 29% of which were positive alerts.

Each month, diagnosis and procedure groups which have generated negative alerts through Dr Foster Intelligence (significantly more deaths than expected) are discussed at the Mortality Review Committee and appropriate action is agreed to address the alerts.

Mortality Indicators: SHMI

- The SHMI value (October 2017 – September 2018) is 1.12 indicating a 'within expected' position.

The Summary Hospital-Level Mortality Indicator (SHMI) differs from HSMR as it not only includes all inpatient deaths, but also deaths which occur 30 days after discharge. It uses a benchmark of 1 instead of 100. SHMI above 1 indicates more deaths than expected, and a SHMI below 1 indicates fewer deaths than expected.

An action plan to focus on the key diagnosis groups of Septicaemia and Intracranial Injury with a view to reduce SHMI has been completed alongside further work to progress collaborative working with the Clinical Commissioning Groups, Partnership Trust, GP's, other local Secondary Care Provides and Public Health to understand patient pathways including advanced care planning on discharge from hospital and explore ways of learning from deaths 30 days after discharge.

The group is initially focussing on reviewing the current SHMI position of local providers within the local area and working with community services to understand the factors that may be influencing patient care and experience including admission and discharge methods.

Learning from Deaths

Learning themes and areas of improvement identified from Secondary reviews of deaths in Q4 include timely diagnosis and treatment, the quality of healthcare records and appropriate ward transfer or hospital admissions

A continued focus on improving the recognition and management of sepsis has resulted in improvements in delivering antibiotics to patients within the hour in the Emergency Department. Sepsis trolleys are being used in both Emergency and selected inpatient areas to enable timely administration of antibiotics for patients with suspected sepsis. During Q4 there has been a consistent reduction in the number of deaths of patients admitted with sepsis.

During March 2019 the weekly safety message highlighted significant learning identified from a patient's death from fulminant meningococcal septicaemia highlighting the importance of active consideration of Sepsis and escalation of deteriorating patients using the NEWS score. The learning from this particular incident was also shared widely across the Trust in teaching and at the Trust Grand Round.

4. Areas of Risk

There are no risks on the risk register

5. Governance

Mortality assurance and reporting is monitored by the Mortality Review Committee chaired by the Deputy Chief Medical Officer (DCMO) and attended by the Chief Medical Officer. The Committee's actions are monitored through Patient Safety and Clinical Effectiveness Committee, which provides assurance to Quality Governance Committee. Trust Board receives a report on mortality performance every 3 months to meet national expectations.

6. Responsibility

The Mortality Review Committee is responsible for assuring the Trust Board that mortality is proactively monitored, reviewed, reported and where necessary, investigated. The committee ensures any lessons and actions are implemented and disseminated to improve outcomes.

7. Recommendations

[A] The Board is invited to **Note** the Trust's mortality performance for the given time period

Author: Sharron Oulds, Associate Director of Quality: Effectiveness and Compliance
15/5/2019

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Controlled Drug Accountable Officer Report April 2018 to March 2019
Executive Sponsor	Richard de Boer, Chief Medical Officer
Author	Mark Easter, Accountable Officer & Janette Knight, Medicines Assurance Lead
Attachment:	Controlled Drug Accountable Officer Report Appendix 1: Breakdown of UHCW NHS Trust LIN incidents reported 2018/2019 Appendix 2: Controlled Drug Quarterly Audit Results - Quarterly Comparison 2018/2019
Recommendation:	This is the second Controlled Drug Accountable Officer's Annual Report to be presented with the Board papers to support and acknowledge the work of the Medicines Committee and Accountable Officer.

EXECUTIVE SUMMARY

This paper is complimentary to the annual Medicines Optimisation Board Report and provides Trust Board with information of the Controlled Drugs safe use and management activities over the last financial year to support the Trust's medicines optimisation strategy. This is the second annual report submitted to the Board which provides the national updates relating to the safe use and management of medicines and the Trust's activities, monitoring, risk and risk mitigation to meet compliance with these regulatory activities.

PREVIOUS DISCUSSIONS HELD

Trust Board May 2018

KEY IMPLICATIONS:

Financial	Cost effective use of medicines
Patients Safety or Quality	Safe use and management of medicines
Human Resources	
Operational	

REPORT TO TRUST BOARD

Controlled Drug Accountable Officer Report

1. INTRODUCTION

- 1.1 'Dangerous or otherwise harmful drugs' known as 'Controlled Drugs' (CDs) are controlled under 'The Misuse of Drugs Act (1971)' and subsequent amendments. The purpose of the Act is to prevent the misuse of CDs and imposes a ban on the possession, supply, manufacture or importation of CDs, except where allowed by regulations.
- 1.2 The purpose of this report is to provide an assurance to the Board on the activities undertaken during the 12 months 2018/19 on the safe and secure management of controlled drugs within the Trust, in accordance with legal and Department of Health requirements.
- 1.3 A number of drugs used within the Trust, hereafter referred to as "controlled drugs" these include opiate analgesics, stimulants (e.g. dexamphetamine), barbiturates and benzodiazepines. The strict legislative controls on who can prescribe, supply, be in possession of and administer controlled drugs, and how and where they can be manufactured, prepared, stored, supplied, transported and destroyed are stated in the Misuse of Drugs Act (1971) and subsequent amendments.
- 1.4 In response to the Shipman Enquiry, the Department of Health (DH) issued the document Safer Management of Controlled Drugs: Guidance on strengthened governance arrangements, which imposes additional controls on the management of controlled drugs. One of the key requirements of this document is the need for all NHS Trusts to appoint an Accountable Officer (AO) for Controlled Drugs. The AO must ensure the safe and effective use and management of controlled drugs within the organisation, and to monitor the use of controlled drugs and take appropriate action when necessary. Revised regulations were issued in February 2013, to account for the re-organised structure of the NHS from that date.
- 1.5 The DH document also requires each Local Area Team to establish a Local Intelligence Network (LIN), comprising AOs, police, counter-fraud, social services and inspecting bodies. The LIN provides a forum where confidential information relating to controlled drugs incidents can be shared.
- 1.6 A subsequent document, Safer Management of Controlled Drugs: 'A guide to good practice in secondary care' (England), issued by the DH in October 2007, provides detailed guidance on the management of controlled drugs in hospitals.
- 1.7 This guidance has been used to compile a detailed Controlled Drugs Policy and supportive Clinical Operating Procedures. The Policy and supportive Clinical Operating Procedures are available on the Trust intranet site and the Pharmacy SOPs upon request. Adherence monitoring is undertaken by the Pharmacy team and assurance reported at the Medicines Management Committee.

2. UPDATES FROM NATIONAL GROUPS

- 2.1 **Department of Health & Social Care - Controlled Drugs (Supervision of Management and Use) Regulations 2013.** The Department of Health & Social Care (DHSC) is continuing to review the Controlled Drugs (Supervision of Management and Use) Regulations 2013. It is anticipated that the DHSC aims to publish the review report later this year (2019) – with the primary recommendation being to maintain the current regulations and update these where necessary.

- 2.2 **The Controlled Drugs (Supervision of Management and Use) Regulations 2013** - The Accountable Officer and Medicines Assurance Lead completed the Department of Health & Social Care (DHSC) on-line questionnaire in April/May 2018 providing their views on the value the Controlled Drugs (Supervision of Management and Use) Regulations 2013 provides to support the safe use and management of these medicines. It is anticipated that the DHSC will present their recommendations to replace the 2013 regulations to ministers later this year, that if accepted will result in new regulations being brought into force before the current regulations cease to have effect on 31 March 2020.
- 2.3 **Home Office Safe Custody Regulations 1973** - The review of the Safe Custody Regulations 1973 is still on-going and it is anticipated that further announcements to the status of the review will be made during 2019.
- 2.4 **Home Office – Medicinal Cannabis** - On 31st October 2018, NHS England issued interim clinical guidance to clinicians on the prescribing of cannabis-based products for medicinal use. They followed up on this on 20th November with an addendum clarifying that whilst there is interim guidance for doctors on the GMC Specialist Register in relation to prescribing cannabis-based products for medicinal use in a limited number of conditions. UHCW NHS Trust Drug & Therapeutics Committee has not received any applications for medicinal cannabis use in 2018/19. The Drug & Therapeutics Committee are awaiting further guidance from NICE that is expected to be published by October 2019.
- 2.5 **Home Office - Pregabalin and Gabapentin schedule reclassification** - In November 2018 the Home Office announced that pregabalin and gabapentin are to be placed in schedule 3 as controlled drugs and the new legislation would come into effect in April 2019. The legislative changes and subsequent actions to ensure the Trust complies with the changes to legislation were presented to the Trust's Medicines Management Committee and were implemented on 1st April 2019.
- 2.6 **CQC Self-Assessment – Annual Review** - The CQC Self-Assessment Tool is designed to be used by the Accountable Officer as part of an annual review to assess their organisation's arrangements for controlled drugs governance and identify areas requiring improvement. The tool covers governance of CDs, including access to these medicines, standard operating procedures, management of CDs in the hospital pharmacy, wards and departments, transport, auditing, reporting of incidents and information sharing. This annual review was completed in April 2019 and presented at the Medicines Optimisation Committee in February. This review has identified areas for improvement associated with transportation of patients own medicines within the Trust between clinical areas.
- 2.7 **NICE NG46 Baseline Assessment Tool – Compliance**. In April 2019 a review of the NICE Baseline assessment tool for Controlled drugs: safe use and management (NICE medicines practice guideline NG46) by the Accountable Officer and Medicines Assurance Lead agreed that 60/65 (92%) relevant recommendations were met. Recommendations not met due to insufficient evidence to provide assurance are scheduled to be discussed and include an action plan to mitigate any risk associated with the guidance not being met at the Medicines Management Committee in May 2019.

3. **TRUST GOVERNANCE OF CONTROLLED DRUGS**

- 3.1 The Trust's Controlled Drugs Accountable Officer (CDAO) quarterly occurrence reports have been prepared by the Trust Medicines Assurance Lead on behalf of the CDAO, presented and approved by the Medicines Optimisation Committee before submission to the NHS Arden & Greater East Midlands Controlled Drug Local Intelligence Network. The format of the reports have been changed to support national reporting and it is anticipated that the data can be evaluated nationally and support future benchmarking initiatives.
- 3.2 The reports provide an overview of moderate to high risk CD related incidents as categorized by the LIN risk, type and category breakdown chart found in appendix 1 the status of the investigation at the time the occurrence report was submitted and the learning from these

incidents is shared by the Trust CDAO and Medicines Assurance Lead during these quarterly LIN meetings.

- 3.3 Assurance of Controlled Drugs governance is provided through the monitoring of incidents managed through the Medicines Governance Committee structure. The Trust's CDAO Local Intelligence Network quarterly occurrence reports are approved by the Medicines Optimisation Committee prior to submission.
- 3.4 The Medicines Optimisation Committee reviewed the Gosport War Memorial Hospital The Report of the Gosport Independent Panel that was published in June 2018 and agreed to include 'fitness to practice concerns' to the committees agenda for the CDAO to be cited on any Trust employee where investigations are taking place or restrictions to practice have been applied.
- 3.5 The Trust has fitness to practice meetings in place for medical and nursing staff. The Director of Pharmacy, Allied Healthcare Professional (AHP) Lead and the Lead for Clinical Scientists are developing a fitness to practice meetings for AHPs, Clinical Scientists and Pharmacy Professionals.
- 3.6 The Medicines Optimisation Committee tasked the Medicines Management Committee to complete a full gap analysis review of the Department of Health & Social Care Learning from Gosport Report, The Government response to the report of the Gosport Independent Panel (Nov 2018) and provide recommendations for actions where necessary to ensure compliance with the recommendations.
- 3.7 In February 2019 the interim secondment post to support the Accountable Officer in the development and ongoing management of the Controlled Drugs Policy, the medicines Governance structures and management of CD related incidents was made substantive.

4. CONTROLLED DRUGS – WARDS AND DEPARTMENTS

- 4.1 The management of controlled drugs on each ward and department are audited quarterly by a pharmacy staff for regulatory and best practice standards compliance. Compliance with the requirements for the management of controlled drugs has generally been very good. The audits have however identified a few recurrent issues as detailed below on some wards and/or departments although these numbers fluctuate with each quarterly audit. Detail of the compliance for each quarterly audit completed in 2018/19 are provided in appendix 2
- 4.2 The following standards have been consistently difficult for clinical areas to achieve compliance.
- 4.3 CD registers were found with damaged covers and torn, loose pages. This was identified as a problem with the Patients Own CD registers and arrangements for these to be procured with hardback covers has reduced the number of torn covers.
 - The CD cabinet was found to contain other non-CD medicines and objects. It should be noted that 100% compliance was achieved for Q3 2018/19.
 - The CD register error entries had been obliterated, amended or crossed out.
 - CD stock reconciliation checks have not always been undertaken twice a day in some wards.
- 4.4 It is anticipated that the automated medicines cabinets, once the standards, procedures, and training programme have been presented and approved for use by the Trust's Medicines Committees will help to address better compliance with these standards, through the use of electronic CD registers and additional storage facilities to enable the segregation of Patients Own Controlled Drugs.
- 4.5 A 95% compliance target was set by the Chief Nursing Officer in be set for the quarterly controlled drug audit and where this target was not met, the ward/department manager would be asked to provide an action plan to address the deficiency identified. Action plan evidence

and feedback discussion are monitored through the controlled drug quarterly audits presentation at the Nursing and Midwifery Quality meetings where concerns in compliance are escalated if appropriate to the CDAO.

- 4.6 The controlled drugs policy requires wards & departments controlled drug stock balances to be checked twice daily by two healthcare practitioners. The controlled drug stock checks are assessed as part of the quarterly audit. Any stock balance discrepancies identified are reported as clinical incidents on Datix and investigated and monitored by the Medicines Assurance Lead through a Datix dashboard as part of their role to support the Accountable Officer with their work.
- 4.7 All Trust employees are actively encouraged to report CD medicines incidents as part of the Quality & Safety strategy and regulatory requirements associated with medicines. Following commencement of the automated medicines cabinets in July 2018, the Trust has experienced a higher number of reported discrepancy incidents relating to schedules 3 and 4 controlled drugs. This increase has been associated with automated medicines cabinets' user incidents following the rapid roll out programme for installation of these new cabinets.
- 4.8 In February 2019 the Controlled Drug Incident Review Group was established to critically review the CD medicines incidents each month to ensure learning opportunities are not missed and provides a monthly feedback report to the Medicines Management Committee and where necessary escalation of any practice concerns. There have been no practice concerns escalated to the Medicines Management Committee associated with these Datix incident reports.

5. **CONTROLLED DRUGS AUDITS – PHARMACY**

- 5.1 The management of controlled drugs in the pharmacy department is assessed by the Senior Technician for Quality and Innovation. The assessment includes an audit undertaken to monitor expired and patients own controlled drugs returned to pharmacy for disposal. The audit was last completed in May 2018 results found 100%. The results are shared with the Accountable Officer and the pharmacy team through the Quality Improvement & Patient Safety (QIPS) meeting.
- 5.2 In July 2018 the pharmacy department installed an automated medicines cabinet for the storage and management of pharmacy controlled drugs stocks. The automated medicines cabinet enables pharmacy to use electronic CD records and registers for all the sale and supply of CD medicines that are required under the Misuse of Drugs Act 1971 and its amended orders.
- 5.3 The pharmacy department undertakes daily rolling stock checks for controlled drugs to reconcile stock levels on the pharmacy JAC stock control system, automated medicines cabinets and physical stocks in pharmacy.
- 5.4 The Pharmacy department at University Hospital holds a Home Office License to enable controlled drugs to be supplied as part of the Pharmacy's Wholesalers Dealers License (WDL). The annual returns submission for Controlled Substances was submitted to the Home Office by the Pharmacy department as part of the WDL regulatory requirements in January 2018.
- 5.5 The Trust is required to ensure medicines waste is stored, transported and disposed of in accordance with the Environmental Act 1990 and Controlled Waste Regulations 2012. An application was made in 2017 to the Environmental Agency for S2 and T28 Waste Exemption Certificates for both St. Cross and University Hospitals for storing, sorting and denaturing controlled drugs for disposal. The current exemption certificates are valid until February 2020.
- 5.6 Pharmacy Outpatient was outsourced in September 2013 to Lloyds. The agreement within the contract requires that any concerns regarding the unsafe use or management of medicines would be reported immediately to the Pharmacy Governance & Safety Team and

the Trust's Accountable Officer. There have been no reports of unsafe use or management of medicines reported to the Trust.

6. MEDICAL GASES

- 6.1 Medical gases are classified as medicines and are subject to the same legislative governance requirements for custody, prescribing and administration.
- 6.2 There has been an increase in the number of thefts of medical gas cylinders containing nitrous oxide (commonly known as laughing gas) from NHS hospitals in England in recent years, due to its popularity for recreational abuse for the purpose of causing euphoria and or hallucinations. In 2018/19 there were no reported thefts of these gases from the Trust following a review and improved security arrangements for storage of these medicines.

7. TRAINING

- 7.1 Medicines management training workshops, that include training for controlled drugs are delivered by the Nurse Practice Facilitator and Medicines Assurance Lead for the nurse preceptorship programme (training for newly qualified nurses), nursing and operating department practitioners (ODPs). See table 1 below for details. The medicines management training workshops continue to receive positive feedback from those who attend and will continue to be delivered monthly in 2018/19.

Type of Training Workshop Delivered 2018/19	No: of Workshops	No: of Attendees
Medicines Management Workshops	9	112
Preceptorship Medicines Management Workshops	5	164
Total	14	276

8. AREAS OF RISK

- 8.1 Misappropriation of medicines is a growing concern due to the society for abuse of medicines that is shared within the Local Intelligence Networks.
- 8.2 Illicit Substances. The Trust experienced 10 incidents during 2018/19 where suspected illicit substances were brought onto the hospital premises by patients or visitors. It is considered a growing area for concern and following the recruitment to the West Midlands Police Controlled Drug Liaison Officer post in November 2018 collaboration to support the development of a new clinical operating procedures to ensure the governance arrangements for the handling, removal and disposal of suspected illicit substances safely by healthcare professionals is imbedded within the Trust and minimize the risks associated with the possession and disposal of these substances.
- 8.3 Training of Medical Staff. Medicines management training workshops are designed to be delivered to nursing and operating department practitioners. There is currently no specific training for controlled drugs practice other than prescribing modules for junior medical staff as part of their FY1 training. Training packages are in development for all trainee doctors and Consultants by Pharmacy and the Associate Medical Director for Education

9. CONCLUSIONS

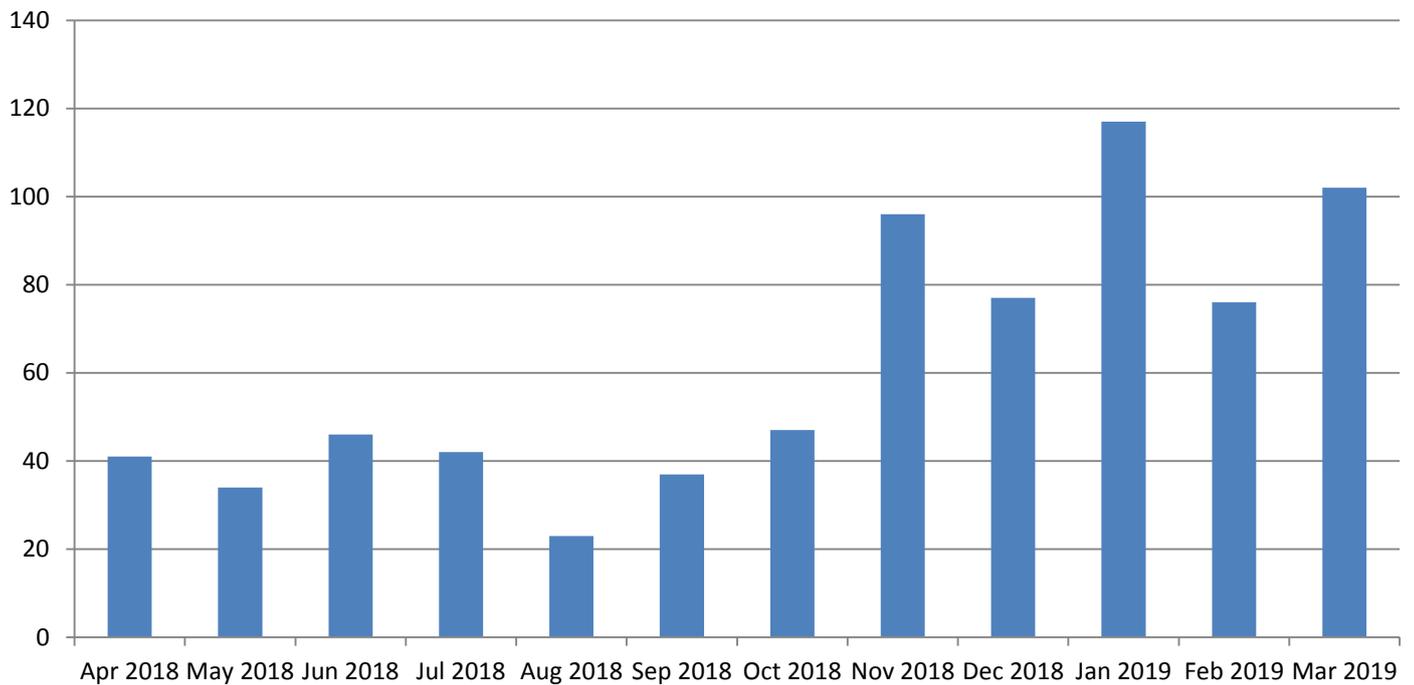
- 9.1 During 2018/19 the medicines committees have continued to monitor the safe use and management of controlled drugs to ensure compliance with legislation, national guidance and best practice. The continual monitoring and auditing of practice continues to provide opportunities for focused actions to drive improvements going forward to 2019/20 including:

- Continue to review and monitor that robust processes ensure the safe use of these medicines and that they are secure at all times.
- Develop a procedure for completing documentation in CD registers
- Provide Controlled Drug training for medical staff
- Encourage the reporting of CD incidents to enable learning from patterns and trends associated with these medicines
- The automated medicines cabinets practice is embedded with the aim to move CDs into the cabinets

Breakdown of UHCW NHS Trust LIN incidents reported 2018/2019

Category / Type of incident		Number of occurrences	LIN Risk Rating			
			Low	Moderate	High	Extreme
Patient Safety Incidents	Prescribing	21	10	10	1	0
	Dispensing	15	11	4	0	0
	Administration	116	66	45	5	0
	Other	585	490	83	12	0
	Annual Total	737	577	142	18	0
Unaccounted for losses such as theft and fraud (from the organisation), unexplained stock discrepancies, lost prescriptions / requisitions		205	159	44	3	0
Accounted for losses such as spillages, breakages		102	97	5	0	0
PSI / Patient / public Patient Safety Incidents or incidents relating to the public (this includes 11 incidents for suspected illicit substances)		101	44	48	9	0
Professional individuals of concern These are relevant individuals i.e. people who work in health or social care		1	0	0	1	0
Governance issues such as CD safe custody, staff competence, audit, statutory requirements, SOPs		104	72	28	4	0
Record keeping		224	205	17	1	0
Annual Totals		737	577	142	18	0

UHCW NHS Trust - Number of Controlled Drug Incidents Reported by Month 2018/19



Examples of NHS England LIN Occurrence Report Risk, type and category chart.

Risk rating	Examples: Type of incident	Category
Low	Recording errors	Record keeping
Low	Storage error	Governance
Low	Dispensing error - before reaching patient	Patient related
Moderate	Destruction error	Unaccounted for losses
Moderate	Delivery error	Unaccounted for losses
Moderate	Lost / Stolen / Missing CDs	Unaccounted for losses
High	Illicit use by patient	Patient related
High	Police investigation	Patient related
High	Discharge procedure error where patient takes drug	Patient related
High	Prescribing error – patient taken	Patient related
High	Never event	Patient related
Extreme	Patient death	Death

Appendix 2																
Controlled Drug Quarterly Audit Results - Quarterly Comparison 2018/2019																
Speciality	Q No	ENQUIRY	2018/2019			2018/2019			2018/2019			2018/2019			OVERALL COMPLIANCE	
			Quarter 1			Quarter 2			Quarter 3			Quarter 4				
			Wards	Theatres	Clinical/ OP											
1. Regulations & Legislation	1.1	Does the CD cabinet comply with B2881 and the requirements of the Misuse of Drugs Act?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Fully Compliant	
	1.2	Confirm that the nurse in charge is in possession of the keys or knows where they are?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	1.3	Is there a printed list of nursing staff and their signatures, authorised to order CD's available on the ward?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	1.4	Was the CD cabinet found locked?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	1.5	Is there a CD current stock list, dated within the last 6 months available on or in the cabinet?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	1.6	Is the CD cabinet free from other non CD medicines and objects? IE, Money, valuables or mobile phones etc.	98%	100%	100%	96%	100%	100%	100%	100%	100%	96%	97%	100%	99%	
	1.7	Are registers and order books stored securely and access restricted to authorised staff?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Not applicable
	1.8	Are registers and the requisition book fit for use, i.e. Covers are intact and there are no loose pages?	93%	90%	100%	85%	97%	100%	94%	90%	100%	93%	100%	100%	95%	
	1.9	Are all CD register entries legible and there are no obliterated entries?	63%	74%	93%	58%	64%	93%	63%	87%	100%	70%	79%	100%	79%	
	1.10	Are CD stock checks undertaken twice daily completed and witnessed by 2 registered individuals?	98%	100%	100%	93%	100%	100%	94%	100%	100%	92%	100%	100%	98%	
	1.11	Is there a separate page in the CD register for each drug, formulation and strength?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	1.12	Are all entries supported by 2 signatories?	100%	100%	100%	98%	100%	100%	98%	100%	100%	93%	100%	100%	99%	
	1.13	Are Controlled drug stock and administration records fully maintained in the ward CD record book and that there is a correct running balance?	100%	100%	100%	98%	100%	100%	100%	100%	100%	94%	100%	100%	99%	
	1.14	Are part used controlled drug ampoules and accidental breakages / spillages disposed of in the denaturing kit?	98%	100%	100%	98%	100%	100%	98%	100%	100%	100%	100%	100%	99%	
	1.15	Is all waste / spillage recorded, documented and witnessed in the CD register?	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	
	1.16	Are CD registers retained / archived for 7 years?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	1.17	Can the nurse provide information on how to report a CD discrepancy?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Regulations & Legislation			97%	98%	99%	96%	98%	99%	97%	99%	100%	96%	99%	100%	98%	
2. Best Practice	2.1	Are the CD keys kept separately from the general keys?	98%	100%	100%	98%	100%	100%	96%	100%	100%	98%	100%	100%	99%	
	2.2	Does the red light work when the cabinet is open?	89%	100%	92%	72%	100%	92%	74%	100%	100%	83%	100%	100%	92%	
	2.3	Are patients own CD's recorded in a separate Patients Own Drugs Register?	100%			95%			100%			98%			98%	
	2.4	Was the last quarterly CD stock check completed within the last 3 months by pharmacy?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	2.5	Are all balances transferred to either a new page or a new register if necessary?	98%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	99%	
	2.6	Are there examples of record keeping in CD registers displayed on the cabinet?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	2.7	Are the signatures and dates in the active ward CD order book to demonstrate receipt of such drugs, not the same as the person who ordered them?	89%	100%	100%	88%	100%	100%	85%	100%	100%	94%	100%	100%	96%	
	2.8	Are epidural CD's segregated from other injectables? NPSA alert:0396	100%	100%		83%	100%		100%	100%		100%	100%		98%	
	2.9	Are high strength opiates separated from low strength opiates?	88%	100%		67%	100%		86%	100%		87%	100%		91%	
	2.10	Are patients own CD's segregated from ward stock? IE. In outer CD cabinet?	90%			95%			91%			78%			88%	
	2.11	Are all stocks within the CD register in date?	98%	100%	100%	98%	100%	100%	100%	100%	100%	98%	100%	100%	99%	
	2.12	Are the tamper evidence seals still unbroken on full boxes?	96%	97%	100%	93%	100%	100%	84%	100%	100%	98%	100%	100%	97%	
Best Practice Compliance			96%	99%	99%	92%	100%	99%	93%	100%	100%	95%	100%	100%	98%	
Overall Compliance:			97%	99%	99%	94%	99%	99%	96%	99%	100%	96%	99%	100%	98%	

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Safe Staffing Report: Acuity and Dependency Q4 2018-19
Executive Sponsor	Nina Morgan , Chief Nursing Officer
Author	Debbie McBride, Lead Nurse - Workforce
Attachment	Safe Staffing Report: Acuity and Dependency Q4 2018-19
Recommendations	Trust Board asked to RECEIVE assurance from this report.

EXECUTIVE SUMMARY

The purpose of this report is to provide assurance that safe staffing is being maintained and systems are in place for active monitoring and oversight.

The report describes the way that the safe staffing, acuity and dependency scores are collected and the frequency of that collection. This report outlines the six areas of analysis for safe staffing for the period Q4 2018-19 (Jan -Mar). Where there is a national or locally set target, this has been identified and rated (red or green) in the summary table one. Within the detail of the report if areas demonstrate any variances they are explained. This report also correlates patient outcome measures (nurse sensitive) indicators such as falls and pressure ulcers alongside ward areas' safer staffing data.

Maternity units have been excluded from SNCT as it was designed for adult in-patient areas. Within this report we describe how we currently monitor maternity services and what we will do in the future.

PREVIOUS DISCUSSIONS HELD

Received at Trust Board bi-annually

KEY IMPLICATIONS

Financial	Ward and department budgets need to be reviewed in line with patient acuity and dependency and CHPPD.
Patients Safety or Quality	The results may highlight safe staffing risks that may impact recruitment and retention
Human Resources	The results may highlight safe staffing risks that may impact on recruitment and retention
Operational	The results may impact on patient flow and patient pathways

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

Safe Staffing Report: Acuity and Dependency Q4 2018-19

1. Background and Links to Previous Papers

It is a requirement that as NHS providers we continue to have the right people, with the right skills, in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements. The systems in place are compliant with the Workforce Safeguards set out by NHS Improvement (NHSi, October 2018).

The methods used are in line with the NQB national guidance received on safer staffing, including the Safer Nursing Care Tool (SNCT), NHSi Care Hours Per Patient Day (June 2018) and use of the 'Safe Care' module. Combined these methods enable triangulation of all data sources.

The Safer Nursing Care tool (SNCT) is an evidence based tool, endorsed by the National Institute for Clinical Excellence (NICE) which enables the measurement of both acuity and dependency which can be applied to patients in adult inpatient areas.

The 'safecare module' enabled the Trust in January 2018 to move from bi annual collection to twice daily data collection. This has enabled twice daily informed decisions alongside professional judgements at the established safer staffing meetings.

The Care Hours per Patient Day (CHPPD) is a measure of the nursing hours providing care to patients in the context of the patient acuity and dependency.

Fill rates are captured to enabling understanding and correlation to CHPPD and Nurse sensitive indicators.

The systems used provide an approach to deciding staffing levels based on patient needs, acuity and risk to enable NHS provider board to make judgments about delivering safe sustainable and productive staffing. This nursing and midwifery staffing report includes general, maternity and paediatric wards and will include any areas of risk and the mitigating actions. The report was last reported to NMC in January 2019 with conclusions and recommendations for 2019/2020.

2. Executive Summary

The report describes the way that the safe staffing, acuity and dependency scores are collected and the frequency of that collection. This report outlines the five areas of analysis for safe staffing for the period Q4 2018-19 (Jan -Mar). Where there is a national or locally set target, this has been identified and rated (red or green) in the summary table one. Within the detail of the report if areas demonstrate any variances they are explained. This report also correlates patient outcome measures (nurse sensitive) indicators such as falls and pressure ulcers alongside ward areas' safer staffing data.

Maternity units have been excluded from SNCT as it was designed for adult in-patient areas. Within this report we describe how we currently monitor maternity services and what we will do in the future.

3. Methodology

UHCW use the Safer Nursing Care Tool (SNCT) to evaluate staffing levels to collect and analyse staffing, dependency and acuity data using an electronic twice daily approach. Each day nurses record the acuity and dependency of every adult inpatient and this is then divided by bed days at midnight. The data is recorded electronically and collated to provide a monthly average of CHPPD, acuity and dependency.

4. Results

The report includes;

- Adult inpatient wards adult acute assessment in-patient areas that collect staff fill rate, SNCT CHPPD.
- Paediatric, maternity and critical care collect staff CHPPD. SNCT is not applied due to the tool not being approved for these areas.
- Maternity services birthrate Plus compliance monitoring

Nursing and Midwifery Committee have agreed six domains for the analysis of safe staffing which are listed below and we will report on these. Outcomes are RAG rated to demonstrate compliance, using only two colours red or green. Amber is excluded because it would add no value and could be ambiguous.

Safe staffing analysis	
1. RN/M fill rate	>95% +or- 10% variance
In Q4 2018-19 the Registered Midwives/Nurses (RN) fill rate in in-patient areas was compliant overall at 95.2% average. Marginal variances were identified due to additional staff requirements for fire stopping works where wards were split across 2 areas, additional capacity requirements and the opening of additional beds eg Ward 10, Ward 50 and General Critical Care across the quarter and impacting on a variance in fill rates. Despite being compliant there are areas where the fill rate is below 90% of the required level in women's and children's. Daily oversight at specialty huddles ensures staff are reallocated according to service demands. Recruitment plans continue with trajectory monitored locally.	Day 94.3% Night 96.1% Av 95.2%
2. HCA (CSW) fill rate	>95 %
In In Q4 2018-19 Care Support Worker (CSW) fill rate is compliant. The recruitment continues to reduce reliance on temporary staffing services. Particular focus on recruiting to the enhanced care in January and February has been successful with planned recruitment within the pipeline to reduce their vacancies form 25.2wte to 6.8wte by July 2019.	Day 93.7% Night 96.6% Av 95.2%

3. CHPPD variance <15% +or- variance

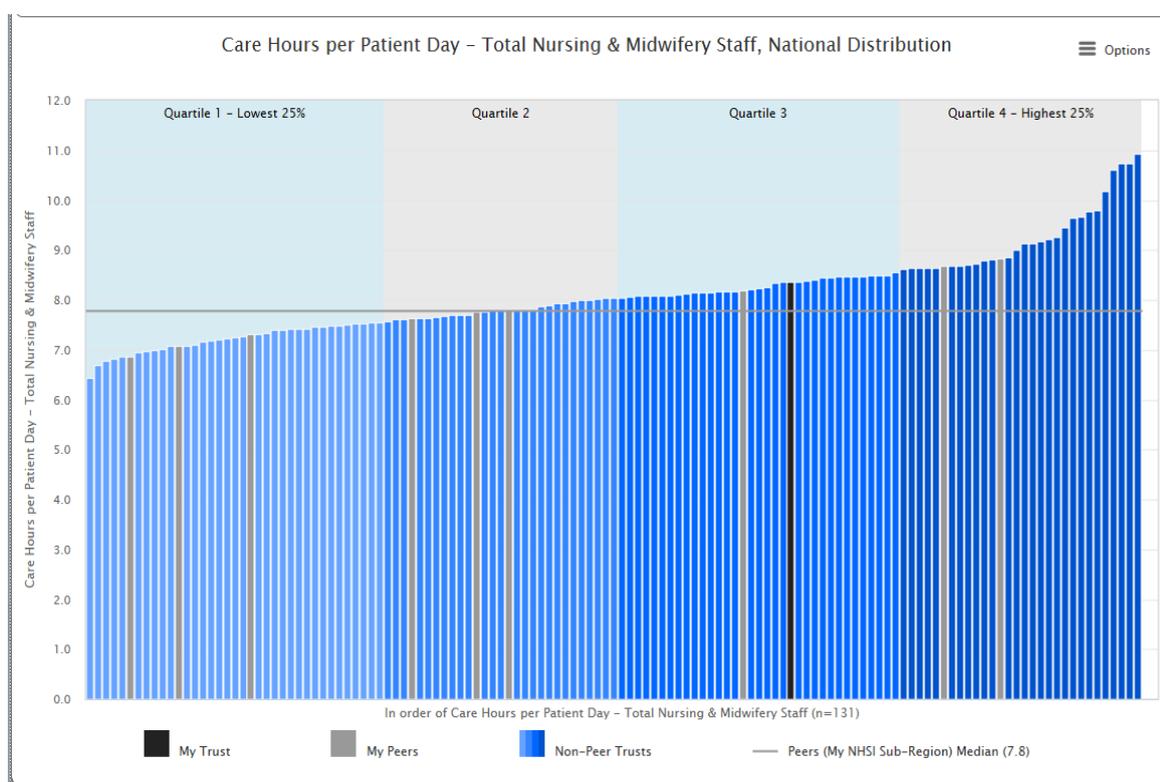
Care Hours per Patient Day (CHPPD) is a measure of the nursing hours providing care to patients in the context of the patient acuity and dependency.

- **Actual CHPPD** are the care hours each patient receives based on real time staffing levels. It gives a single figure that represents, staffing levels (RN and HCA), patient acuity and dependency and bed days and therefore allows comparisons between wards/units.
- **Required CHPPD** is what we should have delivered based on staffing requirements based on what staff hours were available versus acuity and dependency for that month.
- **Model Hospital:** In comparing our CHPPD with our peer groups (January 2019) we remain in Quartile 3. UHCW provides 8.2 CHPPD. Our Peer median provide 7.6 CHPPD and the National median is 7.9 CHPPD. The 2018/19 and current report reflects our regional picture not peer groups.
The plan for future reporting 2019/2020 will reflect against teaching hospital peer group. For assurance early indicators show we are in line eg Shrewsbury & Telford Hospital Trust 8.3 CHPPD and Nottingham University Hospital 8.7 CHPPD
- The plan for 2019/2020 is to review CHPPD including subspecialty benchmarking.

Actual
8.1 hrs
Required
8.6.Hrs

Variance
-5.8%

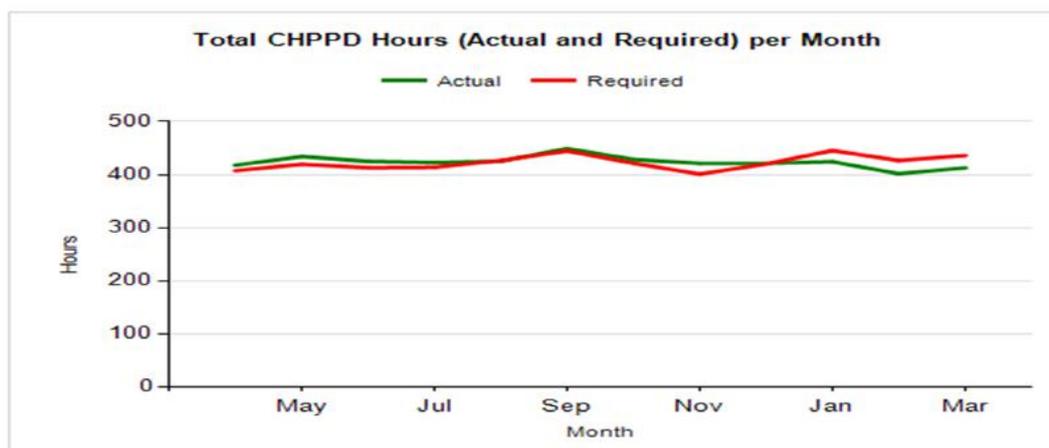
Graph 1 - demonstrating CHPPD against peers from Model hospital (January 2019)



The graph below shows that we were not able to meet the required amount of CHPPD this is supported by the fill rate data. Required CHPPD = 8.6 hours, Actual CHPPD delivered = 8.1 hours demonstrating a small negative variance of -5.9%.

The additional capacity and opening of beds, alongside the increased number of patients requiring increased observation has driven up the required CHPPD within Quarter 4.

Graph 2- showing Total CHPPD for the Trust : Actual / Required



4. Acuity and Dependency

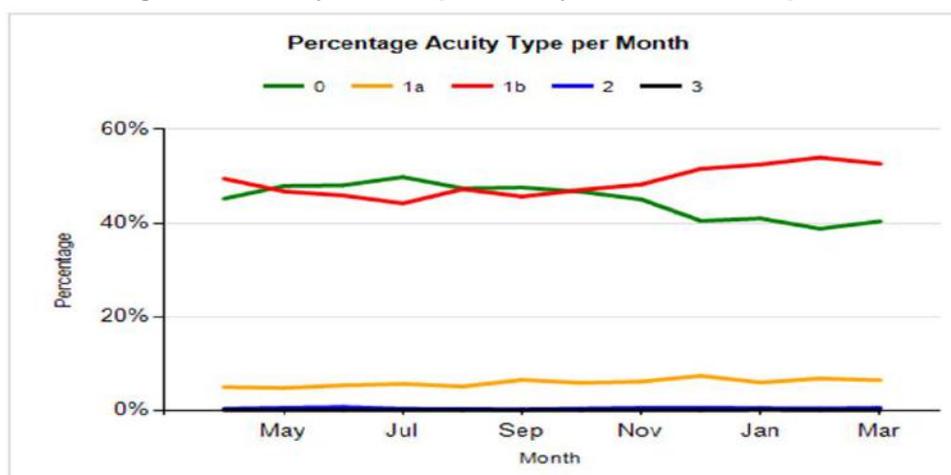
Less than 15% variance

Graph 3 below shows the Safer Nursing Care Tool (SNCT) results for UHCW. The SNCT provides a method to determine how acute or dependant each patient is. Level 0 is the least acutely unwell or dependant patient moving to level 3 which are patients that have multi-organ failure and require intensive care. We analyse this over time to determine if the mix of patients admitted to each ward has changed over time.

<15% variance

The graph shows Q1 2018-2019 to Q4 2018-19 Trust's acuity and dependency Q4 reflects the ongoing increased acuity that would be expected due to the seasonal variation of the winter in January to March and is in line with the extra bed capacity required.

Graph 3- showing Total Acuity and Dependency for the Trust April – Mar 2018-19



5.Nurse Sensitive Indicators

N/A

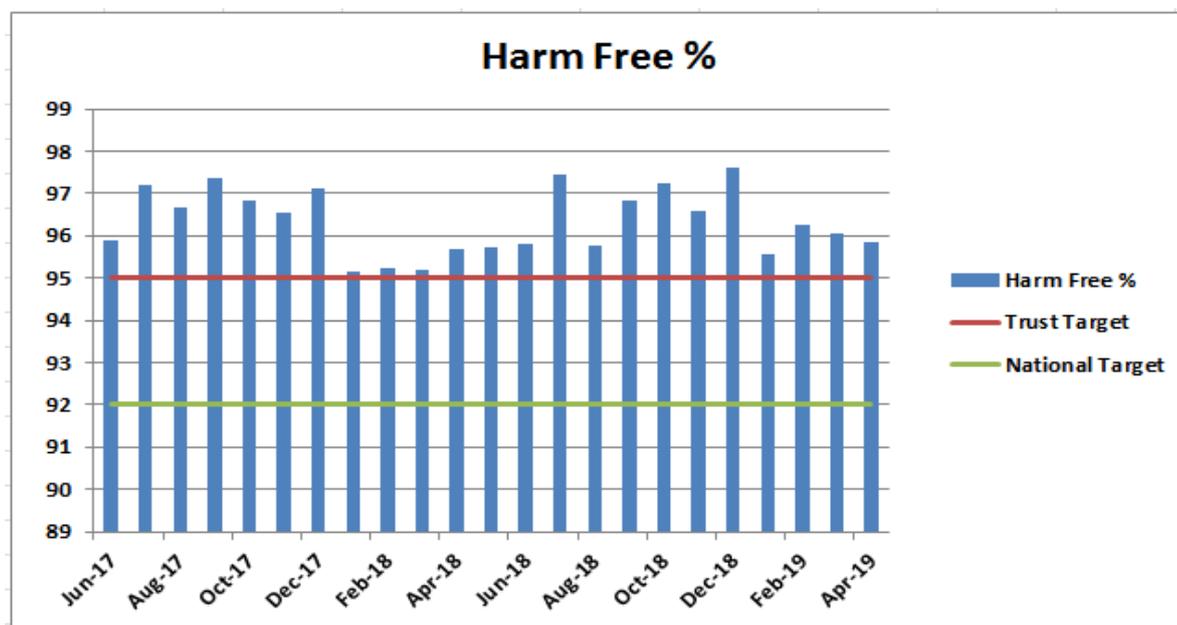
Nurse Sensitive Indicators (NSIs), reflect the quality of care being delivered, such as the number of falls, pressure ulcers, infection rates and drug administration errors specific to each ward area. This data has been analysed to determine if there is any correlation of incidence on wards which were unable to deliver the required amount of CHPPD. The data has been obtained from the QUESTT score cards for each area. NSI's can be used alongside the information captured using the SNCT to review existing workforce establishments and services.

There are no concerns regarding NSI's for wards that have demonstrated a negative variance in CHPPD or regarding RN fill rate.

Ward 10 and Ward 50 both show a marginal negative variation of CHPPD and have engaged in focused support in managing pressure ulcer prevention, assessment accuracy and documentation due to a small increased incidence in each area.

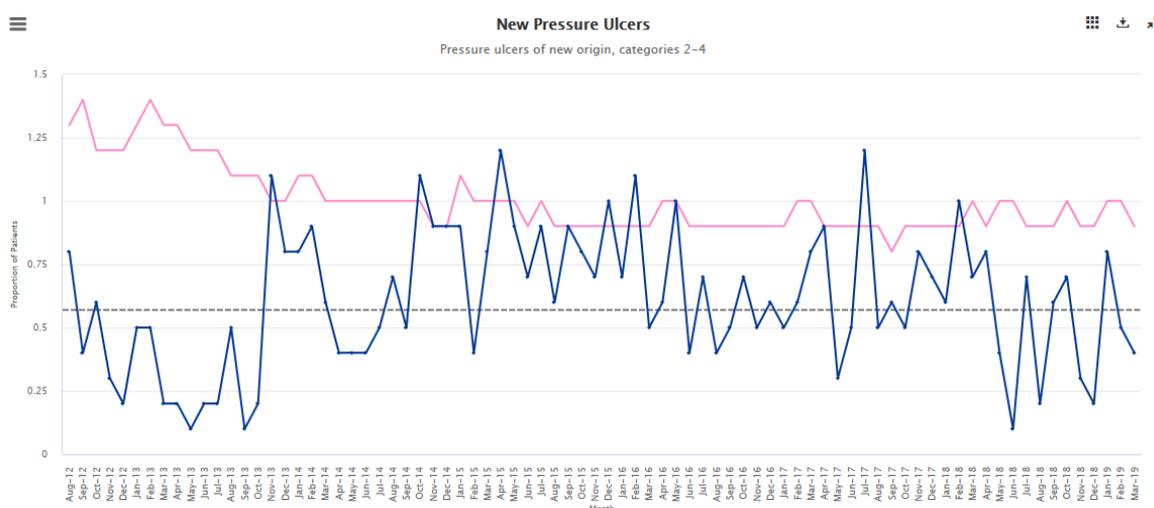
The graph below demonstrates UHCW is consistently achieving above the national 92% harm free care threshold and local stretch target of 95% for all levels of harm both new and old.

Graph 4 showing Harm free care reported from Safety Thermometer



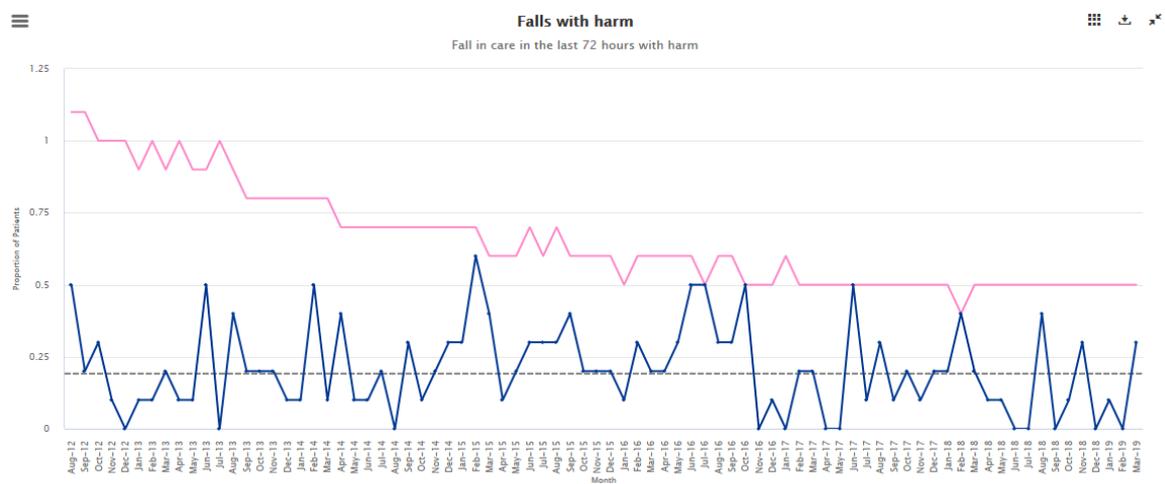
Graph 5 Demonstrating UHCW % Harm Free Care: New Pressure Ulcer June 2017- April 2019

The incidence of all pressure ulcers and all falls for UHCW as recorded on the Safety Thermometer are shown below. The current data on the Safety Thermometer website is from March 2019. For all pressure ulcers UHCW has been consistently below the national line (shown in pink) since January 2018. The target set against the quality account of a reduction of 15% by year end April 2019 has been achieved with a 30% reduction in all avoidable pressure ulcers.



Graph 6 Demonstrating UHCW % Harm Free Care: Falls with harm June 2017- April 2019

For all falls UHCW is consistently below the national average performance regarding the target set for a reduction in all falls against the quality account by year end April 2019 shows a reduction of 28% in all falls. Moderate falls with moderate harm or above has seen a reduction of 43%.



5. Midwifery safe staffing levels

Birth rate plus

A formal birth rate plus assessment was completed in 2017, which reviewed the acuity of women who use UHCW maternity services. The review recommended a birth to midwife ratio of 1:24. A paper was taken to the Trusts Strategy Unit in 2018 and it was agreed to initially support recruitment to ensure a birth to midwife ratio of 1:30 and then undertake a subsequent review to determine subsequent need and this has commenced. A recruitment plan was agreed which included the following: -

- Recognition of the need to employ a large number of newly qualified midwives which was mitigated by the introduction of a new role, Clinical Preceptor Support Midwife, whose role is to support these staff in the clinical areas.
- Introduction of a 'golden hello scheme' to attract new midwives to UHCW
- Ongoing recruitment campaign including a social media campaign.

In order to achieve a birth to midwife ratio of 1:30, an additional 21 WTE were required. This included midwives and Band 3 maternity support workers.

All 21 WTE have been recruited to and it is expected that all staff will be in post by October 2019.

The Trust Chief Medical Officer and Chief Nursing Officer attend a 2-weekly production board / safety huddle to support and seek assurance and to have sight on any potential concerns and escalations in line with any of the Midwifery staffing metrics.

Birth to midwife ratio

The birth to midwife ratio is calculated monthly using Birthrate plus methodology and the actual monthly delivery rate. It is recorded monthly on the maternity dashboard.

Jan 2019	Feb 2019	March 2019
1:30	1:27	1:30

Supernumerary labour ward coordinator

Over the last financial quarter evidence to support the labour ward coordinators being supernumerary has been collected manually. They are now rostered to ensure that they are supernumerary.

One to one care in established labour

The following table outlines the percentage when one to one care has been provided in labour. This information is captured on the maternity dashboard monthly. Although the target remains at 100% no correlation of harm was identified across women and children in midwifery care.

Jan 2019	Feb 2019	March 2019
100%	99%	97%

6. Paediatrics staffing levels

The acute in-patient paediatric areas currently have a vacancy of 20% rate against the budgeted establishment, based on the RCN staffing tool that has been widely adopted whilst a more robust staffing tool is developed nationally. Active recruitment continues with representatives from the paediatric departments attending all open days within the region.

Following the continuation of the robust Recruitment Strategy in 2018 for new starters that included a '*Golden Hello*' and a starting salary of Band 4 whilst awaiting their PIN, we have successfully recruited 18 newly qualified staff for September 2019 and a further 6 experienced nurses pending employment checks. The new recruits are expected to be in post by October 2019. There has been a significant improvement in recruitment over the last 2 years.

The Neonatal Unit has had a positive recruitment drive and their current vacancy rate is 1% for Band 5's.

Daily staffing review and escalation meetings take place to mitigate any requirements in the paediatric unit and for staffing requirements for children in crisis. The paediatric teams communicate risks to the operational team daily and an escalation process is in operation.

Assurance has been gained as no harms occurred as a result of any unmitigated staffing incidence within paediatrics.

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title:	Patient Experience (We Care) Quarterly Report
Executive Sponsor:	Richard de Boer, Interim Chief Medical Officer
Author:	Paula Lloyd Knight, Interim Deputy Director Quality
Attachment:	We Care Quarter 4 2018-19 report
Recommendation:	Trust Board is asked to NOTE the Patient Experience Quarterly Report

EXECUTIVE SUMMARY

1. Purpose

This Quarterly Patient Experience report brings together information on compliments, complaints, PALS, patient feedback, patient involvement, board walk rounds and information from the Involvement Hub.

2. Narrative

In keeping with the Trust's vision of becoming a national and international leader in healthcare and its values, this report aims to bring together the work of the Patient Experience Function of the Quality Department.

Work continues to take place on developing a resilient complaints service for the Trust, performance against the Trust's 25 Working Day Response Standard in Quarter 4 finished at 61%. The reduction in performance was discussed at Chief Officers Group to address the current situation and options to enable consistent achievement of the target.

Using UHCWi methodology an event took place to identify potential activities that could be developed to address the immediate backlog of complaints. The outcome was to pilot a 'Big Event' in one Clinical Group that would potentially result in a number complaint responses being written in one day. The event was due to take place on 23 May 2019 and, if successful, will form part of a set of tools to support a more resilient service.

Clinical Treatment (Surgical Group) is the top subject most complained about (28). This is a change from the previous quarter (communications). The second highest complaint area was Clinical Treatment General Medicine (22) (this did not appear in Q3, and was fourth in Q2). Communications (22) was the 3rd subject, this has dropped from 1st Q3, and 2nd Q2. Values and Behaviors (19) is fourth, (this is similar to the last quarter where it appeared 5th) and Clinical Treatment Accident and Emergency (16) was the 5th most complained about subject, this has been consistently 3rd for the previous 2 quarters.

One complaint was decided by the Parliamentary Ombudsmen in quarter four, and this was partially upheld, the identified failing was around the level of detail provided in the statement, which they believed did not meet the complainants needs

The PALS received 857 enquires in Q4 compared to 958 in Q3 (a decrease of 101) .The response rate for the 5 working day response standard for quarter four is 92% against the standard of 90% (n=789) this is a decrease on quarter three 98% (n=951).

The top five issues remain largely unchanged; appointments remain the top PALS enquiry in quarter four with 229 compared to 279 Q3. Communications remain second with 125 compared to 177 Q3, Trust administration remains third highest and admissions with 80 enquires, Admissions, discharge and transfers remains fourth with 71 enquiries and facilities appears for the first time this year. (Most enquires were around car parking availability and car paying payment methods).

The Trust wide roll out of the values survey was placed on hold due to NHS England's expected changes to the FFT question (these were due April). The changes are expected imminently.

745 responses were received via the Involvement Hub this quarter. The Hub has been utilised by staff and groups more this quarter and has been booked to support numerous awareness campaigns. A charity application for a Feedback Hub at the Rugby site has been approved, and the new Hub should be up and running by summer.

Board Walk rounds continue on a monthly basis with departments sharing their ideas for positive change with senior colleagues.

3. Areas of Risk

The resilience of the complaints team is still the biggest risk, although work has taken place to model some new tools to support resilience. An evaluation of the impact of the new tools will take place to assess the impact it has on aged cases.

4. Governance

NHS Constitution

Principle 4 – The NHS aspires to put patients at the heart of everything it does NHS services must reflect and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers.

Principle 7 - The NHS is accountable to the public, communities and patients that it serves

PREVIOUS DISCUSSIONS HELD

Approved at Patient Engagement and Experience Committee May 2019

KEY IMPLICATIONS:

Financial:	Deliver value for money and other regulatory compliance
Patients Safety or Quality:	NHSI and other regulatory compliance
Human Resources:	To be an employer of choice
Operational:	Operational performance and regulatory compliance



University Hospitals
Coventry and Warwickshire
NHS Trust

We Care

Patient Experience Report Quarter 4 (2018-2019)

30th May 2019



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Compliment of the Quarter

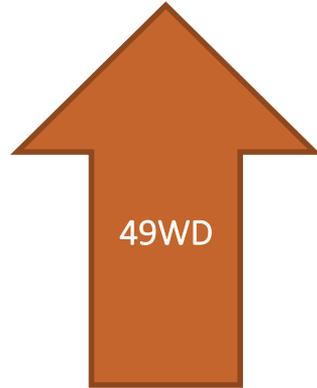
“Thank you so much for all your care, I’ll be here a while, but I think it is important to let you know how much I appreciate all you do and have done for me thank you”



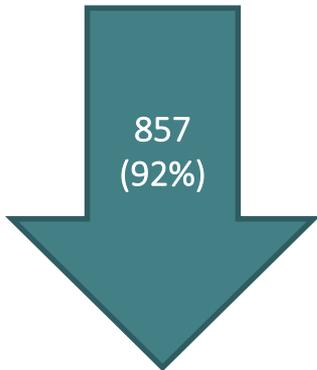
PALS



Total number of PALS enquiries received



The age of oldest PALS case at end of quarter



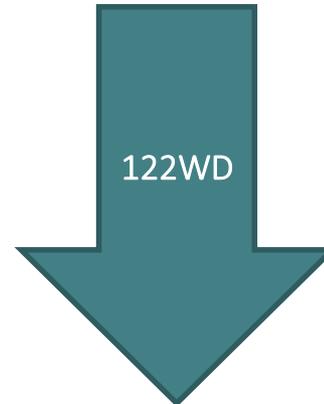
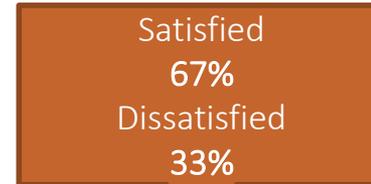
5 working day performance



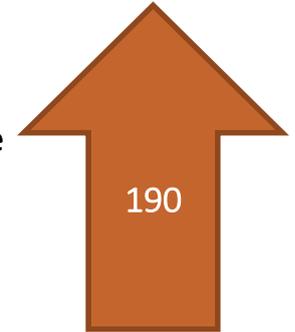
Compliments and Thanks reported about numerous services across the Trust

COMPLAINTS

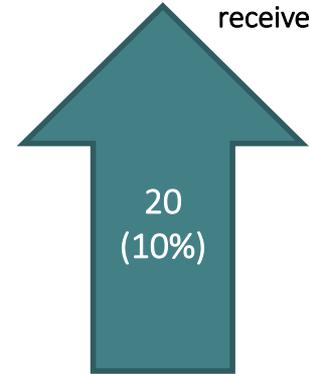
Overall, how satisfied are you with the way your complaint was handled?



The age of oldest complaints case at end of quarter



Total number of complaints received



Total number returned for further local resolution (FLR)*



One complaint was decided by the Parliamentary and Health Service Ombudsman in Quarter 4 and this was partially upheld.



Complaints Activity & Performance

	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	January 2019	February 2019	March 2019			
Total number of formal complaints received	164	177	155	62		67		62	
				Normal complexity	55	Normal complexity	57	Normal complexity	40
				High complexity	7	High complexity	10	High complexity	22
				191					
% of complaints acknowledged within 3 days	146 (89%)	165 (93%)	128 (82%)	48 (71%)		49 (73%)		40 (59%)	
				137 (72%)					
% of complaints responded to in 25 working days	128 (76%)	123 (69%)	130 (84%)	59 (81%)		31 (46%)		27(44%)	
				117 (61%)					
% of complaints responded to or still within agreed timeframe	New Indicator	New Indicator	New Indicator	59(81%)		31(46%)		41(66%)	
				131 (69%)					
Oldest open complaint at end of month	81WD	112WD	185WD	109WD		137WD		122WD	
Total number returned for further local resolution (FLR)*	17 (10%)	19 (11%)	15(10%)	10		5		5	
				20 (11%)					
Total number of new PHSO cases	2	0	2	0		0		0	
				0					

* This is the number of complaints returned for Further Local Resolution. These do not necessarily relate to the complaints received that month as complaints can be returned for further local resolution up to a year after the complaint was responded to.

PALS Activity and Performance

	Quarter 3 2018-19	January 2018	February 2018	March 2018	Quarter 4 Total
PALS Enquires	958	314	292	251	857
Breakdown of enquires below					
Signposting	22	16	18	7	41
Immediate Response	218	65	63	50	178
Liaise and Respond	261	128	98	134	360
Refer to Specialty	403	94	106	57	257
On-going support	16	11	7	3	21
90% of enquires resolved or referred in 5 working days	951 (98%)	297 (95%)	271 (93%)	221 (88%)	789 (92%)

Learning and improving from complaints and PALS

Datix ID	Main Issues of Complaint	Outcome	Actions Taken
COMPLAINTS			
24595	Patient unhappy with the lack of communication from the Renal staff following blood tests being taken. Patient takes an active interest in her care and does not believe this approach is acceptable.	Patients Consultant and group manager visited the patient on the ward and discussed concerns face to face.	Patient was reassured following the discussion and has now received a clear plan of treatment.
22705	Patient was unhappy that information contained in the bereavement booklet was not up to date (including web link to site that did not load). This caused greater distress to the family at an already difficult time.	Apologised and highlighted the distress to the bereavement lead, who agreed to remove the out of date leaflets and replace with a temporary solution.	A permanent solution of a new and up to date booklet will be produced by the bereavement team according to new NHS guidelines.
23202	Family of the patient felt the care at the end of the patients life was very poor and that staff did not support or respect the situation.	A meeting was held with the patient's wife and the decisions made around her husband's care were explained.	The Palliative Care Team have joined forces with the Chaplaincy Team and are running regular workshops for ISS staff in order to raise awareness of the use of the Dove sign as well as the free meal scheme that is available for families who's relatives are at the end of life.
PALS			
25355	Patient had a delayed diagnosis of HIV in the community resulting in the condition spreading to the brain. Therefore the patient is paralysed on the right side. Patient needed funding to be agreed in order to be transferred to Mild May Hospital London.	Following on-going meetings with the staff on the ward the funding was agreed and the patient will be transferred as soon as possible.	Patient transferred to the Mild May Hospital in London for specialist care.

Top 5 Complaint Subjects

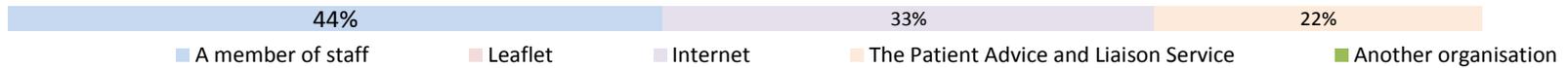
Top 5 Primary Subjects		Top 3 themes		Position of subjects in previous quarters	
				Q2	Q3
Clinical Treatment - Surgical Group	28	Delay or failure in treatment or procedure	6	1 st	2 nd
		Post-treatment complications	4		
		Delay or failure to diagnose (inc e.g. missed fracture)	3		
Clinical Treatment - General Medicine Group	22	Delay or failure in treatment or procedure	3	4 th	Did not appear
		Delay or failure to follow up	3		
		Dispute over diagnosis	2		
Communications	22	Communication with relatives/carers	9	2 nd	1 st
		Communication with patient	5		
		Attitude of Nursing Staff/midwives	3		
Values and Behaviours (staff)	19	Attitude of Medical Staff	6	Did not appear	5 th
		Attitude of Nursing Staff/midwives	5		
		Attitude of Admin & Clerical Staff	4		
Clinical Treatment - Accident & Emergency	16	Delay or failure to diagnose (inc e.g. missed fracture)	4	3 rd	3 rd
		Lack of clinical assessment	3		
		Attitude of Medical Staff	3		

PALS Top 5 Subjects

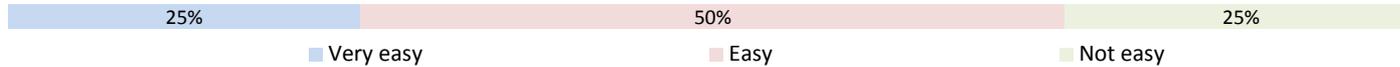
Top 5 Primary Subjects		Top 3 Themes		Position of subjects in previous quarters	
				Q2	Q3
Appointments	229	Appointment delay (inc length of wait)	47	1 st	1 st
		Appointment Cancellations	46		
		Appointment - availability (inc urgent)	42		
Communications	125	Communication with patient	40	2 nd	2 nd
		Communication with relatives/carers	29		
		Other - Communications	21		
Trust Admin / Policies / Procedures incl Pt record management	80	Complaint handling - all aspects	34	3 rd	3 rd
		Access to health records	15		
		Other - Trust Admin issues	13		
Admissions, Discharges & Transfers (excl delayed discharge due to absence of care package - see Integrated care)	71	Discharge Arrangements (inc lack of or poor planning)	19	4 th	4 th
		Other - Admissions, Discharges & Transfers	17		
		Admission Arrangements	8		
Facilities	64	Car parking - availability	30	Did not appear	Did not appear
		Car parking - cost	10		
		Car parking - payment methods/facilities (e.g. cash only, no change)	10		

Complainant Satisfaction Survey

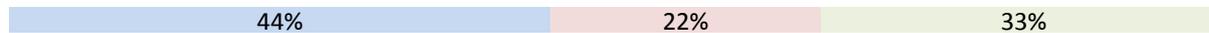
How did you find out how to make a complaint?



Was it easy to find information on how to make a complaint or raise a concern?



Do you feel that your complaint was responded to within a reasonable amount of time?



Did we provide you with a clear and understandable response?



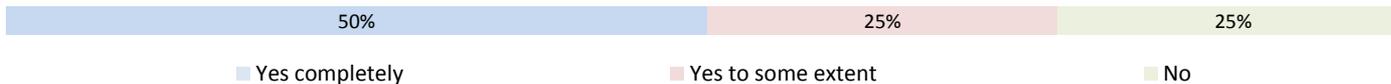
Do you feel that we fully addressed your complaint?



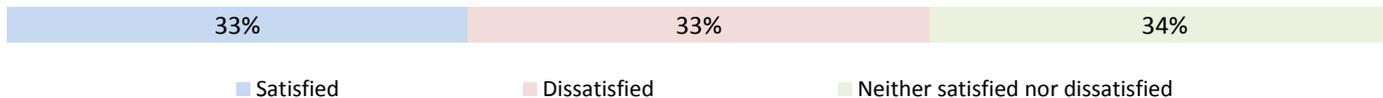
Do you feel that your concerns were treated seriously and with sensitivity?



Did you feel that we understood your complaint?



Overall, how satisfied are you with the way your complaint was handled?



Complaints received a total of 9 responses in Quarter 4 which is reduction of responses from Quarter 3 which was a total of 27 responses.

2a Involvement Activity

Patient Partners' Programme

As at 31st March, 41 Patient Partners have been recruited with a further 5 in various stages of recruitment.

During January, February and March 2019, Patient Partners have taken part in the following activities:

- We Care Event at the Hospital of St Cross
- Dying Matters Week
- Kitchen Table Event in Audiology, Ophthalmology & Cardiac Investigations Outpatient Clinics
- Mini PLACE on Ward 50
- 15 Step Challenge/Observations of Care in Radiology
- RPIW 30 Day Stand Up – Cataracts Day Surgery
- Attendance at Patient Partners Networking Group

Membership of Committees/Meeting Groups includes:

- Patient Experience & Engagement Committee
- Paediatric QIPS
- Independent Advisory Group
- Patient Insight & Safety Learning Group
- Patient Experience & Delivery Group
- End of Life Care Committee
- Dementia Strategy Group
- Patient Public Involvement in Research Group
- Patient Partner Forum

2a Involvement Activity

Involvement Hub Hire

The following specialities/organisations hired the Involvement Hub:

Specialities:

- Infection Control
- Tinnitus Awareness Raising
- Apprenticeship Awareness Raising
- Dietetics
- Delirium (Care of the Elderly)
- Renal Well Being
- Epilepsy Awareness

Organisations:

- Healthwatch Coventry
- Age UK

2b Insight

This section of the report outlines the results of the patient feedback mechanisms overseen by the Trust's Patient Insight and Involvement Team.

Impressions

The Trust has both Patient and Staff Impressions. Patient Impressions consists of a suite of questionnaires available online, in paper and a postcard format. Patient Impressions allows feedback from patients, relatives, carers and visitors across all visit types to be sent on a daily basis to relevant staff across the Trust.

Friends and Family Test

The Friends and Family Test (FFT) is a national initiative overseen by the Insight Team of NHS England. It is an initial single question, which asks patients whether they would recommend the NHS service they have received to friends and family should they need similar care or treatment; in addition there is a supplementary, mandatory question asking why the patient has responded as they have. Guidance stipulates that all patients should be given the opportunity to answer the FFT, either at their point of discharge from hospital or within 48 hours post discharge. The Trust allows users to complete the FFT via a majority of means including postcards, SMS text, online via its website, and QR codes.

National Patient Survey Programme

The National Patient Survey Programme has been running since 2002 and currently consists of an annual Inpatient Survey, with an Emergency Department Survey, Maternity Services Survey and a Children and Young People's Survey being carried out every two years. This is a postal survey and the Trust commissions Quality Health Ltd to carry out the surveys on its behalf.

This section of the report will also present information regarding the Trust's rating on NHS Choices, and the Patient Insight and Involvement Team's presence on social media. In addition to this, an update on the Health Information Service and Trust's suite of patient information leaflets, including their status and developments throughout Quarter 4 is provided.

Patient Insight

BOTTOM 3 SERVICE AREAS OF QUARTER 4 2018-19 - ACTIONS BEING TAKEN IN QUARTER 4 2018-19

Parking: Unfortunately the planning application has yet to be considered by the Council. We are working determinedly with the contractors to address the issues that have arisen and we are hopeful that these will be resolved and the application granted in the near future. *(Lincoln Dawkin, Director of Estates – March 2019).*

Food & Drink: This quarter patient catering has concentrated on the new the International Dysphagia Diet Standardisation Initiative (IDDSI) framework we have worked in partnership with the SALT team and dietetic team to create a whole new special diet menu, Appetito our supplier held a tasting and information day where the new menu choices were chosen it was agreed to use the Level Four (Pureed) and Level Six (Soft & bite size) sections it was also decided to use the easy to chew section from specified items on the main menu these menus will go live on April 1st.

Ward Food Tasting Sessions continue to be held every other month to let the nurses and HCAs taste the food so they can promote this to their patients – with eight sessions held in January and eight on going in March. In May another Visitors' Food Tasting Session took place in Outpatients and proved a success and a Menu Co-ordinator from ISS continues to visit the wards each week to check menu availability. ISS as always will be supporting the nutrition & hydration week with Appetito promoting the new meals in line with IDDSI and joining in the world global tea party on Ward 40. *(Nigel Watson, Catering Logistics Manager- March 2019).*

Doing Things On Time: RTT training is available for all staff to use within ESR. We are working with ESR to align job roles to RTT online modules to enable the Trust to capture compliance and competency. This will enable intelligence reporting for groups and focus on training issues across the Trust. Work is ongoing to improve CRRS outcome training and there has been attendance at QUIPS with dedicated sessions on RTT/CRRS Outcomes which has provided useful engagement and discussion. *(Sarah Roddis, Associate Head of Department - Elective Care- March 2019).*

Friends and Family Test - Activity and Performance

The Friends and Family Test (FFT) is a national initiative overseen by the Insight Team of NHS England. It is an initial single question, which asks patients whether they would recommend the NHS service they have received to friends and family should they need similar care or treatment; in addition there is a supplementary, question asking why the patient has responded as they have. The FFT question is incorporated into Impressions. The results are presented as a percentage of Recommenders and Non-Recommendors. The tables below show UHCW's figures against our internal targets and also the national average.

Recommender %

	January '19 Recommender %	February '19 Recommender %	March'19 Recommender %	Internal Trust Target Recommender %
Inpatients & Day Case Combined	92.07%	91.71%	91.92%	95%
A&E (all areas)	79.94%	77.22%	79.46%	87%
Outpatients all departments	89.36%	90.90%	89.15%	95%
Antenatal (after 36 weeks) Experience	92.73%	90.7%	90.14%	97%
Birth/Labour Experience	77.42%	86.25%	84.71%	97%
Postnatal (hospital) Experience	90.18%	92.06%	94.12%	97%
Postnatal (community) Experience	100%	100%	95.59%	97%

Response %

	January '19 Response Rate %	February'19 Response Rate %	March'19 Response Rate %	Internal Target Response Rate %
Inpatients & Day Case Combined	21.44%	21.6%	23.6%	26%
A&E (all areas)	11.6%	12.9%	12.6%	15%
Outpatients all departments	3.72%	4.15%	3.84%	8%
Antenatal (after 36 weeks) Experience	12.14%	10.24%	14.79%	15%
Birth/Labour Experience	6.84%	19.05%	17.71%	15%
Postnatal (hospital) Experience	24.72%	15%	24.79%	15%
Postnatal (community) Experience	13.59%	8.03%	15.56%	15%

Key:

	Target achieved
	Within 5% of target being achieved
	Target not achieved by more than 5%

Feedback from Involvement Hub Kiosks

Since January 2019, the Involvement Hub Kiosks have asked members of the public the Friends and Family Test question, along with the follow up question.

Q4 2019

	Number of Responses	Number that Recommend Service	Percentage that Recommend Service
Inpatients & Day Case Combined	141	108	77%
A&E (all areas)	140	72	51%
Outpatients all departments	327	261	80%
Antenatal (before 36 weeks) Experience	31	20	65%
Antenatal (after 36 weeks) Experience	22	12	55%
Birth/Labour Experience	49	21	43%
Postnatal (hospital) Experience	35	18	51%
Overall Total	745	512	69%

National and Local Surveys

The National Patient Survey Programme is a mandatory programme overseen by the CQC. It consists of a number of the surveys: Inpatient Survey, A&E Survey, Maternity Survey with the Children and Young People's Survey (conducted every 2 years). The Trust commissions Quality Health Ltd to carry out the surveys on its behalf. Below is a summary of survey programme for 2018/19



Maternity 2019 Survey timeline:

January 2019: Dissemination of leaflets and posters. **February 2019:** Publication of instruction manuals.

March/April 2019: Trusts draw sample.

April 2019: Sample checking by Co-ordination Centre.

April to August 2019: Survey coming underway.

Children and Young People's Patient Experience Survey (CYP) timeline 2018:

Fieldwork has commenced with close of fieldwork: Friday 14th June

Data submission deadline: Friday 21st June

Survey results to Trust: Friday 28th June

Full Management Reports due end July



2018 Inpatient Survey timeline:

Close of fieldwork: Friday 4th January 2019.

Data submission deadline: Friday 11th January 2019.

Survey results : Embargoed Management Reports due end of March. CQC publication of report expected by the end of June 2019



The fieldwork for the Cancer Patient Experience Survey 2018 commenced in October 2018.



2018 Urgent and Emergency Care Survey timeline:

19th March 2019: Survey fieldwork closes.

26th March 2019: Deadline for data submission to the Coordination Centre.

By 28th March 2019: You receive your initial Detailed Results Tables from Quality Health.

End April: You receive your full management reports from Quality Health

Action Log on Impressions

The Action Log on Impressions is managed by the Patient Insight and Involvement Team, currently 250 staff have log on details for the system and receive daily notifications. The action log is used to monitor how individual wards and areas respond to verbatim comments provided as part of the FFT. In addition all National Patient Experience Survey actions are also monitored through the action log.

Below details information from the Action Log for Q4 2018/19.

Number of Actions Q4 2018/2019	Group with highest number of actions Q4 2018/2019	Number of closed Action Q4 2018/2019	Number of open Actions Q4 2018/2019
	Acute & Emergency Medicine 	578 	2 

3. Board Walk Round

Imaging / Radiology

There was good ambition within the department to get from CQC Good to Outstanding. All 3 Should Do's from the 2018 Report were being addressed.

Areas of concern:

- Building works are not completed. Staff are concerned of the impact this has on attracting staff to work here, the patient experience and inefficient use of resources. The areas that are finished have been well received by staff.
- Experience of delays for patients in being brought down from the wards into the Interventional Radiography Area – staff feel theatres take precedent. They have implemented pre-operative clinics where patients are prepared before admission to hospital. They are hoping to implement outreach days where nurses from Radiology go to wards to prep patients. Nurses have been trained in consent. The staff report loss of 1 hour per day in their productivity due to waiting for patients from wards.
- Whilst funding for new CT Scanner in ED is identified the building works to house it is still outstanding.

Actions taken:

- Building works are due to re-start on Monday 8th April with the corridor works as the next phase.
- Delays remain with patients coming from ward however pre-assessment continues therefore patients better prepared.
- 4th CT Scanner to be provided under the PFI contract - but building works required “In house” by the trust. Costs yet to be provided

Ward 52 Orthopaedic

Patient flow was seen as good, as the ward can receive up to 6 NOF patients a day;

Staffing levels were good and agency cover was mostly used for sickness cover.

Areas of concern:

- To improve the transfer of patients to St Cross

Actions taken:

- As a group the ward continued to liaise closely with St Cross and transfer patients as soon as appropriate beds became available
- Bed managers have `LIVE` lists of patients for transfer and follow this up on a daily basis

Ward 22 ECU

It was good to see that recruitment to all vacancies had gone well, with most posts filled.

Good development of overseas staff was also positive to see.

Areas of concern:

- Weekend access to ESR
- Pathway review for colorectal patients
- Improvement for transfer for wardable patients, provision of ring fenced beds
- Stocking and refill for Omnicell

Actions taken:

- There is a national issue and Learning and development are aware with regards to ESR. Staff are encouraged to use booklets when the system is down at the weekends
- A task and finish group has been set up involving staff from 22ECU, 33 colorectal surgery, ACPs and Surgical Matrons. The department are currently reviewing current pathways and updating these. These will be discussed at surgical Quips for consultant involvement.
- The GDO has been helping with the improvement of transfers and provision of ring fenced bed. The ward was in the process of writing a paper to support this.

Ward 43 Neuro and Step-down

Staff morale and confidence had improved greatly over the past months due to successful recruiting of HCA, and the ward had some success with nursing vacancies, as had gone from 64% to 50%

Good communication was seen with relatives and large consultant teams from different areas working together to provide on call and consultant of the day cover.

Areas of concern:

- The day room required updating to support better flow with elective patient clerking and waiting.
- Omnicell issues has impacted around the stock levels and wrong dosage given which might create additional requirements to audit stock. QGC were to review this.

Actions taken:

- We have started to work with Vinci and charitable funds re the day room
- Omnicell stock levels recognised as a trust issue. The ward continue to raise issues locally with the ward pharmacist.

Ward 35

There was great team working and good working relationships seen.

The ward safety huddles that where held every day were working well.

Areas of concern:

- There were Oncology outliers on other wards direct from ED

Actions taken:

- There was a list of all Oncology outliers maintained by ward 35

Ward 33 Urology

Staffing was good with a low vacancy rate.

The ward should be proud of international nurse recruitment and how well they have integrated into team.

The patient feedback received was positive and this was great to see.

Areas of concern:

- MRSA screening for emergencies – how to integrate this into 'business as usual'
- Omnicell – discrepancies and variance – training/embedding
- Mandatory training – static picture (No of indicators <95%)

Actions taken:

- MRSA screening remains a challenge but the department were working to educate the staff around this. The monthly data was reviewed regularly to identify staff who were continually not completing screening.
- There has been a lot of time spent on training staff with the omnicell via Mairaide Varney and the areas clinical education lead.
- Mandatory training had improved but remains below 95% due to long term sickness.



PATIENT EXPERIENCE TEAM
QUALITY DEPARTMENT
3RD FLOOR CENTRAL
EXT 25166



<https://www.facebook.com/NHSUHCW/>



@nhsuhcw



@nhsuhcw

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	2017-2019 CQUIN Scheme (Healthy Eating)
Executive Sponsor	Lisa Kelly, Chief Operating Officer
Author	Lincoln Dawkin, Director of Estates and Facilities
Attachment	2017 – 2019 CQUIN Scheme for Healthy Food for NHS Staff, Visitors and Patients – 2018/2019 Update Appendix A – Confirmation from ISS and WHSmith
Recommendation	The Board is requested to NOTE progress to date in terms of compliance with the CQUIN along with the commitment from our service providers to continue to comply going forward.

EXECUTIVE SUMMARY

In an ongoing effort to improve the Health of our Staff, Visitors, and Patients, in 2016 a number of CQUIN targets were introduced to encourage health eating in every retail outlet within the Hospital. This report provides an update on progress made to date at UHCW in terms of compliance with the initial targets and subsequent targets set since 2016.

PREVIOUS DISCUSSIONS HELD

N/A

KEY IMPLICATIONS

Financial	Non-compliance with this CQUIN has a potential financial consequence.
Patients Safety or Quality	The reduction in HFSS (foods high in fat, sugar or salt) has a significant impact on the health of both our patients/visitors and staff.
Human Resources	N/A
Operational	N/A

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
REPORT TO PUBLIC TRUST BOARD
2017 – 2019 CQUIN Scheme for Healthy Food for NHS Staff, Visitors and Patients –
2018/2019 Update

INTRODUCTION

Since 2016, the Trust has, via CQUIN targets, been working hard to ensure compliance is achieved across both of our Hospital Sites; this report provides an update in relation to these targets and shows the ongoing commitment to maintaining these targets going forward. As all of the retail outlets at UHCW are operated under the PFI agreement via either ISS (the Trust's current soft service provider) or via the retail arm of the PFI (Gentian), the Trust has been working closely with our PFI provider to achieve the desired standard.

CONTENT

Below is a summary of the targets set under this particular CQUIN:

- The banning of price promotions on sugary drinks and foods high in fat, sugar, and salt (HFSS).
- The banning of advertisement on NHS premises of HFSS
- The banning of HFSS from checkouts
- Ensuring that healthy options are available at any point, including for those staff working night shifts.

We are pleased to confirm that both ISS, WHSmith and M&S (who are operated as a franchise by WHSmith) have complied and continue to comply with the above requirements in both 2017/18 and 2018/19 and have committed to continue to comply going forward.

In addition, a number of specific targets were set in terms of changes to food and drink provision at all of our outlets:

In Year One (2017/18):

- a. 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs (sugar sweetened beverages) it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).
- b. 60% of confectionery and sweets do not exceed 250 kcal.
- c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

In Year two (2018/19):

A further shift in percentages was made:

- a. 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added

sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

- b. 80% of confectionery and sweets do not exceed 250 kcal.
- c. At least 75% of pre-packed sandwiches and other savoury pre-packed meals wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

It is again pleasing to report that all of our retail providers have proactively introduced these measures in 2018/19.

Attached at Appendix A are both the confirmation from ISS in terms of their pledge to continue to comply with the initiative going forward and WHSmith's commitment of support for this along with the response provided by NHS England confirming compliance.

RECOMMENDATIONS

Trust Board is requested to note progress to date in terms of compliance with the CQUIN along with the commitment from our service providers to continue to comply going forward.

Author Name: Lincoln Dawkin
Author Role: Director of Estates and Facilities
Date report written: 30th April 2019



WH Smith PLC

133 Houndsditch
London
EC3A 7BX

Telephone (01793) 616161

Dear Trust,

In March 2018, we fully implemented the second set of criteria (2017/2018) for the healthier eating CQUIN in your hospital in order to support both yourselves and NHS England in improving healthier retailing standards across our hospital estate. Whilst we continue to see a decline in sales across the last 2 years we are committed to continuing to support last year's CQUIN requirements across our stores and below outlines how we intend to show our compliance with regards to this year's CQUIN requirements (2018/2019 criteria).

WHSmith is currently compliant with four of the six 2018/19 CQUIN criteria that apply to retail outlets. These include:

- a. No advertisements of sugary drinks and foods high in fat, sugar or salt (HFSS)
- b. All sugary drinks and foods high in fat, sugar or salt (HFSS) banned from checkouts
- c. 80% of confectionery and sweets not exceeding 250 kcal
- d. 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g

The two outstanding criteria relate to price promotions¹ and rate of SSBs sold². However from May 2019, WHSmith will be compliant with the criteria relating to price promotions and in the vast majority of trusts in relation to the SSB criteria.

As per last year we have agreed an implementation plan with NHS England, which is outlined below, that, will allow us to give you, the Trust, assurance over compliance and allows WH Smith to provide a standardised approach across our entire Hospital estate. This 4 point plan (on top of the previous annual compliance letters) will provide the evidence you need to demonstrate to your local commissioner how CQUIN has been implemented by WHSmith in your trust.

WHSMITH will:

- Adhere to the 80% compliance of facings for products under 250kcal (based on centrally created planograms) in store across sweet confectionary areas; this will be looked at from a total space in store for all sweet confectionary space. We will provide a % for each store in our estate. Due to the vast number of planograms we have in our estate we will be fully auditable for any store through NHS England centrally and example planograms of a small, medium and large store will be shared with NHS England to show our compliance.
- Adhere to the 75% compliance of facings for products under 400kcal or less and containing no more than 5g sat fat per 100g (based on centrally created planograms) in store across

¹ No price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)

² Total litres of SSBs sold are 10% or less of all litres of drinks sold



WH Smith PLC

133 Houndsditch
London
EC3A 7BX

Telephone (01793) 616161

- sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads , this will be looked at from a total space in store for all sandwich space. We will provide a % for each store in our estate. Due to the vast number of planograms we have in our estate we will be fully auditable for any store through NHS England centrally and example planograms of a small, medium and large store have been given to NHS England to show our compliance.
- Continue to support the voluntary agreement on sugar sweetened beverages where WHSMITH remains committed to achieving the 90/10 sales mix in each trust and across an average of our entire estate (currently 92.3% as of Q3 data collection 18/19). Due to the different shopping patterns of our customers some stores with the same drinks range are performing very differently from one another, due to this as of March '19 WHSmith has made further cuts to its drinks ranges and we anticipate that on-going only 4-5 units will be over the 10% threshold.
- Price marked packs are being removed from all WHSmith Hospital stores in order to comply, whilst no more stock is being sent to stores we anticipate it will take until May 2019 for stores to finally sell through any residual stock. Additionally, WHST cannot alter a branded supplier decision to place on pack promotions on a high fat, sugar or salt line and as a result these packs will be in situ in our stores throughout the year, however we will not price promote these lines in accordance with CQUIN criteria and we continue to work with our supply base in order to minimize these impacts.

We look forward to continuing to work with yourselves and NHS England to improve the nutrition of food and drink available to NHS staff, visitors and patients.

Yours faithfully,

Ian Rankin

Trading Director WH Smith Travel

Kate Ritchie

Senior Strategy Advisor, NHS England



Strategy Group
NHS England
Skipton House
80 London Road
London
SE1 6LH

19 March 2019

Dear Ian,

We are writing to thank WHSmith for the progress made over the last 2 years towards improving the nutrition of food and drink sold in NHS hospitals, and to confirm your position on compliance with the 2018/19 CQUIN standards based on the plans you have shared with us.

Improving the range and quality of healthy options in food and drink outlets on NHS premises is an ambition we share. The engagement from our commercial partners in this endeavour is crucial; we value our ongoing partnership and appreciate the progress WHSmith has made.

Based on the plans you have shared with us and on the understanding that these plans have been implemented in all stores, WHSmith is currently compliant with four of the six 2018/19 CQUIN criteria that apply to retail outlets, however from May 2019 this will move to 5 out of 6 and also in the vast majority of the WHSmith all six will be achieved. This achievement reflects your ongoing commitment to this agenda and the changes that WHSmith has made during 2018/19. The two outstanding criteria are:

- Due to the need for WHSmith to remove price marked packs from your Hospital stores in order to comply with the 2018/19 CQUIN standards, you cannot ensure that there won't be any residual stock selling through in your stores until May 2019. By this point in time WHSmith will be fully compliant to the promotional criteria of CQUIN 2018/19. We welcome WHSmith's commitment to phasing out price marked packs over a short period of time.
- In relation to the SSB criteria, we welcome WHSmith's ongoing commitment to the Voluntary Reduction Scheme and to ensuring that SSBs constitute less than 10% of all litres of drinks sold. Based on the latest data submitted to us for Q3, we can confirm that that WHSmith stock an average across your entire estate of less than 10% of total drinks. We also welcome that WHSmith has taken further action at a local level to make further de-lists across their SSB range in order to support every trust in achieving the 10% level. However, the 10% threshold needs to be met by each trust.

We strongly encourage you to keep making every effort to comply with all CQUIN criteria, and would be happy to discuss any support we can offer to help you achieve this.

We recognise that to plan for significant change businesses need assurance about the longer-term plan. We remain committed to this agenda and are working with NHS Improvement and Public Health England to agree a consistent set of food and drink standards for healthcare establishments, which will take effect in early 2019. As we discussed, these standards will futureproof the CQUIN targets, and we appreciate your engagement to date on developing this next phase of work.

Health and high quality care for all, now and for future generations

We look forward to continuing to work with you to improve the nutrition of food and drink available to NHS staff, visitors and patients.

Yours sincerely,

Kate Ritchie
NHS Healthy Workforce Programme Manager

Rob Massam
NHS Healthy Workforce Project Manager

ISS Facility Services**Service Provider to University Hospitals Coventry & Warwickshire NHS Trust**

Firstly, we confirm that we have maintained the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19

a. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)

The following are common definitions and examples of price promotions:

1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal);
2. Multi-buy discounting: for example buy one get one free;
3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS);
4. Price pack or bonus pack deal (for example 50% for free); and
5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals).

b. The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS)

The following are common definitions and examples of advertisements:

1. Checkout counter dividers
2. Floor graphics
3. End of aisle signage
4. Posters and banners

c. The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts;

The following are common definitions and examples of checkouts;

1. Points of purchase including checkouts and self-checkouts
2. Areas immediately behind the checkout

d.) Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue.

Secondly, we confirm that we introduced the following three changes to food and drink provision:

In Year One (2017/18):

- a. 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

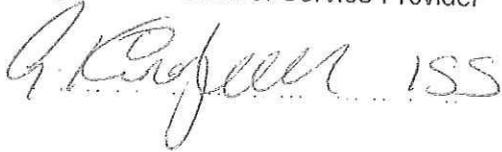
- b. 60% of confectionery and sweets do not exceed 250 kcal.
- c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

In Year two (2018/19):

A further shift in percentages was made

- a. 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).
- b. 80% of confectionery and sweets do not exceed 250 kcal.
- c. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

Signed on Behalf of Service Provider

A handwritten signature in black ink, appearing to read "A. Cooper", followed by the letters "ISS" in a larger, bold font.

Signed on Behalf of UHCW NHS Trust

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**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	UHCW Improvement System (UHCWi)
Executive Sponsor	Karen Martin, Chief Workforce & Information Officer
Author	Neil Griffin, Kaizen Promotion Office Lead
Attachment	UHCW Management & Improvement System (UHCWi) Report
Recommendation	Trust Board is asked to NOTE the progress of the implementation of the UHCW Improvement System (UHCWi).

EXECUTIVE SUMMARY

The report updates on progress with the Trust's cultural transformation as part of the 5 year partnership with Virginia Mason Institute.

The Trust has implemented the UHCW Improvement System (UHCWi) as a management system and has Value Streams in Ophthalmology, Patient Safety (handed back to operational management), Theatres, Simple Discharge and Pre-Operative pathway and has launched new Value Streams in Children's ED & Recruitment. The Value Streams have shown improvements against metrics to capture the benefits to patients.

The number of staff that have received some form of UHCWi training now exceeds 2,200.

PREVIOUS DISCUSSIONS HELD

Previous Reports presented at May 2018, September 2018 and January 2019 Trust Boards and oversight is provided via monthly Trust Guiding Team meetings.

KEY IMPLICATIONS

Financial	The UHCWi method focuses on elimination of waste which in turn will provide cost benefits to the Trust in the longer term.
Patients Safety or Quality	The Patient Safety Value Stream has resulted in daily patient safety huddles in all clinical areas and there is a senior team that respond to serious patient safety issues.
Human Resources	The UHCW Improvement System is a management system that aims to empower all staff in incrementally improving their work to the benefit of patients. The key implication will be to the culture of the Trust.
Operational	UHCWi will be the method that all areas will use as part of their 'Daily Management' to focus on their ability to meet patient demand and to track and respond to defects as part of their daily work.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO PUBLIC TRUST BOARD

UHCW Management & Improvement System (UHCWi)

1. Introduction

The Trust continues in its partnership with the Virginia Mason Institute (VMI) supporting the implementation of the UHCW Management & Improvement System (UHCWi) across our Hospitals and beyond. Virginia Mason have taken learning from Toyota and created a management system called the Virginia Mason Production System to improve the delivery of their healthcare. Learning from them UHCW now has the UHCW Management & Improvement System which we are developing to be the system for our hospitals to benefit our patients.

So that all staff can understand that the UHCW Management & Improvement System is about a culture change there are three simple, but powerful, aims that link it to the Patient First strategy triangle:



This is now the fifth report for Trust Board on the progress and outcomes from the implementation of UHCWi. Some elements will be intentionally re-visited to continue to help spread the awareness and understanding of UHCWi.

2. Background and Links to Previous Papers

The previous papers have outlined the overall governance of the programme, highlighted the progress of the Value Streams, and described the spread of the education and engagement in the method. This report will describe how this work continues to progress based on our latest learning.

3. Update

(i) Governance for Programme

Transformation Guiding Board (TGB)

The five trusts (Leeds, Barking, Havering & Redbridge, Shrewsbury & Telford, Surrey & Sussex and ourselves) in the partnership continue to meet monthly at a Transformational Guiding Board. This comprises the five trust Chief Executives, together with NHSI and VMI representatives, this Board looks at the progress of the partnership and steers the work in each of the Trusts. It is used as a forum to share learning and to evaluate progress using metrics from internally in the Trusts, external surveys and formal evaluations. Recently conversations have focused on introducing Hugh McCaughey, recently appointed as

National Director of Improvement, NHS Improvement and NHS England. Hugh has indicated an ambition to embed improvement throughout the NHS driven through re-empowerment of frontline staff and balancing the central focus on regulation or quality control with quality improvement.

Recent TGB meetings have also focused on how the trusts are each integrating the work so that it becomes their way of doing business. So that our staff think differently about UHCWi we have started to refer to it as a Management System as well as our Improvement System.

Trust Guiding Team (TGT)

The TGT is where the Chief Officers meet monthly with representatives from the Kaizen Promotion Office (members of our own staff trained in the method by VMI) and a Sensei from Virginia Mason Institute to locally monitor progress in embedding UHCW Improvement System as the way we run our hospitals. The TGT monitors the Trust level, Executive-led Value Streams alongside the training and spread of the method to all levels of leadership in the Trust.

Recent TGTs have focused specifically on alignment of the value streams to Trust Strategic Objectives and the selection of new value streams. TGT has looked at not having separate improvement objectives to simplify alignment for staff. Based on the learning from the Seattle visits and the coaching from the Virginia Mason Sensei we have had a session at Chief Officers Forum on alignment of the Trust Strategic Objectives from the Strategy Triangle through to Clinical Groups. This session started the conversations with Senior Leaders around how they will connect the Strategic Objectives into their Groups and cascade into wards and departments as part of creating the 'Golden Thread' down to an individual member of staff and their appraisal objectives. There is a planned additional workshop where the cascade can be modelled and tested so there is a two way flow both up and down the organisation. The intention with this is that there is an alignment of purpose and resources and that any member of staff can see how and where they contribute to the Trust strategy. Once tested this will help leaders revise the Production and Improvement boards across departments, this will be reinforced by Leader Rounding (intentional planned visits to areas) and will also be replicated into the 'Greenhouse' system (the Trust's electronic platform for tracking and monitoring projects).

The training and spread of the Improvement System is undertaken by the Kaizen Promotion Office (KPO), this comprises of four VMI certified staff who can facilitate Rapid Process Improvement Workshops (RPIWs) within Value Streams. Based on learning from other Trusts and in order to support further spread of the method the KPO is recruiting additional staff to increase the training numbers that can be offered and coached.

(ii) Value Streams

The Trust Level Value Streams all have high-level metrics to track improvement, and RPIWs (Rapid Process Improvement Workshops) are run focusing on a part of a process to eliminate waste and add value, measured from a patient perspective.

The metrics are routinely monitored through the Trust Guiding Team and also reported at the Transformation Guiding Board. The Trust has now held 21 RPIW weeks – these are week long improvement events where the staff who do the work are given the time and support to identify and test ways to improve the processes. Based on the two new Value Streams launched there are RPIWs planned in July & September for Children's Emergency

Department and Recruitment respectively. Our commitment to include patient partners and/or volunteers as full members of these improvement events continues to be honoured for each of the RPIWs. This is designed so the 'voice of the patient' is heard directly by staff.

The Trust now has six active Value Streams, each with an Executive Sponsor. The TGT has recently identified two new value streams with scopes of Children's Emergency Department flow and Recruitment Processes. These Value Streams launched with Sponsor Development Sessions (launch events that design a future state) in May. There have been many ideas tested from the RPIWs in each value stream - below features an updated summary of outcomes:

Value Stream #1 Ophthalmology – Executive Sponsor, Nina Morgan

This Value Stream continues to sustain changes from previous RPIWs around huddles, clinic set up and the Eye Casualty immediate triage (Streaming). However the specialty continues to be challenged by the volume of patients that require its services as it draws patients from a wide catchment across Coventry & Warwickshire. The incremental changes are helping improve patient experience but staff recognise there is a lot more scope for improvement. The recent RPIW focused on the pathway for patients on the day of their Cataract procedure as for a relatively brief procedure patients have been observed as waiting for a significant amount of time. Following the week the staff have been testing staggered invites times for patients to improve the patient experience. Staff have rationalized theatre trays so only the necessary instruments are held on cataract trays so reducing the need for fast tracking trays and they have identified regularly used TTO drugs to be held locally on the unit so staff do not have to source these drugs from pharmacy for TTOs, helping staff and reducing patient waiting times for discharge.

Value Steam #2 Patient Safety Incident Reporting – Executive Sponsor, Nina Morgan

This Value Stream has successfully completed its Kaizen (improvement) plan and no further RPIWs are planned for this Value Stream and it has been successfully transferred back to operational management.

Value Stream #3 Theatres – Executive Sponsor, Susan Rollason

This Value Stream has had five RPIWs and more recently the Value Stream Sponsor Team has had its membership reviewed and the new members have decided the Value Stream should continue but with a focus on Emergency Theatre patient flow.

Value Stream #4 Discharge – Executive Sponsor, Karen Martin

This Value Stream looking at the discharge process for Acute Medicine patients has completed five RPIWs. The most recent RPIW was focused on patient requiring an inpatient ultrasound scan. The RPIW ideas are still in testing, but during the week the team tested ideas that:

- Eliminated unnecessary printing by radiology admin staff
- Reduced the time spent by admin staff printing, writing phone numbers/prep and contacting wards from 0.21WTE to 0WTE.
- Time for a patient to have a scan reduced by 56%

The team are working on a satellite ultrasound room to increase access for those patients in the east wing of the hospital, if successful this should mean earlier decision making and discharge for this cohort of patients.

Value Stream #5 Pre-Operative Pathway – Executive Sponsor, Andy Hardy

This Value Stream has focused on preparing Orthopaedic patients for admission for surgery, looking at the pre-operative pathway following the identification of the need for an operation. Following the recent RPIW in March 2019 the team are testing new electronic methods of making patients more visible and testing a new triage system to reduce patient time post clinic and also potentially the number of patient visits.

- The new link showing where a patient is on their 18 week pathway has had a 40% increase in usage since the link went live on 4th April.

Other improvements are in development with ICT.

(iii) Education and Engagement

We continue to engage with staff in a variety of approaches from awareness sessions based on individual tools and concepts, to formal training and coaching in UHCWi System.

The number of staff that have received some training in UHCWi, from simple lean tools (5S - a lean tool to make the workplace safer and more organised) up to Lean for Leaders and Advanced Lean Training is now in excess of 2,200.

Lean for Leaders

Lean for Leaders is a five month programme, which is designed to prepare leaders to lead in new ways, becoming problem framers and empowering staff to make improvements to their services. Staff are taught how to embed UHCWi methodology into their service. Importantly, the programme provides teaching and coaching to leaders to enable them to observe and measure their services from a patient perspective. Leaders develop skills to lead change effectively by developing standard work for daily management, create visual displays to show the status of the department, organise and convene daily staff huddles, perform root cause analyses and promote daily kaizen (improvement), engaging their team in idea generation and testing using the PDSA method.

As more Lean for Leaders complete the course, production boards are becoming more visible across the Trust and senior leaders are being encouraged to undertake genba rounding (visit the area to understand the daily status, ideas for improvement and support the removal of barriers to embed the daily management method). To date, 286 staff have been trained (either completed or completing the course). There are a further 76 leaders commencing in July 2019.

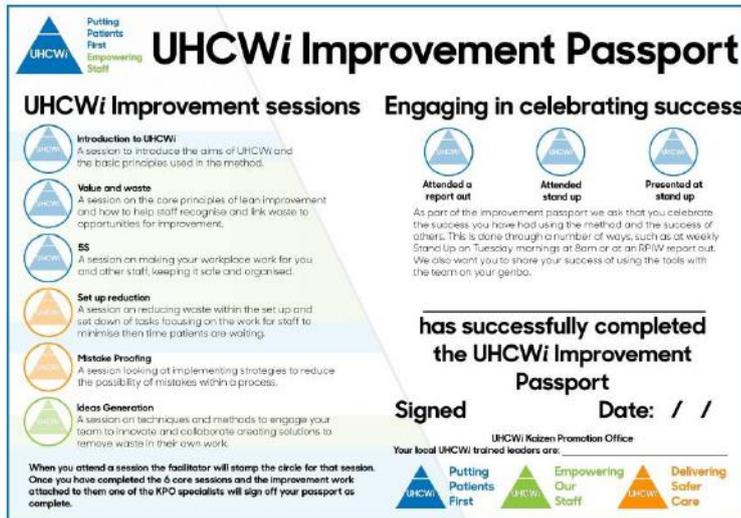
Leadership Training - Leading Together Masterclass

We continue to offer a mandatory Masterclass as part of the Trust's Leading Together Leadership Programme. To date, 545 staff have attended the UHCWi Masterclass.

Passport Sessions

The Improvement Passport sessions have been in progress since February 2018. These are offered to all staff and are 'bite-sized' introductions to the tools and methods as part of UHCWi Improvement System. Staff can attend individual sessions to build up to a completed Passport. We also offer the sessions to individual wards and departments and can design the content to be specific to the staff we teach - this has been particularly popular with areas that want to support a Lean for Leader participant, because other staff learn the method alongside their leader, which increases engagement in improvement.

In addition to advertised sessions, we have provided various bespoke sessions during April: Neonates, Therapy, Clinic 11, Ophthalmology, Cardiac Critical Care, Pathology Networks and Workforce. During May we will provide bespoke sessions to Paediatrics and Preceptorship Nursing.



The number of passports commenced by staff now stands at over 1,400. This training has given staff the tools to make incremental improvements in their own areas and the KPO will follow up with these staff to see what they have tried in their areas and invite them to present their learning and improvements at Stand Up.

Stand Up

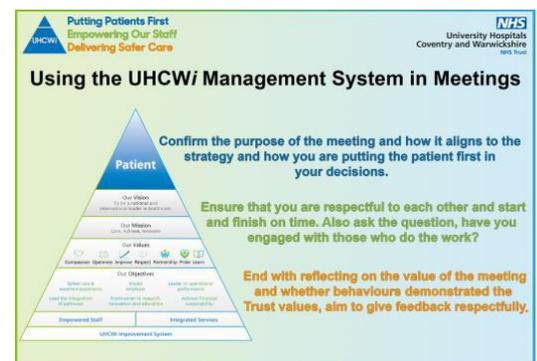
Stand Up continues to occur every Tuesday at 8.00 am. Chief Officers lead Stand Up. It maintains focus and accountability on the ideas being tested following a RPIW. Staff, designated as leads on the improvement weeks, present their progress, celebrate successes and highlight barriers to the Chief Officers, who offer their support. We do invite our patient partners to attend Stand Up so they can see the progress of the improvement work they have been involved in.

During April the Chief Officers presented their learning from Lean for Leaders at Stand Up, they shared their leader standard work with the audience.

Once a month the Stand Up meeting takes place in the main Outpatient area at the Hospital of St Cross, so the improvement work can be openly discussed on both sites.

Visual cues to help embed the method in daily work

Meeting Posters to promote UHCWi Management System in the running of meetings are now displayed in meeting rooms across the Trust. They remind staff to check if the meeting adds value and how its purpose links to the Strategy Triangle as well as encouraging 'in flow' feedback about behaviours during the meeting. These posters keep the Patient First strategy triangle in eye-line of staff.



Celebration and Values

People and Success posters are available as a template to help staff create their own success posters for display in their local area, this is to help staff further connect with the UHCWi method and recognise incremental, locally led improvements.



Values door banners again this is about having our Trust values visible for both our patients and staff, so these banners are on many of the main corridor doors throughout the hospitals and departments are choosing where they would like them to appear on internal department doors.

Some of these visual cues have been introduced following some of the reflections from leaders who visited Virginia Mason in November and March to 'see with their own eyes'. The small group of leaders who visited Virginia Mason in Seattle were inspired by what they saw in how a hospital that has remained committed to a single management system can realise quality, safety and economic benefits. It was noted that Virginia Mason's Patient First Strategy triangle was both visibly evident across the hospital but was also part of their daily huddle discussions in many of their areas. We continue to learn from Virginia Mason in how they use the method in daily repeated behaviours to provoke the right conversations and to ensure alignment with a focus on value

for patients.

Warwick Business School Evaluation of the Partnership with Virginia Mason Institute

Warwick Business School has been appointed to lead the evaluation of the NHS England Partnership with Virginia Mason Institute. They will present their interim report to the five Trusts and NHSI/E in June 2019.

(iv) External Visits/Visitors to the Trust related to UHCWi

Thought Leadership Event – UHCWi Journey

The Trust has dedicated one of the leadership sessions in May to reflecting on the journey of implementing UHCWi. This has been open to leaders within the Trust but also extended to our other colleagues in healthcare across Coventry & Warwickshire as part of our Trust Values of Partnership in Learning and Improving.

4. Recommendation

The Board is invited to **NOTE** the progress of the implementation of UHCWi.

Neil Griffin, Kaizen Promotion Office Lead
Date: **May 2019**

REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019

Subject Title	Research & Development Annual Report 2018-19
Executive Sponsor	Richard DeBoer, Chief Medical Officer
Author	<u>Authors: (Names and Roles):</u> Professor Chris Imray, Director of Research and Development. Ceri Jones, Head of R&D Nic Aldridge, R&D Nurse Lead Gio Bucci, Research Portfolio Development Manager Sean James, Arden Tissue Bank Manager, AHSN Genomics Ambassador. John Hattersley, Head of HMRU Tracy Gazeley, NIHR CRF Manager Kavi Sharma, Trial Manager Isabella Petrie, Research Governance Manager The Research and Development Team
Attachment	Research & Development Annual Report 2018-19
Recommendation	The Trust Board are asked to NOTE the contents of this report and continue to support the R&D strategy.

EXECUTIVE SUMMARY

Strategy: Following the successful delivery of our previous 3 year strategy, we refined the R&D Strategy this year to provide a framework until 2021.

Performance: We continue to deliver against our strategy. 2018-19 was another strong year for the team. Some improvements are required and we have plans to support these.

Quality: Progress has been made in developing systems to enable us to safely deliver our diversifying portfolio this year.

External environment: We are collaborating with the best partners to position ourselves and our research to maximise the potential from external schemes.

Key achievements: Securing centre of excellence 'PathLAKE'; retaining NIHR Clinical Research Facility status, beginning to reverse declining trend in clinical academic workforce.

PREVIOUS DISCUSSIONS HELD

Our renewed R&D strategy was approved by the Trust Board in November 2018.

KEY IMPLICATIONS

Financial	We had a fall in external income from 1 source in 2018/19; this was managed and has been reversed for 2019/20.
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Patients Safety or Quality	We met target of zero serious breaches or critical findings this year.
Human Resources	We are developing leadership and a formal clinical academic pathway in 2019.
Operational	Success is impacting on infrastructure and space.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO TRUST BOARD

RESEARCH & DEVELOPMENT ANNUAL REPORT: 2018/19

1. INTRODUCTION

- 1.1 We are committed to establishing our Trust as an internationally recognised centre of excellence through supporting our staff, working in world class facilities and conducting leading edge, multi-professional, collaborative research focused on the needs of our patients.
- 1.2 To be a Frontrunner in Research, Innovation and Education is a Trust strategic objective.
- 1.3 This report provides Trust Board with a review of progress made during 2018-19 and assurance on delivery against the Research & Development (R&D) Strategy during this period.
- 1.4 Research activity at UHCW NHS Trust is supported by the dedicated R&D team who work tirelessly to make research happen. However, all of this work is driven or supported by our colleagues throughout the Trust, without whom this success would not be possible.

2. CONTENT

2.1 Research continues to thrive

- 2.1.1. **Strategy:** Following the successful delivery of our previous 3 year strategy, we refined the R&D Strategy this year to provide a framework until 2021.
- 2.1.2. **Performance:** We continue to deliver against our strategy. 2018-19 was another strong year for the team, with improvements in national and local performance metrics, increased patient participant participation into research and continued delivery of a high quality service (as demonstrated by absence of serious breaches and a positive external audit).

In some areas (see Research Performance section 2.3.1) , whilst we are performing at above the national average and comparably to West Midlands trusts, improvements are still required and we have plans to support these.

- 2.1.3. **Quality:** The development of our Clinical Research Facility and move towards doing earlier phase research necessitates a proactive governance approach, and much progress has been made in developing systems and training to enable us to safely deliver such projects this year.
- 2.1.4. **External environment:** We are collaborating with the best partners to position ourselves and our research to maximise the potential from National Institute for Health Research (NIHR) and other national drivers. The Life Sciences Strategy is aligned to our ambitions of increasing the number of clinical trials, improving the UK's clinical trial capabilities, supporting translational work and attracting world-class scientists. It also aims to increase collaboration to support evaluation of innovative diagnostics and devices and we have a developing track record in this area.

2.2 Key Highlights:

2.2.1. Retaining our National Institute for Health Research (NIHR) Clinical Research Facility (CRF) status will provide an additional £515K. The CRF will be essential platform for future research applications (particularly for an NIHR Biomedical Research Centre).

2.2.2. UK Research and Innovation are investing £15million into a consortium, 'PathLAKE', led by UHCW as part of the Industrial Strategy Challenge Fund, to collaborate with experts from Philips, NHS hospitals and universities at Warwick, Belfast, Oxford and Nottingham. The project will be hosted by the new UHCW Institute of Precision Diagnostics and Translational medicine to ensure rapid translation into clinical practice. The project aims to revolutionise cancer care by speeding up the detection of some cancers with additional accuracy, as well as paving the way for personalised care.

2.2.3 Through collaborating with a range of academic partners, we have leveraged funding to secure additional clinical academics to lead our research in future. This, along with our strong success rate in securing external grant income, and our developing reputation as a research h leader, will reverse the reduction in external Research Capability Funding experienced in 2018/19 and enable us to deliver more research focussed on the needs of our patients.

2.3 **Report detail and structure:** This report provides a summary of details delivery by each of our 4 strategic research areas as follows:

2.3.1 Increase high quality research activity that impacts across the organisation

- Research Performance – recruitment, set-up and delivery
- Research Portfolio Development – grants development and submitted

2.3.2 Provide quality management and support for research

- Academic Leadership
- Research Governance – quality
- Research Clinical Delivery Team - activity

2.3.3 Provide high quality facilities for clinical research and healthcare innovations capable of responding to change on demand and evolving the collaborative environment

- Trial Management Unit
- NIHR Clinical Research Facility
- Tissue Bank & 100,000 Genome Project
- Human Metabolic Research Unit

2.2.4 Raise the profile of Research

- Patient and Public Involvement and Engagement
- Communications / Awards / Events / Esteem measures

3. **IMPLICATIONS**

- 3.1 Securing significant external income has improved our national profile and provided funding to support additional resources to deliver projects. However, this has resulted in additional pressures on existing infrastructure and space.
- 3.2 The strategies of our local academic partners (Coventry & Warwick) are evolving and both are developing ambitious plans including UHCW which will provide additional opportunities.

4. **OPTIONS**

- 4.1 Given the progress to date, we are confident that no changes are required to the current strategy.

5. **CONCLUSIONS**

- 5.1 Our long term strategic view is paying dividends and we are continuing to build on our previous success.
- 5.2 This report provides assurance that the R&D Strategy is being successfully delivered, with progress continuing in all areas.

6. **RECOMMENDATIONS**

- 6.1 Trust Board should note the contents of this report and continue to support the R&D strategy.

Authors: (Names and Roles):

Professor Chris Imray, Director of Research and Development.

Ceri Jones, Head of R&D

Nic Aldridge, R&D Nurse Lead

Gio Bucci, Research Portfolio Development Manager

Sean James, Arden Tissue Bank Manager, AHSN Genomics Ambassador.

John Hattersley, Head of HMRU

Tracy Gazeley, NIHR CRF Manager

Kavi Sharma, Trial Manager

Isabella Petrie, Research Governance Manager

The Research and Development Team

Date report written: 14/03/19

RESEARCH & DEVELOPMENT ANNUAL REPORT 2018/19:

2.3.1 Increase high quality research activity Area: Research Performance

Background:

In support of the Trusts' strategic aim to be a research based healthcare organisation R&D report performance against a number of metrics at Trust and national level. These include the NIHR Performance in Initiation and Delivery metrics.

Current position:

We recruited 4,914 patients this year, 123% of our patient recruitment target

To provide a more sustainable commercial research environment, our commercial strategy is being implemented and we are working to increase the number of commercial trials at UHCW. Currently, whilst commercial income remains behind target, an increasing number of new studies commenced in 2018/19; we issued confirmation and capacity for 81 trials in 2018/19 (c.20% commercial).

National Benchmarks – Performance in Initiating and Delivery:

	UHCW Year end (Q4)	Target	National (only Q3 available)	West Midlands (only Q3 available)
Performance in Initiation	70%	80%	37%	N/A
Performance in Delivery	50%	80%	N/A	56%

Performance in Initiation: Although we are no longer measured on the 70 day target, we are still using this as a bench march to measure how long studies are taking to be opened. We are close to meeting the target of 80% but understand there is still work to be done to ensure we can meet this. We are confident we are reporting accurate data and are striving towards increasing this metric by proactive performance monitoring and improving relationships with external sponsors to improve efficiency of set-up activities.

Performance in Delivery: We have noticed a significant increase in the number of studies meeting the recruitment target in previous years and this has been due to more realistic targets being set along with a thorough feasibility being completed by all teams. However, only 9 out of 18 studies met the target in Q4 2018/19..

Local Benchmark – Publications 234 publications (79% of target achieved); we believe that this is due to underreporting and will seek to source other means for the provision of publication data in 2019/20

SUMMARY/FUTURE;

Improvement is needed. Our aim for 2019/20 is to reduce our set up times by at least 5%. We are working to increase commercial activity further as we seek to exceed both our Trust and national benchmarks and increase capacity to support further research.

2.3.1 Increase high quality research activity

Area: Research Portfolio Development

Background:

The Portfolio Development team supports and facilitates grant application and helps promote an active research culture. Priority is given to National Institute of Health proposals where the Trust benefits from Research Capability Funding (RCF). Our goal is to maintain RCF at £1 million per annum.

Current position

Progress against targets 2018/19:

- 139 grants were submitted against a target of 128 (9% over target).
- 31 grants have been funded to date (28% of those with an outcome received).
- We are still awaiting the outcome for 30 grant applications.
- RCF allocation (based on 2018/19 performance) is £987,046 for 2019/20, up from £648,951 in 2018/19. Our RCF income is 22nd highest nationally.

Comparative data

Over the last 3 financial years (2016/17 to 2018/19), 401 grants have been submitted and 94 funded – a success rate of 23%. This compares favourably with national success rates, e.g. NIHR Research for Patient Benefit (15%), NIHR Health Technology Assessment (24%) and the Medical Research Council (23%).

Risks/Mitigation: RCF, based on NIHR income, is predicted to be over £1mill in 2020/21, despite recent changes in the national RCF funding formula, which has impacted on our RCF income over the last two financial years. We continue to prioritise our resources to support NIHR applications where the Trust is the lead organisation and, of grants submitted in 2018/19, 33 were to NIHR programmes. We are also diversifying our research portfolio to other funders, including; ESRC, EPSRC, MRC (11 grants) and medical charities (38 grants).

Other success

- 3 successful NIHR grants, including: Digital Pathology (HTA; £2.2m), CERM (EME; £1.85m), and SPHERE (HTA; £1.35m) in Cardiology, Clinical Diagnostics and Reproductive Health and renewal of our CRF designation.
- Innovate UK grant of c. £15m secured to deliver the PathLAKE project, aiming to develop AI in clinical pathology diagnostics.
- Continuing to support the development of non-medical researchers:
 - British Heart Foundation grant (£200,000) led by an Exercise Physiologist
 - Research midwife successful in getting onto a PhD programme after completing on a pre-masters internship and NIHR funded masters.
 - Supported the 2 successful NIHR 70@70 applications (1 nurse, 1 midwife).

SUMMARY/FUTURE:

The number of submitted grant applications exceeded target, and the quality was reflected by a strong success rate in prestigious NIHR and Innovate UK awards. Strategic Trust and R&D investment in Clinical Diagnostics, Orthopaedics, Gastroenterology, Cardiology and Reproductive Health has leveraged significant external funding.

2.3.2 Provide quality management and support for research Area: Academic Leadership

Background:

As an integral part of the Trust's vision to be a National and International Leader in healthcare, there is a requirement to develop research leadership within the Trust to secure external funding, increase our esteem and produce outputs that improve patient care.

Current position:

Whereas some areas can be considered research leaders, characterised by having a defined strategy, senior Clinical Academic Leadership and providing multi-disciplinary support for staff at all levels of their clinical academic career, e.g. Reproductive Health, Musculoskeletal/Rehabilitation and Trauma & Orthopaedics, other areas are still developing.

In previous years, we have experienced a reducing academic base and experienced a fall in successful NIHR funding applications. This meant that we were required to manage a significant drop in Research Capability Funding in 2018-19 (down from £1.16m in 2017-18 to c. £650K in 2018-19). However, we are working to reverse this and have secured the following additional posts this year (and have agreement from a number of our collaborators to develop further joint academic posts in future years):

- Coventry University: Professor in Clinical Nursing (Prof Jane Coad, commenced May 2018).
- Oxford University: a Senior Lecturer in Transplantation (Mr James Hunter).
- Warwick University: a Professor in Midwifery (Professor Debra Bick) and an Associate Professor post in Trauma and Orthopaedics (to start 2019/20).
- Birmingham University: Lecturer in Vascular Surgery (Ruth Benson).

We have developed an Interdisciplinary Clinical Academic Research Health Excellence (i-CAhRE) programme and implementation plan which aligns with the Trust R&D and Nursing and Midwifery Strategic plans to support nurses, midwives, clinical health scientists and allied health professionals through an academic career pathway. This workforce is starting to deliver increasing numbers of research grants and securing national recognition (see 2.3.1 Research Portfolio).

To further develop our research culture, our R&D Strategy commits to the development of a Biomedical Research Centre, to be formed through partnerships to conduct translational research to transform scientific breakthroughs into life-saving treatments for patients; this is being progressed through our Joint R&D Strategy Group with Warwick University.

SUMMARY/FUTURE:

Ongoing collaboration with a range of academic partners enables us to secure increased income, additional academic leadership and provide support for the clinical academics of the future.

2.3.2 Provide quality management and support for research Area: Research Governance

Background:

Research Governance enables us to safeguard our patients taking part in research, protect our researchers by providing a clear framework within which to work, enhance the ethical and scientific quality of what we do, mitigate risk, monitor practice and promote good practice by ensuring lessons are learned.

Current position:

This year the Governance Unit has:

- Merged the Study Set Up team with the Sponsorship Team to improve communication and governance oversight of research into the R&D Department, now entitled the Study Set Up and Governance Team.
- Continued to implement an effective quality control and risk management system for all research trials.
- Updated all our Standard Operating Procedures (SOPs) for Clinical Trials IMP legislation to include:
 - Medicines for Human Use (Clinical Trials) Regulations (2004) UK laws (currently unaffected by our membership European Union status)
 - Current General Data Protection Regulations (GDPR)
- Overseen governance requirements for the Trust's first sole-sponsored and fully trial managed phase 1 trial, in line with the MHRA Phase 1 Accreditation scheme; these processes were subject to an external audit in 2018/19, with no critical findings identified.
- Fulfilled the quality assurance requirements of research, training additional monitors to assess and assure the reliability and integrity of the quality control systems of trials, as a way of measuring performance in line with the UK Policy Framework for Health and Social Care Research.
- Risk based monitoring is ongoing in order to maintain overall improvement in the quality of data and research practice.
- Continued to work closely with Pharmacy and Lead Research Nurse to provide robust corrective and preventative actions plans for incidents reported to the Research Governance & Human Tissue (RG&HT) Committee.
- Continued to provide support for research teams learning lessons from incidents, internal reviews and monitoring visits.
- Kept up to date with laboratory regulatory requirements and MHRA expectations, recognising the compliance issues that are likely to be focussed on during any routine inspections.
- Continued to support the development of the CRF processes to ensure the safe support of earlier phase projects.

Critical findings and serious breaches:

We met our target of zero breaches and critical findings in 2018/19.

SUMMARY/FUTURE:

The Research Study Set Up and Governance Team continues to adapt its processes in line with research developments to ensure that we are meeting the required standards.

2.3.2 Provide quality management and support for research Area: Research Clinical Delivery Team

Background:

The Clinical Delivery team support and facilitate patient recruitment into trials. The team are responsible for the safety of patients when participating in research and continue to develop and maintain a research culture at UHCW, striving for better outcomes and quality of life for all patients at UHCW.

Current position:

2018/19 we exceeded our patient recruitment target, offering more patients across more specialities opportunities to participate in research and access new treatments along with shaping healthcare treatments for the future, 4,914 participants, 123% of target. With an increasingly diverse and complex portfolio, this was achieved across 29 specialities and delivered by our workforce of Research Nurses, Midwives, Assistant Research Practitioners, Clinical Trial Co-ordinators and a Clinical Data / Administrative team

Opportunities taken within 2018/2019: Our UHCW Research work force model, shaped and developed by the collection of over 3000 hours data from across 10 teams utilising the Care Contact App (using codes adapted for research), continues to gain national recognition. This year, we were awarded Silver in the HEE 'Workforce Planning Team of the Year' category for our Workforce Planning using this model.

We have continued to embrace new ways of working and are very pleased to have appointed our first joint role Clinical Nurse Specialist/ Research Nurse within the stroke department. Both roles complimenting each other and offering research opportunities to patients not previously available. The nursing research culture continues to be embraced within other departments also. We are currently rolling out our first Research Champions; 7 nurses have been selected to receive specific research training to support high quality in Critical Care

UHCW Clinical Research Facility status continues and the Clinical delivery team continue to support a mixed portfolio of early phase work. This includes our first UHCW developed early phase research study. We secured funding to support a Neurological research nurse this year.

We continue to develop our commercial research activity, recruiting more commercial participants than ever before. Our clinical teams are building a reputation for delivering high quality research, to create 'preferred supplier' status for future opportunities.

Our key priorities are increasing opportunities for participation in high quality research at UHCW across multiple specialities and sites, delivered by a dynamic and highly skilled clinical workforce.

SUMMARY/FUTURE:

We continue to strive to offer increased opportunities for patients to be involved in research across UHCW and as such are in the process of setting up a Rugby St Cross specific research delivery team.

2.3.3 Provide high quality facilities Area: Trial Management Unit (TMU)

Background:

The Trial Management Unit (TMU) provides in-house trial management and support to aspiring local clinicians to develop and deliver high quality research projects. The Unit provides an essential platform to budding local research clinicians for collecting robust data required to demonstrate the feasibility of their ideas allowing them to apply for larger grants. TMU's strategy includes an active collaboration with Industry, providing a fertile ground for collaborative growth and research

Current position:

- This year, the TMU has supported a variety of different trials, from early phase drug studies to medical device interventions:
 - Securing a funding grant of £780K towards the Trust's first sponsored multicenter, medical device trial with Prof Faizel Osman, in collaboration with Industry, allowing the team to develop with the appointment of 2 Research Fellows; ethical approval for which is now underway.
 - Set up and currently managing the Trust's first sponsored phase 1 drug trials the D4H Trial (Effects of dexamethasone on high altitude cerebral oedema), which is being led by Prof. Chris Imray. This trial is being delivered with support from our Clinical Research Facility.
 - Successfully delivered Prof Richard King's randomised controlled trial, to evaluate novel technology (EXACT: Evaluation of X-ray, Acetabular Guides and CT in Total Hip Replacement). This has prompted the investigator team to develop a new proposal, investigating this novel technology in more detail using motion sensors. The TMU as per its strategy is providing support in developing the proposal for funding application.
 - The successful delivery of Prof Siobhan Quenby's SIMPLANT, a phase II pilot study to repurpose a diabetes drug for recurrent miscarriage treatment has prompted the investigator team to progress towards an application for funding for a larger, multi-centre clinical trial.

To support this work, TMU have collaborated with ICT to develop a regulatory compliant electronic data capture system, reducing expenditure on 3rd party systems and building capability within the Trust to provide similar systems for future studies. The TMU team (1.8WTE) is funded by Research Capability Funding and external grants.

SUMMARY/FUTURE:

The TMU aspires to nurture and support interested clinicians to progress in becoming research leaders. It continues to support the delivery of a growing, increasingly complex, portfolio of Trust-sponsored studies. TMU continues to be self-sustaining, attracting increasing grant funding this year.

2.3.3 Provide high quality facilities

Area: NIHR Coventry and Warwickshire Clinical Research Facility

Background:

The Coventry and Warwickshire Clinical Research Facility (CRF) receives funding from the National Institute of Health Research (NIHR) to provide the infrastructure support required to conduct early translational (experimental medicine) research.

Current position:

Funding: In February 2019 we submitted a Two Year Review Report to the NIHR, outlining the progress of the CRF since funding commenced in April 2017. This was reviewed by an Assessment Panel who recommended that we should continue to be designated as an NIHR CRF and hence the Coventry and Warwickshire CRF will continue to be part of the NIHR infrastructure until 31st March 2022. The NIHR will provide £515K to support the CRF by the NIHR over this period.

Performance: In 2018/19, 51 studies were supported by the CRF, recruiting a total of 1214 participants. In addition to studies in the CRF research themes of cardiovascular and metabolic medicine and reproductive health, experimental medicine studies from other specialties were also undertaken, including; rheumatology, endocrinology and gastroenterology. CRF studies funded by commercial companies have increased by 60% this year; resulting in an increased income for the CRF from industry.

The CRF Team continues to support a number of unique projects, including:

- The Trust's first Phase I Clinical Trial of an Investigational Medicinal Product (D4H: Effects of dexamethasone on high altitude cerebral oedema), which opened to recruitment in January 2019.
- Development of the first point-of-care test to aid the early diagnosis of stroke.
- Safety and tolerability assessment of a ketone ester drink in diabetic patients.

Collaborations: As part of the NIHR, the CRF has opportunity to collaborate with other NIHR infrastructure, both regionally and nationally, through a number of initiatives. In 2018/19 this has included the NIHR-BHF Cardiovascular Partnership and the Midlands Health Alliance.

The Future: To maintain our income and CRF kudos. The NIHR expectation is an exponential growth in early phase studies. We will continually review resources to enable us to adapt to the demands of high-intensity, early-phase studies.

SUMMARY/FUTURE:

The CRF continues to make strong progress in the CRF strategy and our funding and designation have been secured for the next 3 years. However, in order to further develop the experimental medicine portfolio and meet the expectations of the NIHR, we need a stronger translational pipeline, and further develop our overnight stay capacity and our 24/7 service.

2.3.3 Provide high quality facilities Area: Arden Tissue Bank & 100,000 Genome Project

Background:

The Arden Tissue Bank provides ethically approved human tissues to researchers carrying out high quality research. Aspects of the Bank operate under the Trust's Post Mortem licence, number 30019 and regulated by the Human Tissue Authority. In 2018/19, the team led the delivery of the 100,000 Genome project Cancer recruitment at UHCW & George Eliot Hospitals (GEH).

Current position:

Commercial applications:

- Tissue Bank have increased and diversified their supply of consented human tissues on a cost recovery basis, this currently stands at three UK based commercial companies for several tissue types by request e.g. regular supply of ovarian fluid, BKV, EBV and CMV positive serum all surplus to diagnosis.
- Two further commercial companies have approached ATB requesting non-transplantable tissues from NHS BT through Arden Tissue Bank both of whom are brokers for pharmaceutical and contract research organisations.
- We are reliant on a close relationship with Pathology to deliver our objectives.

100,000 Genome Project:

Cancer recruitment ended GEH & UHCW in November 2018 (open 27 months):

- UHCW recruitment - 569 patients recruited (11 cancer types at UHCW).
- GEH recruitment - 69 patients (2 cancer types).

Rare diseases recruitment at UHCW (open 32 months):

- 201 patients were recruited at UHCW, with families travelling from across the local area to take part.

To date, return of results has been slow, 189 UHCW cancer results have been returned to date (3 actionable findings in colorectal cancer, 2 in melanoma and 1 in breast cancer). A further 6 cancer reports have been provided to GEH (colorectal and breast cancer).

Genomic testing is now being embedded into routine clinical practice; this will be the focus of the Genomic Ambassador/Tissue Bank manager's role for the next two years

SUMMARY/FUTURE:

The 100,000 Genome research project has completed - the current challenge from Government is to putting the learning gained from it into clinical service.

Arden Tissue Bank is developing its commercial links to increase external income and leading on the networking of 6 Tommy's centres to collect reproductive tissues in a standardised way.

2.3.3 Provide high quality facilities Area: Human Metabolism Research Unit

Background:

The Human Metabolic Research Unit (HMRU) is a facility within University Hospital that investigates human energy metabolism. The initial development of the unit was funded through grants from Advantage West Midlands (Science City Initiative), with significant contributions from the University of Warwick and UHCW.

Current position:

Research Portfolio Diversity

- Whilst the total number of studies in the Unit reduced, from 5 to 6 this year, projects have been larger and more complex
- We are seeking to expand the type of studies undertaken by the HMRU this year; whilst we continue to conduct studies with Extreme Medicine (Prof Imray) and WISDEM (Prof Randeve, Drs Barber/Dimitriadis), in collaboration with Coventry University, we have engaged with medical imaging, the gait lab and medical physics.
- We have completed a novel study with Birmingham Women's and Children's Hospital, which required HMRU expertise to deliver.

Improved integration with UHCW Service

On the night of the 12th December 2019 an incident occurred, a suspected low-blood glucose measurement, which required clinical support from neighbouring areas. On reviewing this incident it was felt that tighter integration was required between the HMRU and the UHCW clinical teams. After a significant period of consultation with a range UHCW committees and expert teams a new process has been put in place, ensuring continuous education with AMU staff and increasing the awareness of studies to the overnight hospital teams (e.g. Hosp@Night, overnight clinical managers, security). In light of the incident, a complete review of the HMRU process was undertaken, resulting in more robust clinical, procedural and technical processes which have been tested.

Risks / Mitigation

Clinical engagement: the HMRU needs to diversify the number and speciality of clinical collaborators running in the HMRU, this work is being led by our Academic Lead for Medicine.

Our facilities are aging will need replacing or developing to meet the changing needs of the HMRU work in coming years.

SUMMARY/FUTURE:

The HMRU continues to collaborate well with local partners and is increasing links with national UK based universities; we are gaining wider exposure to international collaborators.

2.3.4 Raise the profile of research

Area: Patient and Public Involvement and Engagement

Background:

We are committed to putting our patients at the heart of what we do. Involving patients and the public in research produces higher quality and more relevant research, as they provide alternative views from those of the researcher. Raising awareness and understanding of research amongst patients and is also a priority.

Current position:

Our Patient and Public Involvement and Engagement (PPIE) Lead is available to offer advice and support to researchers regarding PPIE in research.

Patient and Public Involvement (PPI): Established in January 2018, the **Patient and Public Research Advisory Group (PPRAG)**, comprises patients, carers and members of the public who use their own experiences and perspectives to guide researchers. The group currently has 40 members and has been involved in 12 research projects this year. Member involvement has included being co-applicants and Trial Steering Committee members, reviewing patient facing literature and lay summaries, and commenting on research concepts. During 2018/19, three PPRAG meetings were held, where researchers presented their projects for feedback.

Patient and Public Engagement (PPE): In 2018/19, we have raised awareness of research amongst patients, the public and healthcare staff through a variety of media, including the Trust 'We Care' newspaper. In collaboration with our four Patient Research Ambassadors, who promote research from a patient perspective, we have raised awareness at the annual UHCW Research Open Day, a primary school, GP Surgery and several support groups.

Governance: The Patient and Public Involvement Research Steering Group (PPIRSG) was established in June 2018, to ensure that PPIE in research is implemented and delivered in line with national standards and in conjunction with the Trust Patient Experience and Engagement Delivery Plan. The Steering Group, which meets every quarter, consists of lay members and Trust staff who have an active involvement in PPIE and reports to the Trust Patient Experience Delivery Group and R&D Strategy Committee.

SUMMARY/FUTURE:

PPIE in research continues to expand, with the PPIRSG being established to support implementation and delivery and the PPRAG increasing membership and PPI activities. We will continue involving patients/the public in research and raising awareness of research using existing and new approaches. In line with national standards, we also aim to expand the diversity of the people who get involved in both PPI and PPE activities at UHCW

2.3.4 Raise the profile of research Area: Communication / Awards / Events / Esteem Measures (selected highlights of 2018/19):

Nic Aldridge and Liz Bailey secured 2 of
the 70 NIHR '70@70' places



Raising Awareness at our R&D Open Day for patients and staff:



Leadership recognition for Sean James, Tissue Bank Manager from West Midlands Genomics Medicine Centre:



Trust secures 3 of 13 West Midlands
Clinical Research Network Awards
(Pictured: Mojid Khan, Clinical Trials
Pharmacist, for Support Service and
Sukdeep Bhutta, ICT, for Use of Digital
Technology)



Finalists, NIHR / Pharmatimes 'NHS Research Site of the Year': CRF Team (Tracy Gazeley, Julie Jones, Shivam Joshi)



Meridian Celebration of Innovation Awards: Prof Nick Dale, Sarissa Ltd. and Prof Chris Imray were Winners in Advanced Diagnostics category for SMARTChip, their diagnostic test for stroke, with Prof Richard King 'Highly Commended' for Best Developed Medical Technology. (pictured: Norman Philips, Patient representative, collects Innovation award on behalf of SMARTChip).



R&D Workforce Planning national recognition by HSJ and Health Education England Skills for Health:



Biomedical Research Unit Midwifery Team Finalists for 'Bereavement Care' in Royal College of Midwives Awards:



PathLAKE (Pathology image data Lake for Analytics, Knowledge and Education) Award secured: UHCW designated one of 5 national centres of excellence in digital pathology, medical imaging and artificial intelligence

National speakers join us to celebrate research at our Annual R&D Summit, with over 150 attendees:



Friday 6th July 2018
8:00-15:00
Clinical Sciences Building, UHCW NHS Trust

The Research & Development Team at UHCW proudly bring you their annual knowledge exchange and networking day.



**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions
Executive Sponsor	Andy Hardy, Chief Executive Officer Su Rollason, Chief Financial Officer
Author	Geoff Stokes, Director of Corporate Affairs and Acting Director of Quality
Attachment	Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions v11
Recommendation	Trust Board is asked to APPROVE the revised Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

EXECUTIVE SUMMARY

The attached document has been revised as part of a planned review cycle.

The updated document is attached and highlights the proposed changes, most of which relate to changes to terminology and consist of the following ;

- The legislative basis has been updated to reference the NHS Act 2006 (previously shown as the 1977 Act)
- Changed 'Board' to 'Trust Board' to distinguish it from other boards in the Trust
- Changed 'executive director' and 'officer member' to 'chief officer',
- Changed 'non-officer' to 'non-executive'
- Changed 'Chief Finance and Strategy Officer' to 'Chief Finance Officer'
- Updated some definitions (e.g. Chief Executive, Chief Finance Officer, NHSI)
- Added 'Chief Strategy Officer' to the list of chief officers
- Referenced the fact that papers are now distributed electronically
- Removed named references to sub-committees of Quality Governance Committee and Finance and Performance Committee

PREVIOUS DISCUSSIONS HELD

Chief Officers Group, 21 May 2019

KEY IMPLICATIONS

Financial	The attached sets out the framework for financial management and decision making across the Trust.
Patient Safety or	The attached sets out the framework for governance and decision making

Quality	across the Trust.
Human resources	The attached sets out the framework for governance and managerial decision making across the Trust.
Operational	The attached sets out the framework for governance and operational decision making across the Trust.

STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS AND STANDING FINANCIAL INSTRUCTIONS	
eLibrary ID Reference No:	FIN-PROC-001-09
<i>Newly developed Trust-wide CBRs will be allocated an eLibrary reference number following submission of eform for registering on eLibrary. Reviewed Trust-wide CBRs must retain the original eLibrary reference id number.</i>	
Version:	10.011.0
Date Approved by Corporate Business Records Committee (CBRC):	
Date Approved by Trust Board (if Applicable)	
Review Date:	<u>31 May 2022</u>
Title of originator/author:	Associate Director of Finance – Corporate Services Director of Corporate Affairs
Title of Relevant Director:	Chief Finance and Strategy Officer
Target audience:	All Staff
<i>If printed, copied or otherwise transferred from eLibrary, Trust-wide Corporate Business Records will be considered 'uncontrolled copies'. Staff must always consult the most up to date PDF version which is registered on eLibrary.</i>	

This Trust-wide CBR has been developed / reviewed in accordance with the Trust approved ' Development & Management of Trust-wide Corporate Business Records Procedure (Clinical and Non-clinical strategies, policies and procedures) '	Version
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Summary of Trust-wide CBR: <i>(Brief summary of the Trust-wide Corporate Business Record)</i>	These documents set out the regulatory framework for the business conduct of the Trust.
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Purpose of Trust-wide CBR: <i>(Purpose of the Corporate Business Record)</i>	The documents provide a comprehensive business framework within which all directors, managers and staff are required to operate. They provide detailed guidance on the key financial processes and specify the delegation of powers to individual officers and committees of the Trust.
Trust-wide CBR to be read in conjunction with: <i>(State overarching/underpinning Trust approved CBRs)</i>	N/A
Relevance: <i>(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)</i>	Finance
Superseded Trust-wide CBRs (if applicable): <i>(Should this CBR completely override a previously approved Trust-wide CBR, please state full title and eLibrary reference number and the CBR will be removed from eLibrary)</i>	

Author's Name, Title & email address:	Geoff Stokes Director of Corporate Affairs geoff.stokes@uhcw.nhs.uk Alan Jones, Associate Director of Finance – Corporate Services alan.jones@uhcw.nhs.uk
Reviewer's Name, Title & email address:	Rebecca Hough, Head of Corporate Affairs rebecca.hough@uhcw.nhs.uk
Responsible Director's Name & Title:	Su Rollason, Chief Finance and Strategy Officer
Department/Specialty:	Cores services

Version	Title of Trust Committee/Forum/Body/Group consulted during the development stages of this Trust-wide CBR	Date
8.0	Audit Committee	8 September 2014
8.0	Trust Board	24 September 2014
9.0	Audit Committee	12 February 2018
10.0	Audit Committee	16 July 2018
11.0	Chief Officers Group	21 May 2019
<u>11.0</u>	<u>Trust Board</u>	<u>31 May 2019</u>

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

This document sets out the formal rules under which the Trust operates including,

- how formal decisions are made and by whom
- the financial and operational levels that apply to different decision makers in the Trust

It is a statutory document that

- Sets out the statutory framework
- Describes the standing orders, which are the rules which govern formal decision making and the operation of the Trust Board and its committees
- Specifies those matters reserved for the Trust Board and those that are delegated
- Specifies the standing financial instructions that apply across the Trust, including
 - the financial levels that will apply to each level of officer or committee

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

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

~~JULY 2018~~ MAY 2019

VERSION 8.0

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SECTION A - INTERPRETATIONS and DEFINITIONS

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

Save as otherwise permitted by law, at any meeting of the [Trust](#) Board of University Hospitals Coventry & Warwickshire NHS Trust (UHCW) 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 Officer or Director of Corporate Affairs).

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:

"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 Officer.

"Trust" means the University Hospitals Coventry and Warwickshire NHS Trust.

"Trust Board" means the Chair, officer and non-officer members of the Trust collectively as a body.

"Budget" means a resource, expressed in financial terms, proposed by the [Trust](#) Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

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

"Chair of the Board (or Trust)" is the person appointed by the Secretary of State for Health to lead the [Trust](#) 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.

"Chief Executive Officer" ~~means the Chief Executive Officer of the Trust~~ is the Accountable Officer for the Trust

"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.

"Committee" means a committee or sub-committee created and appointed by the Trust [Board](#).

"Committee members" means persons formally appointed by the [Trust](#) Board to sit on or to chair specific committees.

"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.

~~"Chief Finance Officer" means the Chief Finance Officer of the Trust~~ fulfils the statutory function of director of finance for the Trust

"**Funds held on trust**" ~~shall~~ means 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.

"**Member**" means officer or non-officer member of the [Trust](#) Board as the context permits. Member in relation to the [Trust](#) Board does not include its Chair.

"**Associate Member**" 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.

"**Membership, Procedure and Administration Arrangements Regulations**" means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments. *{Appendix 1}*

[NHS Improvement \(NHSI\) The operating title of statutory regulators, including Monitor and the Trust Development Authority.](#)

["NHS Trust Development Authority \(TDA\)" known as NHS Improvement and the regulator for NHS trusts](#)

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

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

"**Officer**" means employee of the Trust or any other person holding a paid appointment or office with the Trust. Officer members are also referred to as executive directors or Chief Officers.

"**Officer member**" 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).

"**Secretary**" means a person appointed to act independently of the [Trust](#) Board to provide advice on corporate governance issues to the [Trust](#) Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance. For this Trust the Director of Corporate Affairs carries out the Secretary function.

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

"**SOs**" means Standing Orders.

"**Vice-Chair**" means the non-officer member appointed by the [Trust](#) Board to take on the Chair's duties if the Chair is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The University Hospitals Coventry and Warwickshire NHS Trust (the Trust) is a statutory body which came into existence on 1st April 1993 under The Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993 No 811, (the Establishment Order) **{Appendix 2}**.

The Establishment Order was subsequently amended by the following Statutory Instruments:

- The Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998 (SI 1998 No 812) **{Appendix 3}**;
- The Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998 (SI 1998 No 3082) **{Appendix 4}**
- The Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1999 (SI 1998 No 1392) **{Appendix 5}**; and
- The Walsgrave Hospitals National Health Service Trust Change of Name and (Establishment) Amendment Order 2000 (SI 2000 No 2886) **{Appendix 6}**.

(1) The principal places of business of the Trust are:

- The University Hospital
Clifford Bridge Road
Coventry
CV2 2DX
- The Hospital of St Cross
Barby Road
Rugby
Warwickshire
CV22 5PX

(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act ~~1977-2006~~ (NHS Act ~~2006-1977~~), ~~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 ~~1977-2006, 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.

- (8) The accounting date of the Trust shall be the 31st March.

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 Section C of this document - Reservation of Powers to the Board and Delegation of Powers (see also 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

The Trust Board operates a system of integrated governance in line with best practice which ensures that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information governance and research governance.

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 [Trust](#) Board shall be:

- (1) The Chair of the Trust (Appointed by the NHS Trust Development Authority);
- (2) Up to six non-officer members (appointed by the NHS Trust Development Authority), one of whom shall be appointed from the University of Warwick (in recognition of the Trust's significant teaching commitment) ;
- (3) Up to six officer members (but not exceeding the number of non-officer members). The Trust has determined that the officer members of the Trust Board shall be:
 - the Chief Executive Officer;
 - the Chief Finance Officer;
 - the Chief Medical Officer;
 - the Chief Nursing Officer;
 - [the Chief Strategy Officer](#); and
 - the Chief Workforce and Information Officer.

The Trust shall have not more than 12 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; please refer to Appendices 1 to 6).

There is to be a provision for individuals to serve as acting Chief Officers when circumstances such as the long term absence of a Chief Officer deem it necessary. The appointment of a person to an acting to a Chief Officer role will require approval from the [Trust](#) Board.

2.2 Appointment of Chair and Members of the Trust

- (1) Appointment of the Chair and Members of the 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 number, who is not also an officer member, 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 [Trust](#) 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 [Trust](#) 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 Trust to establish a Patient and Public Involvement Forum.

2.7 Role of Members

The [Trust](#) Board will function as a corporate decision-making body. In line with the principles of a Unitary Board¹. Officer and Non-Officer Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Members

Executive Members (known as Chief Officers) shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive Officer

The Chief Executive Officer 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

¹ The concept of a unitary board is one where the executive and non-executive directors share the same liability and have the same responsibility for constructively challenging decisions and for developing proposals on priorities, risk mitigation, values, standards and strategy.

Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) Chief Finance Officer

The Chief Finance Officer 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 Officer for ensuring the discharge of obligations under relevant Financial Directions.

(4) Non-Executive Members

The non-executive members 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 [Trust](#) Board and chair all [Trust](#) 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 Trust Development Authority (known as NHS Improvement) 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 Officer and shall ensure that key and appropriate issues are discussed by the [Trust](#) Board in a timely manner with all the necessary information and advice being made available to the [Trust](#) Board to inform the debate and ultimate resolutions.

2.8 Corporate role of the [Trust](#) 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) The powers of the Trust established under statute shall be exercised by the [Trust](#) Board meeting in public session except as otherwise provided for in Standing Order No. 3.
- (4) The [Trust](#) 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 [Trust](#) Board and Scheme of Delegation

- (1) The [Trust](#) Board has resolved that certain powers and decisions may only be exercised by the [Trust](#) Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the [Trust](#) 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 Delegation.

2.10 Lead Roles for [Trust](#) Board Members

The Chair will ensure that the designation of Lead roles or appointments of [Trust](#) 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 [Trust](#) Board Member with responsibilities for Infection Control or Child Protection Services etc.).

2.11 Associate Non-Executive Members

The Trust Board may at its discretion, appoint additional non-executive members to the Trust Board. However, such members will not be afforded voting rights at Trust Board meetings and will not count towards the quorum of any Trust Board meeting.

3. MEETINGS OF THE TRUST

3.1 Calling meetings

- (1) Ordinary meetings of the [Trust](#) Board shall be held at regular intervals at such times and places as the [Trust](#) Board may determine.
- (2) The Chair of the Trust may call a meeting of the [Trust](#) 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 [Trust](#) Board a written notice specifying the business proposed to be transacted shall be delivered [electronically](#) 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 three clear days before the meeting. The notice shall be approved 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.
- (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.
- (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.
- (4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair or Director of Corporate Affairs at least 7 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 7 days before a meeting may be included on the agenda at the discretion of the Chair.
- (5) Before each meeting of the [Trust](#) Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website 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 Agenda will be sent to members six clear days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched 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 [Trust](#) Board wishing to move a motion shall send a written notice to the Chief Executive Officer who will ensure that it is brought to the immediate attention of the Chair.

- (2) The notice shall be delivered at least 7 clear days before the meeting. The Chief Executive Officer 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 [Trust](#) 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 [Trust](#) Board proceed to next business;
- that the [Trust](#) 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 [Trust](#) 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, which 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/director be not further heard;
- a motion under Section 1 (2) or Section 1 (8) of the Public Bodies (Admissions to Meetings) Act 1960 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 [Trust](#) 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 Officer for recommendation.
- (2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director/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 Officer.

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 [Trust](#) Board has appointed one), if present, shall preside.
- (2) If the Chair and Vice-Chair are absent, such member (who is not also an ~~Officer~~ ~~Member~~ ~~chief officer~~ 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 ~~Officer-chief officer~~Member of the Trust and one member who is not) is present.
- ii.) An ~~Officer~~ in attendance for an ~~Executive-Director~~chief officer (~~Officer-Member~~) 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.
- iv.) In the event that a quorum is not present at the time specified on the notice for a meeting, the notice of the meeting shall remain valid for a maximum period of two hours, to permit the assembly of a quorum of members, after which time, another duly notified and constituted meeting shall be necessary.

3.12 Voting

- i.) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - 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 (i.e. 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 ~~Officer-Member~~chief officer during a period of incapacity or temporarily to fill an ~~Executive-Director~~chief officer -vacancy shall be entitled to exercise the voting rights of the ~~Officer-Member~~chief officer.
- vii.) A manager attending the Trust Board meeting to represent an ~~Officer-Member~~chief officer during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the ~~Officer-Member~~chief officer. An ~~Officer's~~Their 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 [Trust](#) Board are present (including at least one member who is an ~~Officer Member~~ [chief officer](#) 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 Officer included on the agenda for the meeting;
- that two thirds of the [Trust](#) 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-Officer~~ [non-executive](#) members 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 Directors/members present at the meeting shall be recorded in the minutes.

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 1960

- the press and public will be excluded from meetings of the Trust Board when discussing matters relating to:
 - i.) Individual patients and members of staff;
 - ii.) Consultations or negotiations with regard to labour relations matters;
 - iii.) Proposals for placing of commercial contracts;
 - iv.) Litigation being pursued by, or on behalf of, or against the Trust; and
 - v.) Other matters determined to be of a confidential nature

Guidance should be sought from the Director of Corporate Affairs to ensure that the correct procedure is followed on matters included in the exclusion to ensure compliance with the Freedom of Information Act.

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 1960.

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 [Trust](#) 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' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the [Trust](#) 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 bodies including the NHS Trust Development Authority ([known as NHS Improvement](#)), 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.)

In order to ensure the efficient and effective working of joint committees, it may be appropriate to vary Standing Orders (including Standing Financial Instructions and the Scheme of Delegation). Any such variation must be agreed as directed in Standing Order 3.14.

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 [Trust Board](#)), as the [Trust 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 to do so by the Trust Board.

4.6 Approval of Appointments to Committees

The [Trust](#) Board shall approve the appointments to each of the committees which it has formally constituted. Where the [Trust](#) 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 [Trust](#) Board as defined by the Secretary of State. The [Trust](#) 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 [Trust](#) 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 [Trust](#) Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Statutory Committees established by the Trust Board

The committees established by the Trust Board as required by statute are:

4.8.1 Audit Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and generally accepted good practice in corporate governance, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The Higgs report and Audit Committee Handbook (~~third~~^{fourth} edition) recommend a minimum of three non-executive directors be appointed, unless the [Trust](#) Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 Remuneration Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, and the Higgs report, a Remuneration Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

The purpose of the Committee will be to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive Officer and other Executive Directors including:

- i.) all aspects of salary (including any performance-related elements/bonuses);
- ii.) provisions for other benefits, including pensions and cars;
- iii.) arrangements for termination of employment and other contractual terms.

4.9 Other Committees

The [Trust](#) Board may also establish such other committees as required to discharge its responsibilities. The terms of reference and membership of these

committees shall be approved by the [Trust](#) Board and shall be subject to periodic review.

The additional committees established by the Trust Board are:

4.9.1 Quality Governance Committee

The Quality Governance Committee acts as the principal source of advice and expertise to the Trust Board on patient safety and quality. The Committee ensures that adequate and appropriate clinical governance structures, processes and controls are in place across the Trust and in each of our Divisions, to:

- Promote safety, quality and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care on a continuing basis
- Ensure the effective and efficient use of resources through evidence-based clinical practice, and
- Protect the safety of our employees and all others to whom we owe a duty of care.

It oversees and monitors the corporate delivery of patient safety, patient experience, clinical risk management and Registration standards, and ensures that ~~we the Trust~~ hasve the appropriate strategies, processes, systems, policies, and procedures in place to deliver the necessary standards of care.

The Committee is responsible for receiving reports from its sub-committees on a scheduled and regular basis as set out in its terms of reference.

- ~~Health and Safety Committee~~
- ~~Patient Safety and Effectiveness Committee~~
- ~~Risk Committee~~
- ~~Patient Experience and Engagement Committee~~
- ~~Information Governance Committee~~
- ~~Workforce and Engagement Committee~~
- ~~Training, Education and Research Committee~~
- ~~Quality Surveillance Committee~~

4.9.2 Finance and Performance Committee

The Finance and Performance Committee is responsible for reviewing Trust performance against key financial and operational targets, key financial strategies and policies, and financial management arrangements. It receives reports from the Chief Finance Officer (and other officers as appropriate) on the following key areas:

- Income and expenditure
- Cash management
- Working capital management
- Capital programme
- Cost improvement programme
- Key financial risks.

The Committee also receives reports from appropriate officers or any advisors engaged by the Trust regarding the efficiency of services and functions across the Trust including:

- Reference cost data
- Service Line Reporting/Patient Level Costing and contribution reporting
- Capacity and productivity data
- Benchmarking data.

The Committee makes recommendations and provides advice to Trust officers and the Trust Board. Additionally, the Finance and Performance Committee reviews the Trust's performance against other operational and contractual targets including activity and waiting time targets, and the performance management arrangements for each division or business unit within the Trust (including any shared service, agency or consortium arrangement) within the Trust. The Committee will also review the performance of all the Service Providers within the PFI Contract, and be responsible for providing effective oversight of all major capital and development projects within the UHCW NHS Trust including risks associated with the projects.

[The Committee is responsible for receiving reports from its sub-committees on a scheduled and regular basis as set out in its terms of reference.](#)

4.9.3 Other Committees

The [Trust](#) Board may also establish such other committees 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 [Trust](#) 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, 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, NHS Trust Development Authority, NHS England or Clinical Commissioning Groups;
- iii.) by arrangement with the appropriate organisation, 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 other bodies including the NHS Trust Development Authority, NHS Trusts, NHS England or Clinical Commissioning Groups.

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 (see also SO 5.7 below).

5.2 Emergency Powers and urgent decisions

The powers which the [Trust](#) 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 Officer and the Chair after having consulted at least two non-~~officer~~ ~~executive~~ members. The exercise of such powers by the Chief Executive Officer 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 [Trust](#) 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 [Trust](#) Board.

5.4 Delegation to Officers

- 5.4.1** Those functions of the Trust which have not been retained as reserved by the [Trust Board](#) or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive Officer. The Chief Executive Officer 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 Officer shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the [Trust Board](#). The Chief Executive Officer may periodically propose amendment to the Scheme of Delegation which shall be considered by the audit committee and then subject to approval by the [Trust Board](#).
- 5.4.3** Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the [Trust Board](#) of the Chief Finance Officer to provide information and advise the [Trust Board](#) in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Executive Officer for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

- 5.5.1** The arrangements made by the [Trust Board](#) as set out in the "Schedule of Matters Reserved to the [Trust Board](#)" and "Scheme of Delegation" of powers 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 are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the audit committee and [Trust Board](#) for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive Officer as soon as possible.

5.7 Hosted Shared Services

- 5.7.1** Where the Trust hosts shared services on behalf of other NHS bodies, powers may be delegated to officers or committees (including joint committees) in line with the provisions set out in Standing Orders 5.1 to 5.6 above.
- 5.7.2** In order to ensure the efficient and effective operation of the shared service, it may be appropriate to vary Standing Orders (including Standing Financial Instructions and the Scheme of Delegation). Any such variation must be agreed as directed in Standing Order 3.14.
- 5.7.3** The governance arrangements (including operational management, financial management) for any such services will be clearly set out in an appropriate governing document which will be approved by the Trust Board.

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

6.1 Policy statements: general principles

The Corporate Business Records Committee (CBRC) will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate CBRC minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

The Audit Committee is also responsible for approving policies that are within its terms of reference. Where this is the case CBRC will be required to approve the policy or procedure prior to submission to the Committee to ensure that it is in keeping with expected Trust Standards.

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 Code of Business Conduct
- the staff Disciplinary and Appeals Procedures adopted by the Trust 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 1998;
- Freedom of Information Act 2000
- Equality Act 2010.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS 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~~England guidance "Managing Conflicts of Interest in the NHS" - requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Trust Board members should declare such interests. Any Trust 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 shareholdings 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 Trust 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 Trust 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 Corporate Affairs.

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 [Trust](#) 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

[Trust](#) 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 [Trust](#) 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 Officer will ensure that a Register of Interests is established to record formally declarations of interests of [Trust](#) 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 executive and non-executive Trust Board members.

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 Officer 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 him/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 [Trust Board](#) from a meeting of the [Trust 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) Power of the Secretary of State to make waivers

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 the University Hospital Coventry and Warwickshire 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) Conditions which apply to the waiver and the removal of having a pecuniary interest

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 Officer 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 Officer;
- (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 Code of Business Conduct Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2). All Trust staff must also comply with the provisions of the Bribery Act 2010.

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 Officer or Director of Corporate Affairs as soon as practicable.
- ii.) An Officer should also declare to the Chief Executive Officer 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 Officer 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 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 Officer 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 i.e. when a contract is executed by deed, it shall only be done so under the authority of the Trust Board. The seal shall be affixed by the Chief Executive Officer or another executive director in the presence of the Chair or another authorised non-~~officer member executive member~~ and shall be attested by them.

8.3 Register of Sealing

The Chief Executive Officer 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. The register shall be presented to the Trust Board on an annual basis.

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 Officer, any Executive Director or any other officer of the Trust duly authorised for this purpose.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of 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 [Trust](#) 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 [Trust](#) 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.

9.2 Equality duty considerations

In confirming a contract to purchase from a voluntary organisation or a local authority the [Trust](#) Board will remain responsible for meeting the equality duty and may therefore need to include obligations relating to equality in the service contract. As a minimum this should include conditions which:

- Prohibit the contractor from unlawfully discriminating under the Equality Act
- Require them to take all reasonable steps to ensure that staff, suppliers and subcontractors meet their obligations under the Equality Act.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

DECISIONS RESERVED TO THE [TRUST BOARD](#)

REF	THE TRUST BOARD	DECISIONS RESERVED TO THE TRUST BOARD
NA	THE TRUST BOARD	<p>General Enabling Provision</p> <p>The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.</p>
NA	THE TRUST BOARD	<p>Regulations and Control</p> <ol style="list-style-type: none"> 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Trust Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive Officer in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Trust Board to committees. 6. Require and receive the declaration of Trust Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 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 Trust Board.

REF	THE TRUST BOARD	DECISIONS RESERVED TO THE TRUST BOARD
		<ul style="list-style-type: none"> 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive Officer's attention in accordance with SO 5.6. 17. Discipline members of the Trust Board or employees who are in breach of statutory requirements or SOs.
NA	THE TRUST BOARD	<p>Appointments/ Dismissal</p> <ul style="list-style-type: none"> 1. Appoint the Vice Chair of the Trust Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Trust Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive Officer for staff not covered by the Remuneration Committee.
NA	THE TRUST BOARD	<p>Strategy, Plans and Budgets</p> <ul style="list-style-type: none"> 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment where the value is above that delegated to the Chief Officers. 5. Approve budgets. 6. Approve and monitor the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature

REF	THE TRUST BOARD	DECISIONS RESERVED TO THE TRUST BOARD
		<p>amounting to, or likely to amount to over [£250,000] over a 3 year period or the period of the contract if longer.</p> <ol style="list-style-type: none"> 11. 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 Officer and Chief Finance Officer (for losses and special payments) previously approved by the Trust Board. 12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. 14. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST).
	THE TRUST BOARD	<p>Audit</p> <ol style="list-style-type: none"> 1. Approve the appointment (and where necessary dismissal) of External Auditors as far as the rules governing the appointment permit Approval of external auditors' arrangements for the separate audit of funds held on trust, and the submission of reports to the Audit Committee meetings which will take appropriate action. 2. Receive the annual audit letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 3. Receive the Head of Internal Audit opinion and agree action on recommendations where appropriate of the Audit Committee.
NA	THE TRUST BOARD	<p>Annual Reports and Accounts</p> <ol style="list-style-type: none"> 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.
NA	THE TRUST BOARD	<p>Monitoring</p> <ol style="list-style-type: none"> 1. Receive such reports as the Trust 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 Trust Board as the Trust Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Trust Board. 4. Receive reports from the Chief Finance Officer on actual and forecast financial performance against budget and Business Plan. 5. Receive reports from the Chief Executive Officer or Chief Finance Officer (as appropriate) on actual

REF	THE TRUST BOARD	DECISIONS RESERVED TO THE TRUST BOARD
		and forecast income from SLA. 6. Receive reports from the responsible Chief Officers relating to general organizational performance and quality

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE OFFICER	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CHIEF EXECUTIVE OFFICER and CHIEF FINANCE OFFICER	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Trust Board.
10	CHIEF EXECUTIVE OFFICER	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 (Annual Governance Statement)
12 & 13	CHIEF EXECUTIVE OFFICER	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: <ul style="list-style-type: none"> • "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 supported by the Director of Corporate Affairs.
13	CHIEF EXECUTIVE OFFICER	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities.

REF	DELEGATED TO	DUTIES DELEGATED
		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	CHIEF FINANCE OFFICER	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE OFFICER	Primary duty to see that Chief Finance Officer discharges this function.
16	CHIEF EXECUTIVE OFFICER	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CHIEF EXECUTIVE OFFICER and CHIEF FINANCE OFFICER	Chief Executive Officer, supported by Chief Finance Officer, to ensure appropriate advice is given to the Trust Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE OFFICER	If the Chief Executive Officer considers the Trust Board or Chair is doing something that might infringe probity or regularity, he should set this out in writing to the Chair and the Trust Board . If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the NHS Trust Development Authority (known as NHS Improvement) and Department of Health.
21	CHIEF EXECUTIVE OFFICER	If the Trust Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive Officer's responsibility for value for money, the Chief Executive Officer should draw the relevant factors to the attention of the Trust 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 Chief Executive Officer should inform the NHS Trust Development Authority (known as NHS Improvement) and the Department of Health. In such cases, and in those described in paragraph 24, the Chief Executive Officer should as a member of the Trust Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	TRUST BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	TRUST 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 TRUST BOARD MEMBERS	Subscribe to Code of Conduct.
1.3.2.4	TRUST BOARD	Trust Board members share corporate responsibility for all decisions of the Trust Board.
1.3.2.4	CHAIR AND NON-EXECUTIVE OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.
1.3.2.4	TRUST BOARD	<p>The Trust Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State:</p> <ol style="list-style-type: none"> 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; 4. 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; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 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.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.24	TRUST BOARD	<p>It is the Trust Board's duty to:</p> <ol style="list-style-type: none"> act within statutory financial and other constraints; be clear what decisions and information are appropriate to the Trust Board and draw up Standing Orders, a schedule of decisions reserved to the Trust Board and Standing Financial Instructions to reflect these, 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; establish performance and quality measures that maintain the effective use of resources and provide value for money; specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Trust Board can fully undertake its responsibilities; 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 Trust Board.
1.3.2.5	CHAIR	<p>It is the Chair's role to:</p> <ol style="list-style-type: none"> provide leadership to the Trust Board; enable all Trust Board members to make a full contribution to the Trust Board's affairs and ensure that the Trust Board acts as a team; ensure that key and appropriate issues are discussed by the Board in a timely manner, ensure the Trust Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; lead Non-Executive Trust Board members through a formally-appointed Remuneration Committee of the main Trust Board on the appointment, appraisal and remuneration of the Chief Executive Officer and (with the latter) other Executive Trust Board members; Recommend the appointment of Non-Executive Trust Board members to an Audit Committee of the main Board; advise the Secretary of State (through the NHS Trust Development Authority) on the performance of Non-Executive Trust Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive Officer is accountable to the Chair and Non-Executive members of the Trust Board

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	OFFICER	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 Officer should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Trust Board. The other duties of the Chief Executive Officer as Accountable Officer are laid out in the Accountable Officer Memorandum.
1.3.2.6	NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by the NHS Trust Development Authority (known as NHS Improvement) 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 DIRECTORS	Declaration of conflict of interests.
1.3.2.9	TRUST 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 establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.4	TRUST BOARD	Appointment of Vice Chair
3.1	CHAIR	Call meetings.
3.9	CHAIR	Chair all Trust 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	TRUST 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 Trust Board)
3.14	TRUST BOARD	Variation or amendment of Standing Orders
4.1	TRUST BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive Officer.)
5.2	CHAIR & CHIEF EXECUTIVE OFFICER	The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive Officer after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE OFFICER	The Chief Executive Officer shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive Officer as soon as possible.
7.1	TRUST BOARD	Declare relevant and material interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.2	DIRECTOR OF CORPORATE AFFAIRS	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. (Chief Executive Officer to report the disclosure to the Trust Board.)
8.1/8.3	DIRECTOR OF CORPORATE AFFAIRS	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE OFFICER / EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings other than where authority has been specifically delegated to another individual.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	CHIEF FINANCE OFFICER	Approval of all financial procedures.
10.1.4	CHIEF FINANCE OFFICER	Advice on interpretation or application of Standing Financial Instructions.
10.1.6	ALL MEMBERS OF THE TRUST BOARD and EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Performance and Finance as soon as possible.
10.2.4	CHIEF EXECUTIVE OFFICER	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 OFFICER and CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	CHIEF EXECUTIVE OFFICER	To ensure all Trust Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	CHIEF FINANCE OFFICER	Responsible for: <ul style="list-style-type: none"> 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 Trust 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 TRUST 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.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.8	CHIEF EXECUTIVE OFFICER	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	AUDIT COMMITTEE CHAIR	Raise the matter at the Trust Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	CHIEF FINANCE OFFICER	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 OFFICER and CHIEF FINANCE OFFICER	Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE OFFICER	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 OFFICER	Compile and submit to the Trust Board a Business Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: <ul style="list-style-type: none"> 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	CHIEF FINANCE OFFICER	Submit budgets to the Trust Board for approval. Monitor performance against budget; submit to the Trust Board financial estimates and forecasts.
13.1.6	CHIEF FINANCE	Ensure adequate training is delivered on an on going basis to budget holders.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	OFFICER	
13.3.1	CHIEF EXECUTIVE OFFICER	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE OFFICER and BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Trust Board.
13.4.1	CHIEF FINANCE OFFICER	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 Trust 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 Chief Executive Officer other than those provided for within available resources and manpower establishment d) a business case is prepared as appropriate for investment, divestment and service change in accordance with the Trust's business planning process which is subject to appropriate authorisation.
13.4.3	CHIEF EXECUTIVE OFFICER	Identify and implement cost improvements and income generation activities in line with the Business Plan.
13.6.1	CHIEF EXECUTIVE OFFICER	Submit monitoring returns
14.1	CHIEF FINANCE OFFICER	Preparation of annual accounts and reports.
15.1	CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Trust Board approves arrangements.)
16.	CHIEF FINANCE OFFICER	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform Chief Finance Officer of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE OFFICER	Tendering and contract procedure.
17.1	CHIEF FINANCE OFFICER AND DIRECTOR OF ESTATES	Contracting procedures governing variations to the PFI contract.
17.5.3	CHIEF EXECUTIVE OFFICER	Waive formal tendering procedures.
17.5.3	CHIEF EXECUTIVE OFFICER	Report waivers of tendering procedures to the Trust Board.
17.5.5	CHIEF FINANCE OFFICER	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive Officer.
17.6.2	CHIEF EXECUTIVE OFFICER	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE OFFICER	Shall maintain a register to show each set of competitive tender invitations dispatched.
17.6.4	CHIEF EXECUTIVE OFFICER and CHIEF FINANCE OFFICER	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE OFFICER	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 Officer.
17.6.8	CHIEF EXECUTIVE OFFICER	Will appoint a manager to maintain a list of approved firms.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.6.9	CHIEF EXECUTIVE OFFICER	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 OFFICER	The Chief Executive Officer or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE OFFICER or CHIEF FINANCE OFFICER	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive Officer.
17.10	CHIEF EXECUTIVE OFFICER	The Chief Executive Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	TRUST BOARD	All PFI proposals must be agreed by the Trust Board.
17.11	CHIEF EXECUTIVE OFFICER	The Chief Executive Officer shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE OFFICER	The Chief Executive Officer 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 OFFICER	The Chief Executive Officer 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 OFFICER	The Chief Executive Officer shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE OFFICER	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE OFFICER	As the Accountable Officer, ensure that regular reports are provided to the Trust Board detailing actual and forecast income from the SLA
20.1.1	TRUST BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	Advise the Trust Board on and make recommendations on the remuneration and terms of service of the Chief Executive Officer, other officer members and senior employees that are subject to local pay arrangements to ensure they are fairly rewarded having proper regard to the Trust's circumstances and

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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 Trust Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	TRUST BOARD	Approve proposals presented by the Chief Executive Officer for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE OFFICER	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE OFFICER	Staff, including agency staff, appointments and re-grading.
20.4.1 AND 20.4.2	CHIEF WORKFORCE & INFORMATION OFFICER	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) 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	CHIEF WORKFORCE & INFORMATION OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
20.5	CHIEF WORKFORCE &	Ensure that all employees are issued with a Contract of Employment in a form approved by the Trust Board and which complies with employment legislation; and

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	INFORMATION OFFICER	Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE OFFICER	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. [It is good practice to append such lists to the Scheme of Delegation document.]
21.1.3	CHIEF EXECUTIVE OFFICER	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	CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	CHIEF FINANCE OFFICER	<ul style="list-style-type: none"> a) Advise the Trust Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; 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 Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; 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 EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
21.2.4	CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform Chief Finance Officer if problems are encountered).
21.2.5	CHIEF EXECUTIVE OFFICER	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer.
21.2.7	CHIEF EXECUTIVE OFFICER & CHIEF FINANCE OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	CHIEF FINANCE OFFICER	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	CHIEF FINANCE OFFICER	The Chief Finance Officer will advise the Trust 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	TRUST BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive Officer and Chief Finance Officer.)
22.1.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OFFICER or CHIEF FINANCE OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	CHIEF FINANCE OFFICER	Will advise the Trust Board on investments and report, periodically, on performance of same.
22.2.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions on the operation of investments held.
23	CHIEF FINANCE	Ensure that Trust Board members are aware of the Financial Framework and ensure compliance

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	OFFICER	
24.1.1 & 2	CHIEF EXECUTIVE OFFICER	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure 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	CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE OFFICER	Issue procedures for management of contracts involving stage payments.
24.1.4	CHIEF FINANCE OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE OFFICER	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	CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	CHIEF FINANCE OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	TRUST BOARD	Proposal to use PFI must be specifically agreed by the Trust Board .
24.3.1	CHIEF EXECUTIVE OFFICER	Maintenance of asset registers (on advice from Chief Finance Officer).
24.3.5	CHIEF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	OFFICER	fixed asset registers.
24.3.8	CHIEF FINANCE OFFICER	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE OFFICER	Overall responsibility for fixed assets.
24.4.2	CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
24.4.4	TRUST BOARD, EXECUTIVE MEMBER CHIEF OFFICERS and ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to Chief Finance Officer, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE OFFICER	Delegate overall responsibility for control of stores (subject to Chief Finance Officer responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	CHIEF FINANCE OFFICER	Responsible for systems of control over stores and receipt of goods.
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*	<i>Security arrangements and custody of keys</i>
25.2	CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
25.2	CHIEF FINANCE OFFICER	Agree stocktaking arrangements.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2	CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	CHIEF FINANCE OFFICER	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 Chief Finance Officer evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE OFFICER	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	CHIEF FINANCE OFFICER	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 Chief Executive Officer and Chief Finance Officer.
26.2.2	CHIEF FINANCE OFFICER	Where a criminal offence is suspected, Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption Chief Finance Officer must inform the relevant Local Counter Fraud Specialist and Counter Fraud and Security Management Service Regional Team in line with Secretary of State directions.
26.2.2	CHIEF FINANCE OFFICER	Notify Counter Fraud and Security Management Service and External Audit of all frauds.
26.2.3	CHIEF FINANCE OFFICER	Notify Trust Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	TRUST BOARD	Approve write off of losses (within limits delegated by DH).
26.2.6	CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
26.2.7	CHIEF FINANCE OFFICER	Maintain losses and special payments register.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.1	CHIEF FINANCE OFFICER	Responsible for accuracy and security of computerised financial data.
27.1	CHIEF FINANCE OFFICER	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	CHIEF EXECUTIVE OFFICER	Shall publish and maintain a Freedom of Information Scheme.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to Chief Finance Officer and Director of ICT
27.3	CHIEF FINANCE OFFICER & CHIEF WORKFORCE & INFORMATION OFFICER	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	CHIEF FINANCE OFFICER & DIRECTOR OF ICT	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
27.5	CHIEF FINANCE OFFICER	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) Chief Finance Officer and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE OFFICER	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.

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	CHIEF FINANCE OFFICER	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
29.1 (3)	CORPORATE TRUSTEE TRUST BOARD	Approve a policy (to be drafted by the Chief Finance Officer) for the management of charitable and other funds held on Trust.
29.4	CHIEF FINANCE OFFICER	Maintain a schedule of designated fund managers and provide guidance to them on the management and operation of funds.
30	CHIEF FINANCE OFFICER	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 OFFICER	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE OFFICER	Risk management programme.
33.1	TRUST BOARD	Approve and monitor risk management programme.
33.2	TRUST 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	CHIEF FINANCE OFFICER	Where the Trust Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements. Where the Trust 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 Chief Finance Officer shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
33.4	CHIEF FINANCE OFFICER	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
	Signatories: GOVERNMENT PROCUREMENT CARDS Approval of procedures and expenditure limits (but not exceeding limits in SFI 21 and 24): Issue of cards approved by:	<input type="checkbox"/> Any nominated senior finance manager at band 8 or above of whom at least two of such nominated officers must be an Associate Director of Finance, Director of Finance and Chief Finance Officer (CFO). <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Chief Finance Officer (CFO) jointly with the Chief Executive Officer	
16 16.1.3	INCOME AND INCOME CONTRACTS Authorised limits for the agreement of NHS acute income contracts and subsequent variations Authorised limits for the agreement of financial concessions to NHS acute income contracts and subsequent variations Authorised limits for the agreement of NHS and non-NHS provider to provider contracts and subsequent variations Authorised limits for the agreement of financial concessions to provider to provider contracts and subsequent variations	<input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance	Unlimited 500,000 Unlimited 500,000 Unlimited 500,000 Unlimited 500,000 30,000

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
16.1.3	<p>Agreement of Commercial / Non-Commercial Contracts (Research)</p> <p>Raising of credit note limits (NHS/non-NHS): [Writing-off bad debts is not covered by these limits]</p> <p>First line signatories:</p> <p>Second line signatories:</p> <p>Third line signatories:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Commercial Finance Manager <input type="checkbox"/> Head of Contracting and Income <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Head of R&D <input type="checkbox"/> R&D Business Manager <input type="checkbox"/> Two first line signatories <input type="checkbox"/> One second line signatory <input type="checkbox"/> One third line signatory <input type="checkbox"/> Chief Executive Officer <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Financial Accountant <input type="checkbox"/> Head of Contracting and Income 	<p>30,000</p> <p>Unlimited</p> <p>500,000</p> <p>99,999</p> <p>10,000</p> <p>Over 500,000</p> <p>500,000</p> <p>50,000</p>
17	CONTRACTING AND TENDERING		
17.5.3 (a)	Limits above which competitive tenders must be sought:	<ul style="list-style-type: none"> <input type="checkbox"/> All initiating officers 	30,000

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
17.7.1	Limits above which competitive quotations are encouraged :	<input type="checkbox"/> All initiating officers	10,000
17.6.2	Amount above which tenders must be addressed to the Chief Executive Officer:		100,000
17.6.6	Value above which contracts must have Trust Board approval before being signed: [A paper must be prepared for the Trust Board according to the standard procurement department template by a nominated representative of the tender evaluation panel.]		500,000
8.4	Value above which contracts must be executed, as a deed, under the common seal of the Trust: <input type="checkbox"/> Building and Engineering works <input type="checkbox"/> Fees		100,000 50,000
17.6.3	Waiving of tender/quotation requirements - limit of authorisation:	<input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance	500,000 100,000
21 & 24	NON-PAY EXPENDITURE (SFI 21) INCLUDING CAPITAL EXPENDITURE which has been subject to capital planning requirements (SFI 24) <i>These limits represent the maximum limits to be</i>		

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
21.1.2	<p><i>applied to Groups of Officers. Actual limits applied to individual officers may be set at a lower level to reflect the level of delegated budgetary authority. The Chief Finance Officer will maintain an Authorised Signatory List specifying individual officer limits – this list shall have effect as if incorporated in this Scheme of Delegation.</i></p> <p>Limit for the placement of order requisitions:</p> <p><i>* This needs to be read in conjunction with the Trust's procedures and financial limits for contracting and tendering (SFI 17) and allocations, planning, budgets, budgetary control and monitoring (SFI 13)</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Level 4 officers <input type="checkbox"/> Level 3 officers <input type="checkbox"/> Level 2 officers <input type="checkbox"/> Level 1 officers <input type="checkbox"/> Executive directors <input type="checkbox"/> Chief Executive Officer with Chief Finance Officer 	<p>Up to 10,000</p> <p>10,000-49,999</p> <p>50,000-99,999</p> <p>100,000-499,999</p> <p>500,000-999,999</p> <p>Unlimited</p>
21.2.3 (c)	<p>Limit for the authorisation of invoices:</p> <p>Countersignature of invoices related to contracts or NHS service level agreements (including goods/services) properly established under these SOs and SFIs:</p>	<p>As per 21.1.2 above plus:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chief Financial Accountant <input type="checkbox"/> Financial Accountant <input type="checkbox"/> Associate Directors of Finance <input type="checkbox"/> Executive Directors 	<p>5,000</p> <p>1,000</p> <p>Unlimited</p> <p>Unlimited</p>
13.3 & 13.3.4 & 13.4 (e)	<p>PAY EXPENDITURE</p> <p>Limit for the authorisation of pay expenditure</p> <p><i>In conjunction with the business case delegated limits, the budget virement policy</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Group management team 	<p>Up to 100,000</p>

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
	<i>and the associated pay roll procedures.</i>		
13.4.2 (d)	<p>BUSINESS CASES (including income generation schemes)</p> <p>Limit for the authorisation of business cases (Revenue)</p> <p>Limit for the authorisation of business cases: Capital : Capital Expenditure <i>[subject to the Trust remaining within its approved capital programme budget, Capital Resource Limit (CRL) and External Financing Limit (EFL)]</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Group management team <input type="checkbox"/> Corporate Directors' Group <input type="checkbox"/> Chief Officer's Group/Trust Delivery Group <input type="checkbox"/> Trust Board <input type="checkbox"/> Capital Planning & Review Group <input type="checkbox"/> Chief Officer's Group/Trust Delivery Group <input type="checkbox"/> Trust Board (if Trust in deficit)* <i>Where the Trust has recorded a deficit in its most recent audited accounts, or has an in-year deficit or forecast deficit in the current year, the NTDA has discretion to apply the lower limit (if the lower limit is applied the NTDA will notify the Trust in writing)</i> <input type="checkbox"/> Trust Board (if Trust in surplus)*: lower of: <input type="checkbox"/> NHS Trust Development Authority* <input type="checkbox"/> Department of Health* <p><i>*These limits may be varied from time to time by the NHS Trust Development Authority and/or Department of Health</i></p>	<p>Under 100,000 250,000 1,000,000 Over 1,000,000</p> <p>100,000 500,000 500,000</p> <p>3,000,000 or 3% of turnover</p> <p>50,000,000 Unlimited</p>
13.4.1 (e)	<p>BUDGET VIREMENT</p> <p>All in year budget virements:</p>	<p>In accordance with the budget virement policy</p>	

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
21.2.6 (k)	<p>PETTY CASH</p> <p>Petty cash limits (maximum payable by Cashier (subject to authorisation limits) without additional authorisation for: patients' monies; staff salary advances; and other</p> <p>Maximum amount payable in exceptional circumstances subject to cash availability:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Cashier <input type="checkbox"/> Cashier <input type="checkbox"/> Cashier <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Financial Accountant <input type="checkbox"/> Financial Accountant <input type="checkbox"/> Finance On-Call Manager 	<ul style="list-style-type: none"> 250 250 50 2,000 2,000 1,000 1,000 500
21.2.4 (e)	<p>PREPAYMENTS</p> <p>Limit for the authorisation of prepayments :</p> <ul style="list-style-type: none"> <input type="checkbox"/> By two signatories <input type="checkbox"/> By a single signatory 	<ul style="list-style-type: none"> <input type="checkbox"/> Chief Finance Officer (CFO) and Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Finance Officer (CFO) or Director of Finance/Associate Director of Finance plus either Chief Financial Accountant or Commercial Finance Manager <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Financial Accountant <input type="checkbox"/> Commercial Finance Manager 	<ul style="list-style-type: none"> Unlimited 500,000 5,000 5,000 1,000 1,000
	ORDERS		

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
21.2.5 (e)	Limits for signing official orders <i>(this needs to be read in conjunction with the limits for order requisitioning)</i> * This needs to be read in conjunction with the Trust's procedures and financial limits for contracting and tendering (SFI 17)	<input type="checkbox"/> Supplies Manager (or Nominated Deputy) <input type="checkbox"/> Director of Pharmacy: pharmaceuticals non-pharmaceuticals <input type="checkbox"/> Director of Estates <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Chief Executive Officer	30,000 60,000 10,000 30,000 Unlimited * Unlimited * Unlimited *
22 22.2.3	EXTERNAL BORROWING AND INVESTMENTS INVESTMENTS Limits for authorisation of investments with approved institutions: First line signatories: Second line signatories: Staff authorised to enact investments with approved institutions after approval by authorised signatories	<input type="checkbox"/> Any one first or second line signatory <input type="checkbox"/> One first & one second line signatory <input type="checkbox"/> Chief Executive Officer <input type="checkbox"/> Chief Finance Officer (CFO) <input type="checkbox"/> Director of Finance/Associate Director of Finance <input type="checkbox"/> Chief Financial Accountant <input type="checkbox"/> Financial Accountant <input type="checkbox"/> Staff delegated by the Chief Finance Officer in operational procedures	Up to 5,000,000 Over 5,000,000

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
22.1.6	<p>LONG-TERM BORROWING (OVER 1 YEAR) All long term borrowing to be approved in principle (within the Prudential Borrowing Limit) by:</p> <p>Limits for authorisation to draw down loan from approved institutions:</p>	<p><input type="checkbox"/> Trust Board</p> <p><input type="checkbox"/> Two signatories from the approved list</p>	<p>Unlimited within PBL</p> <p>Unlimited within Trust Board Approval</p>
22.1.5	<p>SHORT-TERM BORROWING (REPAYABLE WITHIN ONE YEAR) Limits for authorisation to draw down loan from approved institutions:</p> <p><input type="checkbox"/> Without Trust Board approval</p> <p><input type="checkbox"/> With Trust Board approval</p>	<p><input type="checkbox"/> Two signatories from the approved list</p> <p><input type="checkbox"/> Two signatories from the approved list</p>	<p>20,000,000 (within PBL)</p> <p>Unlimited within PBL</p>
22.1.5	<p>APPROVED LOAN SIGNATORIES Officers authorised to draw down loans</p>	<p><input type="checkbox"/> Chief Executive Officer</p> <p><input type="checkbox"/> Chief Finance Officer (CFO)</p> <p><input type="checkbox"/> Director of Finance/Associate Director of Finance</p> <p><input type="checkbox"/> Chief Financial Accountant</p>	
26	<p>DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS</p>		
26.1.3	<p>Condemnations – limit for approval of disposal</p>	<p><input type="checkbox"/> Director of Delivery</p>	<p>Under 5,000</p>

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
	Condemnations - value above which disposal is to be by an authorised officer and register entries made	<input type="checkbox"/> Chief Operating Officer <input type="checkbox"/> Director of Clinical Physics and Biomedical Engineering <input type="checkbox"/> Director of ICT <input type="checkbox"/> Director of Estates	Over 5,000 Over 5,000 Over 5,000 Over 5,000
28	PATIENTS' PROPERTY		
28.5	Deceased patients' property limit above which production of probate or letters of administration are required before property is cleared. The procedures held by the General Office must be consulted.		5,000
29	FUNDS HELD ON TRUST		
	<i>The Director of Finance will maintain a schedule of designated fund managers which be will approved by the Corporate Trustee Board. This schedule shall have effect as if incorporated in this Scheme of Delegation.</i>		
29.4 (1)	Limits for approval of expenditure from individual funds (subject to funds being available)	<input type="checkbox"/> Designated Fund Manager <input type="checkbox"/> Designated Fund Manager plus one Executive Director <input type="checkbox"/> Designated Fund Manager plus one	5,000 30,000

SFI/SO REF		AUTHORISED OFFICER(S)	FINANCIAL LIMITS (£)
	(This needs to be read in conjunction with the Trust's procedures and financial limits for contracting and tendering (SFI 17))	Executive Director and the Chair	Unlimited

Note

The Chief Finance Officer will maintain an Authorised Signatory List specifying individual officer limits – this list shall have effect as if incorporated in this Scheme of Delegation.

Delegated levels for non-pay expenditure

Delegated levels	List of Officers
Level 4 officers	Trust officers (budget holders)
Level 3 officers	Modern matrons General managers Service managers

Delegated levels	List of Officers
Level 2 officers	Clinical directors Director of Pharmacy (pharmaceuticals) Head of Corporate Departments Direct reports to an executive director Director of Operations (Pathology) Associate/Assistant directors
Level 1 officers	Executive directors for their own departments/ areas

Application/Interpretation of the Scheme of Reservation and Delegation

1. The Chief Finance Officer will maintain an Authorised Signatory List specifying individual officer limits – this list shall have effect as if incorporated in this Scheme of Reservation and Delegation.
2. Where the Trust makes changes to job titles, creates new posts; removes posts or changes roles/responsibility of posts, the Chief Executive Officer, Chief Finance Officer, Deputy Chief Finance Officer or Associate Director of Finance will interpret this Scheme of

Reservation and Delegation to apply authorisation limits to officers not specifically identified in the Scheme of Reservation and Delegation. Such interpretation will be formally recorded in the Authorised Signatory List (see 1 above).

3. In exceptional circumstances, authorised officers may wish to delegate responsibility (but not accountability) to authorise transactions on their behalf. Such delegated authority must be formally recorded (in a form approved by the Chief Finance Officer) and be approved by the Chief Executive Officer, Chief Finance Officer, Deputy Chief Finance Officer or Associate Director of Finance. Such delegation of responsibility will only be permissible where appropriate controls and assurances are in place to ensure that the authorised officer effectively maintains accountability. Examples of circumstances under which delegation of responsibility may be appropriate include:
 - Transactions which have to be approved outside normal working hours and are undertaken by officers acting on behalf of or deputising for the authorised officer;
 - Urgent transactions which need to be approved in the absence of authorised officers; or
 - Transactions which are so voluminous that it is impractical for the authorised officer to personally authorise them.
4. From time to time additional restrictions on levels of delegated authority may be imposed by the Chief Executive Officer and the Chief Officers' Group. Where such restrictions are imposed, they will be formally approved and communicated by the Chief Executive Officer and the Chief Finance Officer and shall have effect as if incorporated in this Scheme of Delegation.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS – TENDER AND CONTRACT PROCEDURES LIMITS OF AUTHORITY

Construction and Maintenance of Building, Engineering and Landscape works:

Value of Quote or Tender (£)	Minimum no of Quote/Tenders	Opened by* ⁴ :	Adjudicated by:	Accepted by:
Up to 10,000	At discretion of Director of Estates	Director of Estates or his Deputy	Director of Estates or his Deputy	Director of Estates or his Deputy
10,001 to 30,000	3 quotations	Two representatives of the Chief Finance Officer	Director of Estates/ Professional and Technical Officers	Director of Estates
30,001 to 50,000	3 tenders	Two representatives of the Chief Finance Officer	Director of Estates/ Professional and Technical Officers	Chief Executive Officer/ Chief Finance Officer
50,001 to 100,000	4 tenders	Two representatives of the Chief Finance Officer	Director of Estates/ Professional and Technical Officers	Chief Executive Officer/ Chief Finance Officer
100,000 to 500,000	6 tenders	Two representatives of the Chief Finance Officer	Director of Estates/ Professional and Technical Officers	Chief Executive Officer/ Chief Finance Officer
500,000 to OJEU Limit	6 tenders	Two representatives of the Chief Finance Officer	Director of Estates/ Professional and Technical Officers	Trust Board
Over OJEU Limit * ¹	Invite to tender via OJEU advert	Two representatives of the Chief Finance Officer	Director of Estates/ Professional and Technical Officers	Trust Board

Notes

*1	The OJEU limits may change from time to time under European Union (EU) legislation. As these limits are a legal requirement, officers of the Trust must comply with any revised limits applied by the EU.
2	Business cases are required for all capital expenditure in excess of £100,000
3	Order requisitions for capital expenditure shall be placed by the nominated project manager after acceptance of the tender/quote in line with the rules set out above.
*4	Tender opening: only apply to manual tenders (not e-tenders)

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS – TENDER AND CONTRACT PROCEDURES LIMITS OF AUTHORITY

Goods, Services and Disposals:

Value of Quote or Tender (£)	Minimum no of Quote/Tenders	Opened by* ⁵ :	Adjudicated by:	Accepted by:
Up to 10,000	At discretion of Supplies Manager	Supplies Manager	Supplies Manager or Technical Officer	Director of Estates or his Deputy
10,001 to 30,000	3 quotations	Representatives of the Chief Finance Officer & Supplies Manager	Supplies Manager or Technical Officer	Director of Estates
30,001 to 50,000	3 tenders	Two representatives of the Chief Finance Officer	Supplies Manager and/or Technical Officer	Chief Executive Officer/ Chief Finance Officer
50,001 to OJEU Limit	6 tenders * ²	Two representatives of the Chief Finance Officer	Representatives of the Chief Finance Officer & Supplies Manager	Chief Executive Officer/ Chief Finance Officer
Over OJEU Limit to 500,000 * ¹	Invite to tender via OJEU advert * ²	Two representatives of the Chief Finance Officer	Representatives of the Chief Finance Officer & Supplies Manager & two Executive Directors	Chief Executive Officer/ Chief Finance Officer
Over 500,000 * ¹	Invite to tender via OJEU advert * ²	Two representatives of the Chief Finance Officer	Representatives of the Chief Finance Officer & Supplies Manager & two Executive Directors	Trust Board

Notes

*1	The OJEU limits may change from time to time under European Union (EU) legislation. As these limits are a legal requirement, officers of the Trust must comply with any revised limits applied by the EU.
*2	If the OJEU limit increases beyond £100,000, the Trust should seek 6 tenders where the estimated cost/income exceeds £100,000 and is below the new OJEU limit.
3	Business cases are required for all capital expenditure in excess of £100,000
4	Order requisitions for capital expenditure shall be placed by the nominated project manager after acceptance of the tender/quote in line with the rules set out above.
*5	Tender opening: only apply to manual tenders (not e-tenders)

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 [Trust](#) Board and the Scheme of 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 Chief Finance Officer.

10.1.4

Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer 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 the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the [Trust](#) Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.

10.2 Responsibilities and delegation

10.2.1 The Trust Board

The [Trust](#) Board exercises financial supervision and control by:

- (a) formulating the financial strategy;
- (b) requiring the submission and approval of budgets within overall income;

- (c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
- (d) defining specific responsibilities placed on members of the [Trust](#) Board and employees as indicated in the Scheme of Delegation document.

10.2.2

The [Trust](#) Board has resolved that certain powers and decisions may only be exercised by the [Trust](#) Board in formal session. These are set out in the Scheme of Reservation and Delegation document. All other powers have been delegated to such other committees as the Trust has established.

10.2.3

[-]

10.2.4 The Chief Executive Officer and Chief Finance Officer

The Chief Executive Officer and Chief Finance Officer 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 Officer is ultimately accountable to the [Trust](#) Board, and as Accountable Officer, to the Secretary of State, for ensuring that the [Trust](#) Board meets its obligation to perform its functions within the available financial resources. The Chief Executive Officer has overall executive responsibility for the Trust's activities; is responsible to the Chair and the [Trust](#) Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.5

It is a duty of the Chief Executive Officer to ensure that Members of the [Trust](#) Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.6 The Chief Finance Officer

The Chief Finance Officer 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 Chief Finance Officer include:

- (d) the provision of financial advice to other members of the [Trust](#) 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 [Trust](#) Board Members and Employees

All members of the [Trust](#) Board and employees, severally and collectively, are responsible for:

- (a) the security of the property of the Trust;
- (b) avoiding loss;
- (c) exercising economy and efficiency in the use of resources;
- (d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of 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 Officer to ensure that such persons are made aware of this.

10.2.9

For all members of the [Trust](#) Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the [Trust](#) Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

10.2.10 Scheme of Delegation – Schedule of Financial Limits

The schedule of financial limits included in the Scheme of Delegation should be read in conjunction with these Standing Financial Instructions.

11. AUDIT

11.1 Audit Committee

11.1.1

In accordance with Standing Orders, the [Trust](#) 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 judgements;
- (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 [Trust](#) Board;
- (f) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the [Trust](#) Board and advising the [Trust](#) Board accordingly.

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 [Trust](#) Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the Chief Finance Officer in the first instance.)

11.1.3

It is the responsibility of the Chief Finance Officer 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 Chief Finance Officer

11.2.1

The Chief Finance Officer 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;
- (d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the [Trust](#) Board]. The report must cover:

- i.) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health 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 Chief Finance Officer 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 [Trust](#) Board or employee of the Trust;
- (c) the production of any cash, stores or other property of the Trust under a member of the [Trust](#) 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 Chief Finance Officer 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 Officer of the Trust.

11.3.4

Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, 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 Public Sector 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 Officer and Chief Finance Officer shall monitor and ensure compliance with Directions and standards issued by NHS Protect 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 Chief Finance Officer and shall work with staff in the Counter Fraud and Security Management Services (CFSMS) and the Regional Counter Fraud and Security Management Services (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 Officer 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 [Trust Board](#) for NHS security management.

11.6.4

The Chief Executive Officer 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

[This is 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 Officer will compile and submit to the [Trust](#) Board a Business Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain:

- (a) a statement of the significant assumptions on which the plan is based;
- (b) details of major changes in workload, delivery of services or resources required to achieve the plan.

13.1.2

Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive Officer, prepare and submit budgets for approval by the [Trust](#) Board. Such budgets will:

- (a) be in accordance with the aims and objectives set out in the Business 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 Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the [Trust](#) Board.

13.1.4

All budget holders must provide information as required by the Chief Finance Officer 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 Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.2 [There is no 13.2 in the model DH template so it is not applicable here]

13.3 Budgetary Delegation

13.3.1

The Chief Executive Officer 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 Officer and delegated budget holders must not exceed the budgetary total or virement limits set by the [Trust Board](#).

13.3.3

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive Officer, 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 Officer, as advised by the Chief Finance Officer.

13.4 Budgetary Control and Reporting

13.4.1

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

- (a) monthly financial reports to the [Trust Board](#) in a form approved by the [Trust 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 Officer's and/or Chief Finance Officer'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 in accordance with the budget virement policy.

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 [Trust 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 Officer other than those provided for within the available resources and manpower establishment as approved by the [Trust Board](#);
- (d) a business case is prepared as appropriate for investment, divestment and service change in accordance with the Trust's business planning process which is subject to appropriate authorisation.

13.4.3

The Chief Executive Officer is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business 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 Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Finance Officer, 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 GBS ACCOUNTS

15.1 General

15.1.1

The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

15.1.2

The [Trust](#) Board shall approve the banking arrangements.

15.2 Bank and GBS Accounts

15.2.1

The Chief Finance Officer is responsible for:

- (a) bank accounts and Government Banking Service (GBS) accounts;
- (b) establishing separate bank accounts for the Trust's non-exchequer funds;
- (c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- (d) reporting to the [Trust](#) Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
- (e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1

The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- (a) the conditions under which each bank and GBS account is to be operated;
- (b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

15.3.2

The Chief Finance Officer 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 Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

15.4.2

Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the [Trust](#) Board. This review is not necessary for GBS accounts.

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

16.1 Income Systems

16.1.1

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

16.1.2

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

16.1.3

The Chief Finance Officer is responsible for ensuring proper controls over the cancellation of invoices (including the raising of credit notes). Authorisation limits for the cancellation of invoices/raising of credit notes will be specified in the Schedule of Financial Limits in the Scheme of Delegation (this is not to be confused with writing off bad debts which is dealt with under SFI 26).

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 Chief Finance Officer 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. **All such fees and charges must reflect the following:**

- The price must ensure full cost recovery at a rate the market will bear
- Schemes must be approved in accordance with the schedule of financial limits
- Where a scheme requires investment, the potential risks of disinvestment must be covered by the surplus made such that any exit from the scheme is at no cost to the organisation
- Where the scheme relates to a new service, the business case approval process must be followed.

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.

All income generation schemes must be costed in line with the guidance provided by the Chief Finance Officer and all schemes must be approved in line with the Schedule of Financial Limits in the Scheme of Delegation.

16.2.3

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

16.3 Debt Recovery

16.3.1

The Chief Finance Officer 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 Chief Finance Officer 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 Chief Finance Officer.

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).

Where the Trust seeks a variation to goods, services and facilities under an existing Private Finance Initiative (PFI) contract (see also SFI 17.10), these rules regarding tendering and contracting procedures shall be applied as far as is practicable under the terms of the contract. The Trust's Chief Finance Officer in conjunction with the Director of Estates will prepare formal procedures governing all PFI variations.

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 Equality Act 2010

When undertaking procurement, the Trust must have due regard to equality considerations in order to meet its obligations under the general equality duty. This applies to all procurement regardless of value and includes services which are contracted to an external organisation.

17.4 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

17.5 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".

17.6 Formal Competitive Tendering

17.6.1 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.

17.6.2 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.

17.6.3 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 £30,000;
- (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 Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;
- (e) where the requirement is covered by an existing contract;
- (f) where PASA agreements are in place and have been approved by the [Trust 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 Chief Finance Officer 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.

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. All instances of the waiving of competitive tendering procedures must be approved by the Chief Executive Officer or Chief Finance Officer and reported to the Audit Committee twice per annum in accordance with the committee's work plan.

17.6.4 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.

The minimum number of firms/individuals invited to tender are set out in the Tender and Contract Procedures – Limits of Authority in the Scheme of Delegation.

17.6.5 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 Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive Officer (see SFI 17.6.8 List of Approved Firms).

17.6.6 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

17.6.7 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 Officer, and be recorded in an appropriate Trust record.

17.7 Contracting/Tendering Procedure

17.7.1 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) the tender has been submitted using the Trust's e-tendering system;
 - or
 - (b) where a manual process is being followed:
 - it is submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive Officer or nominated Manager;

- the 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.
- iv.) 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.

17.7.2 Receipt and safe custody of tenders

- i.) Where the Trust's e-tendering system is being used:
- (a) Access to the tenders will be "locked" until the prescribed closing date for the receipt of tenders.
 - (b) The system will automatically record the date and time of receipt of tenders.
- iii.) Where a manual tendering process is being used:
- (a) The Chief Executive Officer or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.
 - (b) The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

17.7.3 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 as follows:
- (a) E-tenders: the Head of Procurement or nominated representative will ensure access to tenders is "unlocked"
 - (b) Manual tenders: two senior officers/managers designated by the Chief Executive Officer and not from the originating department. Officers authorised to open tenders are set out in the Tender and Contract Procedures – Limits of Authority in the Scheme of Delegation.
 - The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.
 - The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Finance Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

- Every tender received shall be marked with the date of opening and initialled by those present at the opening.
- ii.) A register (electronic for e-tenders or manual) shall be maintained by the Chief Executive Officer, or a person authorised by him, to show for each set of competitive tender invitations dispatched:
- 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 (not applicable for e-tenders).

Each entry to this register (manual register only) 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.

- iii.) 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. (Standing Order No. 17.6.5 below).

17.7.4 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 Officer.
- ii.) Where only one tender is sought and/or received, the Chief Executive Officer and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.7.5 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 Officer or his nominated officer decides that there are exceptional circumstances i.e. dispatched 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 Officer 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 Officer or his nominated officer.

17.7.6 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 Officer.
- 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.
- vi.) All tenders will be adjudicated by officers of the Trust as set out in the Tender and Contract Procedures – Limits of Authority in the Scheme of Delegation.

17.7.7 Tender reports to the Trust Board

Except as set out in the Tender and Contract Procedures – Limits of Authority in the Scheme of Delegation, reports to the Trust Board will be made on an exceptional circumstance basis only.

17.7.8 List of approved firms (see SFI No. 17.5.5)

(a) Responsibility for maintaining list

A manager nominated by the Chief Executive Officer 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 age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation and will comply with the provisions of the Equality Act 2010.
- 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 Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.7.9 Exceptions to using approved contractors

If in the opinion of the Chief Executive Officer and the Chief Finance Officer 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 Officer 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.

17.8 Quotations: Competitive and non-competitive

17.8.1 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 £10,000 but not exceed £30,000.

17.8.2 Competitive Quotations

- i.) The minimum number of firms/individuals invited to quote are set out in the Tender and Contract Procedures – Limits of Authority in the Scheme of Delegation.

- ii.) Quotations should be in writing unless the Chief Executive Officer 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 Officer 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.

17.8.3 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 officer, possible or desirable to obtain competitive quotations;
- ii.) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;
- iii.) miscellaneous services, supplies and disposals;
- iv.) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

17.8.4 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 Officer or Chief Finance Officer.

17.9 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 officers of the Trust or the Trust Board as set out in the Tender and Contract Procedures – Limits of Authority in the Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

17.10 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 the NHS Logistics for procurement of all goods and services unless the Chief Executive Officer or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.
- (b) If the Trust does not use the NHS Logistics - where tenders or quotations are not required, because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

17.11 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 [Trust](#) Board proposes, or is required, to use finance provided by the private sector the following should apply:

- (a) The Chief Executive Officer 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.

17.12 Compliance requirements for all contracts

The [Trust](#) Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- (a) The Trust's Standing Orders and Standing Financial Instructions;
- (b) EU Directives and other statutory provisions;
- (c) Equality Act 2010;
- (d) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;
- (e) such of the NHS Standard Contract Conditions as are applicable.
- (f) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.
- (g) 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.
- (h) In all contracts made by the Trust, the [Trust](#) Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive Officer shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.13 Personnel and Agency or Temporary Staff Contracts

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

17.14 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, is a legal document and is enforceable in law.

The Chief Executive Officer shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the [Trust](#) Board.

17.15 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 Officer 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 £5,000, this figure to be reviewed on a periodic basis;
- (d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- (e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.16 In-house Services

17.16.1

The Chief Executive Officer 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.

17.16.2

In all cases where the [Trust](#) Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- (a) Specification group, comprising the Chief Executive Officer or nominated officer/s and specialist.
- (b) In-house tender group, comprising a nominee of the Chief Executive Officer and technical support.
- (c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative. For services having a likely annual expenditure exceeding £1,000,000, a non-~~officer member~~ executive member should be a member of the evaluation team.

17.16.3

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.

17.16.4

The evaluation team shall make recommendations to the [Trust](#) Board.

17.16.5

The Chief Executive Officer shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.17 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 Officer, 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 NHS England or clinical commissioning group's plans and the Trust's Business Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive Officer 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 Officer 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 A 'Patient Led NHS and 'Practice Based Commissioning''

The Department of Health has published its document 'Creating a Patient-led NHS' and 'Practice Based Commissioning' setting out the basis upon which the Government's major reform agenda will be carried forward.

The Department of Health previously published its document 'Creating a Patient-led NHS' and 'Practice Based Commissioning' setting out the basis upon which the then government's major reform agenda would be carried forward.

This involved creating a patient-led NHS as follows:

A 'Patient-led NHS'

Every aspect of the system **was** designed to create a service which is patient-led, where:

- people **had** a far greater range of choices and of information and guidance to help make choices;
- there **were** stronger standards and safeguards for patients;

- NHS organisations **were** 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 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.

18.4 Reports to [Trust](#) Board on SLAs

The Chief Executive Officer, as the Accountable Officer, will need to ensure that regular reports are provided to the [Trust](#) 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

[This section is not normally applicable to NHS Trusts since they are providers rather than commissioners of health services. However, in limited cases Trusts may be responsible for operational commissioning of services. In these circumstances Trusts should refer to the model SFIs on Commissioning for clinical commissioning groups and adopt/amend the relevant paragraphs as appropriate].

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 [Trust](#) 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 [Trust](#) Board about appropriate remuneration and terms of service for the Chief Executive Officer, other officer members employed by the Trust and other senior employees including:
 - i.) all aspects of salary (including any performance-related elements/bonuses);
 - ii.) provisions for other benefits, including pensions and cars;
 - iii.) arrangements for termination of employment and other contractual terms;
- (b) make such recommendations to the [Trust](#) Board on the remuneration and terms of service of officer members 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 officer members (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 [Trust](#) Board the basis for its recommendations. The [Trust](#) Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the [Trust](#) Board's meetings should record such decisions.

20.1.4

The [Trust](#) Board will consider and need to approve proposals presented by the Chief Executive Officer 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-officer members of the [Trust](#) 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 Officer.

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 Officer;
- (b) within the limit of their approved budget and funded establishment.

20.3.2

The [Trust](#) Board will approve procedures presented by the Chief Executive Officer for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1

The Chief Human Resources Officer 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 Chief Human Resources Officer will issue instructions regarding:

- (a) verification and documentation of data;
- (b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- (c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- (d) security and confidentiality of payroll information;
- (e) checks to be applied to completed payroll before and after payment;
- (f) authority to release payroll data under the provisions of the Data Protection Act;
- (g) methods of payment available to various categories of employee and officers;
- (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 Chief Operating Officer's instructions and in the form prescribed by the Chief Operating Officer;
- (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 Chief Operating Officer must be informed immediately.

20.4.4

Regardless of the arrangements for providing the payroll service, the Chief Human Resources Officer 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 [Trust](#) 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 [Trust](#) 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 [Trust](#) Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive Officer will determine the level of delegation to budget managers.

21.1.2

The Chief Executive Officer 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 Officer 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 Chief Finance Officer (and/or the Chief Executive Officer) shall be consulted.

21.2.2 System of Payment and Payment Verification

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.3 The Chief Finance Officer will:

- (a) advise the [Trust](#) Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;
- (b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;
- (c) be responsible for the prompt payment of all properly authorised accounts and claims. Authorisation limits are set out in the Schedule of Financial Limits in the Scheme of Delegation;
- (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 [Trust](#) Board 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 Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
- 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 Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
- (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 Officer if problems are encountered.
- (e) Prepayments must be authorised in line with the Schedule of Financial Limits in the Scheme of Delegation.

21.2.5 Official orders

Official Orders must:

- (a) be consecutively numbered;
- (b) be in a form approved by the Chief Finance Officer;
- (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 Officer.
- (e) be signed by an officer duly authorised in the Schedule of Financial Limits in the Scheme of Delegation

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 Chief Finance Officer and that:

- (a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer 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. 6 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");
- (e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive Officer;
- (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;
- (g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive Officer 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 Chief Finance Officer;
- (k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer and the Schedule of Financial Limits in the Scheme of Delegation;
- (l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

21.2.7

The Chief Executive Officer and Chief Finance Officer 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. 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 Chief Finance Officer which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

22. EXTERNAL BORROWING AND INVESTMENTS

22.1 External Borrowing

22.1.1

The Chief Finance Officer will advise the [Trust](#) 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 Chief Finance Officer is also responsible for reporting periodically to the [Trust](#) Board concerning the PDC debt and all loans and overdrafts.

22.1.2

The [Trust](#) Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive Officer and the Chief Finance Officer.

22.1.3

The Chief Finance Officer 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 Officer, Chief Finance Officer (CFO) or Director of Finance/Associate Director of Finance. The [Trust](#) Board must be made aware of all short term borrowings at the next [Trust](#) Board meeting (see Schedule of Financial Limits in the Scheme of Delegation).

22.1.6

All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Trust Board (see Schedule of Financial Limits in the Scheme of Delegation).

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 [Trust](#) Board.

22.2.2

The Chief Finance Officer is responsible for advising the [Trust](#) Board on investments and shall report periodically to the [Trust](#) Board concerning the performance of investments held.

22.2.3

The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained. Authorisation limits for the investment of surplus cash are set out in the Schedule of Financial Limits in the Scheme of Delegation.

23. FINANCIAL FRAMEWORK

23.1 [There is no paragraph contained within the DH template with this reference]

23.2 [There is no paragraph contained within the DH template with this reference]

23.3 Financial Framework

23.3.1

The Chief Finance Officer should ensure that members of the [Trust](#) Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to the NHS Trust Development Authority regarding resource and capital allocation and funding to Trust's. The Chief Finance Officer 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 Officer:

- (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 Officer 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;
 - iii.) (appropriate project management and control arrangements;
- (b) that the Chief Finance Officer 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 Officer will issue procedures for their management, incorporating the recommendations of "Estatecode".

24.1.4

The Chief Finance Officer 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 Chief Finance Officer 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 Officer 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 Officer will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

24.1.7

The Chief Finance Officer 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 Chief Finance Officer 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 [Trust Board](#).

24.3 Asset Registers

24.3.1

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

24.3.2

Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in accounting instructions issued by HM Treasury and/or 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 Chief Finance Officer 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 accounting instructions issued by HM Treasury and/or the Department of Health.

24.3.7

The value of each asset shall be depreciated using methods and rates as specified in accounting instructions issued by HM Treasury and/or the Department of Health..

24.3.8

The Chief Finance Officer of the Trust shall calculate and pay capital charges as specified in accounting instructions issued by HM Treasury and/or 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 Officer.

24.4.2

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

- (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 Chief Finance Officer.

24.4.4

Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of [Trust](#) Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the [Trust](#) 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 [Trust](#) 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 Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive Officer. 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 Chief Finance Officer. 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 Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4

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

25.2.5

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

25.2.6

The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also 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 Officer shall identify those authorised to requisition and accept goods from the store.

The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy 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 Chief Finance Officer 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 Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3

All unserviceable articles (with a value in excess of the amount included in the Schedule of Financial Limits in the Scheme of Delegation) shall be:

- (a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;
- (b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

The following shall act as condemning officers to the Trust:

Furniture, fittings and hotel services	Chief Operating Officer
Medical equipment	Director of Clinical Physics and Biomedical Engineering
Information technology	Director of ICT
Electrical, mechanical and engineering equipment	Director of Estates

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 Chief Finance Officer who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 Procedures

The Chief Finance Officer 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 Officer and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive Officer. Where a criminal offence is suspected, the Chief Finance Officer 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 Chief Finance Officer must

inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Chief Finance Officer 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 Chief Finance Officer must immediately notify:

- (a) the [Trust](#) Board,
- (b) the External Auditor.

26.2.4

Within limits delegated to it by the Department of Health, the [Trust](#) Board shall approve the writing-off of losses.

26.2.5

The Chief Finance Officer 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 Chief Finance Officer should consider whether any insurance claim can be made.

26.2.7

The Chief Finance Officer 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 to the Audit Committee at every meeting.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Chief Finance Officer

27.1.1

The Chief Finance Officer, 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 Chief Finance Officer 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 Chief Executive Officer 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 Chief Finance Officer and the Director of ICT:

- (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 Chief Finance Officer and the Director of ICT 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 Chief Finance Officer and the Director of ICT shall periodically seek assurances that adequate controls are in operation.

27.4 Risk Assessment

The Chief Finance Officer and the Director of ICT 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 Chief Finance Officer 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) Chief Finance Officer staff have access to such data;
- (d) such computer audit reviews as are considered necessary are being carried out.

27.6 Responsibilities of the Director of ICT

The Director of ICT will:

- (a) provide advice on the acquisition, development and maintenance of all computer systems (including all hardware and software);
- (b) ensure that adequate arrangements are in place to archive and store data for the prescribed time limits laid down by statute or Department of Health guidelines;
- (c) be responsible for ensuring that sound practices exist to prevent contamination of software and data from computer viruses;
- (d) ensure that all software used by the Trust is properly licensed for the intended purpose;
- (e) be responsible for ensuring that appropriate 'business continuity' arrangements are in existence for the Trust's key computer systems.

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 Officer 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 Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all 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 Chief Finance Officer.

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 4.8.3 that defines 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 Chief Finance Officer 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.

- (3) A policy for the management of charitable and other funds held on trust will be prepared by the Chief Finance Officer and approved by the Corporate Trustee [Trust](#) Board (as specified in the Scheme of Reservation and Delegation).

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 [Trust](#) Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All members of the Corporate Trustee Board 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.

29.4 Delegation to Fund Managers

- (1) The Chief Finance Officer will maintain a schedule of designated fund managers and their limits of authority will be as set out in the Schedule of Financial Limits in the Scheme of Delegation.
- (2) The Chief Finance Officer will provide guidance to all appropriate officers of the Trust on the management and operation of charitable and other funds held on trust.

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Finance Officer 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. 6).

31. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Trusts.

32. RETENTION OF RECORDS

- 32.1** The Chief Executive Officer 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 Officer. Detail shall be maintained of records so destroyed.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

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

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 [Trust](#) Board in agreeing Insurance cover

- (1) Where the [Trust](#) Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.
- (2) Where the [Trust](#) Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the [Trust](#) Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer 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 Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Appendix 1

STATUTORY INSTRUMENTS

1990 No. 2024

NATIONAL HEALTH SERVICE, ENGLAND AND WALES

The National Health Service Trusts (Membership and Procedure) Regulations 1990

Made 12th October 1990

Laid before Parliament 19th October 1990

Coming into force 9th November 1990

The Secretary of State for Health, as respects England, and the Secretary of State for Wales, as respects Wales, in exercise of powers conferred by sections 126(4) and (5) and 128(1) of the National Health Service Act 1977^[1] and section 5(7) of the National Health Service and Community Care Act 1990^[2] and of all other powers enabling them in that behalf hereby make the following Regulations:

PART I

GENERAL

Citation, commencement and interpretation

1. (1) These Regulations may be cited as the National Health Service Trusts (Membership and Procedure) Regulations 1990 and shall come into force on 9th November 1990

(2) In these Regulations unless the context otherwise requires-

"the Act" means the National Health Service and Community Care Act 1990;

"appointing authority" in relation to a director means the Secretary of State or Regional Health Authority or the relevant committee as appropriate, which appointed him;

"director" in relation to an NHS Trust includes its Chair;

"executive director" and "non-executive director" have the meaning assigned to them in section 5(5)(a) of the Act. "health service body" means—

(a) a health authority, a Family Health Services Authority or an NHS trust;

(b) a Health Board, a Special Health Board, the Common Services Agency for the Scottish Health Service or an NHS trust respectively constituted under section 2, 10 and 12A of the National Health Service (Scotland) Act 1978^[3];

(c) a State Hospital Management Committee constituted under section 91 of the Mental Health (Scotland) Act 1984^[4];

(d) the Dental Practice Board constituted by Regulations having effect under section 37 of the National Health Service Act 1977^[5];

- (e) the Scottish Dental Practice Board constituted by Regulations having effect under section 4 of the National Health Service (Scotland) Act 1978^[6]
- (f) the Public Health Laboratory Service Board continued in being by section 5(4) of the National Health Service Act 1977;
- (g) the National Radiological Protection Board established by section 1 of the Radiological Protection Act 1970^[7];

"general dental practitioner" means a dental practitioner who is providing general dental services in accordance with arrangements under section 35 of the National Health Service Act 1977;

"general medical practitioner" is a medical practitioner who is providing general medical services in accordance with arrangements under section 29 of the National Health Service Act 1977;

"operational date" has the meaning assigned to it in paragraph 3 (1)(e) of Schedule 2 to the Act;

"the relevant committee" means a committee of an NHS trust appointed under either regulation 17 or regulation 18 whichever is appropriate;

"trade union" has the meaning assigned to it in section 28 of the Trade Union and Labour Relations Act 1974^[8].

(3) in regulation 20-

"public body" includes-

- (a) any body established for the purposes of carrying on, under national ownership, any industry or part of any industry or undertaking;
- (b) the governing body of any university, university college or college, school or hall of a university; and
- (c) the National Trust for Places of Historic Interest or Natural Beauty incorporated by the National Trust Act 1907^[9];

"securities" means-

- (a) shares or debentures, whether constituting a charge on the assets of the company or other body or not, or rights or interests in any shares or such debentures, or
- (b) rights (whether actual or contingent) in respect of money lent to or deposited with any industrial and provident society or building society;

"shares" means shares in the share capital of a company or other body or the stock of a company or other body.

(4) Unless the context otherwise requires, any reference in these Regulations to a numbered regulation is a reference to the regulation bearing that number in these Regulations, and any reference in a regulation to a numbered paragraph is a reference to the paragraph bearing that number in that regulation.

Notes:

[1] 1977 c. 49; section 126(4) was amended by, and section 126(5) was inserted by, section 65(2) of the National Health Service and Community Care Act 1990 (c. 19) ("the 1990 Act"); section 128(1) was amended by the 1990 Act, section 26(2) and is cited for the definition "regulations". [back](#)

[2] [1990 c. 19](#). [back](#)

[3] 1978 c. 29; section 2 was amended by the Health and Social Services and Social Security Adjudications Act 1983 (c. 41), Schedule 7, paragraph 1 and the 1990 Act, section 28; section 10 was amended by the Health Services Act 1980 (c. 53), Schedule 6, paragraph 2; section 12A was inserted by the 1990 Act, section 31. [back](#)

[4] 1984 c. 36. [back](#)

[5] See S.I. 1973/1468. Section 37 was amended by the Health Services Act 1980 (c. 53), Schedule 1, paragraph 69 and by the Health and Medicines Act 1988 (c. 49), section 12. [back](#)

[6] See S.I. 1974/505. Section 4 was amended by the Health and Medicines Act 1988, section 12. [back](#)

[7] 1970 c. 46. [back](#)

[8] 1974 c. 52. [back](#)

[9] 1907 c.xxxvi. [back](#)

Field Code Changed

PART II

MEMBERSHIP

Maximum number of directors

2. The maximum number of directors of an NHS trust shall be eleven.

Appointment of directors

3.—(1) Of the non-executive directors of an NHS trust whose hospital establishment or facility is situated in England-

(a) two shall be appointed by the Regional Health Authority in whose region the hospital establishment or facility is situated, or, if it is situated in more than one region, the Regional Health Authority in whose region it principally carries out its functions; and

(b) the remainder, which shall include the person, if any, appointed pursuant to paragraph 3(1)(d) of Schedule 2 to the Act, shall be appointed by the Secretary of State.

(2) All of the non-executive directors of an NHS trust whose hospital establishment or facility is situated in Wales shall be appointed by the Secretary of State.

(3) The executive directors of an NHS trust shall be appointed by the relevant committee.

Qualifications for appointments

4.—(1) The executive directors of an NHS trust shall include-

(a) the chief officer of the trust;

(b) the chief finance officer of the trust;

(c) except in the case of a trust mentioned in paragraph (2) a medical or dental practitioner and a registered nurse or registered midwife as defined in section 10(7) of the Nurses, Midwives and Health Visitors Act 1979^{[\[10\]](#)}.

- (2) Paragraph 1(c) shall not apply in the case of a trust-
- (a) which does not provide services directly to patients; or
 - (b) whose principal function is to provide ambulance or patient transport services.

Persons to be regarded as executive directors

5. A person who is not an employee of an NHS trust but-
- (a) holds a post in a university with a medical or dental school, and also works for the trust; or
 - (b) is seconded from his employers to work for the trust,
- is nevertheless, on appointment as a director, to be regarded as an executive rather than a non-executive director of the trust.

Joint directors

6. Where more than one person is appointed jointly to a post in an NHS trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become or be appointed an executive director jointly, and shall count for the purposes of regulation 2 as one person.

Tenure of office of Chair and directors

- 7.—(1) Subject to regulation 9, the Chair and non-executive directors of an NHS trust shall be appointed for such period not exceeding four years as the appointing authority may specify on making the appointment.

(2) Subject to regulation 8, the tenure of office of executive directors, other than the chief officer and chief finance officer, shall be for such period as the appointing authority may specify on making the appointment.

Tenure and suspension of tenure of office of executive directors

- 8.—(1) Subject to paragraphs (2) to (4) and regulation 7(2), an executive director of an NHS trust shall hold office-

- (a) if he is not the chief officer or the chief finance officer, for as long as he holds a post in the trust;
- (b) if he is the chief officer or the chief finance officer, for as long as he holds that post in the trust.

(2) If the appointing authority is of the opinion that it is not in the interests of the NHS trust that an executive director of an NHS trust other than the chief officer or chief finance officer should continue to hold office as director the appointing authority shall forthwith terminate his tenure of office.

(3) If an executive director of an NHS trust is suspended from his post in the trust he shall be suspended from performing his functions as director for the period of his suspension.

(4) An executive director other than the chief officer or chief finance officer of an NHS trust may resign his office at any time during the period for which he was appointed by giving notice in writing to the relevant committee.

Termination of tenure of office of Chair and non-executive directors

- 9.—(1) The Chair or a non-executive director of an NHS trust may resign his office at any time during the period for which he was appointed by giving notice in writing to the appointing authority.

(2) Where during his period of directorship a non-executive director of a trust is appointed Chair of the trust, his tenure of office as non-executive director shall terminate when his appointment as Chair takes effect.

(3) If an appointing authority is of the opinion that it is not in the interests of the health service that a person who is appointed as Chair or non-executive director of an NHS trust should continue to hold that office the appointing authority may, subject to the consent of the Secretary of State, unless it is the Secretary of State, forthwith terminate his tenure of office.

(4) If a Chair or non-executive director of an NHS trust has not attended a meeting of the trust for a period of six months, the Secretary of State shall forthwith terminate his tenure of office unless the Secretary of State is satisfied that-

- (a) the absence was due to a reasonable cause; and
- (b) the Chair or non-executive director will be able to attend meetings of the trust within such period as the Secretary of State considers reasonable.

(5) Where a person has been appointed the Chair or non-executive director of an NHS trust-

- (a) if he becomes disqualified for appointment under regulation 11 the appointing authority shall forthwith notify him in writing of such disqualification; or
- (b) if it comes to the notice of the appointing authority that at the time of his appointment he was so disqualified it shall forthwith declare that he was not duly appointed and so notify him in writing,

and upon receipt of any such notification, his tenure of office, if any, shall be terminated and he shall cease to act as Chair or non-executive director.

(6) If it appears to the Secretary of State that the Chair or non-executive director of an NHS trust has failed to comply with regulation 20 (disclosure etc. on account of pecuniary interest) he may forthwith terminate that person's tenure of office.

(7) Where a person appointed as a non-executive director pursuant to paragraph 3(1)(d) of Schedule 2 to the Act ceases to hold a post in the university in question the Secretary of State shall terminate his appointment as non-executive director.

Eligibility for reappointment

10.—(1) Subject to regulation 11 the Chair or non-executive director of an NHS trust shall, on the termination of the period of his tenure of office, be eligible for reappointment.

(2) An executive director of an NHS trust other than the chief officer and the chief finance officer shall on the termination of the period of his tenure of office be eligible for re-appointment.

Disqualification for appointment of Chair and non-executive directors

11.—(1) Subject to regulation 12 a person shall be disqualified for appointment as the Chair or non-executive director of an NHS trust if-

- (a) he has within the preceding five years been convicted in the United Kingdom, the Channel Islands or the Isle of Man of any offence and has had passed on him a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine; or
- (b) he has been adjudged bankrupt or has made a composition or arrangement with his creditors; or
- (c) he has been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body; or

(d) he is a person whose tenure of office as the Chair member or director of a health service body has been terminated because his appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

(e) he is a Chair, member, director or employee of a health service body; or

(f) he is a general medical practitioner or general dental practitioner or an employee of either of those; or

(g) he holds a paid appointment or office with a trade union which represents the interests of members who are employed by a health service body; or

(h) he has had his name removed, by a direction under section 46 of the National Health Service Act 1977, from any list prepared under Part II of that Act and has not subsequently had his name included in such a list.

(2) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the ordinary period allowed for making an appeal or application with respect to the conviction expires, or if such an appeal or application is made, the date on which the appeal or application is finally disposed of or abandoned or fails by reason of it not being prosecuted.

(3) For the purposes of paragraph (1)(c) a person shall not be treated as having been in paid employment by reason only of his Chairship, membership or directorship of the health service body.

(4) A person shall not be disqualified by paragraph (1)(e) from being the non-executive director of an NHS trust referred to in paragraph 3(1)(d) of Schedule 2 to the Act by reason of his employment with the trust.

Cessation of disqualification

12.—(1) Where a person is disqualified under regulation 11 (1)(b) by reason of having been adjudged bankrupt-

(a) if the bankruptcy is annulled on the ground that he ought not to have been adjudged bankrupt or on the ground that his debts have been paid in full, the disqualification shall cease on the date of the annulment;

(b) if he is discharged the disqualification shall cease on the date of his discharge.

(2) Where a person is disqualified under regulation 11 (1)(b) by reason of his having made a composition or arrangement with his creditors, if he pays his debts in full the disqualification shall cease on the date on which the payment is completed and in any other case it shall cease on the expiry of five years from the date on which the terms of the deed of composition or arrangement are fulfilled.

(3) Subject to paragraph (4) where a person is disqualified under regulation 11(1)(c) (dismissed employees) he may, after the expiry of a period of not less than two years, apply in writing to the Secretary of State to remove the disqualification and the Secretary of State may direct that the disqualification shall cease.

(4) Where the Secretary of State refuses an application to remove a disqualification no further application may be made by that person until the expiration of two years from the date of the application.

(5) Where a person is disqualified under regulation 11 (1)(d) (certain chairmen and directors whose appointments have been terminated), the disqualification shall cease on the expiry of a period of two years or such longer period as the appointing authority specifies when terminating his period of office but the Secretary of State

may on application being made to him by that person or by that appointing authority, reduce the period of disqualification.

Notes:

[10] 1979 c. 36, [back](#)

Field Code Changed

PART III

CONSTITUTION AND PROCEEDINGS

Appointment of vice-Chair

13.—(1) For the purpose of enabling the proceedings of the trust to be conducted in the absence of the Chair, the directors of an NHS trust may appoint a non-executive director from amongst them to be vice-Chair for such a period, not exceeding the remainder of his term as non-executive director of the trust, as they may specify on appointing him.

(2) Any non-executive director so elected may at any time resign from the office of vice-Chair by giving notice in writing to the Chair and the directors of the trust may thereupon appoint another non-executive director as vice-Chair in accordance with paragraph (1).

Powers of vice-Chair

14. Where the Chair of an NHS trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform his duties, be taken to include references to the vice-Chair.

Appointment of committees and sub-committees

15.—(1) Subject to regulations 17 and 18 an NHS trust may appoint committees of the trust consisting wholly or partly of directors of the trust or wholly of persons who are not directors of the trust.

(2) A committee appointed under this regulation may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include the directors of the trust) or wholly of persons who are not members of the committee (whether or not they include directors of the trust).

Arrangements for the exercise of functions

16. Subject to regulations 17 and 18 an NHS trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee appointed by virtue of regulation 15 subject to such restrictions and conditions as the trust thinks fit.

Committee for appointing chief officer as director

17. An NHS trust shall appoint a committee whose members shall be the Chair and non-executive directors of the trust whose function will be to appoint the chief officer as a director of the trust.

Committee for appointing executive directors other than chief officer

18. An NHS trust shall appoint a committee whose members shall be the Chair, the non-executive directors and the chief officer whose function will be to appoint the executive directors of the trust other than the chief officer.

Meetings and Proceedings

19.—(1) The meetings and proceedings of an NHS trust shall be conducted in accordance with the rules set out in the Schedule to these Regulations and with Standing Orders made under paragraph (2).

(2) Subject to those rules and to regulation 20 an NHS trust shall make and may vary or revoke Standing Orders for the regulation of its proceedings and business and provision may be made in such Standing Orders for the suspension of them.

(3) An NHS trust may make, vary and revoke Standing Orders relating to the quorum, proceedings and place of meetings of a committee or sub committee but, subject to regulation 20 and to any such Standing Orders, the quorum, proceedings

and place of meeting shall be such as the committee or sub-committee may determine.

(4) The proceedings of an NHS trust shall not be invalidated by any vacancy in its membership or by any defect in a director's appointment.

Disability of directors in proceedings on account of pecuniary interest

20.—(1) Subject to the following provisions of this regulation, if a director of an NHS trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration and discussion of the contract or other matter or vote on any question with respect to it.

(2) The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this regulation, in any case in which it appears to him in the interests of the health service that the disability shall be removed.

(3) An NHS trust may, by Standing Orders made under regulation 19 provide for the exclusion of a director from a meeting of the trust while any contract, proposed contract, or other matter in which he has a pecuniary interest, direct or indirect, is under consideration.

(4) Any remuneration, compensation or allowances payable to a director by virtue of paragraph 9 of Schedule 2 to the Act shall not be treated as a pecuniary interest for the purpose of this regulation.

(5) Subject to paragraphs (2) and (6), a director shall be treated for the purposes of this regulation as having indirectly a pecuniary interest in a contract, proposed contract or other matter if-

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

(b) he is a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration and, in the case of married persons living together, the interest of one spouse shall be deemed for the purpose of this regulation to be also an interest of the other.

(6) A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only-

(a) of his membership of a company or other body if he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in paragraph (5) which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(7) Where a director-

(a) has an indirect pecuniary interest in a contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

(b) the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less; and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has the beneficial interest does not exceed one hundredth of the total issued share capital of that class,

this regulation shall not prohibit him from taking part in consideration or discussion of the contract or other matter or from voting on any question in respect to it without prejudice however to his duty to disclose his interest.

(8) This regulation applies to a committee or sub-committee of an NHS trust as it applies to the trust and applies to any member of any such committee or sub-committee (whether or not he is also a director of the trust) as it applies to a director of the trust.

K. Clarke

Secretary of State for Health

12th October 1990

David Hunt

Secretary of State for Wales

12th October 1990

SCHEDULE

Regulation 19(1)

RULES AS TO MEETINGS AND PROCEEDINGS OF NHS TRUSTS

1. The first meeting of an NHS trust shall be held on such day and at such place as may be fixed by the Chair and he shall be responsible for convening the meeting.

2.—(1) The Chair may call a meeting of the NHS trust at any time.

(2) If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of directors, has been presented to him or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him, such one third or more members shall forthwith call a meeting.

(3) Before each meeting of an NHS trust, a notice of the meeting, specifying the business proposed to be transacted at it and signed by the Chair, or by an officer of the trust authorised by the Chair to sign on his behalf, shall be delivered to every director or sent by post to the usual place of residence of such director so as to be available to him at least three clear days before the meeting.

(4) Lack of service of the notice on any director shall not affect the validity of a meeting.

(5) In the case of a meeting called by directors in default of the Chair, the notice

shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.—(1) At any meeting of an NHS trust the Chair, if present, shall preside.

(2) If the Chair and vice-Chair (if any) are absent such non-executive director as the directors present shall choose shall preside.

(3) Every question at a meeting shall be determined by a majority of the votes of the directors present voting on the question and, in the case of any equality of votes, the person presiding shall have a second casting vote.

(4) The names of the directors present at the meeting shall be recorded.

(5) No business shall be transacted at a meeting of an NHS trust unless one third of the whole number of directors are present including on or after the operational date at least one executive director and one non-executive director.

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

4. Where a post of executive director is shared by more than one person in pursuance of regulation 6-

- (a) both persons shall be entitled to attend meetings of the NHS trust;
- (b) either of those persons shall be eligible to vote in the case of agreement between them;
- (c) in the case of disagreement between them no vote shall be cast;
- (d) the presence of either or both of those persons shall count as one person for the purpose of paragraph 3(5) of this Schedule.

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make provision concerning the membership and procedure of NHS trusts established under the National Health Service and Community Care Act 1990. They include in Part II provisions relating to the number, appointment, qualifications and description of directors and joint directorships (regulations 2 to 6), the tenure of office of directors and the termination of tenure of office and eligibility for re-appointment (regulations 7 to 10) and for disqualification for appointment as director and cessation of disqualification (regulations 11 and 12). In Part III provisions are included relating to vice-chairmen (regulations 13 and 14), the appointment of and the exercise of functions by committees and sub-committees (regulations 15 to 18) and meetings and proceedings of a trust including disability for taking part in proceedings on account of pecuniary interest (regulations 19 and 20 and the Schedule).

ISBN 0 11 005024 X

Appendix 2

STATUTORY INSTRUMENTS

1993 No. 811

NATIONAL HEALTH SERVICE, ENGLAND AND WALES

The Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993

Made 19th March 1993

Coming into force 1st April 1993

The Secretary of State for Health, in exercise of powers conferred on her by section 5(1) of and paragraphs 1, 3, 4, 5 and 6(2)(d) of Schedule 2 to the National Health Service and Community Care Act 1990^[1] and of all other powers enabling him in that behalf, having directed the relevant Regional Health Authority, as defined in section 5(4) of that Act, to consult the persons or bodies referred to in section 5(2) of that Act and having received and considered the results of that consultation, hereby makes the following Order:

Citation, commencement and interpretation

1.—(1) This Order may be cited as the Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993 and shall come into force on 1st April 1993.

(2) In this Order unless the context otherwise requires—
"the Act" means the National Health Service and Community Care Act 1990;

"operational date" has the meaning assigned to it in paragraph 3(1)(e) of Schedule 2 to the Act;

"the trust" means the Walsgrave Hospitals National Health Service Trust established by article 2 of this Order.

Establishment of the trust

2. There is hereby established an NHS trust which shall be called the Walsgrave Hospitals National Health Service Trust.

Nature and functions of the trust

3.—(1) The trust is established for the purpose specified in section 5(1)(a) of the Act.

(2) The trust's functions (which include functions which the Secretary of State considers appropriate in relation to the provision of services by the trust for one or more health authorities) shall be to own and manage hospital accommodation and services provided at Walsgrave Hospital, Clifford Bridge Road, Walsgrave, Coventry CV2 2DX and associated hospitals.

Directors of the trust

4. The trust shall have, in addition to the Chair, 5 non-executive directors and 5 executive directors.

Operational date and accounting date of the trust

5.—(1) The operational date of the trust shall be 1 April 1993.

(2) The accounting date of the trust shall be 31 March.

Restriction on disposal of assets

6. The sum specified for the purposes of paragraph 6(2)(d) of Schedule 2 to the Act (maximum value of freely disposable assets) in relation to the trust shall be £1,000,000.

Virginia Bottomley

Secretary of State for Health

19th March 1993

EXPLANATORY NOTE

(This note is not part of the Order)

This Order establishes the Walsgrave Hospitals National Health Service Trust, an NHS trust provided for in section 5 of the National Health Service and Community Care Act 1990. It also provides for the functions of the trust after (article 3) its operational date (the date on which it assumes all its functions). It specifies the operational date and the accounting date of the trust (article 5). It specifies the value of assets in excess of which the Secretary of State is to consider the disposal of the asset (article 6).

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Appendix 3

STATUTORY INSTRUMENTS

1998 No. 812

NATIONAL HEALTH SERVICE, ENGLAND AND WALES

The Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998

Made

18th March 1998

Coming into force

1st April 1998

The Secretary of State for Health, in exercise of the powers conferred on him by section 126(3) of the National Health Service Act 1977[1] and section 5(1) of the National Health Service and Community Care Act 1990[2] and of all other powers enabling him in that behalf, having completed the consultation prescribed by section 5(2) of that latter Act[3], and considering it appropriate that the functions of the trust should include functions in relation to the provision of services for one or more Health Authorities[4], hereby makes the following Order: -

Citation, commencement and interpretation

1. - (1) This Order may be cited as the Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998 and shall come into force on 1st April 1998.

(2) In this Order -

"the Order" means the Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993[5];

"the trust" means the Walsgrave Hospitals National Health Service trust established by the Order.

Amendment to functions of NHS trust

2. In Article 3(2) of the Order, after the words "Coventry CV2 2DX" there shall be inserted ", the Hospital of St. Cross, Barby Road, Rugby, Warwickshire CV22 5PX, Hollies, Lower Hillmorton Road, Rugby, Warwickshire CV21 3SX and Board Room, Lower Hillmorton Road, Rugby, Warwickshire CV21 3SX".

Signed by authority of the Secretary of State for Health

Alan Milburn

Minister of State Department of Health

18th March 1998

EXPLANATORY NOTE

(This note is not part of the Order)

This Order amends the Order ("the Establishment Order") which established the Walsgrave Hospitals National Health Service Trust.

The Establishment Order is amended to add to the list of premises owned and managed by the trust.

This Order should be read in conjunction with the North Warwickshire National Health Service Trust (Establishment) Amendment Order 1998[6] and the Rugby National Health Service Trust (Dissolution) Order 1998[7].

Notes:

[1] 1977 c. 49; section 126(3) was amended by section 65(2) of the National Health Service and Community Care Act 1990 (c. 19) and by paragraph 57 of Schedule 1 to the Health Authorities Act 1995 (c. 17) ("the 1995 Act").[back](#)

[2] 1990 c. 19; section 5 was amended by paragraph 65 of Schedule 1 to the 1995 Act.[back](#)

[3] *See* S.I. 1996/653, regulation 2(2).[back](#)

[4] *See* section 5(6) of the 1990 Act.[back](#)

[5] S.I. 1993/811.[back](#)

[6] S.I. 1998/814.[back](#)

[7] S.I. 1998/813.[back](#)

ISBN 0 11 065817 5

Appendix 4

STATUTORY INSTRUMENTS

1998 No. 3082

NATIONAL HEALTH SERVICE, ENGLAND AND WALES

The Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998

Made 8th December 1998

Coming into force 21st December 1998

The Secretary of State for Health, in exercise of the powers conferred on him by section 126(3) of the National Health Service Act 1977^[1] and section 5(1) of the National Health Service and Community Care Act 1990^[2] and of all other powers enabling him in that behalf, after completion of the consultation prescribed under section 5(2) of the latter Act^[3], hereby makes the following Order:

Field Code Changed

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Field Code Changed

Citation and commencement

1. This Order may be cited as the Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998 and shall come into force on 21st December 1998.

Amendment of NHS trust Establishment Order

2. In Article 4 of the Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993^[4] for "5 non-executive" there shall be substituted "6 non-executive" and for "5 executive" there shall be substituted "6 executive".

Field Code Changed

Signed by authority of the Secretary of State for Health

Alan Milburn
Minister of State, Department of Health

8th December 1998

EXPLANATORY NOTE

(This note is not part of the Order)

This Order amends the constitution of an NHS trust established by Order under Part I

of the National Health Service and Community Care Act 1990, by increasing the numbers of non-executive and executive directors from 5 to 6 in each case.

Notes:

[1] 1977 c. 49; section 126(3) was amended by section 65(2) of the National Health Service and Community Care Act 1990 (c. 19), [back](#)

[2] 1990 c. 19, [back](#)

[3] *See* S.I 1996/653, regulation 2(3), [back](#)

[4] S.I. 1993/811, [back](#)

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Appendix 5

STATUTORY INSTRUMENTS

1999 No. 1392

NATIONAL HEALTH SERVICE, ENGLAND AND WALES

The Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1999

Made 18th May 1999

Coming into force 1st June 1999

The Secretary of State for Health, in exercise of the powers conferred on him by section 126(3) of the National Health Service Act 1977^[1] and section 5(1) of the National Health Service and Community Care Act^[2] and of all other powers enabling him in that behalf, after completion of the consultation prescribed under section 5(2) of the latter Act^[3], hereby makes the following Order:

Field Code Changed

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Field Code Changed

Citation and commencement

1. This Order may be cited as the Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1999 and shall come into force on 1st June 1999.

Amendment of NHS trust Establishment Order

2. In article 4 of the Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993^[4], for “6 executive” substitute “5 executive”.

Field Code Changed

Signed by authority of the Secretary of State for Health

John Denham
Minister of State, Department of Health

18th May 1999

EXPLANATORY NOTE

(This note is not part of the Order)

This Order amends the constitution of the Walsgrave Hospitals National Health Service Trust, an NHS trust established by Order under Part I of the National Health Service and Community Care Act 1990, by decreasing the number of executive directors from 6 to 5. The amendment is required because the Walsgrave Hospitals National Health Service Trust (Establishment) Amendment Order 1998 (S.I. 1998/3082), in error, increased from 5 to 6 the number of the Trust’s executive directors. Under the National Health Service Trusts

(Membership and Procedure) Amendment Regulations 1998 (S.I. 1998/1975), the maximum permitted number of executive directors of an NHS trust is 5.

Notes:

[1] 1977 c. 49; section 126(3) was amended by section 65(2) of the National Health Service and Community Care Act 1990 (c. 19), by paragraph 57 of Schedule 1 to the Health Authorities Act 1995 (c. 17) (“the 1995 Act”) and by section 41(10) and paragraph 27 of Schedule 2 to the National Health Service (Primary Care) Act 1997 (c. 46).[back](#)

[2] 1990 c. 19; section 5 was amended by paragraph 69 of Schedule 1 to the 1995 Act.[back](#)

[3] See S.I. 1996/653, regulation 2(3).[back](#)

[4] S.I. 1993/811 as amended by S.I. 1998/812 and 1998/3082.[back](#)

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Appendix 6

STATUTORY INSTRUMENTS

2000 No. 2886

NATIONAL HEALTH SERVICE, ENGLAND

The Walsgrave Hospitals National Health Service Trust Change of Name and (Establishment) Amendment Order 2000

Made 20th October 2000
Coming into force 30th October 2000

The Secretary of State for Health, in exercise of the powers conferred on him by section 126(3) of the National Health Service Act 1977^[1] and section 5(1) of the National Health Service and Community Care Act 1990^[2] and of all other powers enabling him in that behalf, after completion of the consultation prescribed under section 5(2) of the latter Act^[3], hereby makes the following Order:

Field Code Changed

Field Code Changed

Field Code Changed

Citation, commencement and interpretation

1. - (1) This Order may be cited as the Walsgrave Hospitals National Health Service Trust Change of Name and (Establishment) Amendment Order 2000 and shall come into force on 30th October 2000.

(2) In this Order -

"the Order" means the Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993^[4];

"the trust" means the National Health Service trust established by the Order.

Field Code Changed

Change of name of NHS trust and transitional provisions

2. - (1) The trust shall be called the University Hospitals Coventry and Warwickshire National Health Service Trust instead of the Walsgrave Hospitals National Health Service Trust, and accordingly in article 1 of the Order in the definition of "the trust", and in article 2 of the Order, for the words "Walsgrave Hospitals" there are substituted the words "University Hospitals Coventry and Warwickshire".

(2) The change of name effected by paragraph (1) shall not -

(a) affect any right or obligation of any person; or

(b) be taken as invalidating any instrument (whether made before, on or after the day on which this Order comes into force) which refers to the trust by its previous name,

and all instruments and other documents which refer to the trust under its previous name shall be construed as if referring to it under its new name.

Further amendments of NHS trust Establishment Order

3. - (1) In article 1 of the Order, in paragraph (2), after the definition of the Act, there shall be inserted -

"community health services" means any services which the Secretary of State may provide under section 3(1)(d) or (e) of or Schedule 1 to the National Health Service Act 1977 and any service which he has a duty to provide under section 5(1) or (1A) of that Act[5];"

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(2) For article 3 of the Order (nature and functions of the trust) there shall be substituted the following article -

" Nature and functions of the trust

3. - (1) The trust is established for the purposes specified in section 5(1) of the Act.

(2) The trust's functions shall be to provide goods and services, namely hospital accommodation and services, and community health services for the purposes of the health service, at or from:

- (a) Walsgrave Hospital, Clifford Bridge Road, Walsgrave, Coventry CV2 2DX;
- (b) Coventry and Warwickshire Hospital, Stoney Stanton Road, Coventry CV1 4FH;
- (c) The Hospital of St. Cross, Barby Road, Rugby, Warwickshire CV22 5PX;
- (d) Hollies, Lower Hillmorton Road, Rugby, Warwickshire CV21 2SX;
- (e) Board Room, Lower Hillmorton Road, Rugby, Warwickshire CV21 3SX,

and at or from any associated hospitals, establishments and facilities."

(3) After article 6 of the Order there shall be added the following article -

" Significant teaching commitment

7. - (1) The trust is to be regarded as having a significant teaching commitment for the purposes of paragraph 3(1)(d) of Schedule 2 to the Act.

(2) One of the non-executive directors of the trust shall be appointed from the University of Warwick."

Signed by authority of the Secretary of State for Health.

Yvette Cooper

Parliamentary Under-Secretary of State for Public Health, Department of Health

20th October 2000

EXPLANATORY NOTE

(This note is not part of the Order)

This Order amends the Walsgrave Hospitals National Health Service Trust (Establishment) Order 1993 ("the Establishment Order") which established the Walsgrave Hospitals National Health Service Trust.

Article 2 of the Order changes the name of the trust to the University Hospitals Coventry and Warwickshire National Health Service Trust. Article 3 substitutes a new article 3 of the Establishment Order (functions of the trust), provides for recognition of the trust as having a significant teaching commitment and for one of its non-executive directors to be appointed from the University of Warwick.

Notes:

[1] 1977 c. 49; section 126(3) was amended by section 65(2) of the National Health Service and Community Care Act 1990 (c. 19) and by paragraph 57 of Schedule 1 to the Health Authorities Act 1995 (c. 17) ("the 1995 Act") and by section 41(10) and paragraph 27 of Schedule 2 to the National Health Service (Primary Care) Act 1997 (c. 46). [back](#)

Field Code Changed

[2] 1990 c. 19. Section 5 was amended by paragraph 69 of Schedule 1 to the 1995 Act and by the Health Act 1999 (c. 8) section 13; paragraph 3 of Schedule 2 was amended by the Health Act 1999 section 13(7); paragraph 6 of Schedule 2 was amended by the Health Act 1999 Schedule 4 paragraph 83(4). [back](#)

Field Code Changed

[3] See S.I. 1996/653. [back](#)

Field Code Changed

[4] S.I. 1993/811, amended by S.I. 1998/812, S.I. 1998/3082 and S.I. 1999/1392. [back](#)

Field Code Changed

[5] Section 5 was amended by and section 5(1A) inserted by the Health and Medicines Act 1988 (c. 49) section 10(1); Schedule 1 was amended by the Education Act 1980 (c. 20), Schedule 1, and the Health and Medicines Act 1988 (c. 49); Schedule 2, paragraph 7. [back](#)

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ISBN 0 11 018709 1

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Employee Relations Report
Executive Sponsor	Karen Martin, CWIO and Deputy Chief Executive
Author	Wendy Bowes, Associate Director of Workforce
Attachment	Employee Relations Report
Recommendation	To NOTE the Report

EXECUTIVE SUMMARY

This report provides an overview of the Trust's Employee Relations cases during the period November 2018 to April 2019, including an analysis of the number and type of case, including demographics.

The purpose of the report is to provide assurance to Trust Board that Employee Relations cases are managed in a timely, effective and compassionate way. Employee Relation Cases include suspensions, employment tribunals, disciplinary cases, formal MHPS investigations, grievances, performance management and mediation.

The report seeks to provide assurance that action is taken to address inappropriate behaviour or conduct and to support staff that may be experiencing performance issues. Trust Board members are asked to provide support by giving assurance to their teams that action is taken to address concerns when they are raised and to encourage staff to report incidents of concern.

During the reporting period there have been:

- 26 Disciplinary Investigations
- 5 Suspensions (Please note that there is currently 1 suspension)
- 7 Dismissals
- 10 Grievances
- 7 Employment Tribunal Claims

PREVIOUS DISCUSSIONS HELD

A previous paper presented to the Trust Board in November 2018 provided an update on employee relation activities for the period May – November 2018. The purpose of this paper is to provide an update for the period November 2018 – April 2019.

KEY IMPLICATIONS	
Financial	Fair and consistent HR policies and practice ensures that the Trust meets its objective to be a model employer and minimises financial risk through lost time and tribunal claims.
Patients Safety or Quality	\
Human Resources	Fair and consistent HR policies and practice ensures that the Trust meets its objective to be a model employer.
Operational	\

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

REPORT TO TRUST BOARD

Employee Relations Report

1. INTRODUCTION

- 1.1 This report provides an overview of the Trust's Employee Relations cases during the period November 2018 to April 2019, including an analysis of the number and type of case, including demographics.
- 1.2 The purpose of the report is to provide assurance to Trust Board that Employee Relations cases are managed in a timely, effective and compassionate way. Employee Relation Cases include suspensions, employment tribunals, disciplinary cases, formal MHPS investigations, grievances, performance management and mediation.
- 1.3 The report seeks to provide assurance that action is taken to address inappropriate behaviour or conduct and to support staff that may be experiencing performance issues. Trust Board members are asked to provide support by giving assurance to their teams that action is taken to address concerns when they are raised and to encourage staff to report incidents of concern.

2. CONTENT

- 2.1 A previous paper presented to the Trust Board in November 2018 provided an update on employee relation activities for the period May – November 2018. The purpose of this paper is to provide an update for the period November 2018 – April 2019.

2.2 Governance

The team utilise a range of methods to ensure that the processes are robust including:

- A Case Management Tracker, detailing all disciplinary, grievance and performance management cases including named responsible officers, milestones and outcomes
- Monthly Case Management Reviews with attendance by the full Workforce Operational team
- A weekly “screening” process for all new non-medical staff potential cases to ensure consistency of approach and the identification of lead investigating managers and support
- Fortnightly meetings to discuss all Medical Staff Concerns, with attendance of the CMO/CWIO, Associate Director of Workforce and Deputy CMO's to ensure consistency of all new potential medical staff cases and to ensure that any investigation is conducted in accordance with Maintaining High Professional Standards (MHPS)
- A designated Board Member (Non-Executive Director) who will oversee all MHPS investigations
- Regular reporting of the number of cases, demographics and themes to the Partnership and Engagement Forum, JNCC and the Chief Officers Forum

The Workforce team will undertake case reviews to identify lessons learned in specific cases e.g. when an appeal panel overturn a disciplinary panel decision or following any recommendations from Employment Tribunal decisions.

2.3 Key Findings – Disciplinary Investigations

2.3.1 Analysis by Staff Group:

Staff Group	No. of Disciplinary Investigations undertaken
Additional Clinical Services	4
Administrative and Clerical	9
Medical and Dental	1
Nursing and Midwifery Registered	12
Grand Total	26

2.3.2 Analysis by Group

The highest numbers of cases were within the Medicine Group, with a total of 7 cases, all relating to misconduct/inappropriate behaviour.

Department	No. of Disciplinary cases
Clinical Support	4
Medicine	7
Core	4
Clinical Diagnostics	3
Trauma and Neuro Services	3
Surgery	1
Emergency Medicine	3
Women & Children's	1
Grand Total	26

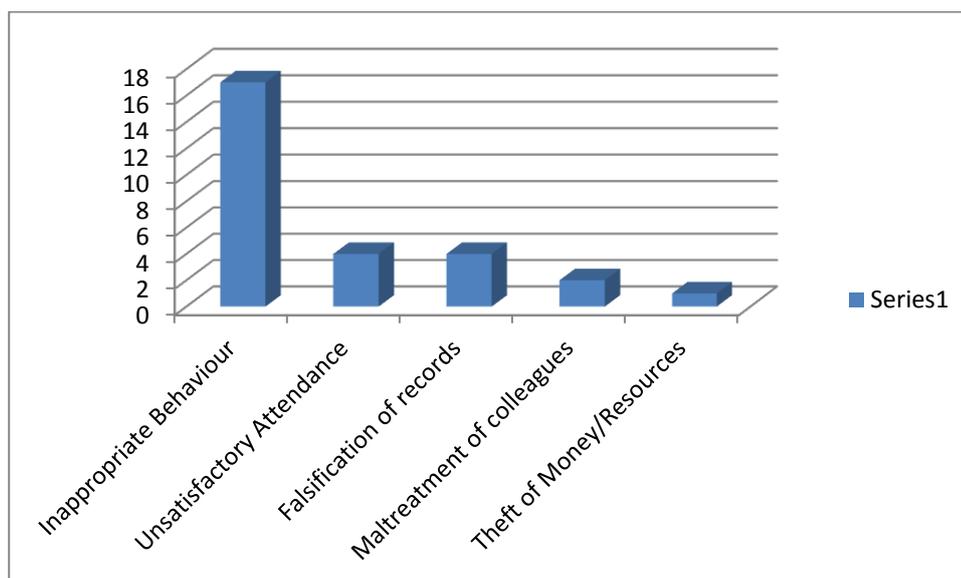
2.3.3 Analysis by Gender

50% of the cases involved females and 50% involved males.

2.3.4 Analysis by Ethnicity

Ethnic Origin	Disciplinary cases
White - British	16
White - Irish	1
Black or Black British African	1
Black or Black British Caribbean	1
Asian or Asian British - Indian	3
Not Stated	4
Grand Total	26

2.3.5 Analysis of Themes of Disciplinary Investigations:



The main reasons for disciplinary investigations relate to misconduct and inappropriate behaviour. Examples include:

- Inappropriate use of CRRS
- Inappropriate use of social media
- Failure to comply with Trust policies

The Trust routinely issues reminders to staff about these key issues in Trust wide communications and the Workforce Newsletter.

Depending on the severity of the issue, informal action will be taken where appropriate to educate and make staff aware of their responsibilities. In more serious cases or where informal action has not been successful, formal action will be pursued.

The appropriate use of CRRS has been a challenge for the Trust as there have been 4 investigations related to this during the November 2018 to April 2019 period. During the last report, it was highlighted that the inappropriate use of social media was a concern, but this has however reduced from 7 investigations during that monitoring period down to 1 in this period.

2.4 Key Findings - Disciplinary Outcomes

In total, there were:

- 2 members of staff received informal action
- 4 Final Written Warnings was issued
- 7 Dismissals
- All other investigations remain ongoing.
- 57% of those dismissed were male and 85% of those dismissed were white.

2.5 **Key Findings - Suspensions by Staff Group**

- 2.5.1 A suspension (or exclusion for medics) will take place if there is an allegation of potential gross misconduct and when there the employee's presence constitutes a serious risk to themselves, patients or other employees. Whilst technically a suspension is not considered as disciplinary sanction and is not a presumption of guilt, we recognise that any suspension can be damaging to both the individual affected and the longer-term employment relationship between the individual and the Trust. It is imperative therefore that suspensions only occur when all other options (such as temporary redeployment or move to a different area) have been considered and rejected. It is also crucial that any suspension is only undertaken for the minimum period of time, that the investigation is completed as a priority and that regular and meaningful contact with the individual is maintained throughout, including the regular review of the suspension and consideration if the suspension can be lifted. All appropriate support should also be provided including Occupational Health, staff side representation and support from their manager and the Workforce Operational team. A suspension checklist has been put in place to ensure that all options are fully explored before any member of staff is suspended and a key professional lead is always involved in suspension decisions.
- 2.5.3 During November 2018 – April 2019, there have been 5 suspensions across the Trust. Of these, 4 suspensions have resulted in dismissals, and 1 Final Written Warning.
- 2.5.4 The reasons for suspensions relate to; theft (2), falsification of records (2) and sharing records (1).
- 2.5.5 From the total number of suspensions; there was 1 Midwife, 1 ODP, 1 AHP, 1 Nurse, and 1 Technician.
- 2.5.6 The gender ratio of suspensions is 40% (2) male and 60% (3) female.
- 2.5.7 The ethnicity of the majority of staff on suspensions are 60% White British (3), followed by Asian British 20% (1), and Asian Indian 20% (1).
- 2.5.8 The total number of suspensions has reduced by 3 suspensions from the previous review period May 2018 – October 2018.
- 2.5.9 For information, the position in May 2019 is that there is 1 individual suspended from the Trust and a disciplinary hearing will be held before the end of May 2019.

2.5.10 **Suspensions by Department:**

Department	May 18 – Oct 18 Number	Nov 18 – Apr 19 Number
Bowel Cancer Screening	1	
Emergency Department	1	
Labour Ward	1	1
Ophthalmology	-	1
PALS	1	
Pathology	2	1
Sterile Services	1	1
Theatres	1	1

Total	8	5
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2.5.11 Suspensions by Gender:

	May 18 – Oct 18	Nov 18 – Apr 19
Gender	Percentage	Percentage
Male	50% (4)	40% (2)
Female	50% (4)	60% (3)

2.5.12 Suspensions by Ethnicity:

	May 18 – Oct 18	Nov 18 – Apr 19
Ethnicity	Percentage	Percentage
White British	75% (6)	60% (3)
Asian British	12.5% (1)	20% (1)
Asian Indian	-	20% (1)
Not Stated	12.5% (1)	-

2.6 **Key Findings – Grievances**

2.6.1 There were 10 grievances investigated during the specified time period. 30% of these were raised by Admin/Clerical staff, 20% by AHPs and 30% by nursing staff, 10% by Senior Management, and 10% by Technicians.

2.6.2 70% of those whom raised a grievance were female, 20% were men and 10% were raised collectively.

2.6.3 60% of those whom raised a grievance were White British by ethnicity, 30% were Asian British – Indian and 10% were collective.

2.7 **Key Findings – Formal Mediations**

2.7.1 There were a total of 8 mediation cases during the specified time period, compared to 2 during the previous period.

2.8 **Key Findings – Employment Tribunals**

2.8.1 During the reporting period there have been 7 Employment Tribunal claims:-

Staff Group	Demographic	Reason	Outcome
Medical	Male	Unfair Dismissal Disability Discrimination	Ongoing
Medical	Female	Racial and sexual victimisation	Ongoing
ISS (RoE)	Female	Unfair Dismissal Disability Discrimination Race Discrimination	Ongoing – now completed. The Trust was successful in defending this claim.

Nursing	Female	Unfair Dismissal Disability Discrimination Less Favourable Treatment of Part Time Workers	Ongoing
Nursing	Female	Unfair Dismissal Disability Discrimination	Ongoing
BMS x 9	Female and Male	Wages claim	Withdrawn
BMA	Female	Unfair Dismissal Disability Discrimination	Ongoing

3. CONCLUSION

This report has provided an overview of the Trust's approach to managing employee relation cases and also provided an analysis of the number and type of case during the period November 2018 to April 2019 including demographics.

The report has highlighted that regular and repeated key messages to staff are important and that the Trust provides a robust and fair system for managing employee relations issues.

4. RECOMMENDATIONS

The Board is invited to **note** this report on the detail of employee relation activity within the last 6 months.

Name and Title of Author: Wendy Bowes, Associate Director of Workforce

Date: 20th May 2019

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Register of Interests 2019/20 and Gifts/Hospitality 2018/19
Executive Sponsor	Andy Meehan, Chair
Author	Rebecca Hough Head of Corporate Affairs
Attachments	Register of Interest 2019/20 Register of Gifts, Hospitality and Sponsorship received during 2018/19
Recommendations	The Trust Board is asked to APPROVE the register of interests and register of gifts and hospitality and NOTE the requirement to declare interests and any gifts/hospitality received on an on-going basis.

EXECUTIVE SUMMARY

In accordance with the NHS Code of Accountability, the Trust's Standing Orders and the Managing Conflicts of Interest in the NHS; Interests, Gifts, Sponsorship and Hospitality Policy & Procedure, the Trust is required to hold and maintain a Register of Interests and a Register of Gifts and Hospitality, and to make these available for public inspection.

In addition to meeting regulatory requirements, declaring any relevant interests, benefits and hospitality received in connection with an individual's employment at the Trust is in keeping with the Trust's openness value and supports the transparency agenda, thereby promoting public confidence in the organisation. It also evidences that there are processes in place to ensure compliance with statutory and regulatory requirements, including those of the Bribery Act 2010.

For the purpose of this report, the attached extract from the registers of interests and gifts and hospitality only details the interests of members of the Trust Board, although both registers contain relevant declarations made by other members of Trust staff. Board members are asked to declare any interests that they have that are relevant to their role as a Board member upon appointment, at each meeting of the Trust Board and also on an annual basis. Board members are also reminded of their on-going responsibility to declare interests to the Director of Corporate Affairs at the point that they arise during their tenure.

The Trust is required to publish its Register of Interest and this can be found on the Trust website using the link: <https://www.uhcw.nhs.uk/our-organisation/annual-report/>.

There has been one receipt of hospitality by a member of the Trust Board. All staff are however required to declare any gifts or hospitality received in the course of their employment, as described in the policy, and a corresponding entry is then made on the register. Staff are reminded of the requirement to declare interests, gifts and hospitality on an annual basis and the full registers are scrutinised at the Audit Committee on an annual basis.

There are no specific risks highlighted within the paper; the risk relates to failing to have processes for making declarations and registers in place, in that this does not comply with regulatory and statutory requirements and could adversely impact on the Trust's reputation and standing.

PREVIOUS DISCUSSIONS HELD

None - In accordance with the transparency, openness and accountability agenda, the Trust Board receives this report on an annual basis.

KEY IMPLICATIONS

Financial	\
Patient Safety or Quality	\
Human resources	\
Operational	\

Conflicts of Interest Register

Surname	Forename	Job Title	Directorships	Ownership	Shareholdings	Charity or Voluntary Organisations	NHS Service Contracts:	Research Funding/Grants	Pooled Funds	Paid employment, office, profession:
Buckley	Ian	Non-Executive Director	Director- Whitehall Manor Maintenance Ltd, Property management	None	None	Trustee - UHCW charity	Consultant/facilitator leadership Trust. Guest lecturer - Bristol Business School	None	None	None
de Boer	Richard	Deputy Chief Medical Officer	None	None	None	None	None	None	None	None
Gould	Jeremy	Non-Executive Director	None	None	None	None	Birmingham Community Healthcare NHS Foundation Trust - Non-Executive Director (Date arose July 2012)	None	None	None
Hardy	Andy	Chief Executive Officer	None	None	None	Director/ Trustee Albany Theatre Trust (Date Arose: April 2015) Board member of CIPFA and Trustee (Date Arose: June 2017)	None	None	None	None
Kelly	Lisa	Chief Operating Officer	None	None	None	Trustee of GAPD - African charity for improving anaesthesia (Date Arose: Dec 2017)	None	None	None	None
Kumar	Sudhesh	Non-Executive Director	None	Medinova Ltd - Shareholder	Medinova Ltd - Shareholder (Minority shareholding only)	Various bodies including MRI, NIHR, Wellcome etc - Head of Department, responsible for receiving grants	None	None	None	Dean of Medicine, University of Warwick. Non-Executive Director, NHS Digital
Macalister-Smith	Ed	Non-Executive Director	None	None	None	None	None	None	None	Occasional day-rate work (none for past 12 months) with CQC as IRR
Martin	Karen	Chief Workforce & Information Officer	Director of Qgov Consultancy	None	None	None	None	None	None	None
Mawby-Groom	Jenny	Associate Non-Executive Director	None	None	None	None	None	None	None	None
Meehan	Andrew	Chairman	Director - Lanthorne Ltd- Business Consultancy Chair - Ramsden Holdings PLC (Date arose Sept 2014) Chair - NEF Holdings Ltd (Date arose 01 April 2019) Director - Cheviot Court (Luxborough Street) Ltd (Date arose 2003)	None	None	Chair of Coventry Cathedral Council Chairman of UHCW Charity Chair - Mayday Trust Pro Chancellor and Deputy Chair - Coventry University	None	None	None	Former Director of Direct Healthcare Services Group which sells various types of equipment into health and social care sectors to prevent, amongst other things, pressure sores and related tissue viability problems 1% equity stake retained
Morgan	Nina	Chief Nursing Officer	University Hospital Coventry & Warwickshire charity Date Arose: 29/12/2017	None	None	None	None	None	None	None
Richards	Justine	Chief Strategy Officer	None	None	None	None	None	None	None	None
Rollason	Susan	Chief Finance Officer	None	None	None	None	None	None	None	None
Sheils	Brenda	Non-Executive Director	None	None	None	Trustee NACRO (National Association for the Care & Rehabilitation of Offenders). Date arose February 2017.	Trustee NACRO (National Association for the Care & Rehabilitation of Offenders). Date arose February 2017.	None	None	Director; Sheils Associates LTD. Provides mentoring/coaching/education & consultancy. Not provided for any NHS organisations.

Gifts, Sponsorship and Hospitality Register 2018-19

Surname	Forename	Job Title	Date gift/benefit rec'd	Source of Gift or benefit	Nature of gift/benefit	start/end date of visit	Date Declared	Destination	Event details	Purpose of visit	Annual leave taken for visit (Y/N/NA)	Study leave taken for visit (Y/N/NA)
Ahmed	Imtiaz	Consultant Dermatologist	09/08/2018	Organised one day surgical workshop, with commercial sponsorship Pharmaceutical sponsors for meetings and events Pharmaceutical sponsor	Sponsorship to support the workshop No direct payment to me or the department. Any monies go to trust fund Payments for speaker and organising meetings	19th, 20th October 2017 2001 2001-2014	10/10/2018	Manchester psoriasis update	Psoriasis update organised by Janssen	Educational update	N/A	Yes
Anderson	Neil	Group Clinical Director	26/08/2018	Abbott Diagnostics	Sunday evening, Flight from UK to Chicago Monday day, Meet with Abbott Execs Monday evening, return flight to UK	26/08/2018 - 28/08/2018	13/08/2018	Chicago	Day meeting with Abbott Diagnostics to discuss R&D (equipment and assays) with company executives	To gain insight into company R&D programme; to assess value to future potential strategic partnership	No	N/A
Andreatta	Walter	Consultant Ophthalmologist	01/06/2018	Patient	M&S gift card - £10 - Handed over to Sister in charge. Agreed to spend on food for Team and receipt provided to Sister regarding spending. Food left on Staff Room Table for Team to enjoy.	N/A	22/10/2018	N/A	N/A	N/A	N/A	N/A
Arastu	Mateen	Consultant Trauma and Orthopaedic Surgeon	26/04/2018	DePuy Synthes	Course attendance Complex wrist trauma course - Cadaveric Hamburg, Germany. Hotel and travel provided - cost unknown	26-27th April 2018	19/04/2018	Cadaveric Hamburg, Germany	Course attendance Complex wrist trauma course	Course attendance Complex wrist trauma course	No	Yes
Balasubramanian	Shyam	Consultant in Pain Medicine & Anaesthesia	22/11/2018	Platform-14, Medical Devices, 65 Bath Road, Stroud, Gloucestershire, GL5 3LA	Sponsorship to attend a cadaver workshop (pain intervention course) in Hamburg. Travel and Accommodation paid by the sponsoring company.	21/11/2018 - 23/11/2018	02/12/2018	Hamburg	Hands-on workshop on cooled radiofrequency denervation (a technique used for managing chronic pain)	Learn an interventional pain skill. We already have the kit in our hospital and other colleagues are offering the treatment. This training will help me offer the procedure for patients with joint pain	Yes	Yes
Barker	Thomas	Consultant Cardiac Surgeon	22/05/2018	Patient	Tie and silver cufflinks	N/A	22/05/2018	N/A	N/A	N/A	N/A	N/A
Barua	Ankur	Consultant Ophthalmologist	14/06/2018	European Society of Cataract & Refractive Surgeons (ESCRS)	Sponsorship, £2000	22-26 Sep 2018	25/10/2018	Vienna	ESCRS meeting in Vienna - for educational purposes (conference) over 4 days sponsored by Santen. Accommodation, travel, food and conference fees provided		N	Yes
Chohan	Ik-Onkar	Physiotherapist	01/06/2018	Patient	£10 M&S gift card; handed over to sister in charge. Agreed to spend on food for team.	N/A	01/06/2018	N/A	N/A	N/A	N/A	N/A
De Boer	Richard	Chief Medical Officer	17/05/2019	Local Medical Committee	Hospitality - Food	N/A	23/05/2019	N/A	N/A	N/A	No	No
Echebarria	Juan Jose	Consultant Anaesthetist	19/07/2018	Natalie Carter, AMBU UK.	No sponsorship required as the course was offered free of charge. No approval required as no sponsorship was accepted.	24/10/2018-26/10/2018	10/02/2019	N/A	Course on Thoracic Anaesthesia	N/A	No	No
Grammatopoulos	Dimitris	Consultant Professor in Clinical Biochemistry	26/08/2018	Abbott Diagnostics	Sunday evening, Flight from UK to Chicago Monday day, Meet with Abbott Execs Monday evening, return flight to UK	26/08/2018 - 28/08/2018	15/08/2018	Chicago	Day meeting with Abbott Diagnostics to discuss R&D (equipment and assays) with company executives	To gain insight into company R&D programme; to assess value to future potential strategic partnership	No	N/A
Haile	Ermias	CT Radiographer	16/05/2018	Patient - for finding lost necklace	£100 - shared between 4 x staff	N/A	25/05/2018	N/A	N/A	N/A	N/A	N/A
Hillermann	Carl	Consultant Anaesthetist	11/09/2018	Pajunk	Travel, accommodation and course fees were subsidised to attend the conference	11 - 14/09/2018	25/09/2018	Dublin	European Soc. of Regional Anaesthesia annual conference in Dublin	To update CPD and to stay update with new advances in regional anaesthesia. Some of which can be applied at UHCW	No	No
Hussain	Rahim	Locum Consultant Neurosurgeon	13/11/2018	Stryker Company	TRAVEL & ACCOMMODATION	13-14/10/2018	05/10/2018	Cologne, Germany	Stryker advances in technologies and techniques: mis spine solutions	Learn the minimally invasive techniques in spine surgery	No	Yes
Jones	Katie	CT Radiographer	16/05/2018	Patient - for finding lost necklace	£100 - shared between 4 x staff	N/A	25/05/2018	N/A	N/A	N/A	N/A	N/A
King	Richard	Consultant Orthopaedic Surgeon	13/06/2018	Biocomposites PLC	Dinner	13/06/2018	17/06/2018	N/A	Educational event	to discuss bone infection issues	N/A	N/A
King	Richard	Consultant Orthopaedic Surgeon	12/10/2018	Corin Group PLC	Fee received for educational services provided in my personal time	11 October 2018 (1 day)	12/10/2018	ISTA conference, London, UK	I went to ISTA to present a paper. In the evening I contributed to an educational event put on by Corin	I went to ISTA to present a paper. In the evening I contributed to an educational event put on by Corin	No	No
Kitchen	Richard	Consultant in Palliative Medicine	16/11/2018	Oxford Centre for Education and Research	£500 honoarium paid. It was agreed I could keep £250 and give £250 to the trust for our team's educational fun.	01/08/2018	16/11/2018	Oxford Centre for Education and Research OxCERPC: Sobell House.		For giving two presentations at the Advanced Pain and Symptom Management Course (a national palliative care course).	Yes	Yes
Madden	George	Consultant Anaesthetist	12/09/2018	Next of kin - patient	Bottle of Whisky	N/A	12/09/2018	N/A	N/A	N/A	N/A	N/A
Marshall	Katharine	Locum Consultant Oncologist	11/03/2019	Novartis - Pharmaceutical Company (Dabrafanib and Trametanib).	Received Honorarium for speaker services at educational meeting.	11/03/2019	08/04/2019	N/A	Acted as Chairperson for an educational meeting.	N/A	No	No
Marshall	Katharine	Locum Consultant Oncologist	30/04/2019	Pierre-Fabre Pharmaceutical Company.	Received Honorarium for speaker services.	30/04/2019	08/04/2019	N/A	Speaker / chair services for an education meeting	N/A	No	No

Surname	Forename	Job Title	Date gift/benefit rec'd	Source of Gift or benefit	Nature of gift/benefit	start/end date of visit	Date Declared	Destination	Event details	Purpose of visit	Annual leave taken for visit (Y/N/NA)	Study leave taken for visit (Y/N/NA)
Millerchip	Sue	Lead Nurse Acute Pain	11/09/2018	Pajunk UK	Assistance with funding to attend ESRA for professional development purposes	11 - 14/09/2018	25/09/2018	Dublin	European Society of Regional Anaesthesia and Analgesia	To gain further relevant professional knowledge	No	Yes
Overington	Adele	CT Assistant	16/05/2018	Patient - for finding lost necklace	£100 - shared between 4 x staff	N/A	25/05/2018	N/A	N/A	N/A	N/A	N/A
Pye	Eleanor		01/11/2019 01/04/2018 05/03/2018 12/11/2018	Accommodation and registration fee for "At the limits" MS conference. Prof Giovannoni, Barts and The London School of Medicine and Dentistry. Pharma Industry sponsors underwrite and support this event which is free to healthcare professionals. Hospitality at the Holiday Inn in order to provide a regional SpR training day in neurology – one-off costs. Numerous Pharma Industry sponsors who had no input into the content or agenda of the day. Usually 2 -3 sponsors per training day Hospitality at the Holiday if for half-day, off-site MS team meetings held 2 – 3 times per year. Various Pharma sponsors – different for each meeting. Sponsors have no input to the agenda/content of the meeting and are no in attendance for the majority of the meeting.	One-off to attend MS conference Full costs not disclosed to me but settled by my pharma colleagues, in the region of £600. Full costs not disclosed to me but settled directly with the Holiday Inn. Will have been in the region of £300 for each meeting.	N/A	28/12/2018	N/A	N/A	N/A	N/A	Yes
Ramoutar	Darryl	Consultant Trauma and Orthopaedic Surgeon	26/04/2018	DePuy Synthes UK	Sponsorship (course fees)	N/A	03/08/2018	N/A	AO Current Concepts Course, Coventry	N/A	No	Yes
Reece	Rachel	Tissue viability nurse	01/10/2018	Covatec	Assembling and printing of Tissue viability link worker handbook	N/A	16/10.18	N/A	N/A	N/A	N/A	N/A
Saravana	Shanmugam	Consultant Rheumatologist	01/09/2018	Drug company	Sponsored a continual medication event (CME) meeting	7/9/2018–8/9/2018	03/10/2018	London	Rheumatology CME meeting	CME	No	Yes
Stuart-Thomas	Emma	Rehabilitation Co-ordinator	25/06/2018	Patient previously in ICU	Dyson Cool Fan for ICU	N/A	25/06/2018	N/A	N/A	N	N	N
Verdon	Amy	Tissue Viability CNS	15/11/2018	Talley medical	Mirrors and product literature for staff training on assessment of skin to detect pressure ulcers	N/A	19/10/2018	N/A	N/A	N/A	N/A	N/A
Vincent	Leonie	CT Radiographer	16/05/2018	Patient - for finding lost necklace	£100 - shared between 4 x staff	N/A	25/05/2018	N/A	N/A	N/A	N/A	N/A

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Trust Seal Register 2018/19
Executive Sponsor	Andy Meehan, Chairman
Author	Rebecca Hough, Head of Corporate Affairs
Attachment	Register – Signings and Sealing’s
Recommendation	The Board is asked to NOTE the usage of the common seal of the Trust 2018/19.

EXECUTIVE SUMMARY

The report sets out the usage of the common seal of the Trust during the year 2018/19 and is provided for noting.

The common seal of the Trust is affixed when a document needs to be executed as a deed as opposed to a simple contract. Affixation is governed by the Trust’s Standing Orders, which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board. This report therefore satisfies these requirements in that it details each time the seal has been affixed during the year 2018/19.

There are no areas of risk as corporate governance requirements are satisfied through the submission of this report.

The seal is kept in safe custody by the Director of Corporate Affairs and is affixed in line with the requirements laid out in the Standing Orders, which are aimed at preventing it from misuse.

PREVIOUS DISCUSSIONS HELD

A report detailing the use of the common seal of the Trust is reported to the Trust Board on an annual basis and was last presented in April 2017.

KEY IMPLICATIONS

Financial	\
Patients Safety or Quality	\
Human Resources	\
Operational	\

Register of Sealings 2018/19					
Consecutive Number	Date of Sealing	Description of document sealed	Names and titles of persons attesting sealing	Dissemination of Document:	Name of Solicitor
307	07.01.2019	Provision of Energy and Energy Management Facilities at UHCW and Hospital of St Cross	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer	Lincoln Dawkin	Bevan Brittain
308	05.03.2019	Licence for Alterations by Undertenant - Gentian and Stock Shop	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
309	05.03.2019	Licence for Alterations by Undertenant - Gentian and Stock Shop	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
310	05.03.2019	Licence for Alterations by Undertenant - Gentian and Stock Shop	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
311	05.03.2019	Licence to Underlet Gentian - Stock Shop	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
312	05.03.2019	Licence to Underlet Gentian - Stock Shop	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
313	05.03.2019	Licence to Underlet Gentian - Stock Shop	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
314	28.03.2019	Licence to Assign - Gentian	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Pinsent Masons
315	28.03.2019	Deed of Variation to Project Agreement for CHP scheme	Mr Andrew Meehan, Chairman Professor Andrew Hardy, Chief Executive Officer		Bevan Brittain

REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019

Subject Title	Declaration of Compliance against the NHS Provider Licence
Executive Sponsor	Andy Hardy, Chief Executive Officer
Author	Geoff Stokes, Director of Corporate Affairs
Attachments	Self certification – G6 (4) Self certification Condition - FT4 declaration
Recommendations	Trust Board is invited to: <ol style="list-style-type: none"> 1. NOTE the requirement to make a declaration against conditions G6(3) and FT4(8) of the Provider Licence and the self-assessment process that has been undertaken 2. CONSIDER the robustness of the evidence that is in place against each condition and the recommendation of the Director of Corporate Affairs 3. RAISE any questions or concerns 4. DETERMINE whether compliance can be declared 5. AUTHORISE the Director of Corporate Affairs to complete the self-certify and publish the statement onto the Trust website

EXECUTIVE SUMMARY

The NHS Provider Licence was introduced in 2013 as part of the Foundation Trust Regime and replaced the former authorisation process. Whilst NHS Trusts are exempt from holding a Provider Licence, the Secretary of State requires NHSI to ensure that trust's comply with the conditions set out in the licence that are relevant to NHS trusts. The requirement links to the NHSI Single Oversight Framework and the Well Led framework and is a new requirement for this year. Providers will then be selected at random to provide evidence to support a declaration of compliance.

NHSI have requested that providers carry out a self-assessment process of their compliance condition G6 and FT4 of the licence by 31st May and 30th June 2019 respectively. NHSI have not set out a single approach that must be adopted by organisations but have issued guidance which states that Trust Boards must assure themselves that the Trust complies with the requirements set out within each of the conditions before a declaration of compliance can be made.

The relevant licence conditions comprise the following:

Condition	Requirement
G6(3)	The licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS constitution.
FT4 (8)	Providers must certify compliance with required governance standards and objectives through:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence and (b) regular review of whether these processes and systems have been implemented and of their effectiveness.
--

The Director of Corporate Affairs has considered each of the requirements and has reviewed the evidence that is available against each of these. A table of that evidence is considered relevant to each requirement is attached to this paper to aid the Trust Board's decision making around whether compliance can be declared.

The provisions of the Single Oversight Framework, which is the framework by which NHSI assess NHS Trusts have also been reviewed and are cross referenced within the appendix. The five themes outlined in the Single Oversight Framework are as follows:

- Quality of Care
- Finance & Use of Resources
- Operational performance
- Strategic change
- Leadership

In the view of the Director of Corporate affairs, the Trust is able to demonstrate that a robust system of corporate governance in place, which has been subject to independent assessment and on the basis of the evidence available, would recommend to the Trust Board that compliance be declared.

If the Trust does not have appropriate systems of governance in place, risk may not be properly identified and mitigated, which could lead to patient and staff safety incidents, failures to meet financial and performance targets, failure to comply with regulatory and statutory duties and reputation damage. The systems and processes that are in place as described in this paper are intended to mitigate this risk.

NHSI will audit selected providers to ensure the G6 self-certification is uploaded onto the Trust website.

The Trust is obliged to comply with constitutional standards and regulatory requirements and the role of the Trust Board is to ensure that there are appropriate systems and processes in place to monitor compliance and ensure that risks are identified and acted upon.

PREVIOUS DISCUSSIONS HELD

May 2018 – this reported is presented on annual basis

KEY IMPLICATIONS

Financial	\
Patient Safety or Quality	\
Human resources	\
Operational	\

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates

2018-19

Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name: []

Name: []

Capacity: [job title here]

Capacity: [job title here]

Date: []

Date: []

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

[]

Worksheet "FT4 declaration"

Financial Year to which self-certification relates

2019-20

Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

Corporate Governance Statement	Response	Risks and Mitigating actions
1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust Board provides appropriate oversight of governance across the Trust, overseen by the Audit Committee. This is described in the Annual Governance Statement which forms part of the Annual Report. The Trust Board reviews its list of statutory functions on an annual basis.
2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust regularly refreshes its policies and processes in line with NHSI and other guidance.
3 The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board Committee structure is reviewed regularly with Terms of Reference of committees being reviewed regularly
4 The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board receives an integrated performance, quality and finance report at each meeting and is sighted on key performance challenges. The Board Assurance Framework is presented every other Board meeting, along with the Corporate Risk Register to ensure that Board members are sighted on the key risks to strategy and the operations of the Trust The Audit Committee oversees the governance framework for the Trust, including receiving reports from both Quality Governance Committee and Finance and Performance Committee on their respective effectiveness. This is then assessed and reported to the Board.

#REF!

#REF!

#REF!

#REF!

- 5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:
- (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
 - (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
 - (c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
 - (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
 - (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
 - (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Confirmed

Remuneration Committee, which comprises all the non-executive directors and chaired by the Chairman, reviews the capacity and capability of the Board. It also receives reports relating to succession planning to assess the resilience, capability and capacity of the rest of the senior management cadre.

The Quality Governance Committee oversees the quality governance aspects of the Trust and ensures that quality and safety are maintained, providing assurance to the Board.

The Board receives patient stories at each meeting and non-executive directors and chief officers regularly participate in ward walk-rounds across the Trust.

#REF!

- 6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Confirmed

Remuneration Committee, which comprises all the non-executive directors and chaired by the Chairman, reviews the capacity and capability of the Board. It also receives reports relating to succession planning to assess the resilience, capability and capacity of the rest of the senior management cadre.

#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name:

Name:

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

**REPORT TO PUBLIC TRUST BOARD
HELD ON 30 MAY 2019**

Subject Title	Raising Concerns policy – extension request
Executive Sponsor	Geoff Stokes, Director of Corporate Affairs and Acting Director of Quality
Author	Geoff Stokes, Director of Corporate Affairs and Acting Director of Quality
Attachment	None
Recommendation	Trust Board is asked to APPROVE the extension of the Raising Concerns – Freedom to Speak up Policy

EXECUTIVE SUMMARY

The Raising Concerns: Freedom to Speak Up Policy was approved by the Trust Board on 30 March 2017. It was due for review in February 2019 but unfortunately this review has not taken place and approval is sought to extend the current policy for a further six months to enable a full review to take place by the newly appointed Freedom to Speak up Guardian, Lorna Shaw, who formally takes up her role on 24 June 2019.

If this request is approved, then the revised policy will be scheduled for formal approval at the Board meeting on 28 November 2019.

PREVIOUS DISCUSSIONS HELD

None.

KEY IMPLICATIONS

Financial	None relevant to this report.
Patient Safety or Quality	None relevant to this report.
Human resources	None relevant to this report.
Operational	None relevant to this report.

**REPORT TO TRUST BOARD
HELD ON 30 May 2019**

Audit Committee Report following the meeting held on 11 April 2019
Chair of the Committee: Jerry Gould
Was this meeting quorate: Yes
Purpose: This report is to provide assurance that the Audit Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to RECEIVE ASSURANCE from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
<u>Key Issue discussed</u>	<u>Resolution or outcome of discussion</u>
Draft Annual Governance Statement	The Committee reviewed the draft committee and will formally recommend acceptance to Board at the extraordinary meeting on 24 May 2019
Draft Annual Report and Quality Accounts 2018/19	The Committee agreed that in future the draft report won't be brought to the Audit Committee; instead an update on the timetable will be provided.
Internal audit report – agency bookings	The Chief Workforce and Information Officer presented an update following the internal audit report, demonstrating to the Committee the progress has been made. A particular issue raised about looking 'upstream' at the cause for agency bookings.
Clinical Audit Performance Update	The report highlighted performance at quarter 3 against the programme during 2018/19. The Committee raised concerns about the level of clinical engagement in the audit programme and the impact operational decision had on its delivery.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
<u>Item or issue</u>	<u>Purpose for escalation</u>	<u>Escalated to</u>
Clinical Audit Performance Update	To address the concern raised regarding the extent to which operational arrangements and decisions have affected the delivery of the clinical audit programme, compared to previous years.	Board (via Chief Officers Group)

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
<u>Item from terms of reference</u>	<u>State which agenda item achieved this</u>
Governance, risk management and internal control (in part, by overseeing the work of the Quality Governance Committee)	Draft annual governance statement Draft annual report and quality account 2018/19 Clinical audit performance update Tendering for internal audit service – timetable and plan
Internal Audit	2018/19 Annual Internal Audit Report and Head of Internal Audit Opinion Internal audit report – agency bookings Internal audit report - injury cost recovery scheme

	arrangements Internal audit report – Data Security & Protection Toolkit Compliance
External Audit	External Audit Progress Report
Raising concerns	
Anti-fraud	Counter fraud work plan 2019/20 and risk assessment Counter fraud annual report 2018/19 and draft self review toolkit Changes to NHS Counter Fraud Authority Standards for Providers for 2019/20
Other assurance functions	
Financial reporting	Losses and special payments Debt write-offs Waivers of standing orders/SFis

MEETING CYCLE: Achieved for this month: Yes / No

Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.

Item from meeting cycle	Reason for not taking item

		Feb 19	Apr 19	May 19	Jul 19	Oct 19	Jan 19
Was the meeting quorate?		✓	✓				
Jerry Gould	Chair		✓				
David Poynton	Chair	✓					
Barbara Beal	Member	X	X				
Ian Buckley	Member	✓	X				
Ed Macalister Smith	Member	X	✓				
Jenny Mawby Groom	Attendee		✓				
Su Rollason	Attendee	X	✓				
Geoff Stokes	Attendee	✓	✓				

**REPORT TO TRUST BOARD
HELD ON 30 MAY 2019**

Quality Governance Committee Report following the meeting held on 15 April 2019
Chair of the Committee: Ed Macalister-Smith
Was this meeting quorate: Yes
Purpose: This report is to provide assurance that Quality Governance Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to RECEIVE ASSURANCE from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
<u>Key Issue discussed</u>	<u>Resolution or outcome of discussion</u>
CQC action plan	The Committee reviewed the action plan and discussed the plan to introduce a self-assessment approach of Groups' own areas for readiness.
Clinical harm review	The clinical harm database was demonstrated and the committee was Impressed with its functionality and usefulness to keep track of the impact of delays in decision making and follow up. The Committee felt it was important to protect the intellectual property
Maternity	The Committee received a comprehensive report from the Head of Midwifery. This will be regularly updated on its way to being presented at the Board.
Patient Experience & Engagement Committee	Concern was expressed that PEEC had not been quorate for several meetings and asked Chief Officer to review attendance.
Integrated Quality, Performance and Finance Report (including Flash Report)	Good improvement was noted in key safety measures, e.g. HSMR and crude mortality rates, infection control, continued reporting of zero 52 week waits and reduction in referral to treatment times.

ITEMS FOR ESCALATION, WHY AND TO WHERE
None

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
<u>Item from terms of reference</u>	<u>State which agenda item achieved this</u>
Providing a forum for scrutiny of any of the Trust's quality indicators or priorities at the request of the Board.	Integrated Quality, Performance and Finance Report (including Flash Report) Quality Schedule Quality Account priorities update
Providing assurance to the Board that arrangements are in place for identifying, prioritising and managing risk and that risks are escalated to the Board as appropriate.	Risk Committee report Internal audit repots – agency booking process Internal audit repots – Data Security and Protection toolkit Quality Impact Assessment reporti
Promoting safety, quality and excellence in patient care	Update on CQC action plan Quality and Safety Trigger Tool report Maternity report

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
	Medical examiner/Coroner's report
Ensuring the effective and efficient use of resources through evidence-based clinical practice	Strategic Workforce Committee report
Protecting the safety of employees and all others to whom the Trust owes a duty of care	
Ensuring that effective systems and processes are in place to support high quality care through an effectual training and education and ICT infrastructure	
Ensuring that the Health and Safety Committee has an overarching view of health and safety and provide assurance that non-clinical risks are effectively managed on behalf of the organisation.	
Other	Information Governance Committee report

MEETING CYCLE: Achieved for this month: Yes
Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.

ATTENDANCE LOG													
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Was the meeting quorate?		Y	Y	Y	Y								
Ed Macalister-Smith	Chair	✓	X	Y	Y								
Barbara Beal	Member	✓	✓	X	X								
Brenda Sheils	Member	✓	✓	✓	✓								
Richard de Boer	Member	✓	✓	✓	X								
Lisa Kelly	Member	X	Y	X	✓								
Sudhesh Kumar	Member	X	Y	X	✓								
Karen Martin	Member	✓	✓	X	X								
Nina Morgan	Member	✓	✓	✓	✓								

**REPORT TO TRUST BOARD
HELD ON 30 May 2019**

Quality Governance Committee Report following the meeting held on 23 May 2019
Chair of the Committee: Ed Macalister-Smith
Was this meeting quorate: Yes
Purpose: This report is to provide assurance that Quality Governance Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to RECEIVE ASSURANCE from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
<u>Key Issue discussed</u>	<u>Resolution or outcome of discussion</u>
Integrated Quality, Performance and Finance Report. Complaints Update.	The Committee heard of a change in definition for the CDiff indicator which widens the cases captured by this measure. The Trust is making greater use of Rugby St Cross with bed occupancy now at 93% and the number of night-time transfers much reduced. This is directly due to decisions taken to, amongst other things, appoint a Rugby St Cross site manager. The Committee discussed the issue relating to stranded patients, especially in understanding the impact on patients and the areas in which the Trust can actively place patients in more appropriate settings than an acute hospital.
Complaints update	A verbal update was given to the Committee on actions being undertaken to change the process for managing complaints. These include trialling of a 'big event' to aim to close a number of complaints in a dedicated session with relevant clinicians and other group staff involved and having a weekly huddle with clinical group representatives to provide focus.
CQC Action Plan Update	Progress continues for the next CQC inspection which is now imminent. The Committee heard of increasing engagement by clinical groups in taking ownership of the actions in their areas, but more importantly in ensuring that they view their clinical areas with a critical eye through the Patient Ready Report.
Forward work programme	The Committee reviewed the next three agendas in order to limit agenda size and enable more in depth discussions.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
<u>Item or issue</u>	<u>Purpose for escalation</u>	<u>Escalated to</u>
Utilisation of Rugby St Cross	Celebrate success	Board

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
<u>Item from terms of reference</u>	<u>State which agenda item achieved this</u>
Providing a forum for scrutiny of any of the Trust's quality indicators or priorities at the request of the Board.	Integrated Quality, Performance and Finance Report. Complaints Update. Quality Account.
Providing assurance to the Board that arrangements are in place for identifying, prioritising and managing risk and that risks are escalated to the Board as appropriate.	

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
<u>Item from terms of reference</u>	<u>State which agenda item achieved this</u>
Promoting safety, quality and excellence in patient care	CQC Action Plan – Update. Patient Safety & Clinical Effectiveness Committee (PSEC).
Ensuring the effective and efficient use of resources through evidence-based clinical practice	
Protecting the safety of employees and all others to whom the Trust owes a duty of care	
Ensuring that effective systems and processes are in place to support high quality care through an effectual training and education and ICT infrastructure	IG Committee Report.
Ensuring that the Health and Safety Committee has an overarching view of health and safety and provide assurance that non-clinical risks are effectively managed on behalf of the organisation.	
Other	Forward work programme

MEETING CYCLE: Achieved for this month: Yes	
Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.	
<u>Item from meeting cycle</u>	<u>Reason for not taking item</u>
Deep Dive: National Patient Survey (Update)	Mis-communication about intention and purpose for the item led to lack of preparedness to address the item.

ATTENDANCE LOG													
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Was the meeting quorate?		Yes	Yes	Yes	Yes	Yes							
Ed Macalister-Smith	Chair	✓	N	✓	✓	✓							
Barbara Beal	Member	✓	✓	N	N								
Brenda Shiels	Member	✓	✓	✓	✓	✓							
Richard de Boer	Member	✓	✓	✓	N	✓							
Lisa Kelly	Member	N	✓	N	✓	N							
Sudhesh Kumar	Member	N	✓	N	Y	N							
Karen Martin	Member	✓	✓	N	N	N							
Nina Morgan	Member	✓	✓	✓	✓	✓							

**REPORT TO TRUST BOARD
HELD ON 30 May 2019**

Finance and Performance Committee Report following the meeting held on 30 April 2019 (NB March meeting cancelled)
Chair of the Committee: Ian Buckley
Was this meeting quorate: Yes
Purpose: This report is to provide assurance that Finance and Performance Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to RECEIVE ASSURANCE from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
<u>Key Issue discussed</u>	<u>Resolution or outcome of discussion</u>
Integrated Finance Report (Including flash report)	The Committee noted that the reporting cycle has now changed and should enable escalation to Board rather than delegation from Board.
Research and Development Income and Expenditure	Discussion about the potential for commercial exploitation of research and development activities.
4-Hour Urgent Care Update	Concern raised about the continuing poor performance to deliver the 4 hour target and the perception that there is system support needed.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
<u>Item or issue</u>	<u>Purpose for escalation</u>	<u>Escalated to</u>
ED 4 hour performance	Raise concerns about need for system support in solving the 'front door' problem	Board

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
<u>Item from terms of reference</u>	<u>State which agenda item achieved this</u>
Monitoring monthly income and expenditure variance to provide assurance to the Board and escalate any emerging issues of concern	Integrated Finance Report (Including flash report)
Monitoring delivery of key access targets and operational delivery plans to provide assurance to the Board and escalate any emerging issues of concern.	Referral to Treatment (RTT) Update 4-Hour Urgent Care Update
Providing a forum for scrutiny of any of the Trust's performance indicators at the request of the Board, referring any potential impact on quality to the Quality Governance Committee.	Integrated Finance Report (Including flash report)
Reviewing the performance management arrangements for each Group, scrutinising the arrangements in place to meet financial and operational targets.	Hospital Pharmacy Transformation Plan Procurement Transformation Plan Research and Development Income and Expenditure

Reviewing the performance of Service Providers within the PFI contract.	
Providing effective oversight of all major capital and development projects including associated risks with the projects.	
Ensuring adequacy of the Trust's Strategic Financial Planning	
Other	Sustainable Development Group update

MEETING CYCLE: Achieved for this month: Yes / No

Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.

Item from meeting cycle	Reason for not taking item
March meeting cancelled	Meeting would have been inquorate

ATTENDANCE LOG													
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Was the meeting quorate?		Yes	Yes	Meeting cancelled	Yes								
Ian Buckley	Chair	✓	✓		✓								
Karen Martin	Member	✓	✓		✓								
Lisa Kelly	Member	✓	✓		X								
Su Rollason	Member	✓	X		✓								
David Poynton	Member	✓	✓										
Jerry Gould	Attendee	✓	X		✓								
Jenny Mawby-Groom	Attendee	✓	X		✓								

**REPORT TO TRUST BOARD
HELD ON 30 MAY 2019**

Finance and Performance Committee Report following the meeting held on 23 May 2019
Chair of the Committee: Ian Buckley
Was this meeting quorate: Yes
Purpose: This report is to provide assurance that Finance and Performance Committee has formally constituted its duties in accordance with the terms of reference and to advise of the business transacted.
Recommendation: The Board is asked to RECEIVE ASSURANCE from the business discussed at the meeting and to raise any questions in relation to the same.

KEY HIGHLIGHTS OF DISCUSSION HELD DURING MEETING	
<u>Key Issue discussed</u>	<u>Resolution or outcome of discussion</u>
Integrated Finance Report (Month 1) 2019/20.	A demonstration of Greenhouse, the new Trust system to track projects and which will be used to track the Waste Production Programme was given which gave the Committee assurance of the relevant level of granularity in tracking.
Integrated Quality, Performance & Finance Report	The Committee heard of some concerns raised about the impact that the current pensions issue is causing to operations and the ability to tackle extra work at weekend etc.
Referral to Treatment (RTT) Update.	Reviewing speciality performance has identified some issues that will inform the focus of the waste reduction scheme on theatre performance.

ITEMS FOR ESCALATION, WHY AND TO WHERE		
<u>Item or issue</u>	<u>Purpose for escalation</u>	<u>Escalated to</u>

TERMS OF REFERENCE: Did the meeting agenda achieve the delegated duties?	
<u>Item from terms of reference</u>	<u>State which agenda item achieved this</u>
Monitoring monthly income and expenditure variance to provide assurance to the Board and escalate any emerging issues of concern	Integrated Finance Report (Month 1) 2019/20.
Monitoring delivery of key access targets and operational delivery plans to provide assurance to the Board and escalate any emerging issues of concern.	Referral to Treatment (RTT) Update. 4-hour Urgent Care Update.
Providing a forum for scrutiny of any of the Trust's performance indicators at the request of the Board, referring any potential impact on quality to the Quality Governance Committee.	Integrated Quality, Performance & Finance Report (Month 1) 2019/20.
Reviewing the performance management arrangements for each Group, scrutinising the arrangements in place to meet financial and operational targets.	Efficiency and capacity within Groups - Update on issues and required improvements. UHCW Performance Benchmarking Report.
Reviewing the performance of Service Providers within the PFI contract.	PFI Liaison Committee.
Providing effective oversight of all major capital and development projects including associated risks with	

the projects.	
Ensuring adequacy of the Trust's Strategic Financial Planning	
Other	2018/19 National Cost Collection. Workforce Information Report Q4 2018/19.

MEETING CYCLE: Achieved for this month: Yes / No	
Reference any items that were not taken at this meeting, explaining why and when it has been rescheduled.	
Item from meeting cycle	Reason for not taking item

ATTENDANCE LOG													
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Was the meeting quorate?		Yes	Yes	Meeting cancelled	Yes	No							
Ian Buckley	Chair	✓	✓		✓	✓							
Karen Martin	Member	✓	✓		✓	X							
Lisa Kelly	Member	✓	✓		X	X							
Su Rollason	Member	✓	X		✓	✓							
David Poynton	Member	✓	✓										
Jerry Gould	Attendee	✓	X		✓	✓							
Jenny Mawby-Groom	Attendee	✓	X		✓	✓							